

Mental Health Services Program for Youth Transition

From Paul Mendis, MD, Chief Medical Officer of Neighborhood Health Plan



Paul Mendis, M.D.

For the last decade, NHP has operated the Mental Health Services Program for Youth (MHSPY) as a special pilot for MassHealth.

Founded by a noted child psychiatrist, Dr. Katherine Grimes, MHSPY has used a unique blended funding stream from multiple state agencies (Medicaid, Department of Children and Families, Department of Mental Health, Department of Youth Services, and the Department of Education) to provide coordinated services to several hundred children and adolescents with serious emotional disturbances (SED) residing in five local communities.

Utilizing social workers as care managers, MHSPY has delivered services that are individualized, child-centered, strength-based, family-focused and culturally competent.

Among its many accomplishments the program has consistently demonstrated reduced behavioral health hospitalizations and use of diversionary services, reduced use of emergency room services, more appropriate prescribing of psychiatric medications, reduced out of home placements, and improvement in the functional status of its enrolled children.

The success of MHSPY was one of the examples used by the plaintiffs as they prevailed in the "Rosie D. vs. Romney" lawsuit. As a result the Commonwealth is required to make available a broad array of community based services (similar to MHSPY) for all Medicaid children with SED state-wide.

Many of you have already participated in the early phases of this project which is now referred to as the Children's Behavioral Health Initiative (CBHI). Medicaid children

have been undergoing primary care-based behavioral health (BH) screens at well child visits for over a year now, and since November 2008, BH clinicians have been trained and certified to use the CANS tool for referred Medicaid children. CBHI implementation will be completed by June 30, 2009 when new Community Service Agencies (CSAs) will begin offering and coordinating court mandated services.

As the CSAs become operational MassHealth will be ending its contract with NHP for the MHSPY pilot. Those enrolled children still qualifying for CBHI services will be transitioned to CSAs in their community. As we thank the MHSPY staff for their extraordinary service to a very challenging population, we anticipate their experience and skill will ensure that they are highly sought after in the new CBHI model. ■

FEATURED TOPICS

- ▶ **Adolescent Depression and Suicidality** | Beacon Health Strategies
- ▶ **Something Remarkable is Happening...A New System of Behavioral Health Care** | MassHealth
- ▶ **Routine Lumbar Imaging No Help for Low Back Pain** | Crystal Phend; Staff Writer, *MedPage Today*

Routine Lumbar Imaging No Help for Low Back Pain

By Crystal Phend, Staff Writer, MedPage Today
Published: February 5, 2008

Reviewed by Robert Jasmer, MD
Associate Clinical Professor of Medicine,
University of California, San Francisco

Patients with low back pain who had radiography, MRI, or CT scans done without a clear indication had no significant improvement in pain or function in the short or long term through 12 months compared with patients who did not have imaging done, Roger Chou, M.D., of the Oregon Health and Science University here, and colleagues reported in the Feb. 7 issue of *The Lancet*.

Based on their meta-analysis findings, clinicians should refrain from routine, immediate lumbar imaging for patients with acute or subacute low back pain unless they present with “red-flag” features suggestive of a serious underlying condition, such as cancer, infection, or cauda equina syndrome, the researchers said.

Their results support clinical guidelines, which have consistently recommended against routine imaging studies for acute low back pain, they said.

But implementation of these diagnostic-imaging guidelines could be a challenge, Michael M. Kochen, M.D., Ph.D., of the University of Goettingen in Germany, and colleagues, said in an accompanying commentary.

Factors such as “patients’ expectations about diagnostic testing, reimbursement structures that provide financial incentives

for imaging, or the fear of missing relevant pathology are likely to hamper clinicians from changing practice,” they wrote.

Education of patients about the limited value of imaging may be a promising approach, Dr. Kochen’s group said.

The researchers noted that imaging can be harmful because of radiation exposure with radiography and CT, risk of labeling of patients with an anatomic diagnosis that might not be the actual cause of symptoms, and high indirect costs, such as higher rates of spinal surgery without a clear outcome benefit.

They pooled findings from six randomized controlled trials that compared immediate, routine lumbar imaging versus usual clinical care without immediate lumbar imaging or without routine provision of imaging results.

Four of the trials used lumbar radiography, two assessed MRI or CT. All were done in primary- or urgent-care settings for mainly acute or subacute low back pain with symptom duration of less than 12 weeks.

Among the 1,804 patients with low back pain, but no indications of serious underlying conditions, the proportion with sciatica or radiculopathy generally ranged from 24% to 44%, although one trial excluded these patients.

Patients who underwent routine lumbar imaging did not have an overall improvement in outcomes, either short term (relative risk 0.83 within the first three months, 95% confidence interval 0.65 to 1.06) or over long-term follow-up (RR 0.82 months six to 12, 95% CI 0.64 to 1.05).

Among the individual outcome measures, none were significantly improved with immediate routine imaging. The majority of standardized mean differences actually favored usual clinical care as indicated by positive values.

Routine lumbar imaging was associated with no less pain in short- or long-term follow-up (standardized mean difference 0.19, 95% CI -0.01 to 0.39, and -0.04, 95% CI -0.15 to 0.07, respectively).

Functional outcomes were likewise not significantly different between patients who had immediate imaging versus those who had usual clinical care (standardized

mean difference 0.11 short term, 95% CI -0.29 to 0.50, and 0.01 long term, 95% CI -0.17 to 0.19).

Nor did imaging hold any significant benefits for short term or long term mental health or quality of life.

The results did not vary by trial quality, use of different imaging methods, or duration of low back pain.

Although the researchers noted that the results were limited by small numbers of trials for some analyses, they noted that the maximum plausible benefits based on the confidence intervals would be small or trivial.

“This result suggests that, even if statistical power could be increased by other trials, clinically important benefits from routine lumbar imaging are unlikely, assuming that future results are similar to those currently available,” they concluded. ■

The Study was funded by the American Pain Society.
The researchers reported no conflicts of interest.
Dr. Kochen’s group reported no conflicts of interest.
Primary source:
The Lancet
Source reference:
Chou R, et al “Imaging strategies for low-back pain: systematic review and meta-analysis” *Lancet* 2009; 373: 463-72.
Additional Source:
The Lancet
Source reference:
Kochen MM, et al “Imaging for low-back pain” *Lancet* 2009; 373: 436-37.
Reprinted with permission, © MedPage Today, LLC, All Rights Reserved www.medpagetoday.com

Appropriate Practitioners Available to Discuss UM Decisions

In all instances of medical necessity denials, it is NHP’s policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner. NHP is accessible to practitioners seeking information about the utilization management process, and authorization requests and decisions from 8:30-5:30, Monday through Friday. Please call 1-800-462-5449 or 617-772-5565. The fax number is 617-772-5512 or 617-478-7175. For after-hour requests and utilization management issues, you may leave a message or fax. These lines are available 24/7. All requests and messages will be retrieved on the next business day. ■

Action Points

- Clinical guidelines, including those from the Agency for Healthcare Policy and Research, have consistently recommended against routine imaging studies for acute low back pain.
- Note that education of patients on the limited utility of routine imaging for low back pain was recommended.

Something remarkable is happening in Massachusetts. A New System of Behavioral Health Care

From *MassHealth*

Beginning July 1, 2009, our state's mental health system for MassHealth-enrolled children under the age of 21 will radically change. What initially began as a class-action lawsuit, known as *Rosie D. v. Romney* (Rosie D.), will soon become a coordinated, child-centered and family-focused, culturally-competent and strength-based system of care for thousands of MassHealth-covered children as part of the Children's Behavioral Health Initiative (CBHI).

We've already begun to see change. Requirements include: behavioral health screens using approved, standardized screening tools at each Early and Periodic Screening Diagnosis and Treatment (EPSDT)/Pediatric Preventative Healthcare Screening and Diagnosis (PPHSD) visit; a uniform behavioral health assessment process for MassHealth-enrolled children under the age of 21 that includes a comprehensive needs and strengths assessment tool; and the development of an enhanced information technology system for these assessments. CBHI has already begun to implement significant improvements, marking the beginning of the transformation of the system of care for MassHealth-enrolled children with behavioral health care needs.

New Behavioral Health Services

Starting July 1, 2009, CBHI will offer several innovative behavioral health services for MassHealth members under the age of 21. New services and implementation dates are as follows:

- Intensive Care Coordination (ICC)
July 1, 2009
- Caregiver Peer-to-Peer Support (Family Partner) Services
July 1, 2009
- Mobile Crisis Intervention
July 1, 2009
- In-Home Behavioral Services (Behavioral Management Therapy and Behavioral Management Monitoring)
October 1, 2009
- Therapeutic Mentoring Services
October 1, 2009

- In-Home Therapy Services
November 1, 2009
- Crisis Stabilization Services
December 1, 2009

It should be noted, however, that all services must first be approved by the federal Center for Medicare and Medicaid Services (CMS) prior to implementation. Late last year, CMS approved Intensive Care Coordination Services (ICC). Approval for all other services is still pending.

ICC Using Wraparound Care Planning

ICC, an intensive care coordination service for children with serious emotional disturbance, will be delivered through a comprehensive network of over 30 community service agencies located throughout the state. ICC will use the Wraparound model, a structured series of steps for building a community support network for children and adolescents with complex needs who require behavioral and emotional support. The Wraparound model puts the family at the center of the planning process and builds a team around the family's vision for their child's future. The team typically includes both formal supports (e.g., physicians, educators, therapists, and caseworkers) and natural supports (e.g., extended family, friends, and people in the community connected to the child and family). Over a period of several months, the team works to make the child's plan a reality, brainstorming ways to overcome obstacles and to develop resources to help the child succeed. Over time, initial plans usually undergo revision and the persistence of the team is a key factor in the development of a plan that supports lasting change.

Eligibility

The Final Judgment in the *Rosie D.* case requires MassHealth to provide remedy services to any child or youth who is eligible for Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, meets either the Substance Abuse and Mental Health

Services Administration (SAMHSA) or Individuals with Disabilities Education Act (IDEA) definitions of "emotional disturbance" and for whom the service is medically necessary. However, MassHealth will be providing all remedy services except ICC to any EPSDT-eligible child or youth who has a medical need for the service. ICC will be implemented as a "targeted case management" service that is limited to the target group of children and youth under the age of 21 who meet the SAMHSA or IDEA definitions of "emotional disturbance."

Going Forward

2009 will be a very important year in Massachusetts. What began as a lawsuit filed against the state will become a vastly improved system of behavioral health care for MassHealth-enrolled children, adolescents and their families.

We will continue to keep you updated about CBHI developments in the *Clinician Quarterly*. For more information, you may also visit Beacon Health Strategies website, www.beaconhealthstrategies.com, and/or the Official website of the Massachusetts Office of Health and Human Services (EOHHS) at www.mass.gov/eohhs, and click on the CBHI—Children's Behavioral Health Initiative tab. ■

Affirmation

NHP recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, NHP promotes appropriate utilization of services. NHP's utilization management decisions are based only on appropriateness of care and service and existence of coverage. NHP does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does NHP provide financial incentives to UM decision-makers to encourage decisions that result in underutilization. ■

Effective July 1, 2009

Important New Specialist Copayment Changes to NHPCare HMO for Group Insurance Commission (GIC) Members

In 2007, NHP implemented provider tiering* for physicians specializing in primary care (at the group practice level) and, individually, physicians specializing in cardiology, OB/GYN, and endocrinology. In 2008, gastroenterology specialists were included.

For the 2009 plan year, tier designations have been changed to include specialists in ENT/otolaryngology, orthopedic surgery, pulmonology, and rheumatology in the three distinct tier assignments:

- *** Tier 1 (excellent);
- ** Tier 2 (good); or
- * Tier 3 (standard).

These tier designations will be reflected in NHP's provider directories and remain in effect for the duration of the GIC contract year or until June 30, 2010.

Summary of NHP Tiering

Methodology for PCPs in FY10

NHP tiers Primary Care Providers (PCP) at the group practice level. To improve the validity of the data and to be consistent with NCQA recommendations, all physician groups must have a combined total of at least 30 occurrences reported by all carriers to be evaluated on quality; otherwise, they are evaluated on cost efficiency measures alone. When evaluating for efficiency, provider groups with less than a combined 30 episodes of care will be assigned to Tier 2.

- NHP calculated a quality score for PCP groups using the average of all physicians within the group practice. All quality scores were obtained from GIC consultant, Resolution Health Inc. (RHI), and were applied without modification.
 - Groups that perform in the 10th percentile are assigned to Tier 3 and are not eligible for cost efficiency tiering.
 - Groups performing above the 10th percentile in quality of care are eligible for cost efficiency tiering.

- Only those groups with scores at or above the 50th percentile for quality of care are eligible for the designation of Tier 1.
- Cost efficiency scores developed for GIC by Mercer/ViPs were used for establishing upper and lower threshold limits and were not modified by NHP.
 - Physician groups that exceed the upper threshold limit and performed above the 50th percentile in quality of care are placed into Tier 1.
 - Physician groups falling within the upper and lower threshold limits or have insufficient data to be evaluated are placed into Tier 2.
 - Physician groups that fall below the lower threshold limit are placed into Tier 3.

Primary Care Tiers

Primary care office visit copayments are based on the site at which that PCP practices. The Tier 1 copayment is \$10 per office visit, the Tier 2 copayment is \$20 per office visit, and the Tier 3 copayment is \$25 per office visit.

Summary of FY10 NHP Tiering Methodology for Specialists

For FY10, cardiologists, endocrinologists, ENT/otolaryngologists, obstetricians/gynecologists, and rheumatologists will be tiered using both quality and efficiency measures. Due to insufficient quality of care measures, orthopedic surgeons, gastroenterologists, and pulmonologists will be tiered using efficiency measures.

A summary of the NHP tiering methodology for individual specialties is outlined below.

- GIC consultant, Resolution Health Inc. (RHI), assigns a Quality Designation of "A," "B," or "C" with "A" being the highest quality of care.
 - All physicians who have a 75% or greater probability of a "C" Quality

Designation as defined by RHI are automatically placed into Tier 3.

- The remaining list of physicians including those who have insufficient quality data are then evaluated on cost efficiency.
- Cost efficiency scores developed for GIC by Mercer/ViPs were used for establishing upper and lower threshold limits for each specialty.
 - Individual specialists that exceed the upper threshold limit are placed into Tier 1.
 - Individual specialists that fall within the upper and lower threshold limits or have insufficient data to be evaluated are placed into Tier 2.
 - Individual specialists that fall below the lower threshold are placed into Tier 3.

Specialty Provider Tiers

The patient's choice of cardiology, endocrinology, ENT/otolaryngology, gastroenterology, OB/GYN, orthopedic surgery, pulmonology, and rheumatology specialist will determine the office visit copayment. The Tier 1 specialist copayment is \$20, the Tier 2 copayment is \$30 and the Tier 3 copayment is \$40 per office visit. The copayment for those specialties that are not tiered is \$30. The copayment for outpatient mental health or substance abuse providers is \$20.

To obtain the most up-to-date information on provider tiers, please refer to the online version of NHP's provider directory for GIC members located at www.nhp.org. Provider eligibility websites will also reflect the new copay structure. ■

*In 2003, the Massachusetts Group Insurance Commission (GIC) spearheaded the establishment of the Clinical Performance Improvement Initiative (CPII) in an effort to promote quality improvement and cost efficiency in the delivery of health care. The CPII involved the aggregating of a consolidated, multi-plan claims database to construct cost-efficiency and quality of care profiles. This physician profile information was the source by which health plans "tiered" their physician networks.

Adolescent Depression and Suicidality

From *Beacon Health Strategies*

Depression is one of the most common chronic conditions of adolescence. According to Saluja (2004), studies estimate the prevalence of depression among older adolescents to be as high as 8.3% with much less known about prevalence of, and risk factors for, depression among young adolescents (ages 11-15). Often depressive symptoms among youths are attributed to the normal stress of adolescence; misdiagnosed as conduct, attentional, or substance abuse disorders; or seen as a stage the youths are going through. "Depression is associated with an increased risk of suicide, and teen suicide rates have nearly tripled in the last 50 years." A critical step to reducing the prevalence of depression among older individuals, managing depression more effectively, and preventing negative outcomes is recognizing depression as early as possible.

According to the Centers for Disease Control and Prevention (CDC), suicide is the third leading cause of death for adolescents 15 to 19 years old with adolescent males having a rate 6 times greater than the rate for females. Data collected by the CDC indicates that one in five teenagers in the U.S. seriously considers suicide annually. In 2003, 8% of teenagers attempted suicide, representing approximately 1 million teenagers. For every completed suicide, it is estimated that 100 to 200 attempts are made. According to the American Association of Suicidology (2007), "the risk of suicide in people with Major Depressive Disorder is about 20 times that of the general population."

Although no specific tests are capable of identifying suicidal persons, several factors can put a person at risk for attempting or committing suicide. Risk factors for suicide include:

- previous suicide attempt(s);

- history of depression or other mental illness, alcohol or drug abuse;
- family history of suicide or violence; and/or
- physical illness and feeling alone.

According to the World Health Organization (WHO), additional risk factors of adolescent suicide include:

- being a victim of physical/sexual/emotional abuse or peer bullying;
- availability and access to weapons or means to complete suicide;
- exposure to others who have committed suicide;
- psychosocial stressors;
- recent loss through death, divorce, or romantic relationship;
- feeling worthless and hopeless;
- poor coping skills;
- impaired judgment;
- lack of impulse control;
- self-destructive behaviors;
- struggles with sexual identity, and rejection by family and peers.

It is essential to mention that warning signs of acute suicide risk include threats to hurt or kill one-self, looking for ways to hurt or kill oneself, and/or talking or writing about death, dying, or suicide. It is estimated that as many as 90% of individuals who have ended their lives by committing suicide had a mental disorder, 60% were depressed at the time. Depression and symptoms, such as sadness, lethargy, anxiety, irritability, sleep and eating disturbances, should alert all providers to the potential risk of suicide. "Risk is greatest when an individual has the means, opportunity, a specific plan to carry out the suicide, and the lack of a deterrent."

Beacon and NHP believe adolescents should be assessed for both Depressive Disorders and suicidal intent. As part of the new Children's Behavioral Health Initiative, NHP will reimburse providers

for administering a Behavioral Health screen during a Well Child Visit. ■

ⁱ The American Psychological Association. (2007). Teen suicide is preventable [on-line]. Available: <http://www.psychologymatters.org/teensuicide.html>

ⁱⁱ American Association of Suicidology. (2006). Youth suicide fact sheet [on-line]. Available: www.suicidology.org

ⁱⁱⁱ American Association of Suicidology. (2007). Facts about suicide and depression [on-line]. Available: www.suicidology.org

^{iv} Center for Disease Control. (2006). Understanding suicide fact sheet [on-line]. Available: www.cdc.gov/injury

¹ Saluja G., Iachan R., Scheidt P.C., Overpeck, M.D., Sun, W., & Giedd, J.N. (2004). Prevalence of and risk factors for depressive symptoms among young adolescents. *Arch Pediatr Adolesc Med*, 158, 760-765.

² Saluja G., Iachan R., Scheidt P.C., Overpeck, M.D., Sun, W., & Giedd, J.N. (2004). Prevalence of and risk factors for depressive symptoms among young adolescents. *Arch Pediatr Adolesc Med*, 158, 760-765.

³ Saluja G., Iachan R., Scheidt P.C., Overpeck, M.D., Sun, W., & Giedd, J.N. (2004). Prevalence of and risk factors for depressive symptoms among young adolescents. *Arch Pediatr Adolesc Med*, 158, 760-765.

⁴ Centers for Disease Control and Prevention/ National Center for Health Statistics. (1999). *Death Rates From 72 Selected Causes by 5-Year Age Groups, Race, and Sex: United States, 1979-1997*. Atlanta, GA: Author.

^v World Health Organization. (2006). Preventing Suicide: A Resource for Counselors [on-line]. Available: http://whqlibdoc.who.int/publications/2006/9241594314_eng.pdf

^{vi} American Association of Suicidology. (2007). Warning signs [on-line]. Available: www.suicidology.org

^{vii} World Health Organization. (2006). Preventing Suicide: A Resource for Counselors [on-line]. Available: http://whqlibdoc.who.int/publications/2006/9241594314_eng.pdf

^{viii} World Health Organization. (2006). Preventing Suicide: A Resource for Counselors [on-line]. Available: http://whqlibdoc.who.int/publications/2006/9241594314_eng.pdf

^{ix} World Health Organization. (2006). Preventing Suicide: A Resource for Counselors [on-line]. Available: http://whqlibdoc.who.int/publications/2006/9241594314_eng.pdf

¹⁴ American Academy of Child and Adolescent Psychiatry. 2007. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders [on-line]. Available: www.aacap.org

Specialty Formulas Reminder

If your Neighborhood Health Plan MassHealth Patient is having difficulty obtaining specialty formulas, please notify the DME department at NHP by calling 1-800-462-5449. ■

Quality Program's Spotlight on Prevention

A key component of healthy behavior is the timely receipt of recommended preventive services. Neighborhood Health Plan ranked #2 in *US News & World Report* and *NCQA Best Medicaid Plans* with an overall score of 5 stars in the Prevention domain.

Top Performance in Prevention and Screening Measures

NHP's Children and Adolescent Well-Care Visits and Immunizations are higher than the national 90th percentile benchmarks.

Member interventions include:

- Health Record "checkbook" and bookmark reminder included in postpartum mailing
- 8 month immunization reminders and magnet
- 18 month immunization reminders
- Birthday card reminders (children and teens)
- Reminder mailings to those missing a well-care visit in the past year

Provider interventions include:

- *Have you immunized Me?* report sent to all primary care sites

Our targeted member communications have contributed to NHP's HEDIS Medicaid Effectiveness of Care measures that are above the 90th percentile in almost all areas of prevention and screening, as well as comprehensive Diabetes and Mental Health. Examples include:

- Influenza vaccine reminders for high risk populations
- Yearly mammography reminders
- Reminders to members with diabetes about yearly recommended diabetes screening
- Outreach to mothers in the postpartum period to schedule postpartum visits
- Mailings to all women after delivery that includes NHP's *Welcome Home Baby*, a resource guide for new parents, *Thumbs Up for Healthy Food Choices*, *What to Do When Your Child Is Sick* book, and a child Immunization Health Record. ■

Utilization Management Criteria

NHP develops medical necessity guidelines and criteria to review medical appropriateness of targeted services based on its member population and service utilization. Guidelines and criteria are objective and based on medical evidence utilizing various professional and

NHP Member Rights and Responsibilities

NHP Member Rights

As a valued member of Neighborhood Health Plan (NHP), you have the right to:

- Receive information about NHP, our services, our providers and practitioners, your covered benefits, and your rights and responsibilities as a member of NHP.
- Receive oral interpretation services free of charge for any materials in any language.
- Have your questions and concerns answered completely and courteously.
- Be treated with respect and with consideration for your dignity.
- Have privacy during treatment, and expect confidentiality of all records and communications.
- Discuss and receive information regarding your treatment options, regardless of cost or benefit coverage, with your Provider in a way which is understood by you. You may be responsible for payment of services not included in the Covered Services list for your coverage type.
- Be included in all decisions about your health care, including the right to refuse treatment.
- Change your Primary Care Provider.
- Access emergency care twenty-four (24) hours a day, seven (7) days a week.
- Access an easy process to voice your concerns, and expect follow-up by NHP.
- File an Appeal or Complaint if you have had an unsatisfactory experience with NHP or with any of our contracted Providers, or if you disagree with certain decisions made by NHP.
- Make recommendations regarding NHP's Member rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Freely apply your rights without negatively affecting the way NHP and/or your Provider treats you.
- Ask for and receive a copy of your

medical record and request that it be changed or corrected.

- Receive the Covered Services you are eligible for as outlined in your Member Handbook

NHP Member Responsibilities

You also have responsibilities as a Member of NHP. It is your responsibility to:

- Choose a Primary Care Provider, the Provider responsible for your care.
- Call your Primary Care Provider when you need health care.
- Tell any health care Provider that you are an NHP member.
- Give complete and accurate health information that NHP or your Provider needs in order to provide care.
- Understand the role of your Primary Care Provider in providing your care and arranging other medical services that you may need.
- To the degree possible, understand your health problems and take part in making decisions about your health care and in developing treatment goals with your Provider.
- Follow the plans and instructions agreed to by you and your Provider.
- Understand your benefits—what's covered and what's not covered.
- Call your Primary Care Provider within forty-eight (48) hours of any emergency or out-of-area treatment. If you experienced a behavioral health (mental health and substance abuse) emergency you should contact your behavioral health provider, if you have one.
- Notify NHP and MassHealth of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.
- Understand that you may be responsible for payment of services you receive that are not included in the Covered Services list for your coverage type. ■

government agencies and local health care delivery plans.

Utilization management (UM) criteria and procedures for their application are reviewed at least annually, and criteria are updated when appropriate. NHP elicits opinions, advice and comments from area practitioners on the development and adoption of UM criteria.

NHP applies the criteria based on individual circumstances and needs and

takes into account the local delivery system when determining the medical appropriateness of health care services. Criteria used to make UM decisions are available upon request.

To receive Utilization Management criteria information, or to share any related questions, please contact: Catherine Jason, Manager of Clinical Compliance and Education, Clinical Operations Department at 617-204-1427 or 1-800-433-5556 x1427. ■

Pharmacy and Therapeutics Update

The NHP pharmacy benefit strives to provide a high quality benefit while controlling the ever rising cost of a pharmacy benefit. As part of this effort, NHP uses several different programs including medication tiering, mandatory generic substitution, prior authorization, step therapy and quantity limits. All pharmacy programs are reviewed by the NHP P&T committee on an annual basis to assure the programs are clinically sound and relevant. The NHP P&T committee reviews new to market medications after they have been available for six months. Prior to P&T review, new to market medications are blocked and reviewed as a prior authorization.¹

Preferred Drug List (PDL) Update

The Pharmacy and Therapeutics Committee has reviewed the following medications.

Tier 1 (Generics)

Depakote (divalproex ER)
 Imitrex (sumatriptan)
 Keppra (levetiracetam)
 Pulmicort Susp (budesonide)
 Zerit (stavudine)

Tier 2

Alvesco (ciclesonide)

Tier 3

Cimzia (certolizumab)
 Relistor (methylnaltrexone)

Quantity Limitations²

The Pharmacy and Therapeutics Committee has voted to implement a quantity limit² on the following:

Prestiq

Quantity Limit of of
 30 tablets per 30 days

Step Therapy Program³

The Pharmacy and Therapeutics Committee has voted to add Prestiq (desvenlafaxine) to the step therapy³ program for Serotonin-Norepinephrine Reuptake Inhibitors:

1st Line Medications

Generic SSRI's:
 fluoxetine
 paroxetine
 citalopram
 fluvoxamine
 sertraline

2nd Line Medications

venlafaxine tablets
 Effexor[®] XR capsules

3rd Line Medications

Cymbalta[®] (duloxetine)
 Pristiq (desvenlafaxine)

The Pharmacy and Therapeutics Committee has voted to change the step therapy³ program for HMG-Co-A Reductase Inhibitors:

1st Line Medications

lovastatin
 pravastatin
 simvastatin

2nd Line Medications

Altoprev (lovastatin ER)
 Crestor (rosuvastatin)
 Lescol/XL (fluvastatin)

3rd Line Medications

Lipitor (atorvastatin)
 Vytorin (ezetimibe/simvastatin)

The Pharmacy and Therapeutics Committee has voted not to cover⁴: Treximet (sumatriptan/naproxen)

The Pharmacy and Therapeutics Committee has voted to place a Prior Authorization¹ program on: Cimzia (certolizumab), Relistor (methylnaltrexone)

For the most up-to-date information regarding the NHP pharmacy programs and the current medical necessity criteria, check the drug look-up and pharmacy section on www.nhp.org by clicking on "Drug Lookup" under "Quick Links."

¹ Prior Authorization is an individual case review compared to P&T-established guidelines, or NHP New-to-Market policy, before a prescription for the specific medication will be covered.

² Quantity Limits promote cost-effective prescribing by limiting the number of units of medication that can be dispensed over a given time. These are established based on strengths available and the recommended doses.

³ Step Therapy is an automated case review, based on P&T-established guidelines and the individual member's NHP pharmacy profile. This process occurs with a pharmacy claim submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.

⁴ Requests for a not covered medication are reviewed on a case by case basis.

Neighborhood Health Plan

Coverage within reach. Care beyond expectations.

Deborah Enos
President and Chief Executive Officer

David Segal
Chief Operating Officer

Paul Mendis, MD
Chief Medical Officer

James Glauber, MD, MPH
Senior Medical Director

Laurie Hill Dunning
Senior Communications Specialist
Marketing & Corporate Communications

NONPROFIT ORG
U.S. Postage
PAID
Permit No. 52093
Boston, MA

NHP's Care Management Programs

NHP's internal Care Management and Disease Management programs serve Members across physical, behavioral and psychosocial conditions. Our Care Management programs are designed to provide comprehensive, multidisciplinary and fully integrated care management services that compliment and support the care delivered by Providers as they help our members make effective use of available health care resources. Our holistic and culturally sensitive model is intended to support member adherence to Providers recommended treatment and facilitate self-management. Program participation is voluntary and part of NHP's health plan benefit, at no cost. Members are identified through our enrollment process, medical and pharmacy utilization resource data, clinician, provider and self-referrals.

In addition to NHP's internal Care Management and Disease Management Programs, including Regional Care Man-

agement, the Care Partnership Program, Social Care Management, Parent Advisor, Smoking Cessation, HIV/Aids, Maternal Child Health, Pediatric, Behavior Health, Diabetes and Asthma, NHP has engaged AccordantCare to provide expanded Disease Management Programs to members with chronic conditions. Accordant works collaboratively with NHP's Clinical Operations Department to refer members who may require services beyond their disease specific program for assessment of expanded care management services under one of NHP's Care Management programs. ■

Introducing AccordantCare

As of February 2, 2009, NHP offers, through its delegated partnership with AccordantCare,™ Disease Management, programs to help members manage their special health needs. AccordantCare Disease Management programs provides member access to:

- An AccordantCare team of nurses 24 hours a day, 7 days a week

- Regular follow up with a registered nurse to monitor changes in health
 - Easy to read booklets and newsletters
 - Useful health management tools
- AccordantCare offers Disease management programs in:

Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Heart Failure, Seizure Disorders, Rheumatoid Arthritis, Multiple Sclerosis, Crohn's Disease, Parkinson's Disease, Systemic Lupus Erythematosus (SLE), Myasthenia Gravis, Sickle Cell Disease, Cystic Fibrosis, Hemophilia, Scleroderma, Polymyositis, Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP), Amyotrophic Lateral Sclerosis (ALS), Dermatomyositis, Gaucher Disease.

Learn more about these programs, by calling an AccordantCare Nurse at 1-866-940-2584 (TTY: 1-800-735-2962) from 8:00 a.m. to 9:00 p.m. Monday through Thursday and 8:00 a.m. to 5:00 p.m. on Friday. The program is part of the NHP member's health plan benefit's coverage and is offered at no cost.

Providers can refer patients to this program by calling the NHP Customer Care Center at 1-800-462-5449. ■