Health Alliance™

Carle December Informed Newsletter

December 15, 2020

As It Relates to You

It's Not Too Late to Get a Flu Shot

As healthcare providers, you know how important flu shots are to your patients, their families and the community in general. This winter, they're more essential than ever due to the ongoing COVID-19 pandemic. Flu shots are especially important for those at high risk from influenza, many of whom are also at high risk for contracting COVID-19 or developing serious outcomes if they do.

Remind your patients it's not too late to get their flu shot. It varies according to health plan, but flu shots are covered at no cost to the member in most cases. Your patients can call the number on the back of their Member ID card to learn more about costs and where they can go to get their vaccinations. Together we can help keep our community healthy and well.

Home Infusion Administrative Codes

We recognize that the Centers for Medicare and Medicaid Services (CMS) has identified new codes used by home infusion providers effective January 1, 2021. At this time, all contracted home infusion providers should continue billing existing administrative codes per their current contract. If you have specific questions please contact your Provider Relations Specialist.

Items Required for Provider Credentialing

Just a reminder that if you use CAQH, please use this form when adding a new provider to your contract. If you don't use CAQH or aren't an Illinois MD/DO/DC, please make sure you're submitting all the required documents noted here. Thank you.

Happy Holidays!

From your Provider Relations staff, we wish you all a happy, healthy and prosperous new year! Each day, you give your patients one of the most important gifts of all – the best health and livelihood possible. Thank you for everything you do!

COVID-19 Vaccines and Utilization Management Flexibilities During the Public Health Emergency

Throughout the pandemic, we've worked hard to make sure we support our providers and ensure that our members have access to the most safe and effective care. We're happy to announce that we're reinstating some of the flexibilities related to Utilization Management during this unprecedented public health emergency. Beginning December 1, 2020, we'll offer the following flexibilities through January 31, 2021:

- Waiving of inpatient acute hospital concurrent review, regardless of diagnosis.
- Extending prior authorization for elective surgeries and referrals from 90 days to 180 days.

Please continue to notify us within 24 hours of a hospital admission. We expect to be notified of all member transfers and discharges. It's critical that our members receive their benefits of post-acute care management from our care management team.

As a reminder, additional modifications related to Utilization Management during the public health emergency remain active.

COVID-19 Vaccine Distribution

Like others in the healthcare sector across the country, we're also engaged in planning related to the availability of a COVID-19 vaccination. We expect that many of you are already in the midst of working with state and federal officials to plan for obtaining and administering doses of a vaccine when it's authorized by the United States Food and Drug Administration.

Based on what we know today, we want to clarify our understanding of billing and payment for the vaccine and its administration outlined in the Interim Final Rule with Comment Period. All information is subject to change based on state and federal regulatory guidance.

Vaccine Reimbursement:

- Initially, the federal government will cover the cost of the vaccine.

Vaccine Administration Fee:

- The Centers for Medicare and Medicaid Services will reimburse the vaccine administration costs for any Medicare beneficiary. These claims should be submitted to your local MAC.
- For members of our fully-insured group or individual plans, or members of a self-funded group health plan we administer, providers can submit a claim for the vaccine administration directly to us, using the appropriate, product-specific administration code.

We'll cover the cost of the vaccine administration for commercial and self-funded members (with the exception of short-term, limited-duration and grandfathered health plans) at no cost to the member.

As always, please contact your provider relations specialist with any questions, concerns or feedback. We also invite you to visit our COVID-19 webpage for up-to-date information about the illness, our response and questions about coverage.

Our Health Coaching Services are Expanding

We're excited to announce that beginning in January, our Health Coaching staff will begin outreach to members newly diagnosed with hypertension. Previously, we've proactively reached out to our members with diabetes, but we'll now also connect with those age 18 to 85 who've had at least one outpatient visit with a diagnosis of essential hypertension.

We're very proud of our Health Coaches and the work they do to improve the well-being of our members. We created our Health Coaching program six years ago, and its primary focus is supporting members who've had early diagnoses of chronic conditions such as diabetes and hypertension. Our coaches offer services and support through a wellness lens, providing disease-specific education and finding ways to remove barriers and close gaps in our members' care. Through motivational interviewing, members work with our coaches telephonically to set wellness goals related to weight loss, physical activity, stress management and healthy eating. If we find that a member needs additional support for more complex conditions or requires

help with care coordination, our team discusses this with the member and, if agreeable, helps set them up with a Nurse Care Coordinator. For each individual member, our coaches ensure they get the right care at the right time.

Members can access our Health Coaching program in several ways:

- Members can call the Customer Service number on the back of their insurance ID card and ask to speak with someone from the Health Coaching team.
- Providers or care teams can refer a patient (who's a member of one of our plans) by emailing us at Care.Coordination@healthalliance.org. Please include the patient's name, date of birth and the best phone number to reach them at.
- We proactively reach out to members via text and/or phone to tell them about our programs and give them additional information.

Our coaches are available to work with members Monday-Friday, 7:30 a.m. to 5 p.m., and on Monday evenings. These hours allow for flexibility in supporting our members throughout the week, fitting their busy schedules. For more information about Health Coaching, check out this flier. Let our Health Coaches support you in promoting your patients' health and well-being.

Help Us Move the Needle

Star Ratings Start With You!

As providers, you know nothing is more important than the quality of the care you deliver and the excellence of your services. Medicare's Star Ratings help measure this. Make sure to do your part every day to improve patient satisfaction and close gaps in care.

- Ask your patients if they've seen other providers. If you know they've received specialty care, mention this and discuss with them as needed.
- Ask your patients if they're taking any medications prescribed by other providers.
- Let your patients know you keep a record of their complete medical history. Always ask if there have been any changes to their medical history since their last visit.
- Regularly assess your patients' physical activity levels and discuss any lifestyle changes they could make to improve their health and well-being.
- Conduct a fall risk assessment and make appropriate referrals if necessary.

- Ask and address your patients' concerns about urinary incontinence.
- Conduct an annual wellness visit and review your patients' health assessment results with them.
- Encourage your patients to take advantage of the wellness perks offered by their health plan, such as health coaching and care coordination, fitness reimbursements and our Wellness Rewards program.
- Conduct medication reconciliation with your patients for appropriate usage, and modify their prescriptions as needed.
- Be proactive and help prevent gaps in care by calling your patients months in advance to schedule needed screenings, tests or physicals.

The "Big Six" – Congestive Heart Failure

It's incredibly important for us to receive accurate diagnosis code reporting, along with detailed documentation that supports each diagnosis. With such information, we can together plan the most appropriate and timely care for our members. Did you know that Congestive Heart Failure is one of the "Big Six" diagnosis categories that's most frequently unsupported in documentation?

Here are a few tips to consider when documenting and reporting any diagnoses in the Congestive Heart Failure condition category:

- If the condition is acute and resolved, it's now a historical condition and shouldn't be reported.
- Document all treatment related to an ongoing condition, to remove any doubt that the condition is historical.
- Remember that the category of Congestive Heart Failure is not comprehensive – in fact, there are 61 diagnoses that belong to this Hierarchical Condition Category (HCC).

Some diagnoses that belong to this HCC:

- Heart failure: systolic, diastolic, combined, unspecified/acute or chronic
- Myocarditis, unspecified
- Myocardial degeneration
- Pulmonary hypertension, unspecified
- Eisenmenger's syndrome
- Dilated cardiomyopathy
- Cor pulmonale
- Hypertensive heart disease with heart failure

Remember to use at least ONE component of M.E.A.T. to support the diagnosis you are reporting:

- **M**onitor: disease progression/regression, symptoms and give a status
- **E**valuate: review test results, medication and/or treatment effectiveness
- **A**ssess: counsel, order tests, review records
- **T**reat: medications, therapies, referrals

Thank you for your constant care and dedication to our members' health and well-being.

Pharmacy Updates

All Plans

New Specialty Drug Reviews

- Fintepla (fenfluramine)—Treatment of seizures associated with Dravet syndrome in patients age 2 years and older
  - Formulary placement recommendations
    - Commercial—Non-Preferred Specialty with PA
    - Medicare—Tier 5 with PA
- Evrysdi (risdiplam)—Treatment of spinal muscular atrophy in patients ≥ 2 months of age
  - Formulary placement recommendations
    - Commercial—Non-Preferred Specialty with PA
    - Medicare—Non-Formulary
- Givlaari (givosiran)—Treatment of adults with acute hepatic porphyria
  - Formulary placement recommendations
    - Commercial—Tier 6 with PA
    - Medicare—Part B with PA
- Kesimpta (ofatumumab)—Treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
  - Formulary placement recommendations
    - Commercial—Non-Preferred Specialty
    - Medicare—Non-Formulary
- Palforzia (peanut allergen powder)—Oral immunotherapy for mitigation of allergic reactions including anaphylaxis, that may occur with accidental exposure to peanut in patients with a confirmed diagnosis of peanut allergy. Initial dose escalation may be administered to patients 4 to 17 years of age. Up-dosing and maintenance may be continued in patients ≥4 years of age. Peanut allergen powder is to be used in conjunction with a peanut-avoidant diet.

    - Formulary placement recommendations
        - Commercial—Preferred Specialty with PA
        - Medicare—Non-Formulary
- Viltepso (viltolarsen)—Treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amendable to exon 53 skipping
    - As with Exondys 51 and Vyondys 53, we're waiting on trials showing clinical benefit before adding to formulary.
    - Formulary placement recommendations
        - Commercial—Excluded
        - Medicare—Non-Formulary
- Enspryng (satralizumab)—Treatment of neuromyelitis optica spectrum disorder (NMOSD) in adults who are anti-aquaporin-4 (AQP4) antibody positive
    - Formulary placement recommendations
        - Commercial—Non-Preferred Specialty with PA
        - Medicare—Non-Formulary
- Uplizna (inebilizumab)—Treatment of neuromyelitis optica spectrum disorder (NMOSD) in adults who are anto-aquaporin-4 (AQP4) antibody positive
    - Formulary placement recommendations
        - Commercial—Non-Preferred Specialty with PA
        - Medicare—Non-Formulary
- Xcopri (cenobamate)—Treatment of focal (partial) onset seizures in adult patients
    - Formulary placement recommendations
        - Commercial—Non-Preferred Brand with PA
        - Medicare—Tier 4 (drug is in protected class so cannot have PA requirement)

Commercial

Tier Changes – Commercial

Proposed Positive Tier Changes

- Xiidra: Move from Non-Preferred Brand to Preferred Brand
    - Approved via e-vote; change effective 10/1/20
- Nexletol, Nexlizet: Move from Non-Preferred Brand to Preferred Brand
    - Positive member change allows for plan savings
    - PA criteria still applies
- Praluent, Repatha: Move from Non-Preferred Brand to Preferred Brand
    - Positive member change allows for plan savings
    - PA criteria still applies
- Entresto: Move from Non-Preferred Brand to Preferred Brand

    - Positive member change allows for plan savings
- Durysta: Move from Tier 6 Non-Formulary Specialty to Tier 5 Non-Preferred Specialty
    - Change is only for plans with the Standard formulary
    - Line extension

Proposed Negative Tier Changes—Effective 1/1/21

- Reyvow: Move from Non-Preferred brand to Preferred Specialty
    - Places Reyvow in parity with Ubrelvy and Nurtec ODT
    - PA criteria still applies
    - Manufacturer assistance available with $0 monthly copay up to $3,400 maximum benefit
- Nuplazid: Move from Non-Preferred Brand to Preferred Specialty
    - Considered a specialty product, manufacturer assistance available with $0 monthly copay and no maximum benefit
- Dificid: Move from Non-Preferred Brand to Preferred Specialty
    - Considered a specialty product, manufacturer assistance available with copay no morethan $50/month up to $3,400 maximum annual benefit
- Tudorza: Move from Preferred Brand to Excluded
    - Spiriva and Incruse Ellipta remain as preferred products
    - Manufacturer assistance available that lowers copay to $10 for up to 12 refills

New Specialty Policy

- Lokelma (sodium zirconium cyclosilicate)
    - Comparable to Veltassa
    - MDL of 90 packets per 30 days

Criteria Changes

- Acute CGRP Antagonist Therapies
    - For us to receive manufacturer rebate, policy language had to be updated with removal of documentation requirements
- Hereditary Angioedema
    - Updated age requirement on Haegarda from 12 years and older to 6 years and older to align with FDA guidelines
- Leuprolide Acetate (Fensolvi, Lupron Depot, Lupron Depot-Ped, Leuprolide acetate, Lupaneta)
    - Added criteria for GnRHa stimulation test in the diagnosis of CPP
    - Brian requested one-time approval be for one month to add clarity for pharmacists when they approve authorization
- Nexletol (bempedoic acid) and Nexlizet (bempedoid acid-ezetimibe)

    - For us to receive manufacturer rebate, policy language had to be updated with removal of documentation requirements (as with Acute CGRP Antagonist policy)
- Plaque Psoriasis Immunomodulator Therapies
    - Updated age requirement on Stelara from 12 years and older to 6 years and older to align with FDA guidelines
- Soliris (eculizumab)
    - Mirrors criteria for NMOSD for Emspryng and Uplizna and will include specialist revision requested for those drugs
- Spinraza (nusinersen)
    - Added exclusion of Spinraza in combination with Evrysdi
- Spravato (esketamine)
    - Added criteria for MDD with suicidality
    - Changed initial approval from 12 months to 3 months with re-approval for 12 months
- Kuvan
    - Existing criteria will also apply to new generic
    - Coverage of brand will require allergic reaction to generic

Contact Us

1-800-851-3379, option 3