HealthyPractices™

MVP HEALTH CARE®

A Bi-Monthly Publication for MVP-Participating Health Care® Providers

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New York

In this Issue:

MVP Provider Directory

You can search the current MVP Provider Network for primary care physicians and specialists. Visit **mvphealthcare.com** and select *Find a Doctor.*

$ Un-Cashed Checks?

Visit **longlostmoney.com** to see if MVP has any un-cashed checks in your name or in the name of your business.

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Sign up today! The email version is easy to share with your entire office. Visit **mvphealthcare.com** and *Sign In/Register*, then select *Account Profile*, then *Communication Preferences* to enroll in MVP e-communications.

MVP Professional Relations

MVP Corporate Headquarters	**1-888-363-9485**
Southern Tier	**1-800-688-0379**
Central New York	**1-800-888-9635**
Midstate New York	**1-800-568-3668**
Mid-Hudson	**1-800-666-1762**
Buffalo/Rochester	**1-800-684-9286**

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We welcome your comments.

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MVPPR0001 (01/2018)

Professional Relations Updates

Locum Tenens Policy Update

MVP Health Care (MVP) follows Centers for Medicare & Medicaid Services (CMS) guidelines regarding Locum Tenens. CMS recently updated its policy as it relates to Locum Tenens in June 2017. Effective April 1, 2018, MVP will continue to follow the CMS guidelines for these providers. The CMS policy allows for Locum Tenens to fill in for physicians while they are on a leave of absence by utilizing a Q6 modifier when billing under the participating physician's NPI. MVP currently follows this guideline; however, the time limit for a Locum Tenen will now be 60 days per CMS guidelines. This time frame can only be extended in the event that the participating physician is deployed for military duty. In addition, CMS will only reimburse Locum Tenens when they are covering for an existing participating physician, they will not reimburse Locum Tenens in the event that a physician has left and a provider group/hospital is in the process of hiring a new physician. To comply with this policy, MVP will no longer register Locum Tenens covering for a physician who has left the practice; all physicians who are covering in this capacity must go through MVP's contracting and credentialing process. Providers wishing to participate should visit **mvphealthcare.com** and select *Providers*, then *Join MVP*. You may also refer to Section 15 of the Provider Resource Manual regarding MVPs Locum Tenen Payment Policy.

Online Demographic Form Coming Soon

You spoke, we listened! In the coming weeks, MVP will be announcing the ability for providers to submit provider demographic updates through an online form. No more printing out a demographic change form, filling it out, and emailing it to MVP. The new online form will allow providers to communicate easily when they are changing or adding a new address, updating their Tax ID information, or even notifying MVP that a provider has left their group. Providers will be able to submit the form electronically and will receive a reference number for use when checking on the status of a change.

Keep an eye out for additional communication on this new and exciting functionality. We think this will make it easier to submit changes, saving you time to focus on patient care.

Quality Improvement Updates

HEDIS/QARR and CAHPS Measures Spotlight

Healthcare Effectiveness Data & Information Set (HEDIS) is a nationally recognized set of health care quality measures that contribute significantly to MVP's National Committee for Quality Assurance (NCQA) accreditation score. MVP collects HEDIS data from claims information and by chart review in many offices across our service area. MVP monitors its performance in these measures on an ongoing basis and submits results to NCQA annually.

(Read more on page 2)

(HEDIS/QARR and CAHPS Measures Spotlight continued from page 1)

State and federal governments also monitor these measure results to assess the quality of care that members of health plans receive from their contracted physicians. The CMS Star Rating program and state Quality Assurance Reporting Requirements (QARR) program are two examples.

Information on Select HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures

Medication Reconciliation Post-Discharge (MRP)
This measure is one of the clinical quality indicators that CMS includes in the Star Rating program for Medicare Advantage health plans.

The MRP measure shows the percentage of Medicare members (ages 18 and older) who had an acute or non-acute inpatient discharge, and had a medication reconciliation review completed and documented within 30 days of discharge.

Medication Reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Examples that meet criteria:

- Documentation of current medications with a notation that references the discharge medication(s), e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications.
- Documentation of the member's current medications with a notation that discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service.
- Notation that no medications were prescribed or ordered upon discharge.

The following documentation must be included in the chart:

- Evidence of medication reconciliation (current versus discharge medications) and the date it was performed.
- Reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse on the date of discharge through 30 days after discharge.

Note: Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required (it can be done over the phone).

Measure Codes Volume 2 for Measure ID MRP

Measure Name: Medication Reconciliation Post-Discharge Measure
Value Set Name: Medication Reconciliation
Code System: CPT

Code: 1111F
Definition: DSCHRG MED/CURRENT MED MERGE

Code: 99495
Definition: TRANS CARE MGMT 14 DAY DISCH

Code: 99496
Definition: TRANS CARE MGMT 7 DAY DISCH

How Your Patients Respond to CMS Services Health Outcome Surveys (HOS)— What is the Physician's Role?

CMS requires health plans to monitor the care members receive from their health care providers. As discussed in previous editions of this newsletter, the CMS Star Ratings include many measures that are associated with care given by physicians who care for MVP Medicare Advantage members. Some measures are self-reported by your patients through the HOS that is mailed to them each spring. The HOS assesses each Medicare Advantage plan's ability to maintain or improve the physical and mental health functioning of its beneficiaries and how the physicians work together with their patients to achieve their goals. The survey includes questions that ask your patients if their Primary Care Physician has talked to them about physical activity, their risk of falls, and urinary incontinence. CMS is expecting that an assessment of these issues is completed and that a treatment plan is in place to improve the quality of life for your patients if any issues are identified. Assessment of a patient's physical and mental health is a critical part of any office visit.

The CMS Star Ratings of the three MVP Medicare contracts on these measures for the last reporting period are:

- **Monitoring physical activity** rated 2 and 3 out of 5 Stars
- **Reducing fall risk** rated 2 and 3 out of 5 Stars
- **Improving bladder control** rated 4 and 4 out of 5 Stars
- **Improving or maintaining physical health** rated 1 and 3 out of 5 Stars
- **Improving or maintaining mental health** rated 4 and 4 out of 5 Stars

MVP Health Care and Magellan Healthcare Partnership

In keeping with our commitment to promoting continuous quality improvement for services provided to MVP members, MVP has entered into an agreement with **Magellan Healthcare** (Magellan), to implement a Musculoskeletal (MSK) Management program. This program requires prior authorization for MVP members for non-emergent MSK procedures, including outpatient interventional spine pain management services (IPM), and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under the terms of the agreement between MVP and Magellan, MVP will oversee the MSK program and continue to be responsible for claims adjudication and medical policies. Magellan will manage non-emergent outpatient interventional spine pain management services, and inpatient and outpatient MSK surgeries through the existing contractual relationships with MVP.

MVP plans on a March 1, 2018 implementation. This correspondence serves as notice of changes to the program under your Participating MVP Health Care Provider Agreement.

We appreciate your support and look forward to your assistance in assuring that MVP members receive MSK services delivered in a quality, clinically appropriate fashion.

Does Your Practice have a Gaps in Care Program in Place?

A Gap in Care is the discrepancy between evidence-based best practices and the care that's actually delivered to a patient. Every chance to close gaps in medically necessary care is an opportunity for providers to realize incremental revenues while doing what is right for their patients. By identifying these gaps and communicating that data to the front lines of care, interventions can be targeted to increase performance and improve ratings.

The monthly MVP Gaps in Care (GIC) report shows the member level detail you need to know to assess which patients have and have not received the care as outlined per HEDIS specifications. If you are not receiving monthly MVP Gaps in Care reports, please email **gapsincarereports@mvphealthcare.com** with your updated contact information.

Consider using your GIC reports to create an Electronic Medical Record (EMR) or flagged chart alerts. Commit to routine pre-visit planning to prepare to discuss gaps with patients and to write orders that may have otherwise been overlooked. Create patient lists in early September to have patients come in by the end of the measurement year to close as many gaps as possible. From there, staff can perform immunizations, order lab tests and preventive screenings that were missed, and most importantly, schedule patients for face-to-face visits with their PCP. The most meaningful patient engagement occurs in the exam room. Face-to-face contact is the number one tool to close gaps in care, outranking mobile apps, patient portals, social media, or surveys.

A Gaps in Care program must be continuous to make an impact (not seasonal), and quality improvements will need to be prioritized to create change.

Care Management Update

Care and Health Management Programs Accepting Referrals

MVP offers dedicated Health Management programs to members at a variety of service levels. Drawing on the combined strengths of our wellness strategists, registered nurses, social workers, respiratory therapists, physicians, pharmacists, and community health care providers, MVP offers a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum. MVP Care Managers utilize key principles within the framework of nursing case management established by the American Nursing Association and the Case Management Society of America.

The MVP Health Management program focuses on members with:

- Asthma
- Low back pain
- Cardiac condition (post-event based)
- COPD
- Diabetes
- Heart failure

MVP's Care Management Focuses on High-Risk Target Populations

Factors considered for identifying eligible members for case management include diagnosis, cost, utilization

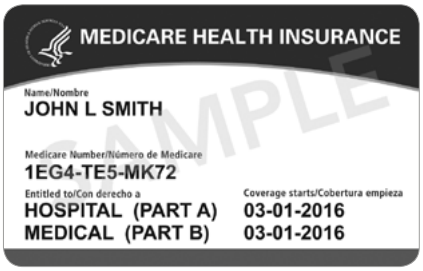
(emergency room and inpatient admissions), and qualitative variables (social risk, support network), as well as a members' willingness to participate in case management.

Case management activities also include care of members who undergo organ transplant, have cancer, end stage renal disease, HIV/AIDS, or experience a high-risk pregnancy. Additional factors for consideration when determining member eligibility include members who are non-adherent to the plan of care and/or members who require additional guidance in navigating the health care continuum. Members who experience a critical event or diagnosis can be referred for case management services through multiple avenues.

To make a referral to the MVP Health Management program, call **1-866-942-7966**, fax **1-866-942-7785**, or email **phmreferrals@mvphealthcare.com**.

Medicare Update

New Medicare Cards



The Centers for Medicare & Medicaid Services (CMS) will be issuing new Medicare cards to members starting April of 2018 and extending to April 2019. The new cards will no longer bear the Social Security number, with the aim to prevent fraud, fight identity theft, and protect health care and financial information for Medicare beneficiaries in the U.S.

The new Medicare cards will have a new unique, randomly assigned number called a Medicare Beneficiary Identifier (MBI) which will replace the existing Health Insurance Claim Number (HCIN), typically the beneficiary's Social Security number. Medicare beneficiaries received information about the new card in the Medicare handbook, *Medicare & You 2018*, mailed to Medicare households in October 2017. It is also available **medicare.gov**.

There will be a transition period for providers beginning April 2018 and lasting 21 months in which providers can use either the MBI or the HICN for billing purposes. CMS is encouraging providers to start updating their business and system processes to be able to accept the MBI numbers by April 2018.

As providers, your patients may contact you with questions about this change. To help with the transition, make sure your office staff is informed and can work with patients accordingly. It is important that your staff verify patient information through the electronic eligibility transaction system and if any of the information is not accurate, instruct the patient contact Social Security to update their Medicare records. If you work with a software vendor and have not been informed of how they plan to update your system, contact them immediately.

To help with this transition for you and your staff, you can subscribe to the weekly *MLN (Medicare Learning Network) Connects* newsletter by visiting **cms.gov** and selecting *Outreach & Education*, then *Get Training*, then *Medicare Learning Network® (MLN)*, then *MLN Connects® Newsletter.*

Medicaid Updates

Enrollment with New York State Medicaid Program

Effective January 1, 2018, Federal law requires that all providers treating any Medicaid Managed Care and Child Health Plus members be enrolled with the New York State Medicaid program. This requirement does not require you to participate in the New York State Medicaid Fee-for-Service program, but you must have a New York State Medicaid number on file with the State and with MVP.

Please note that if you are enrolled in any MVP Value Based Programs for Medicaid or any other incentive program that requires participation in all MVP lines of business, failure to obtain this number may forfeit your participation in these programs.

If you have questions during the New York State Medicaid application and enrollment process, please contact CSRA's eMedNY Call Center at **1-800-343-9000**. For questions about your MVP Health Care participation, please contact your MVP Professional Relations representative.

Translated Viral Prescription Pads

Communication between health care providers and patients is crucial, especially concerning whether antibiotics are appropriate for a particular infection.

Explaining why antibiotics won't work for viral infections is a key part of antibiotic stewardship and a means of combating antimicrobial resistance. But what happens

when English is not a patient's primary language? For many providers in parts of New York, that is a key concern.

Based on the success of the Centers for Disease Control and Prevention's (CDC) English and Spanish-version *viral prescription pads*, the New York State Department of Health has translated the pads into 10 additional languages: Simple Chinese, Haitian Creole, Italian, Korean, Russian, Cambodian, Burmese, Somali, Arabic, and Karen.

The prescription is a tangible takeaway for patients to:

- Educate them about antibiotic resistance
- Offer supportive treatment suggestions, such as drinking liquids, using a cool mist vaporizer, using ice chips, or sore throat spray
- Give them a contingency plan to check back with your office if they do not feel better in a few days.

Not only will patients benefit from this improved communication, but it may also save providers valuable time when having the conversation about antibiotic use with their patients. Limited free copies of the pads may be ordered by emailing Mary Beth Wenger at **MaryBeth.Wenger@health.ny.gov**.

Vision Benefit Management Change

Effective April 1, 2018, MVP will no longer be using Superior Vision for the administration of vision benefits for our Medicaid, Child Health Plus, MVP Harmonious Health Care Plan, and Essential Plans. As of this date, MVP will self-manage the administration of vision benefits for these programs.

MVP will begin adjudicating routine vision claims starting with dates of service April 1, 2018, and will also respond to benefit and eligibility inquiries for our Medicaid, Child Health Plus, MVP Harmonious Health Care Plan, and Essential Plans.

Any claims for dates of service through March 31, 2018 should be billed to Superior Vision; however, claims for dates of service from April 1, 2018 forward should be billed directly to MVP.

Pharmacy Updates

Policy Updates Effective April 1, 2018

Respiratory Syncytial Virus/Synagis: No Changes

Male Hypogonadism: Medicare variation added for Aveed; testosterone cypionate 250mg/ml removed—no longer manufactured; quantity limit for testerone cypionate 100mg/ml and 200mg/ml changed to 10ml per 30 days

Metformin ER: Approval of brand Glumetza will require failure of the generic product

Disposable Insulin Devices: No changes

Infertility Drug Therapy: No changes

Growth Hormone Therapy: Language updated for Idiopathic Short Stature exclusion

Kuvan: No changes

Transgender: Criteria for gonadotropin-releasing agents added

Mepron: Atovaquone suspension will now have a quantity limit of 140ml per 180 days; criteria for additional therapy added for severely immunocompromised patients

Zinplava: New policy

Movement Disorder: New policy for Austedo, Ingrezza, and Xenazine

Physician Prescription Eligibility: No changes

Prescribers Treating Self or Family Members: No changes

Mail Order: Cardiovascular and Gastroenterology categories updated

Formulary Updated for Commercial, Marketplace, and Medicaid

New drugs–recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid plans.

Drug Name	Indicator
Yescarta	B-cell lymphoma
Benzinidazole	Chagas disease
Calquence	Mantle cell lymphoma
Fasenra	Eosinophilic phenotype asthma
Durolane	Mild to moderate OA of knee
Rebinyn	Hemophilia B
Vyzulta	Glaucoma
Hemlibra	Hemophilia A
Mepsevii	Sly syndrome
Prevymis	CMV prophylaxis

*(**New drugs**–recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid plans continued)*

Drug Name	Indicator
Cinvanti	Chemotherapy induced N/V
Ozempic	Type 2 diabetes
Heplisav-B	Prevention of Hepatitis B
Odactra	House mite allergic rhinitis
Juluca	HIV
Luxturna	RPE65 mutation associated retinal dystrophy
Qtern	Type 2 diabetes
Varubi IV	Chemotherapy induced N/V
Sublocade	Opioid use disorder

Drugs Added to Formulary

Tier 1 for Commercial/Medicaid and Tier 2 for Marketplace

Carvedilol ER

Oseltamivir suspension

Sildenafil 25mg, 50mg, 100 mg

Tizanidine capsules will be excluded from the Commercial, Marketplace, and Medicaid formularies. Tizanidine tablets will continue to be covered.

Actos and Prandin will be excluded from the Commercial, Marketplace, and Medicaid formularies.

Methergine will have a quantity limit of 28 tablets per 365 days for the Commercial, Marketplace, and Medicaid formularies.

Drugs Removed from Prior Authorization

Alunbrig	Imfinzi	Intrarosa
Rydapt	Xadago	Zejula