MetroPulse provider newsletter

FALL 2018

For additional articles and more information, view our expanded newsletter at:
https://www.metroplus.org/provider-services/news-communications

NEW OUTPATIENT DIAGNOSTIC CENTER AT CONEY ISLAND

NYC Health + Hospitals Coney Island has opened an Outpatient Diagnostic Center / Women's Health imaging suite that offers the most advanced services and equipment available today. They include:

- **GE 3D mammography unit, the Senographe Pristina:** allows radiologists to see breast tissue details more clearly, uncovering cancers that may have otherwise escaped detection.
- **Hologic bone densitometry (DEXA) / Osteoporosis scanning unit:** an enhanced form of x-ray technology that can detect early stages of osteoporosis, improve the identification of certain spinal column fractures, and identify predictors of cardiovascular disease.
- **Henry Schein panorex unit:** allows x-rays to be taken of jawbones, using digital radiography that reduces exposure to harmful radiation.
- **Philips ultrasound unit:** uses high-frequency sound waves to capture images for a range of purposes, including ultrasound-guided biopsies.

For more information, call **718.616.3737**.

NOVEMBER IS DIABETES MONTH!

SEASONAL FLU SHOTS

This year marks the 100th anniversary of the 1918 Flu Pandemic, a sobering reminder of how deadly influenza could be in the days before antibiotics and vaccines. Medicine offers more protection today — but only if patients get their annual flu shot. Autumn, which marks the onset of the influenza season, is the optimal time for injections to be administered.

Vaccination is recommended for everyone over six months old. Children between six and 59 months, adults over 50, and pregnant women are among the high-risk groups, as are their caregivers or those who come in frequent contact with them. For 2018–19, there are three different types of age-appropriate influenza vaccine: IIV, RIV4, or LAIV4.

HYPERTENSION MANAGEMENT

High blood pressure (BP) should be treated earlier with lifestyle changes and in some patients with medication — at 130/80 mm Hg rather than 140/90 — based on new American College of Cardiology / American Heart Association guidelines for the detection, prevention, management and treatment of hypertension. The new guidelines — the first comprehensive set since 2003 — lower the definition of high blood pressure, which will in nearly half of the U.S. adult population (46%) being diagnosed with it. Prevalence is expected to triple among men under age 45, and double among women under 45.

It is critical that health care providers follow the standards for accurate BP measurement. The new BP categories are:

- Normal: Less than 120/80 mm Hg
- Elevated: Systolic between 120 – 29 and diastolic less than 80
- Stage 1: Systolic between 130 – 139 or diastolic between 80 – 89
- Stage 2: Systolic at least 140 or diastolic at least 90 mm Hg
- Hypertensive crisis: Systolic over 180 and/or diastolic over 120, with patients needing prompt changes in medication if there are no other indications of problems, or immediate hospitalization if there are signs of organ damage

Basic testing for primary hypertension includes fasting blood glucose, complete blood cell count, lipids, basic metabolic panel, thyroid stimulating hormone, urinalysis, electrocardiogram with optional echocardiogram, uric acid, and urinary albumin-to-creatinine ratio.

Nonpharmacologic effort to reduce BP remain the preferred first approach. They include: weight loss for overweight or obese patients with a heart-healthy diet (low in sodium and fat; high in fruits, vegetables, and grains), sodium restriction, and potassium supplementation within the diet, plus increased physical activity with a structured exercise program. Men should be limited to no more than two, and women no more than one, alcoholic drinks per day.

Despite the rise in the prevalence of high BP, only a small increase is expected in the number of adults requiring antihypertensive medication. The new guidelines recommend only prescribing medication for Stage I hypertension if a patient has already had a cardiovascular event such as a heart attack or stroke, or is at high risk of heart attack or stroke based on age, the presence of diabetes mellitus, chronic kidney disease or calculation of atherosclerotic risk. Chlorthalidone (12.5 – 25 mg) is the preferred diuretic because of long half-life and proven reduction of CVD risk. Spironolactone or eplerenone is preferred for the treatment of primary aldosteronism and in resistant hypertension. Initial first-line therapy for stage 1 hypertension includes thiazide diuretics, CCBs, and ACE inhibitors or ARBs.

The new guidelines also call for recognizing that many people will need two or more types of medications to control their blood pressure, and it's best if these are combined into a single pill. Socioeconomic status and psychosocial stress should be recognized as risk factors for high blood pressure that should be considered in a patient's plan of care.

VIRAL LOAD SUPPRESSION (HIV UNDETECTABLE = UNTRANSMITTABLE)

If taken as directed, HIV medication — also known as **Anti-Retroviral Therapy (ART)** — reduces the amount of HIV in the body to a level that is difficult to detect in blood with the current technology. People that are in ART and have undetectable viral load eliminate the risk of sexual transmission of HIV. Most patients will achieve an undetectable viral load within six months of starting ART.

The strategy of HIV treatment as prevention has transformed the HIV prevention landscape. Over the past two years, a grassroots movement has emerged to promote the value of HIV treatment as prevention through the "Undetectable = Untransmittable" campaign, also known as U=U. Local milestones include:

- In August 2016, the New York City (NYC) Health Department signed a consensus statement affirming that people with HIV who have maintained an undetectable viral load for at least six months do not sexually transmit HIV.
- In September 2017, the New York State Department of Health agreed with this finding.

The U = U campaign not only promotes the HIV treatment as an effective way to prevent HIV transmission but is also a powerful tool to reduce the stigma and social isolation of HIV patients. Patients who feel empowered by the fact that they cannot transmit HIV to their sexual partners if they maintain an undetectable viral load can feel encouraged to achieve and maintain an undetectable state and increase social interaction with others.

An undetectable viral load is essential for the Undetectable = Untransmittable HIV prevention strategy to be effective. So it's important to remember that even when the viral load is undetectable, HIV is still present in the body, and the virus rebounds to detectable levels if treatment is stopped. Also, ART does not prevent the transmission of other sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or hepatitis B and C; therefore, it is essential to educate patients about the use of condoms to prevent those infections.

Taking ART as prescribed is the best way to achieve and maintain an undetectable viral load and to ensure that people with HIV have effectively no risk of transmitting the virus to their HIV-negative sexual partners.

DENTAL CARE FOR CHILDREN AND ADULTS

Ranging from cavities to cancer, oral diseases cause pain and disability for millions of Americans each year, and can often be a sign of illness elsewhere in the body. Yet many problems can be treated with simple measures, or prevented outright by good dental hygiene. Encourage members to have regular check-ups and to consult a provider if they're experiencing pain or difficulties. For any questions related to dental benefits, contact **Healthplex** at **800.468.9868**.

BREAST CANCER SCREENINGS

The latest statistics from the Centers for Disease Control and Prevention show that death rates from breast cancer among all women in the 50 to 74 age group decreased 15.1% from 2006 to 2016. Early detection plays a pivotal role in the treatment of breast cancer. For that reason, women 50 to 74 years old should receive a mammogram every two years, per HEDIS guidelines. Please remember to reach out to patients who might be due for this procedure, reminding them to schedule their mammogram.

OFFICE WAITING TIME STANDARDS

It's important to remember that excessive office waiting time significantly affects members' overall satisfaction with both the provider and the health plan. Please follow these standards, which are listed in our MetroPlus *Provider Manual* under "Office Waiting Time Standards":

- **Waiting room times must not exceed one (1) hour for scheduled appointments. Best practice is to let the patient know they can expect to wait an hour. Everybody is busy and waiting an hour with no communication will lead to dissatisfied patients!**
- **Members who walk in with urgent needs are expected to be seen within one (1) hour.**
- **Members who walk in with non-urgent "sick" needs are expected to be seen within two hours or must be scheduled for an appointment to be seen within 48 to 72 hours, as clinically indicated.**

DATA COLLECTION

MetroPlus Health Plan collects data from providers that support quality measures included in HEDIS/QARR reporting, MetroPlus Pay-for-Performance (P4P) Program and Value-Based Payment (VBP) Contracts. To ensure your scores are as accurate as possible, MetroPlus collects the following information during the timeframes specified below:

Data Collection	Timeline	Purpose and Request
Claims Data	**January 2018 – February 2019**	Claims should be submitted immediately following the rendering of services and will be applied to your quality performance if they are received before February of the reporting year and are appropriately coded. We strongly recommend that you review the HEDIS/QARR Reference Guide and Coding Sheet to ensure the services you performed will be captured as per HEDIS specifications. *Go to https://www.metroplus.org/provider-services/tools for the reference guide and code sheet*
Encounter Files	**January 2018 – February 2019**	Encounter files are accepted for all measures **throughout the measurement year and into the beginning of the reporting year** to account for claims that have run out. While you may submit encounter files for any measure, we strongly recommend prioritizing non-hybrid measures when submitting encounters. You may email us at QMOPHEDIS4@metroplus.org if you would like information on how to submit encounter files.
Supplemental Files	**January 2018 – February 2019**	Supplemental files that are electronically extracted from your Electronic Medical Record (EMR) or billing system are accepted throughout the measurement year and into the beginning of the reporting year. You may email us at QMOPHEDIS4@metroplus.org if you would like information on how to submit supplemental files.
Supplemental Record Review	**January 2018 – February 2019**	MetroPlus collects medical record documentation for selected measures to supplement administrative claims and encounter data included in quality performance. The format can be PDF or image and may include the entire medical record or a portion of it. MetroPlus will mail medical record requests to providers in **October 2018**.
Hybrid Record Review	**January 2019 – May 2019**	Hybrid measures are reported using a **sample** of about **411** members across the Plan's entire provider network for each product line. Once the sample selection is drawn for each hybrid measure, medical record requests for documentation of services will be mailed to providers in **February 2019**.

REMINDER: QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

- Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.)
- The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost sharing, including deductibles, coinsurance, and copays.
- Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost sharing payments, under certain circumstances.
- Persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost sharing.

CERVICAL CANCER SCREENING

This past August, the U.S. Preventive Services Task Force (USPSTF) announced updates to its cervical cancer screening guidelines. USPSTF recommendations now include three options for women and their healthcare providers for cervical cancer screening tests.

The major change: For women between the ages of 30 and 65, the USPSTF now recommends screening every five years with a high-risk human papillomavirus test (hrHPV) as an alternative to screening every three years with a Pap smear. Or, women can opt for a hybrid, hrHPV and Pap co-testing, every five years. The HPV test detects the presence of the human papillomavirus, which causes 99% of cervical cancer cases; the Pap smear detects the presence of abnormal cells that can indicate cervical cancer or the danger of developing it.

Women aged 21 to 29 should still get a Pap smear every three years. The USPSTF recommends against screening for women under 21 or over 65, as well as women who have had a hysterectomy.

The number of deaths from cervical cancer in the United States has decreased substantially since the implementation of widespread screening in the 1950s – by 80%, in fact. The mortality rate has declined from 2.8 per 100,000 women in 2000 to 2.3 deaths per 100,000 women in 2015 alone. Let's keep the trend going. Metroplus has a Quality Improvement Project (QIP) currently in place to improve screening rates. Please continue outreach to members who may not have been adequately screened – the group for whom cervical cancer proves most fatal.

ADOLESCENT WELL CARE VISIT RECOMMENDATIONS AND DOCUMENTATION

MetroPlus uses Bright Futures as its cornerstone for clinical recommendations for delivering care to adolescents. Bright Futures specializes in prevention and health promotion for children and young adults, with a strong set of Adolescence Tools to support and guide providers.

The core tools, available in both English and Spanish, are broken down into three age groups (11–14 years old, 15–17 years old, and 18–21 years old). They consist of:

- **Pre-visit Questionnaires:** to determine what the family or adolescent would like to discuss during the visit, assist in initiating recommended medical screening for integrating risk assessment questions, and aid in obtaining development surveillance information.
- **Visit Documentation Forms:** to provide a convenient resource to document activities during a typical health supervision visit, simplify proper coding, and help secure appropriate payment for each visit's activities.
- **Parent/Patient Education Handouts:** to summarize Bright Futures anticipatory guidance, written for readers with limited literacy skills.

In addition, the Bright Futures toolkit includes Medical Screening Reference Tables for Clinicians – user-friendly MSR tables to compile history, risk-assessment questions and actions to take. There are also supplemental and medical-screening questionnaires specific to different age groups.

To see these materials and learn more about Bright Future, please visit https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/adolescence-tools.aspx.

BEHAVIORAL HEALTH / BEACON

Beacon Health Options is partnering with MetroPlus to administer behavioral health benefits, as well as to develop and maintain the network of behavioral health providers.

Beacon's system is built on a strong support structure of doctors, nurses, advocates, and mentors. It is equipped to deal with a range of issues: substance use/abuse, autism, eating disorders, mental health (both inpatient and outpatient), Attention-Deficit/Hyperactivity Disorder (ADHD) and workforce performance. More than 80% of Beacon's leadership has first-hand experience with mental health and substance use disorders, either personally or with a loved one. So the firm's expertise is not just clinical or academic, but real-life.

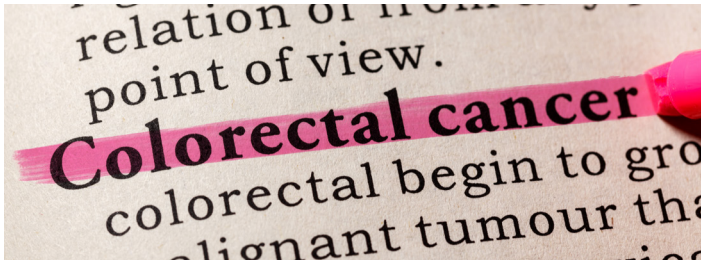
Primary care settings are the first line of identification for behavioral health (BH) issues, especially depression, and Beacon supports primary care providers as the locus of treatment. Its online toolkit (pcptoolkit.beaconhealthoptions.com) can help with identification of BH conditions, as well as next steps in treatment. Whenever possible it encourages the integration of mental and substance disorders treatment with primary care. Delivering mental health services in primary care settings reduces stigma and discrimination, is cost-effective, and enables patients to remain in the community.

However, should treatment at a facility prove necessary, Beacon supports primary care providers with education on member engagement after inpatient discharge, specifically outlining various post-discharge techniques such as medication reconciliation and discharge planning review. The member's primary care provider will be notified of a member's inpatient hospital stay either by the discharging facility and/or a MetroPlus nurse care manager. Once notified, MetroPlus will work with the provider to ensure a visit is scheduled and the appropriate actions are carried out.

For more information about Beacon and its services, call **855.371.9228** or go to: www.beaconhealthoptions.com.

COLORECTAL CANCER SCREENING

Colorectal cancer (CRC) is the third most common malignant neoplasm worldwide and the second leading cause of cancer deaths in men and women combined in the United States. For the great majority of people, the major factor that increases the risk for colorectal cancer (CRC) is increasing age: The risk of CRC begins to increase after the age of 40 years and rises sharply at ages 50 to 55 years.



For the past 20 years, the CRC mortality rate has been declining in both men and women; however, the decline is sharper in caucasians than in other ethnicities. Psychosocial factors and racial disparities had been identified as a possible explanation of the differences in the divergent trend. As with cancer in general, early detection is key. The U.S. Preventive Services Task Force recommends screening for colorectal cancer start at age 50 and continue until 75 years; the decision to screen older adults should be an individual one, considering the patient's overall health and screening history.

Primary care providers play a crucial role in the screening process. Unfortunately, many providers don't recommend screening at all, or they don't recommend the right test at the right time for a specific patient. They don't help patients understand why or when they need to be screened. They may fail to alleviate patients' fears about the process needed to prepare for the procedure or qualms about its embarrassing or intrusive nature.

But providers can increase CRC screening among their patients. Among the steps they can take:

- set up standard reminders in patient charts or electronic medical records
- send personalized letters or make phone calls to patients
- provide screening on site so patients don't have to go to a strange place
- offer individualized instructions in preparation for the procedure
- ensure continuity of care throughout the process
- discuss all the available CRC screening options with your patients

Research has shown that screening rates will go up when providers and health systems that make CRC screening part of routine patient care. The best test is the one that a patient receives.

Access and Availability Standards

MetroPlus Members must secure appointments within the following time guidelines:

Emergency Care	Immediately upon presentation
Urgent Medical or Behavioral Problem	Within 24 hours of request
Non-Urgent "Sick" Visit	Within 48 to 72 hours of request, or as clinically indicated
Routine Non-Urgent, Preventive or Well Child Care	Within 4 weeks of request
Adult Baseline or Routine Physical	Within 12 weeks of enrollment
Initial PCP Office Visit (Newborns)	Within 2 weeks of hospital discharge
Adult Baseline or Routine Physical for HIV SNP Members	Within 4 weeks of enrollment
Initial Newborn Visit for HIV SNP Members	Within 48 hours of hospital discharge
Initial Family Planning Visit	Within 2 weeks of request
Initial Prenatal Visit 1st Trimester	Within 3 weeks of request
Initial Prenatal Visit 2nd Trimester	Within 2 weeks of request
Initial Prenatal Visit 3rd Trimester	Within 1 week of request
In-Plan Behavioral Health or Substance Abuse Follow-up Visit (Pursuant to Emergency or Hospital Discharge)	Within 5 days of request, or as clinically indicated
In-Plan Non-Urgent Behavioral Health Visit	Within 2 weeks of request
Specialist Referrals (Non-Urgent)	Within 4 to 6 weeks of request
Health Assessments of Ability to Work	Within 10 calendar days of request

MetroPlus Health Plan
plan ahead.
METROPLUS.ORG 1.855.809.4073
160 Water Street, 3rd Floor, New York, NY 10038

CHANGES TO YOUR DEMOGRAPHIC INFORMATION

Notify MetroPlus of any changes to your demographic information (address, phone number, etc.) by directly contacting your Provider Service Representative. You should also notify us if you leave your practice or join a new one. Alternatively, changes can be faxed in writing on office letterhead directly to MetroPlus at **212.908.8885**, or by calling **1.800.303.9626**.

METROPLUS COMPLIANCE HOTLINE

MetroPlus has its own Compliance Hotline: **1.888.245.7247**. Call this line to report suspected fraud or abuse, possibly illegal or unethical activities, or any questionable activity. You may choose to give your name or you may report anonymously.

SERVING NEW YORKERS FOR OVER 30 YEARS

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Editor: Elizabeth Colombo