Washington June Newsletter

June 22, 2017

Transplant Service Changes

Important message from Robert Good, DO, Chief Medical Officer and April Vogelsang, RN, MS, VP of Medical Management:

In order to streamline transplant services for our members and providers, we are changing the way transplant services are managed.

Once we approve a member for a transplant, services will be managed through Your Health Alliance for providers and office personnel. Any services that occur before our approval of the transplant should follow current preauthorization processes.

If you have questions about this information, contact your provider relations specialist.

2017 Medicare Provider Manual Available

You can find the Medicare provider manual for all of our plans in the Forms & Resources section of Your Health Alliance for providers. In it, you'll find more information about:

- Our Quality Improvement program, including its purpose, goals, objectives, scope, structure, key personnel, and technical resources and systems
- Our complex case management program and how to refer a member
- How to access and request our utilization management and pharmaceutical management criteria
- Affirmative statement about incentives related to UM decision making
- When decision timeframes begin for non-urgent pre-service requests received after business hours
- How to use our pharmacy management procedures and processes, including our formulary, pharmaceutical classes, tier information, preauthorizations, managed dose limitations, step-therapy, generic substitution, pharmacy savings programs, and how to request a medical exception
- Our disease management programs, including what we do and how you and your patients can access program services

- A comprehensive list of clinical guidelines, including non-preventive, preventive, and behavioral health
- Preventive care guidelines for all age groups
- Members' rights and responsibilities

Preauthorization Update

Currently, our Medical Management department is preparing for Wave 2 of eviCore, which will start for dates of service on August 1 or after. You'll be able to access eviCore for these Wave 2 updates starting on July 14.

Our Medical Management team also manages the Clear Coverage requests that come in through Your Health Alliance for providers, and we are following the established CMS and NCQA regulations regarding standard and urgent timeframes for organization determinations.

In order to meet these timeframes, you should be sure to follow the evidenced based guidelines for that particular service or procedure and to provide all necessary supporting medical documentation. Attaching the necessary medical records while completing the online request will help expedite the decision and response time.

Clinical Documentation Through eviCore

When submitting a preauthorization request to eviCore, it is very important that you include any requested clinical documentation with the original submission. This will help avoid unnecessary delays with processing your requests and denials and appeals that are later overturned once relevant clinical information has been received.

For commercial members, there is also a reconsideration period, but you must request the reconsideration within the 14-day window.

Metabolic Panel Coverage

Starting August 1, all metabolic panel codes (80047, 80048, 80050, and 80053) will be paid under the medical benefit for most plans. Some of these codes may still be considered wellness for certain self-funded plans.

If you have any questions, contact your provider relations specialist.

Modifier 50 – Bilateral Procedures Type 3

If you have questions about the reimbursement of the 50 modifier for radiology services, these details about bilateral indicator 3 can help.

Modifier 50 is used as a payment modifier, rather than an informational modifier. Adding this modifier could affect payment, depending on the procedure code and the bilateral surgery indicator. The bilateral surgery indicator for each procedure code can be found on the Medicare Physician Fee Schedule, which we follow.*

Many radiology services have a bilateral indicator 3, which means the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported to us with modifier -50, it will affect your allowed since it's configured as a pricing modifier in our system.

Report services with a bilateral indicator 3 on 2 lines of service, using RT on one line and LT on the other, with one unit of service each, for the expected reimbursement.

**Please review your claims for surgical procedures codes appended with modifier 50. If reimbursement is different than expected, contact your PRS to ensure you have been configured correctly.*

State Legislative Activity

Recently, several state legislatures have altered state insurance laws. We maintain a team that analyzes statutory and regulatory modifications, and we follow an accountability process to ensure changes are implemented throughout our system.

Changes have various effective dates and may not be implemented on a yearly basis, but rather as policies renew. Many times, we don't have to change our processes since we already provide the services at the level set by the new rule. All operational and benefit changes are shared with our stakeholders and partners as necessary to ensure compliance.

No specific action regarding any changes is needed from our network at this time.

Some recent changes include:

- In Washington, the governor signed a law on medical license and physical therapy compacts and 12-month contraceptive coverage mandates, right to try (experimental drugs) legislation, and a telemedicine initiative that expands the definition of home specific to locations where individuals can receive telemedicine services.

The 5 W's of HEDIS

What

The National Committee for Quality Assurance (NCQA) continues to be the gold standard for health plan accreditation, and we've worked with the NCQA since 1995. The NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS® (Healthcare Effectiveness Data and Information Set), the performance measurement tool used by more than 90% of the nation's health plans.

HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare health care quality. The annual HEDIS audit includes distribution and reporting of the CAHPS® (Consumer Assessment of Health Plan Survey). Results of the annual HEDIS audit are combined with the NCQA survey scores to provide the overall NCQA score for health plans. The overall score consists of 50 possible points for the NCQA standards, 37 possible points for the annual HEDIS audit, and 13 possible points for the annual CAHPS results.

Why

For our members, your patients, healthcare quality is imperative. By working together, we can improve care and service, as measured through HEDIS scores from the health plan perspective, which also drives improvement efforts through:

- Medicare Stars
- Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
    - Merit-based Incentive Payment System (MIPS)
    - Advanced Alternative Payment Models (APMS)

Who

The HEDIS team consists of 2 key leaders, a HEDIS technician, a dedicated reporting analyst, and 6 coordinators that ensure timely and accurate completion of HEDIS data collection and reporting. Key leaders with a diversity of knowledge and skills help to integrate the data through our quality improvement programs.

Our Quality Improvement Committee (QIC)'s primary responsibility is to provide direction, oversight, and appropriate resources for quality. Data from the annual HEDIS audit is reported to the QIC to evaluate and refine quality improvement programs, including disease management, wellness, and other interventions and initiatives that continuously improve the care and service provided to our members, your patients.

When

The HEDIS timeline to ensure continuous quality improvement includes:

- January through May
    - CAHPS survey populations identified and survey tool distributed.
    - External HEDIS auditors are onsite at Health Alliance to perform a complete assessment of our systems and processes.
    - Random samples are pulled to start the data abstraction process begins. (***Note:*** In 2017, our medical record review team reviewed approximately 16,486 medical records as part of the annual HEDIS submission process.
- May through June
    - HEDIS medical record data is finalized and submitted to the external HEDIS auditors. Once the audit is final, data is submitted to NCQA.
- June through July
    - Current HEDIS results are evaluated to assess the impact of interventions.
    - Mid-year adjustments to programs are made as needed.
    - Provider-specific HEDIS is gathered for reporting on key measures.
- August through December
    - CAHPS results are reviewed and interventions developed.
    - Prospective HEDIS is conducted to identify care gaps and provide the catalyst for change to ensure programs continue to evolve.

Where

HEDIS data is gathered 2 ways, depending on the HEDIS technical specifications for each measure:

- Administrative data, which is based on claims submitted to the health plan.
- Hybrid data, where each hybrid measure is sample-driven, and data is obtained from medical record review (via either remote EMR access or at provider offices). HEDIS staff is trained on abstraction of hybrid measures and undergo inter-rater reliability testing on each measure to ensure accuracy of the data.

Watch for additional information on specific HEDIS measures in future InforMED newsletters. For more information on how we can help support your quality efforts, contact the Quality Management Department at 217-337-8112.

Pharmacy Updates

Medicare & Washington Public Exchange (WA Public) Plans

Formulary Additions

- Adlyxin (lixisenatide) – Indicated for the treatment of Type 2 Diabetes Mellitus to improve glycemic control in adult patients as an adjunct to diet and exercise.
    - WA Public – Tier 3 with preauthorization (PA)
    - Medicare – Non-formulary
- Soliqua 100/33 (insulin glargine and lixisenatide) – Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (< 60 units daily) or lixisenatide.
    - WA Public – Tier 3 with PA
    - Medicare – Non-formulary
- Xultophy 100/3.6 (insulin degludec and liraglutide) – Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (less than 50 units daily) or liraglutide (less than or equal to 1.8mg daily).
    - WA Public – Tier 3 with PA
    - Medicare – Tier 4 with step-therapy (ST), either a formulary GLP-1 or basal insulin
- Rayaldee (calcifediol) – Indicated for the treatment of secondary hyperparathyroidism in adults with stage 3 or 4 chronic kidney disease and serum total 25-hydroxyvitamin D levels less than 30 ng/mL.
    - WA Public – Tier 5 with PA
    - Medicare – Non-formulary
- Trulance (plecanatide) – Indicated for treatment of Chronic Idiopathic Constipation in adults.
    - WA Public – Tier 3 with quantity limits (QL) #30/30 days
    - Medicare – Non-formulary

WA Public Plans

Criteria Changes

- Diabetes Drug Therapies
    - Added Januvia, Janumet, and Janumet XR to preferred DPP-4’s
    - Created criteria for non-preferred DPP-4’s, which requires failure of at least one product in each group of preferred DPP-4’s
    - Added Invokana, Invokamet, Invokamet XR, Jardiance, and Synjardy to preferred SGLT-2’s
    - Created criteria for non-preferred SGLT-2’s, which requires failure of at least one product in each group of preferred SGLT-2’s

        - Updated SGLT-2/DPP-4 criteria to require failure of at least one product in each group of preferred SGLT-2's
        - Created Medical Necessity for Immediate Dual Therapy criteria – Aligns policy with 2017 Standards of Medical Care in Diabetes
        - Created ST for Novolog and Novolin products through the preferred Humalog and Humulin products
- Gastroenterology
    - Entyvio
        - Ulcerative Colitis Changes
            - Added coverage for fulminate UC
            - Removed coverage for Ulcerative Proctitis
            - Removed Humira ST
        - Crohn's Disease Changes
            - Updated criteria to allow severe members to skip conservative therapy if hospitalized or evidence of severe disease
            - Removed Humira ST
        - Added exclusions
    - Remicade & Inflectra
        - Ulcerative Colitis Changes
            - Added coverage for fulminate UC
            - Removed Humira ST
        - Crohn's Disease Changes
            - Updated criteria to allow severe members to skip conservative therapy if hospitalized or evidence of severe disease
            - Removed Humira ST
        - Added exclusions
    - Humira
        - Combined Crohn's disease and pediatric Crohn's disease criteria
        - Updated criteria to allow severe members to skip conservative therapy if hospitalized or evidence of severe disease
        - Added exclusions
    - Cimzia, Simponi, Stelara, and Tysabri
        - Updated criteria to allow severe members to skip conservative therapy if hospitalized or evidence of severe disease
        - Added exclusions
- Operations
    - Erectile Dysfunction Drugs – Added criteria for Cialis once daily
        - **Exchange only**
    - Male Erectile Dysfunction Medications – Includes Cialis once daily criteria
    - Cialis Once Daily – Retired because Cialis once daily criteria are included in Male Erectile Dysfunction Medications policy
    - Veltassa – Removed sodium polystyrene requirement

New Policies

- Doxercalciferol – PA necessitated by recent manufacturer price increase

- Rayaldee – Details given above in formulary additions

Utilization Management Changes

- DPP-4 medications (Onglyza, Kombiglyze, Kombiglyze XR, Nesina, Oseni, Kazano, alogliptin, alogliptin-pioglitazone, alogliptin-metformin) – Require step through Tradjenta or Jentadueto, AND Januvia, Janumet, or Janumet XR (see updated Diabetes Drug Therapies policy)
    - **Effective July 1, 2017**
    - Step medications are available at Tier 2 copay
- Glyxambi and SGLT2 medications (Farxiga, Xigduo XR) – Require step through Invokana, Invokamet, or Invokamet XR, AND Jardiance or Synjardy (see updated Diabetes Drug Therapies policy)
    - **Effective July 1, 2017**
    - Step medications are available at Tier 2 copay

Tier Changes

- Auvi-Q – **Starting June 15, 2017**, move from Tier 3 to Excluded
    - Epinephrine Auto Injector covered at Tier 1
- Epi-Pen – Covered at Tier 3
- Basaglar – Moved from NDTM to Tier 3
    - Biosimilar to Lantus, covered at Non-Preferred Brand tier
- Veltassa – Moved from Tier 5 to Tier 3 on **May 1, 2017**
    - No longer limited distribution, available at retail pharmacies
    - Price doesn't warrant specialty copay
- Januvia, Janumet, Janumet XR – Moved from Tier 3 to Tier 2 on **May 1, 2017**
    - Moved to preferred products
- Invokana, Invokamet, Invokamet XR – Moved from Tier 3 to Tier 2 on **May 1, 2017**
    - Moved to preferred products
- Jardiance, Synjardy – Moved from Tier 3 to Tier 2 on **May 1, 2017**
    - Moving to preferred products

Contact Us

1-800-851-3379, option 3