aetna™

AetnaBetterHealth.com/Michigan

Aetna Better Health® of Michigan

Telemedicine.

Aetna Better Health of Michigan is offering telehealth services to support our members in receiving health care services in a more convenient way. Telehealth is widely viewed as an effective care delivery alternative that can support and complement traditional face-to-face visits for both medical and behavioral care (e.g., face-to-face consultations, assessments or examinations).

Aetna's telehealth program seeks to improve our members' health by permitting real-time interactive communication between the member, their primary care provider, their care team or other skilled practitioner located at a distant site.

Our telehealth program is designed and modeled on the state's regulations, which state: Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid-enrolled health care professional in a different location. The Michigan Department of Health and Human Services requires a Health Insurance Portability and Accountability Act of 1996-compliant, real-time interactive system at both the originating and distant sites, allowing instantaneous interaction between the beneficiary and practitioner via the telecommunication system. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a real-time, interactive audio or video (or both) telecommunications system, and the patient must be able to interact with the off-site care professional at the time the services are provided.

Go to **Telehealth.HHS.gov/providers/getting-started** for more information about telehealth.

Provider Newsletter
Winter 2020
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Aetna Better Health® of Michigan
28588 Northwestern Highway
Suite 380B
Southfield, MI 48034

Single Pharmacy Drug List.

On October 1, 2020, the Michigan Department of Health and Human Services (MDHHS) implemented a Single Pharmacy Drug List (PDL). This change is because of an MDHHS policy change and affects all Michigan Medicaid Health Plans.

The PDL is a listing of drugs that are covered by Michigan Medicaid. There are two categories of coverage: preferred and non-preferred.

As of September 30, 2020, drugs that are non-preferred or not on the PDL will no longer be covered.

You may find that a drug your patient is currently taking will no longer be covered. Letters have been mailed to both members and providers if a drug is no longer covered. Your patient may need your assistance to switch them to a different drug.

Pharmacies have also been informed to contact prescribers in the event that a drug is no longer covered at point-of-sale due to PDL status.

For patients to remain on a non-preferred or non-PDL drug, a prior authorization form will need to be submitted. The MDHHS has developed specific criteria for these inquiries, and medical documentation may need to be provided for approval.

Please visit **Michigan.MagellanRx.com/provider/external/medicaid/mi/doc/en-us/MIRx_PDL.pdf** for a complete listing of the PDL.

You can visit **Michigan.MagellanRx.com/provider/external/medicaid/mi/doc/en-us/MIRx_clinical_criteria.pdf** for a listing of PDL criteria requirements.

If you have any questions, please contact us at **1-866-314-3784**.

Remote patient monitoring: A new way to help your patients.

Did you know Aetna Better Health of Michigan care managers can refer members for remote patient monitoring (RPM)? RPM is a tool that can improve health outcomes for your chronic condition and/or high-risk members. The tool is available for members living with diabetes and/or congestive heart failure, in addition to members experiencing a high-risk pregnancy.

Participating patients submit biometric data daily and engage in regular sessions with nurse health coaches. If submitted biometric data is deemed out-of-range, their practitioner is notified by phone and appropriate interventions are implemented. Health plan care managers may be actively involved.

Members who participate receive our in-home remote monitoring technology package, which includes an iPad mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff and glucometer. All members participating in RPM will be assigned an Aetna Better Health care manager to assist with development of a care plan and to offer education and support to each participant.

Fraud, waste and abuse.

Know the signs — and how to report an incident.

Health care fraud means getting benefits or services that are not approved. Fraud can be committed by a provider, member or employee. Abuse is doing something that results in needless costs. Waste goes beyond fraud and abuse. Most waste does not involve a violation of law. It relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Some examples are:
- Inefficient claims processing and health care administration
- Preventable hospital readmissions
- Medical errors
- Unnecessary emergency room (ER) visits
- Hospital-acquired infections or conditions

Everyone has a right and duty to report suspected fraud, waste and abuse. An example of provider fraud is billing for services, procedures and/or supplies that were not provided. Abuse is treatment or services that do not agree with the diagnosis. Hostile or abusive behavior in a doctor's office or hospital is also abuse.

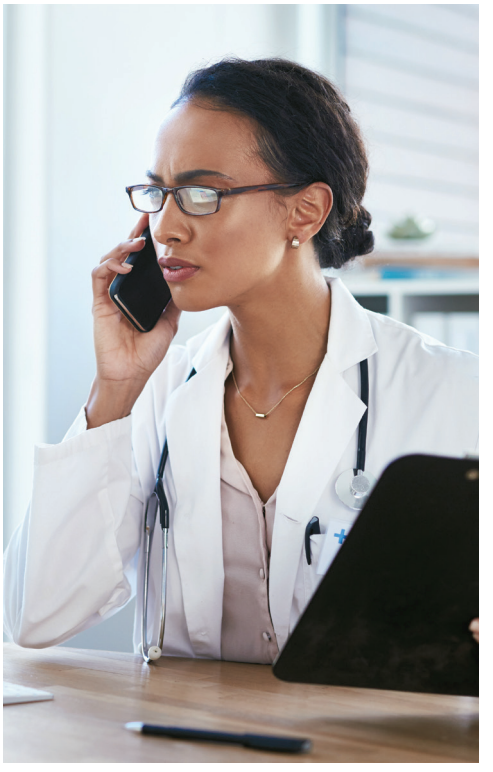
Suspected use of altered or stolen prescription pads is an example of member fraud. An example of abuse would be a member asking the transportation driver to take him or her to an unapproved location.

Penalties

Criminal Health Care Fraud. Persons who knowingly make false claims may be subject to:
- Criminal fines up to $250,000
- Prison for up to 20 years
- Being suspended from Michigan Medicaid

If the violations resulted in death, the individual may go to prison for years or for life. For more information, refer to 18 U.S.C. Section 1347.

Anti-Kickback Statute. The Anti-Kickback Statute bans knowingly and willingly asking for, getting, offering or making payments (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicare program).



For more information, refer to 42 U.S.C. Section 1320a-7b(b).

How to report fraud, waste and abuse

If you suspect a colleague, member or other individual of fraud, waste or abuse, report it. You can report anonymously on the Aetna Better Health of Michigan Fraud, Waste and Abuse Hotline at **1-855-421-2082**. You may also write to:

Aetna Better Health of Michigan
28588 Northwestern Highway, Suite 380B
Southfield, MI 48034

You may also anonymously report fraud, waste and abuse to the Michigan Department of Health and Human Services' Office of the Inspector General by calling **1-855-643-7283**, going online at **Michigan.gov/Fraud** or writing to:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

You do not have to leave your name when you report fraud, waste or abuse.

Key update: Asthma and inhaled corticosteroids.

The 2020 Global Initiative for Asthma (GINA) report is no longer recommending the use of a short-acting beta agonist (SABA) alone, without an inhaled corticosteroid (ICS), as this has potential to increase risk for severe exacerbations. By adding an ICS, the risk would be greatly reduced, with an aim to reduce both the probability of serious adverse outcomes as well as exacerbations at a population level.

An inhaled SABA has been first-line treatment for asthma for 50 years; this dates from an era when asthma was thought to be a disease of bronchoconstriction. Patient satisfaction and reliance on SABA treatment has been reinforced by its rapid relief of symptoms, its prominence in emergency department and hospital use to manage exacerbations, and its low cost.

For safety, GINA no longer recommends SABA-only treatment for intermittent asthma use (Step 1).

- This decision was based on evidence that SABA-only treatment increases the risk of severe exacerbations and that adding any ICS significantly reduces the risk.

Regular or frequent use of SABA is associated with adverse effects, such as:

- Receptor downregulation, decreased broncho-protection, rebound hyperresponsiveness, decreased bronchodilator response
- Increased allergic response and increased eosinophilic airway inflammation

Higher use of SABA is associated with adverse clinical outcomes:

- Dispensing of ≥3 canisters per year (average 1.7 puffs/day) is associated with higher risk of ED presentations.
- Dispensing of ≥12 canisters per year is associated with higher risk of death.

GINA now recommends all adults and adolescents with asthma receive an ICS-containing controller treatment to reduce risk of serious exacerbations.

- The ICS can be delivered by regular daily treatment or, in mild asthma, delivered by as-needed, low-dose ICS-formoterol.
- This is a population-level risk reduction strategy.

Reference:

1. Global Strategy for the Diagnosis, Management and Prevention of Asthma, Global Initiative for Asthma (GINA) Updated December 2019. GINAsthma.org/GINA-Reports

2. Global Strategy for the Diagnosis, Management and Prevention of COPD. Global Initiative for Chronic Obstructive Lung Disease (GOLD)

Updated December 2019. GOLDCOPD.org/wp-content/uploads/2019/11/GOLD-2020-REPORT-ver1.0wms.pdf

Grievances and appeals.

Our provider/member grievances and appeals mailing address has changed. We kindly ask you that you update your records accordingly and to address all future grievances and appeals to our new mailing addresses as follows:

Non-participating provider grievances and appeals NEW address

Aetna Better Health
of Michigan
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Member grievances and appeals NEW address

Aetna Better Health
of Michigan
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Key update: Chronic obstructive pulmonary disease and inhaled corticosteroids.

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2019 introduced blood eosinophil counts as a biomarker for estimating efficacy of inhaled corticosteroids (ICS) in prevention of exacerbations. The 2020 GOLD initiative added information regarding the role of eosinophil counts as a biomarker along with clarification of the diagnosis of exacerbations.

Exacerbations represent the main clinically relevant endpoint when assessing the anti-inflammatory efficacy of a drug. A key point is that long-term use of **ICS monotherapy is not recommended in COPD**, as most studies are finding that regular treatment with an ICS alone does not affect the long-term decline of FEV1 nor show improvements in patient mortality rates.

ICS in combination with long-acting bronchodilator therapy

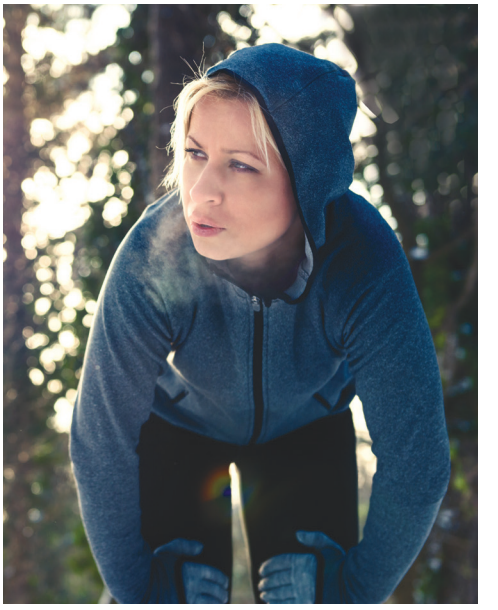
- For patients having moderate to severe COPD with exacerbations, the combined use of an ICS and a long-acting beta-agonist (LABA) has been found to be more effective than either of these components alone.
- At higher blood eosinophil concentrations, in populations with high exacerbation risk (>2 exacerbations or 1 hospitalization per year), use of ICS/LABA decreases exacerbations to a greater extent than use of a long-acting muscarinic antagonist (LAMA) monotherapy or a LABA/LAMA combination.
- Improvements are noted in lung function, health status and reduction of exacerbation.

When to add ICS for combination treatment of COPD management

- History of hospitalization for exacerbations of COPD
- Two or more moderate exacerbations of COPD per year
- Blood eosinophils ≥300 cells/microliter
- History of asthma, or concomitant asthma

Stepwise progression guide to pharmacological treatment

- Zero or one moderate exacerbation (not leading to hospital admission):
  - **Group A: Minimally symptomatic, low risk of exacerbation**
    - Bronchodilator (either SABA or LABA)



  - **Group B: More symptomatic, low risk of exacerbation**
    - LABA or LAMA
- Two or more moderate exacerbations OR one or more leading to hospitalization:
  - **Group C: Minimally symptomatic, high risk of exacerbation**
    - LAMA
  - **Group D: More symptomatic, high risk of exacerbation**
    - LAMA
    - LAMA and LABA
      - Patient is highly symptomatic with COPD assessment test (CAT) >20
    - ICS and LABA
      - Patient's blood eosinophils ≥300 cells/microliter

Global Strategy for the Diagnosis, Management and Prevention of COPD. Global Initiative for Chronic Obstructive Lung Disease (GOLD)

Updated December 2019. GOLDCOPD.org/wp-content/uploads/2019/11/GOLD-2020-REPORT-ver1.0wms.pdf

Clinical inertia in patients with type 2 diabetes.

A prolonged delay to intensify therapy is known as clinical inertia. Studies have shown that the median time to intensifying therapy in patients with type 2 diabetes is longer than one year.

Type 2 diabetes is a complex disease that requires individualized treatment plans based on patient characteristics to reach A1c goals, and today there are more therapeutic options available to help patients with type 2 diabetes reach their A1c goal.

Early intervention to set and attain A1c goals has many clinical advantages:
- Can help preserve beta cell function
- Extends time to treatment failure
- Reduces the risk of diabetes-related complications

However, it is estimated that up to one-half of patients with type 2 diabetes are not reaching their targeted A1c goals.

There are many challenges when trying to intensify therapy in patients with type 2 diabetes, and patient barriers may account for up to 30% of the factors contributing to clinical inertia.

Common barriers and strategies to overcome clinical inertia in type 2 diabetes:

Barrier	Strategy
Belief disease has worsened	Discuss progressive nature of type 2 diabetes
Injection related-anxiety	Demonstrate the needles and injection devices that will be used, provide instruction on needle injection, allow supervised injection rehearsals
Perception that insulin is ineffective	Assure patients that therapy will improve symptoms
Fear of weight gain	Use once-daily insulin analogues to minimize weight gain, use insulin in combination with metformin, discuss benefits of other diabetes medication related to weight loss
Fear of hypoglycemia	Use once-daily insulin analogues to minimize hypoglycemia risk, use diabetes medications with low risk of hypoglycemia
Fear of injection-related pain	Identify patient experience and perceptions related to injections, encourage deep breathing or forceful exhalation during injection

Discussing resistance to insulin therapy

Open-ended questions can help explore patient concerns related to intensifying therapy. Many patients with type 2 diabetes are particularly hesitant to initiate therapy with insulin. Here are some questions that may facilitate a conversation around initiating insulin therapy:

- How do you think insulin can help with your diabetes?
- Who do you know who has used insulin, and what was their experience?
- What is your greatest concern about using insulin?
- How confident are you that you can inject insulin on a regular basis?
- What information or support do you need to be willing to take insulin injections?

The progressive nature of type 2 diabetes requires intensifying therapy over time. Identifying patient concerns and barriers toward insulin and intensifying treatment can help reduce the time to reach A1c goals.

References:

1. Pantalone K, Misra-Hebert A, Hobbs T, et al. Clinical Inertia in Type 2 Diabetes Management: Evidence from a large, real world data set. Diabetes Care 2018;41:e113–e114

2. Cavaiola TS, Kiriakov Y, Reid T. Primary Care management of patients with Type 2 diabetes: overcoming inertia and advancing therapy with the use of injectables. Clin Ther. 2019;41:352e367

Don't let your network status change — complete your FDR attestation today.

If you are a participating provider in our Medicare plans and/or our Medicare-Medicaid plans (MMPs), you must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities. You also have to confirm your compliance with these requirements through an annual attestation.

How to complete your attestation

You'll find the resources you need to ensure your compliance on the "Medicare Compliance FDR Attestation" page at **Aetna.com/health-care-professionals/medicare.html**. Once on the page, under the "Need more information on the Medicare Compliance requirements?" heading, click on "Medicare compliance FDR program guide" or "Office manual."

Once you review the information and ensure that you've met the requirements, you're ready to complete your attestation. Simply click the link on the "Medicare Compliance FDR Attestation" page that corresponds to your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

Claims submission and resubmission.

We would like to remind all providers of the clean claim process, claim resubmission process, claims mailing address and electronic claim submission process. To prevent processing delays, please make sure you are using the information provided below.

Aetna Better Health of Michigan requires clean claims submissions for processing. To submit a clean claim, a participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure

Claims resubmission

All submissions to the claims department must include a completed claim form. For resubmissions, please stamp or write one of the following in black ink on the paper claims: Resubmission, Rebill, Corrected Bill, Corrected or Rebilling.

Claims mailing address

All participating providers should submit claims disputes to:

Aetna Better Health of Michigan
P.O. Box 66215
Phoenix, AZ 85082

Electronic claims submission

Aetna Better Health of Michigan encourages participating providers to electronically submit claims through Emdeon. Please use the following Payer ID when submitting claims to Aetna Better Health of Michigan: Payer ID# Emdeon Payer ID (837 Claim): 128MI.

For electronic resubmissions, participating providers must use resubmission code 7.

Access to our clinical staff.

If you need access to a nurse during normal business hours, 8 AM to 5 PM, call Member Services at **1-866-314-3784** and ask to speak to a nurse.

If you need a nurse after business hours, call **1-866-711-6664**. You will be connected to our 24-hour nurse line. Members or providers with hearing impairment, please use our TTY line at **711**.

Language translation is also provided for free by calling.

This newsletter is published as a community service for the providers of Aetna Better Health® of Michigan. Models may be used in photos and illustrations.