MetroPulse provider newsletter

SPRING 2020

AVOIDANCE OF ANTIBIOTICS

Antibiotic resistance is rising to dangerously high levels, caused in part by overprescribing antibiotics. It is crucial that providers prescribe antibiotics only when necessary for a patient's condition.

During the winter season, patients often specifically request antibiotics for things like cold, flu, or other illnesses that cannot be treated by antibiotics. Providers should explain to patients that these treatments would be ineffective and expose them to unnecessary side effects.

You can also utilize "Watchful Waiting" and "Delayed Prescribing" in situations where a patient is unlikely to need antibiotics:

- **Watchful Waiting** instructs patients to rest, drink fluids, and try other methods to recover from their illness. If they are still ill after a set period, instruct them to call your office for a prescription or a second visit.
- **Delayed Prescribing** instructs patients to wait before filling their antibiotic prescription, in order to see if they recover on their own. Delayed Prescribing is helpful for patients who cannot make multiple appointments.

Provider offices are routinely monitored for the appropriate testing of children with pharyngitis. Unfortunately, quality monitoring of our providers still reveals the unnecessary prescribing of antibiotics. Good care calls for performing a rapid strep test or throat culture before prescribing an antibiotic. There are ways to improve your office's use of testing of children with pharyngitis:

- **Offer** your staff training on the best ways to communicate with patients regarding expectations about antibiotic use.
- **Utilize** patient handouts (see below for a link) to explain bronchitis symptoms and treatments.
- **Implement** EMR systems that have decision-support tools that help facilities track and monitor inappropriate prescribing.

For more information, including handouts for patients explaining about antibiotics, antibiotic resistance, watchful waiting and delayed prescribing, visit https://www.cdc.gov/antibiotic-use/

IN-NETWORK LAB USAGE

MetroPlus would like to remind providers that you should refer your MetroPlus patients to in-network labs. This will ensure members will not be billed for out-of-network services.

To check if a lab is in-network, you can use the "Find a Doctor" page on our website, check an online provider directory, or call Member Services.

MEDICATION MONITORING AND ADHERENCE RECOMMENDATIONS

Some of the most common chronic conditions — pain, heart disease, stroke, high blood pressure, pulmonary conditions, mental health disorders — can be controlled or improved with medication, if taken on a precise, regular schedule. Yet an alarming number of patients fail to take their medicine as prescribed — a practice called "non-adherence" or "non-compliance." This can lead to preventable consequences, including worsening of disease, shorter lives and sudden death. Up to one-half of all patients in the U.S. do not take their medications as prescribed by their doctors.

Poor medication adherence is responsible for avoidable hospital admissions, and 33 to 69 percent of all medication-related hospital admissions in the U.S., costing about $100 billion per year.

STRATEGIES FOR IMPROVING ADHERENCE

PCPs and specialists should always look for signs of poor adherence in their patients. Clinicians can enhance adherence by emphasizing the value of the patient's regimen, making the regimen simple, and customizing the regimen to the patient's lifestyle. If possible, try to decrease the number of medications a patient is taking. Focus on educating the patient on why continuing to take their medications as directed is important.

For more information about medication adherence, visit these resources:

- National Conference of State Legislatures
- The Role of Medication Adherence in the US Healthcare System

The finding that adherence declines with time suggests that patients may need some periodic reinforcement of the message that their medication is important and beneficial. For example, after 3 months of treatment a patient is likely to be in remission, but the risk of non-adherence begins to rise. It may pay to contact the patient after 90 days and reinforce the message that continuing with treatment is beneficial to their health.

STATIN THERAPY FOR ACD PREVENTION

As part of our ongoing statin initiative, MetroPlus has reached out to members to discuss the importance of taking their statin medication and reporting any side effects to their providers. Members are also reminded about 90-day-fills, mail order program, and/or PillPack (home delivery) through educational materials.

One of the major barriers to medication adherence for these members is that they are not prescribed the appropriate moderate or high intensity statin that they need. If your patient is over 21 years old and falls into one of the categories below, consider prescribing them a moderate or high-intensity statin.

Moderate Intensity	High Intensity
If the patient is diagnosed with clinical atherosclerotic cardiovascular disease, 75 years old or younger, and not a candidate for a high-intensity statin	If the patient is diagnosed with clinical atherosclerotic cardiovascular disease, 75 years old or younger, and a candidate for a high-intensity statin
If the patient is diagnosed with Type 1 or 2 Diabetes, between ages 40 – 75, and has an estimated 10-year atherosclerotic CVD risk of less than 7.5%.	If the patient is diagnosed with Type 1 or 2 Diabetes, between ages 40 – 75, and has an estimated 10-year atherosclerotic CVD risk of 7.5% or higher.
If the patient is between ages 40 – 75 and has an estimated 10-year atherosclerotic CVD risk higher than 7.5%	If the patient is between ages 40 – 75, and has an estimated 10-year atherosclerotic CVD risk higher than 7.5%
If the patient is between ages 40-75 and has an estimated 10-year atherosclerotic CVD risk between 5-7.5%, and LDL > 160 mg/dl, family history, hs CRP > 2, CAC>300 or 75%, ABI < .9, or high lifetime risk	If the patient has LDL-C ≥ 190 mg/dl

Click here for more information.

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

By the time a child is 15 months old, they should have attended at least six comprehensive well-child visits with their PCP. The acceptable time frame for the visits includes newborn, as well as 1, 2, 4, 6, 9, 12, and 15 months. The visits must also be at least 14 days apart.

At this early age, it is especially crucial to follow best practices for documentation of visits. The child's medical record should include:

- **Health history** – history of disease or illness; can include past illness, surgery or hospitalization, and family health history
- **Physical development history** – physical developmental milestones and progress with developing skills needed to become a healthy child
- **Mental development history** – Assessment of mental developmental milestones and progress toward developing the skills needed to become a healthy child
- **Physical exam** – Comprehensive head to toe exam with vital signs and assessment of at least 3 body systems
- **Anticipatory guidance/health education** – information given to parents or guardians to educate them on emerging issues, expectations and things to watch for at the child's age.

TIPS AND RECOMMENDATIONS:

- Make every visit count! Preventive services may be provided on sick visits as well, if coded correctly.
- Use templates that allow you to check off the completion of standard counseling activities.
- Use correct diagnosis and procedure codes.

CODES TO IDENTIFY WELL-CHILD VISITS

CPT	HCPCS	ICD-10
99381 99382 99383	G0438 G0439	Z00.110 Z00.111 Z00.129

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 see patients within 15 minutes of arrival. If there is unavoidable delay in seeing the patient they should be told and updated every 10 minutes. Let the patient know they can expect to wait an hour if that is the case. Everybody is busy and waiting an hour with no communication will lead to dissatisfied patients! Consider calling patients before they arrive to let them know you are running behind and reschedule if needed.
- 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.

HOW PROVIDERS CAN IMPACT SMOKING CESSATION

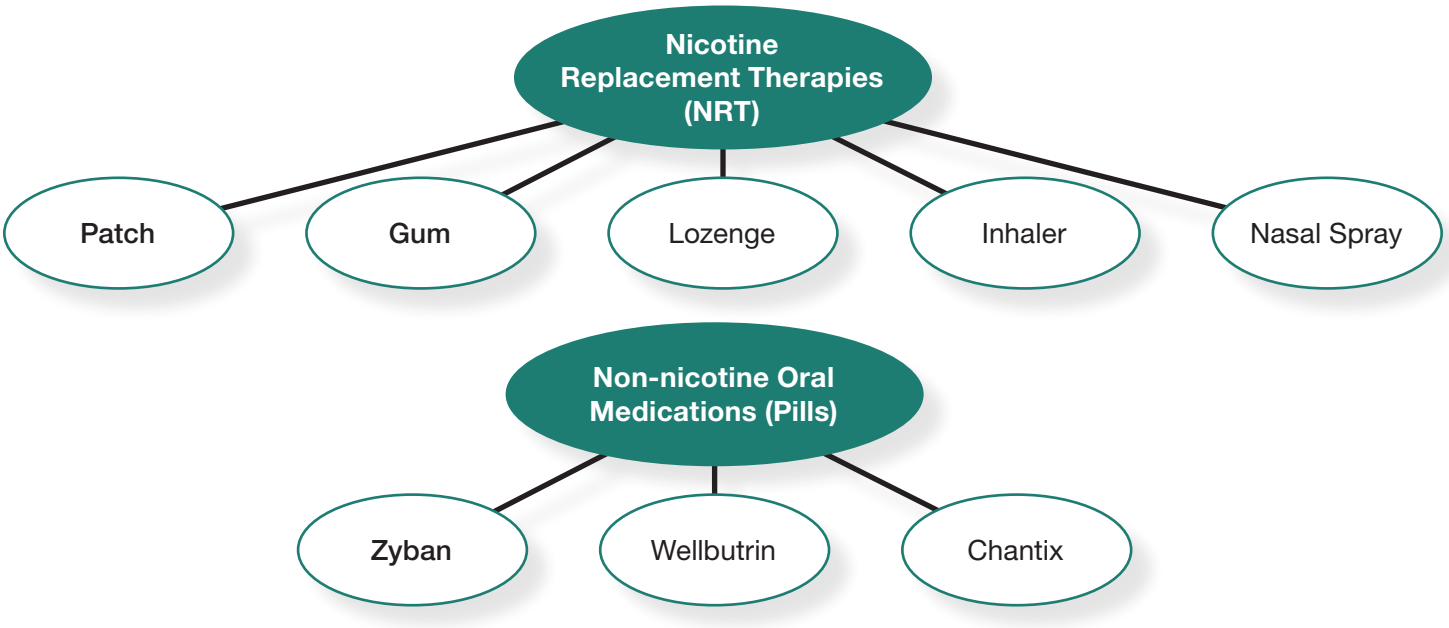
The US Public Health Service has sponsored a Clinical Practice Guideline to encourage best practices for treating tobacco use in patients. Tobacco dependence is a chronic disease, that often requires repeated interventions and multiple quit attempts.

At every appointment, assess your patient for all forms of tobacco use, including vaping (also known as electronic nicotine device system (ENDS). For all patients who use tobacco, follow the 5 A's:

1. **Ask** every patient if they use tobacco
2. **Advise** the patient to quit
3. **Assess** the patient's willingness to make a quit attempt
4. **Assist** the patient in making a quit attempt by providing or referring the patient to counseling and offering medication (if appropriate)
5. **Arrange** for follow-up care in order to prevent relapse.

For pregnant smokers, it is important to encourage them even more strongly to quit because of the potential risks to the fetus. Try asking pregnant women about tobacco use with multiple choice questions, instead of a simple yes/no, as this has been shown to increase the likelihood of disclosure. For more information about the guidelines, click here.

MetroPlus covers smoking/vaping treatments delivered by health care providers, such as:



ENDS USERS CAN RECEIVE NRT COMPARABLE TO TRADITIONAL TOBACCO USERS.

For patients who smoke or vape, have a conversation on the dangers of tobacco and ENDS product use and offer advice on available treatment options with them. We request that you document their tobacco and ENDS product use status, and counsel them to quit. For those willing to make a quit attempt, please offer medication or, encourage them to utilize available resources, such as the New York Smokers' Quitline (866.NY.QUITS), or H+H & NYC Smoking Cessation Programs (click here).

The CPT codes for billing for smoking and tobacco use cessation counseling include:

- **99406** – Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407** – Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Other information is available on the MetroPlus website, including information about programs to help quit, health information, and support services.

TREATING CHRONIC CONDITIONS WITH 90-DAY SUPPLIES

Medication non-adherence is a significant problem for members with chronic conditions. It can lead to ER visits, hospitalizations, and extra tests to treat complications that could have been avoided by taking medication appropriately. There are many reasons for non-adherence, but some of the most common are forgotten doses, late renewals, and missed refills. Sometimes, small changes to a patient's medication regimen can go a long way toward addressing non-adherence.

To help providers improve medication adherence, we've made some changes to our pharmacy benefit. We now offer 90-day fills for most medications used to treat chronic conditions across all MetroPlus plans, so members are less likely to run out of medication. There are no special requirements to use this benefit, just a prescription for a 90-day supply.

Your patients can continue using their usual pharmacy, or, if they would like the convenience of home delivery, we offer mail-order service for certain lines of business.

When medication is delivered to the patient, forgetting to pick up refills is no longer an issue.

If a member has a complicated regimen that is difficult to keep track of, we also offer pill packaging services. With these services, a convenient dispenser will be delivered to your patient's home every month, with all their medications organized in separate packs, labeled with the date and time of each dose. This option simplifies the process of taking the right medication at the right time.

All these benefits are available at no additional cost for MetroPlus members, so consider taking advantage of 90-day prescriptions, mail-order delivery, or pill-packaging services.

LONG ACTING INJECTABLES

Historically, Long Acting Injectable (LAI) formulations of antipsychotic medications have been used for non-adherent patients who have experienced multiple episodes of psychosis. LAIs are generally administered by injection at two to four-week intervals. Current guidelines generally recommend LAI antipsychotics for the maintenance treatment of schizophrenia among other available treatment options and/or when it is necessary to improve adherence to medication.

The availability of new LAIs, which are more well tolerated due to a better side effect profile provides the option of extending such treatment to younger patients in the earlier stages of schizophrenia. This is particularly relevant considering the risk of relapse after discontinuation of treatment and the serious consequences associated with relapse.

Studies have shown that utilization of LAIs improves medication adherence and patient functioning as well as enhancing member tenure in the community and helping to prevent hospitalizations.

CLOZAPINE

MetroPlus is participating in a NY State Office of Mental Health (SOMH) Performance Opportunity Project (POP), that aims to increase the utilization of clozapine to treat clinically appropriate patients diagnosed with schizophrenia who are high utilizers of inpatient and/or emergency services for psychiatric conditions.

Clozapine is a second-generation oral antipsychotic medicine used to treat schizophrenia in patients whose symptoms are not adequately controlled with standard antipsychotic drugs. While it has been demonstrated to be highly effective in treating individuals with treatment resistant schizophrenia, it can cause serious side effects which necessitate close monitoring and collaboration with behavioral health and medical providers.

MEDICARE
MODEL OF CARE

PCPs play a key role in the coordination of care for our Medicare Special Needs Plan (SNP) members. This includes managing and arranging specialty care, ancillary services and maintaining patients' continuity of care. Our SNP (MetroPlus Advantage Plan) coordinates members' medical, social and mental health services. This improves their access to such services and enhances their medical and psychosocial care.

High-risk members are assigned to a Case Manager, who works with the member and the PCP to develop individual care plans based on the member's assessed needs. You will receive copies of your patient's Health Care Plan, and we welcome your input. A Health Risk Assessment, or HRA, is completed by members upon enrollment. If completed, a copy of the HRA will be mailed to the PCP to assist in caring for the member.

The Case Manager may call you from time to time to collaborate on the Plan for your individual patients. Please feel free to contact the Case Manager for assistance and about any issues by calling **212.908.3636**.

Please review our Model of Care training document, located in our *Provider Manual*. Click here for your *Provider Manual*. If you have any questions, please contact your provider relations representative.

PATIENT-PROVIDER EXPERIENCE

Patient engagement is a growing priority within the MetroPlus physician network and NYC Health + Hospitals. We are dedicated to supporting our providers in delivering the highest quality care and experience.

The CAHPS surveys ask patients about their experiences with their doctors. The following targeted tips can help guide the patient-provider experience:

PATIENT INTERACTION

- **Know** the patient's medical record details before entering the exam room; patients are surveyed if their doctor knew their medical history
- **Ask** patients about other doctors and specialists they have seen
- **Involve** patients in decision making
- **Communicate** test results and specialist findings to your patient within 24-48 hours and review together at the next follow up appointment
- **Use** MetroPlus Gaps in Care reports to identify additional clinical services needed
- **Discuss** Urinary Incontinence and treatment options/physical activity levels with patients over 65 years old
- **Discuss** aspirin use for cardiovascular health when appropriate
- **Discuss** tobacco use and cessation treatment options when appropriate
- **Encourage** patients to get a flu vaccination for the flu season
- **Encourage** patients to sign up for MyChart

REVIEW PATIENTS' MEDICATIONS

- **Review** patient medications during office visits and reinforce medication adherence
- **Reconcile** medications post-hospital discharge
- **Prescribe** an extended days' supply of 90-day fills whenever possible to support adherence

IMPROVING AND MAINTAINING PHYSICAL AND MENTAL HEALTH IN OLDER ADULTS

Older adults are a rapidly growing age group, with some of the most complex health care needs—and they're less likely to be physically active than other age groups. However, physical activity can help maintain and improve health and physical function in older adults, including reduced risk of falls.

If your patient is over 65 years old (or 50-64, with impairments or limitations), evaluate their health history and current activity levels. If they're physically capable of exercise, encourage them to do so at a level appropriate to their health status. If they have an increased fall risk, encourage them to do exercises to maintain or improve balance.

Research published by JAMA Internal Medicine determined that the most benefits were seen when people exercised three times per week, 50 minutes per session, in programs that included several components, such as balance exercises, strength training for the lower limbs, and aerobic exercise (the kind that gets hearts and lungs pumping, like brisk walking). Even less exercise than recommended still brings health benefits—so if patients are unable to exercise at the recommended level, they can still gain some of the benefits.

Talk to your patients about their activity levels at every appointment.

WHY YOU SHOULD DISCUSS BMI WITH YOUR PATIENTS

When used correctly, Body Mass Index (BMI) can be an excellent tool for screening patients for obesity and its health risks. BMI is easy to calculate using inexpensive and noninvasive measures, and BMI levels correlate with body fat and future health risks.

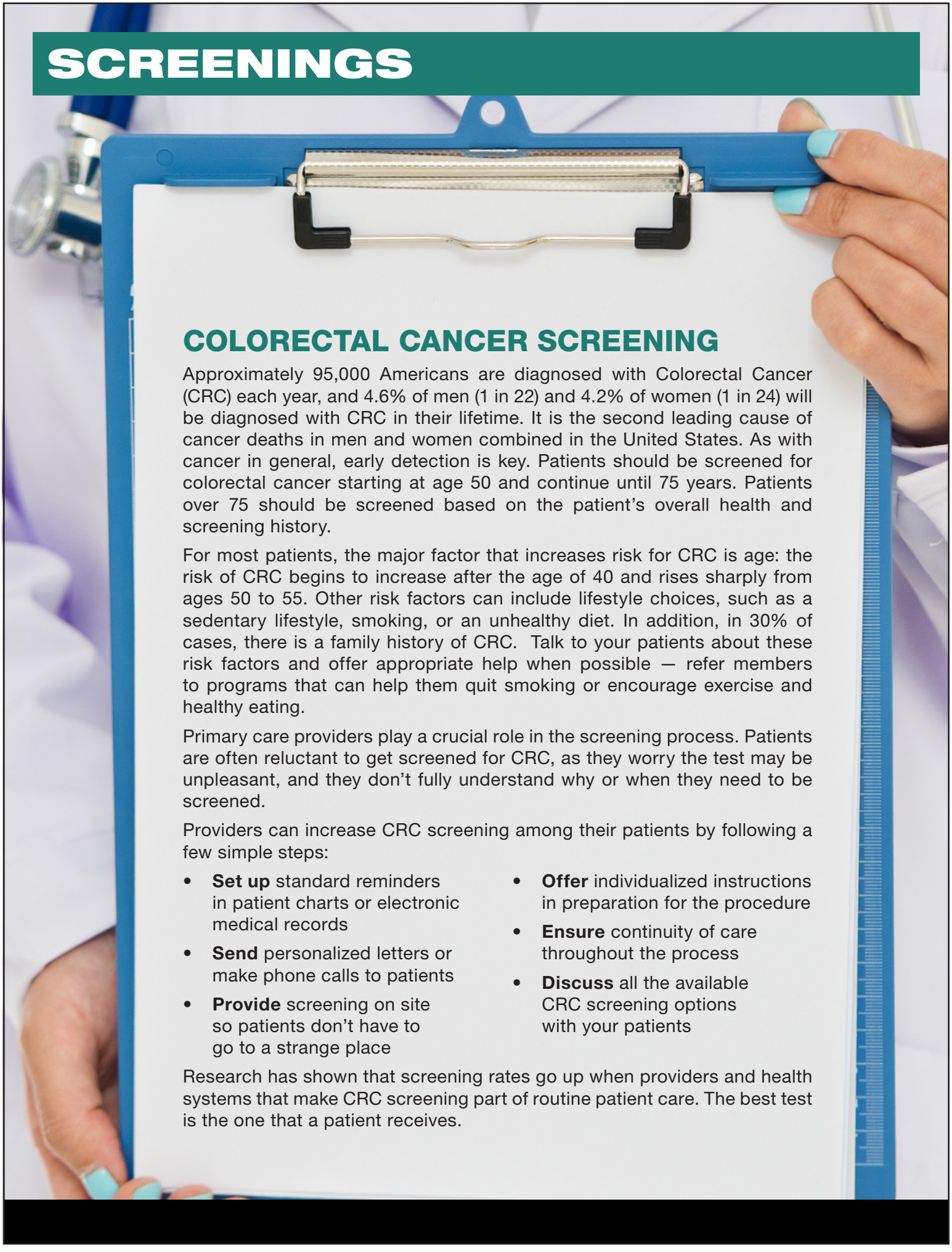
People who have obesity, compared to those with a normal or healthy weight, are at increased risk for many serious diseases and health conditions, including the following:

- Hypertension
- High LDL cholesterol, low HDL cholesterol, or Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Osteoarthritis
- Sleep apnea and breathing problems
- Endometrial, breast, colon, kidney, gallbladder, and liver cancers
- Low quality of life
- Mental illness such as clinical depression, anxiety, and other mental disorders
- All causes of death (mortality)

BMI should serve as an initial screening to identify potential weight problems for adults. Other factors, such as fat distribution, fitness level, and age, should also be considered when assessing an individual patient's disease risk.

For more information, you can visit the CDC's website here.

SCREENINGS



COLORECTAL CANCER SCREENING

Approximately 95,000 Americans are diagnosed with Colorectal Cancer (CRC) each year, and 4.6% of men (1 in 22) and 4.2% of women (1 in 24) will be diagnosed with CRC in their lifetime. It is the second leading cause of cancer deaths in men and women combined in the United States. As with cancer in general, early detection is key. Patients should be screened for colorectal cancer starting at age 50 and continue until 75 years. Patients over 75 should be screened based on the patient's overall health and screening history.

For most patients, the major factor that increases risk for CRC is age: the risk of CRC begins to increase after the age of 40 and rises sharply from ages 50 to 55. Other risk factors can include lifestyle choices, such as a sedentary lifestyle, smoking, or an unhealthy diet. In addition, in 30% of cases, there is a family history of CRC. Talk to your patients about these risk factors and offer appropriate help when possible — refer members to programs that can help them quit smoking or encourage exercise and healthy eating.

Primary care providers play a crucial role in the screening process. Patients are often reluctant to get screened for CRC, as they worry the test may be unpleasant, and they don't fully understand why or when they need to be screened.

Providers can increase CRC screening among their patients by following a few simple steps:

- **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 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.

BILLING AND CODING

QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM – BILLING REQUIREMENTS

The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low income Medicare beneficiaries. More than 1 in 8 Medicare beneficiaries are enrolled in the QMB program.

All original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – must refrain from charging individuals enrolled in the QMB program for Medicare cost sharing for covered Parts A and B services.

Note that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay. Click here for more information.

Providers can take steps to ensure that they maintain compliance with these billing rules:

- **Establish** processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services.
- **Ensure** that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid

Click here for an FAQ from CMS.

RISK ADJUSTMENT DOCUMENTATION AND CODING FOR DEMENTIA

Dementia is a growing health concern for seniors, with over 5 million Americans living with some form of the condition. In response to the increasing numbers of patients seeking care for dementia and related complications, CMS has introduced two new hierarchical condition categories (HCCs) for risk adjustment. These categories are in effect now:

- **51:** Dementia with Complications
- **52:** Dementia without Complications

When coding for patients with dementia, it is crucial that highest level of specificity is used in order to accurately reflect the patient's condition and determine what other resources may be needed. Always include the appropriate ICD-10 code on your claim and be sure that the supporting documentation (diagnosis and treatment plan) is in the patient's medical record.

Listed here are some of the most common diagnoses within the new HHCs:

- **F0390:** Unspecified dementia without behavioral disturbance
- **G309:** Alzheimer's disease, unspecified
- **F0280:** Dementia in other diseases classified elsewhere without behavioral disturbance
- **F0391:** Unspecified dementia with behavioral disturbance
- **F0281:** Dementia in other diseases classified elsewhere with behavioral disturbance
- **G301:** Alzheimer's disease with late onset
- **F0150:** Vascular dementia without behavioral disturbance
- **F0151:** Vascular dementia with behavioral disturbance
- **G300:** Alzheimer's disease with early onset
- **G3181:** Dementia with Lewy bodies

CHOOSING WISELY: LABORATORY TESTS

MetroPlus is committed to helping our providers deliver the best level of service and care to our members. Below are recommendations from the American Society for Clinical Pathology's ***Choosing Wisely*** campaign that identified non-evidence based and over-utilized laboratory tests in the general population. We highly recommend that you review and use this information. For more information, please visit: https://www.choosingwisely.org.

Amylase:

Do not test for amylase in cases of suspected acute pancreatitis. Instead, test for lipase.

Current guidelines and recommendations indicate that lipase should be preferred over total and pancreatic amylase for the initial diagnosis of acute pancreatitis and that the assessment should not be repeated over time to monitor disease prognosis. Repeat testing should be considered only when the patient has signs and symptoms of persisting pancreatic or peripancreatic inflammation, blockage of the pancreatic duct or development of a pseudocyst. Testing both amylase and lipase is ***unnecessary*** because it increases costs while only marginally improving diagnostic efficiency.

Bottom Line: If you suspect, pancreatitis, order a serum lipase.

Folic acid, red blood cell or serum:

Do not order red blood cell or serum folate levels at all.

In adults, consider folate supplementation instead of serum folate testing in patients with macrocytic anemia. With the mandatory fortification of foods (with processed grains) with folic acid incidence of folate deficiency has declined dramatically. In rare cases of folate deficiency, simply treating with folic acid is a more cost-effective approach than blood testing.

Helicobacter pylori antibody:

Do not request serology for H. pylori. Use the stool antigen or breath tests instead.

Serologic evaluation of patients to determine the presence/absence of Helicobacter pylori (H. pylori) infection is no longer considered clinically useful. Alternative noninvasive testing methods (e.g., the urea breath test and stool antigen test) exist for detecting the presence of the bacteria and have demonstrated higher clinical utility, sensitivity, and specificity. Finally, several laboratories have dropped the serological test from their menus, and many insurance providers are no longer reimbursing patients for serologic testing.

Erythrocyte Sedimentation Rate (ESR) in patients with undiagnosed conditions:

Don't order an erythrocyte sedimentation rate (ESR) to look for inflammation in patients with undiagnosed conditions.

Thyroxine, total; Thyroxine, free; Triiodothyronine T3 (TT-3) in the initial evaluation of a patient with suspected, non-neoplastic thyroid disease, and routine screening Thyroid Stimulating Hormone testing:

Don't order a total or free T3 level when assessing levothyroxine (T4) dose in hypothyroid patients or when you are trying to determine if someone is hypothyroid or hyperthyroid. Don't order TSH for routine screening.

T4 is converted into T3 at the cellular level in virtually all organs. Intracellular T3 levels regulate pituitary secretion and blood levels of TSH, as well as the effects of thyroid hormone in multiple organs. However, T3 levels in blood are not reliable indicators of intracellular T3 concentration. Compared to patients with intact thyroid glands, patients taking T4 may have higher blood T4 and lower blood T3 levels. Therefore, in most patients all you need is a TSH to determine the correct dosing of levothyroxine.

Bottom Line: Order a TSH to monitor and adjust levothyroxine dosing. Don't order TSH for routine screening; only for someone in whom you clinically suspect hypothyroidism or hyperthyroidism.

Vitamin D, including fractions:

Don't routinely measure 1,25-dihydroxyvitamin D unless the patient has hypercalcemia or decreased kidney function.

Many practitioners become confused when ordering a vitamin D test. Because 1,25-dihydroxyvitamin D is the active form of vitamin D, many practitioners think that measuring 1,25-dihydroxyvitamin D is an accurate means to estimate vitamin D stores and test for vitamin D deficiency, which is incorrect.

Prealbumin:

Do not use prealbumin test to screen for or diagnose malnutrition.

Studies have shown that as a nutritional marker, prealbumin is not specific enough to show changes in nutritional status; additionally, it is not sensitive to detection of malnutrition at an early stage. Furthermore, improvement in nutritional intake have not resulted in notable change in prealbumin. Instead, consider a multidisciplinary approach that includes consulting with dieticians to better understand the patient's medical history and to ensure the selected metrics are used appropriately for diagnosis and documentation. Click here for more information.

Ammonia:

Do not use an ammonia test, in patients with chronic liver disease, to measure blood ammonia level because normal levels do not rule out hepatic encephalopathy.

Click here for more information.

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES) SERVICES

DSMES provides an evidence-based foundation to empower people with diabetes to navigate self-management decisions and activities. It has been proven to improve health outcomes and behavior among people with diabetes. Despite this, utilization of DSMES is at a low level nationwide.

The CDC has released a toolkit that provides resources and tools to increase the use of DSMES programs, focusing on access, health care provider referrals, and reimbursement. It is our hope that by increasing the utilization of DSMES, we can improve the overall health outcomes of our diabetic members.

To view the DSMES toolkit, visit https://www.cdc.gov/diabetes/dsmes-toolkit/index.html.

MEMBER REWARDS

Members in our Medicaid, CHP, HIV SNP, HARP, EP, QHP, SHOP and Medicare plans are automatically enrolled in the **MetroPlus Rewards Program**. The program allows members to earn points for participating in fitness challenges, receiving cancer screenings, and refilling medications. These points can be redeemed for athletic equipment, toys, personal care items, and more.

MetroPlus is committed to keeping our members healthy. Encourage your patients to visit www.metroplusrewards.org for more information and to redeem rewards. If your patients are interested in learning more about the MetroPlus Member Rewards Program, they can contact Member Services at **1.800.303.9626**.

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

Medicaid Managed Care PCPs are required to schedule appointments in accordance with the aforementioned appointment and availability standards. Providers ***must not*** require a new patient to complete prerequisites to schedule an appointment, such as a copy of their medical record, a health screening questionnaire, and/or an immunization record. The provider may request additional information from a new member, if the appointment is scheduled at the time of the telephonic request.

MetroPlusHealth

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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.

Editor: Elizabeth Colombo