SPRING 2017

NETWORK INSIDER

Cigna news you can use

REMINDER:

HEDIS DATA COLLECTION IS QUICKLY APPROACHING

Each year, we collect data for the Healthcare Effectiveness Data and Information Set (HEDIS), a core set of performance measures that provides an in-depth analysis of the quality of care that health care organizations provide. The National Committee for Quality Assurance (NCQA), employers, and health plans have developed HEDIS as an industry-wide method to help compare and assess a health plan's performance in a variety of areas.

What you need to know

- Our initial requests for medical record reviews are mailed to health care professionals' offices in February each year.
- The mailing includes a list of patients and a detailed description of what is needed from each patient's medical record. The patients identified on each list are chosen through a random selection process.
- The HEDIS medical record review is time-sensitive. Please return the requested documentation within the time-frame noted on the letter of request. We appreciate your timely response.
- HEDIS requests can be completed remotely if you have a secure electronic medical record (EMR) system and allow access through our secure network. This is a more efficient process that can help minimize any disruption to your office. You can also securely fax the requested documentation to us.

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Inside

Cigna®

MISDIRECTED CLAIMS

We strive for patient and provider-centricity every day. Misdirected claims have an adverse impact on both patients and providers. To learn more please visit:
CignaHealthSpring.com > Health Care Professionals > Misdirected Claims Information

HEDIS DATA COLLECTION *continued*

- All personal health information (PHI) is kept confidential, and only shared to the extent permitted by federal and state law. Data is aggregated to reflect just the presence or absence of a particular procedure at the health plan's level.
- HEDIS record collection is considered a health care operation under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, Patient authorization is not required.
- Under your Cigna provider agreement, you are required to cooperate with the HEDIS data collection process.

Vendor collaboration

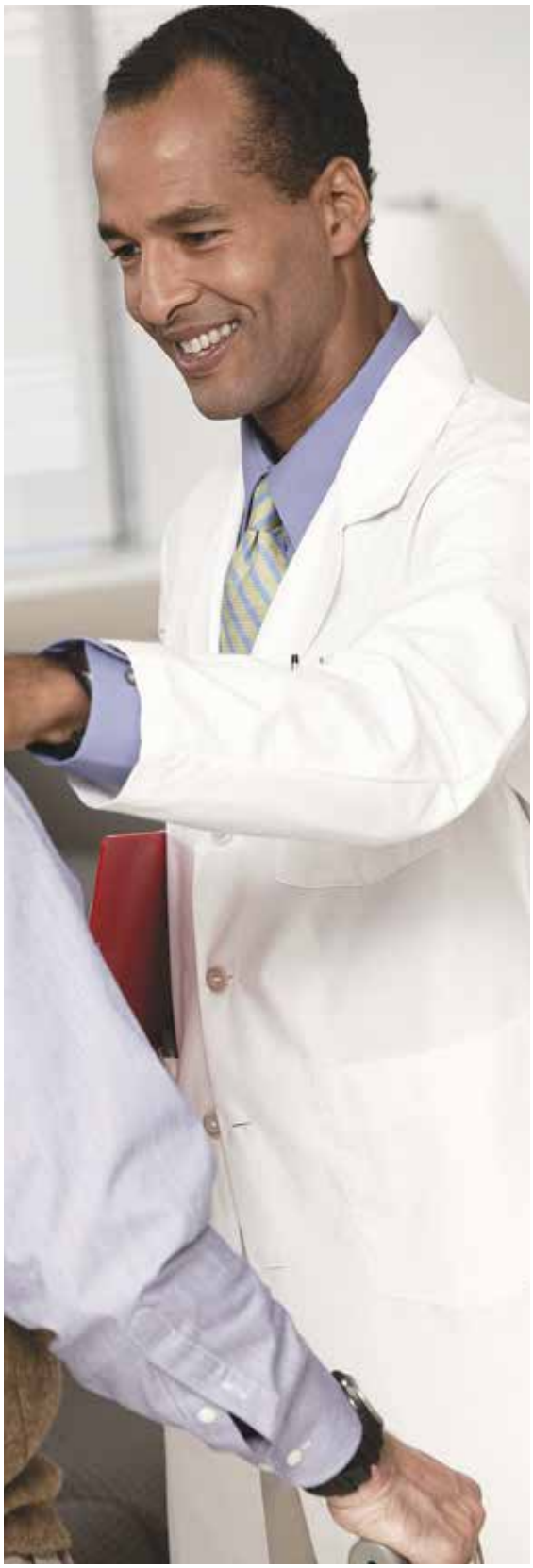
Cigna has partnered with CIOX Health to retrieve medical records selected for the HEDIS data collection process in certain areas. Please note that we have executed a business associate agreement with CIOX and their employees. Any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records, as well as current HIPAA requirements. Please anticipate receiving a call from CIOX to schedule the review. They will work with you to minimize disruptions in patient care activities. We appreciate your cooperation with this request.

Online information

Go to Cigna.com/Medicare/Healthcare-Professionals

- Click Current Provider Manual in the drop-down menu
- Go to HEDIS Record Collection.

You may also visit NCQA.org for more information on HEDIS.



CAHPS AND HOS SURVEY SEASON IS UNDERWAY

As a provider, you play an important role in caring for patients. Thank you for being kind, understanding, and listening to your patients. Your actions affect a patient's overall healthcare experience.

Taking time to talk with patients to make sure they understand their diagnosis, how to take their medications, the importance of sticking to the prescribed medication amount, and also that they understand what the next steps are in their treatment are important for our customers.

Sometimes patients have a hard time discussing uncomfortable or embarrassing topics like urinary incontinence. Keep encouraging patients by asking questions and helping them through the process.

Together we can make a difference in our customer's experience. We are looking forward to a great 2017 of teamwork and positive patient experiences on our 2017 CAHPS survey.

Thank you for all you do.

STATIN USE IN PERSONS WITH DIABETES (SUPD)

SUPD is a new display measure initiated by the Centers for Medicare & Medicaid Services (CMS). Statin use reduces cardiovascular disease (CVD) in people with diabetes, resulting in better health outcomes for our patients and improved Star Quality Ratings. Pharmacy Quality Alliance (PQA) endorsed the SUPD measure and CMS has indicated their intention for the measure inclusion for the 2019 Stars Program (for 2017 dates of service).

CVD is the biggest contributor to morbidity and mortality in diabetic patients, and accounts for the majority of diabetes-associated costs.[1] Use of statin medications has been shown to significantly reduce CVD events.[2] Current diabetes (ADA) and lipid (ACC/AHA) guidelines agree that a statin should be initiated in **all diabetic patients age 40-75 years of age**, in addition to lifestyle modifications, to prevent CVD events.[1,2] All patients 40-75 years of age who have two or more fills of a diabetes medication during the calendar year are included in the measure. Once the patient has one fill of a **statin medication** they will have fulfilled this measurement for the calendar year.

What statins are on the 2016 formulary? Current Cigna formulary statins include

- Tier 1: Atorvastatin, Lovastatin, Pravastatin, Simvastatin
- Tier 2: Rosuvastatin
- Tier 3: Livalo (Step Therapy Required)
- Tier 4: Crestor (Step Therapy Required)

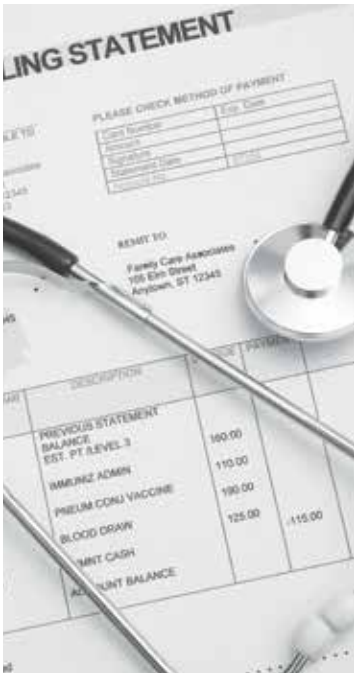
What options are available if my patient experiences intolerance to statins? We recommend alternate-day dosing, adding a Coenzyme (CoQ10) supplement and increased water consumption to improve tolerability.

1 American Diabetes Association. Standards of Medical Care in Diabetes – 2016. Diabetes Care. 2016;39(Suppl. 1):S1-S112.

2 Stone NJ, Robinson J, Lichtenstein AH, et. al. 2013 ACC/AHA Guideline on Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014; 129 (25 suppl 2): S1-45.

BILLING RULES FOR DUAL ELIGIBLE BENEFICIARIES

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. Balance billing prohibitions may also apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. Note that the prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low Income Subsidy copayments still apply for Part D benefits. (Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; 42 C.F.R. §422.504(g)(1)(iii))



For additional Information Regarding Dual Eligible Billing Rules, Cigna-HealthSpring Cost-Sharing, and Medicaid Coverage Groups please visit our provider manual.

https://www.cigna.com/medicare/healthcare-professionals/provider-manual/ Select Customer Information>Dual Eligible Individuals> Cigna-HealthSpring Cost-Sharing Chart> Medicaid Coverage Groups

MAKE SURE YOUR CONTACT INFORMATION IS CORRECT

Check your listing in the Cigna Arizona Medicare directory.

We want to be sure that patients have the right information they need to reach you when seeking medical care. We also want to accurately indicate whether you are accepting new patients. Please check your listing in our provider directory, including your office address, telephone number, and specialty. To view your listing in the directory please visit https://providersearch.hsconnectonline.com/OnlineDirectory

If your information is not accurate or has changed, it's important to notify us. Submit changes electronically using the online form available on the Cigna for Health Care Professionals website (https://www.cigna.com/healthcare-professionals/). Select Find a Form and then select Cigna Medicare Advantage Health Care Professional Change Form. After you select Health Care Professional Change Form, you will be directed to the electronic form to complete and submit. You may also submit your changes via:

Email: **AZMA_PDV@Cigna.com**

Fax: **888-230-7302**

Mail: **Attn: Cigna Medicare**
25500 N Norterra Dr Bldg. B
Phoenix, AZ 85085

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER AND SYSTEMS (CAHPS)

Did you know CMS could send a survey to your Medicare patients to evaluate their experiences with their health care services? This includes their communication and connection with you, their provider, as they navigate the health system. There is increasing evidence linking patient experience to other important clinical and business outcomes. Good patient experience is associated with lower medical malpractice risk and a major predictor of patient loyalty.[i] Also, positive patient-doctor interactions lead to higher adherence to medical advice and treatment, and help to encourage patients to demonstrate greater self-management skills.[ii] [iii] Together, we can work to make sure our patients are getting the best possible healthcare experience.

The CAHPS survey asks questions to assess measures on matters that are proven to be important to the patient. Answers are collected by mail or phone from March-June of every year. It includes the following areas:

Getting Needed Care

- In the last 6 months, how often was it easy to get appointments with specialists?

Getting Appointments and Care Quickly

- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Annual Flu Vaccine

- Have you had a flu shot since July 1, 2016?

Care Coordination

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

What can you do to help make the patient experience become more positive?

1. **Wait times -** we know that it's hard to get patients in within 15 minutes of their appointment time but sometimes a simple explanation from YOU could help alleviate member frustration. Also, a clear statement of how long the wait will be at the start of the visit is also proven to help. Make sure your waiting room is well stocked with current magazines to help patients pass the time.
2. **Flu Shots -** this seasonal vaccine is the single best way to avoid the flu. Make sure your patients are well protected.

[i] Sequist TD, Schneider EC, Anastario M, Odigie EG, Marshall R, Rogers WH, et al. Quality monitoring of physicians: linking patients' experiences of care to clinical quality and outcomes. J Gen Intern Med. 2008; 23(11):1784–90.

[ii] DiMatteo, MR. Enhancing patient adherence to medical recommendations. JAMA. 1994; 271:79-83.

[iii] Beach MC, Keruly J, Moore RD. Is the quality of the patient-provider relationship associated with better adherence and health outcomes for patients with HIV? Journal of General Internal Medicine 2006; 21(6):661-665.

FORMULARY UPDATES

Effective 3/1/ 2017 (unless otherwise noted)

Name of Affected Drug	Description of Change
Ezetimibe	Addition to formulary
Epinephrine Auto-Injector	Addition to formulary (effective 1/30/17)
Anoro Ellipta	Addition to formulary (AZ MAPD only)
Oseltamivir	Addition to formulary with Quantity Limit
Rasagaline	Addition to formulary with Quantity Limit
Kyprolis	Addition to formulary with Prior Authorization
Ribavirin	Addition to formulary with Prior Authorization
Aprepitant	Addition to formulary with Prior Authorization and Qty Limit
Epclusa	Addition to formulary with Prior Authorization and Qty Limit
Rubraca	Addition to formulary with Prior Authorization and Qty Limit
Tecfidera	Addition to formulary with Prior Authorization and Qty Limit
Zubsolv	Addition to formulary with Prior Authorization and Qty Limit
Livalo	Addition to formulary with Step Therapy and Qty Limit
Voltaren Gel	Removal of Step Therapy Edit (effective 1/25/17)

PHARMACY UPDATE

60-day formulary change notifications

Every month, the Preferred Drug List (formulary) is updated. Changes include but are not limited to removal of brand products, addition of new products including generics and removal/addition of UM restrictions such as quantity limit, step therapy, or prior authorizations. Information regarding changes may be found on our website at cigna.com/medicare/part-d/drug-list-formulary.

60-day notification for medical removal from formulary

When a medication is removed from the list, providers will be notified at least 60 days before it is removed, or if prior authorization, quantity limit or step therapy restrictions have been placed on a medication. This information will also be updated, along with any drugs added to the formulary, on our website at cigna.com/medicare/part-d/drug-list-formulary.

Formulary exception requests

Physicians may request exceptions to our coverage rules if medically necessary. Cigna-HealthSpring will make a determination within 72 hours after we receive the request from the physician. Formulary exception request forms are available on our website cigna.com/medicare/resources/2017-customer-forms and may be faxed to **1-866-845-7267**.

ANNUAL AMBULATORY MEDICAL RECORD REVIEW REMINDER

Cigna conducts an annual Ambulatory Medical Record Review to assure physicians are addressing all elements in a patient's record as required by national documentation standards. A random sample is reviewed which includes Medicare and Medicaid contracts. Though the review exceeded the passing score of 70% in 2016, the top three standards consistently lacking supportive evidence of inclusion in the record were:

- Opportunity to complete Advance Directives either offered or reviewed for update purposes
- Sexual practices discussed
- Medication profile included refill dates (other than new prescriptions)

Thank you for assisting us in our efforts to encourage superior quality of care and effective care coordination for your Cigna patients by reviewing these items with patients or their caregivers at least once each calendar year. The current Cigna 360 examination form is an excellent tool for covering required documentation elements.

For more information:
(860) 907-5573
billie.wallace@healthspring.com

OPIOID QUALITY IMPROVEMENT PLEDGE

As a health care provider, you have likely seen the many harmful affects of opioids on individuals, families, and communities, including a growing number of overdoses and deaths. This is a complex problem that will take many different solutions and stakeholders to solve. But, working together, we can take actions that can make a difference.

Let's help turn the tide

To help prevent patients from becoming dependent on opioid prescription drugs, and stem the tide of deaths, we are developing initiatives to work collaboratively with providers. One of these initiatives is the Opioid Quality Improvement Pledge. Its goals are to raise awareness of the Surgeon General's '*Turn the Tide*' prescriber pledge[1], and to ask providers for their commitment to quality improvement activities that will:

- Reduce potentially hazardous opioid prescribing.
- Improve the coordination and quality of care for patients who are taking opioids.

In addition, the Provider Opioid Quality Improvement Pledge asks providers to develop quality improvement activities focused on reducing potentially hazardous prescribing and coordination of care for patients currently taking an opioid.

How to sign the pledge

We invite you to review and sign the Opioid Quality Improvement Pledge by going to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Pharmacy > Pharmacy Clinical Programs > Enhanced Narcotic Therapy Management > Opioid Quality Improvement Pledge). Once you have completed and signed the pledge, please email it to PledgeResponses@Cigna.com

Additional Information and Resources, including guidelines for prescribing opioids for chronic pain, are available on the CDC website (CDC.gov > CDC A-Z index > O > Opioid Overdose > Opioid Basics > *Understanding the Epidemic*).

[1] "*The Surgeon General's Call to End the Opioid Crisis*" (turnthetiderx.org).

ICD-10 LATERALITY PROVIDER COMMUNICATION

Beginning **July 1,** 2017, Cigna will update policies and claims payment systems align with correct-coding initiatives from CMS guidelines, national benchmarks and industry standards, such as the American Medical Association (AMA) Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases, 10th Edition/Revision (ICD-10) code sets regarding physician/health care provider and facility claims.

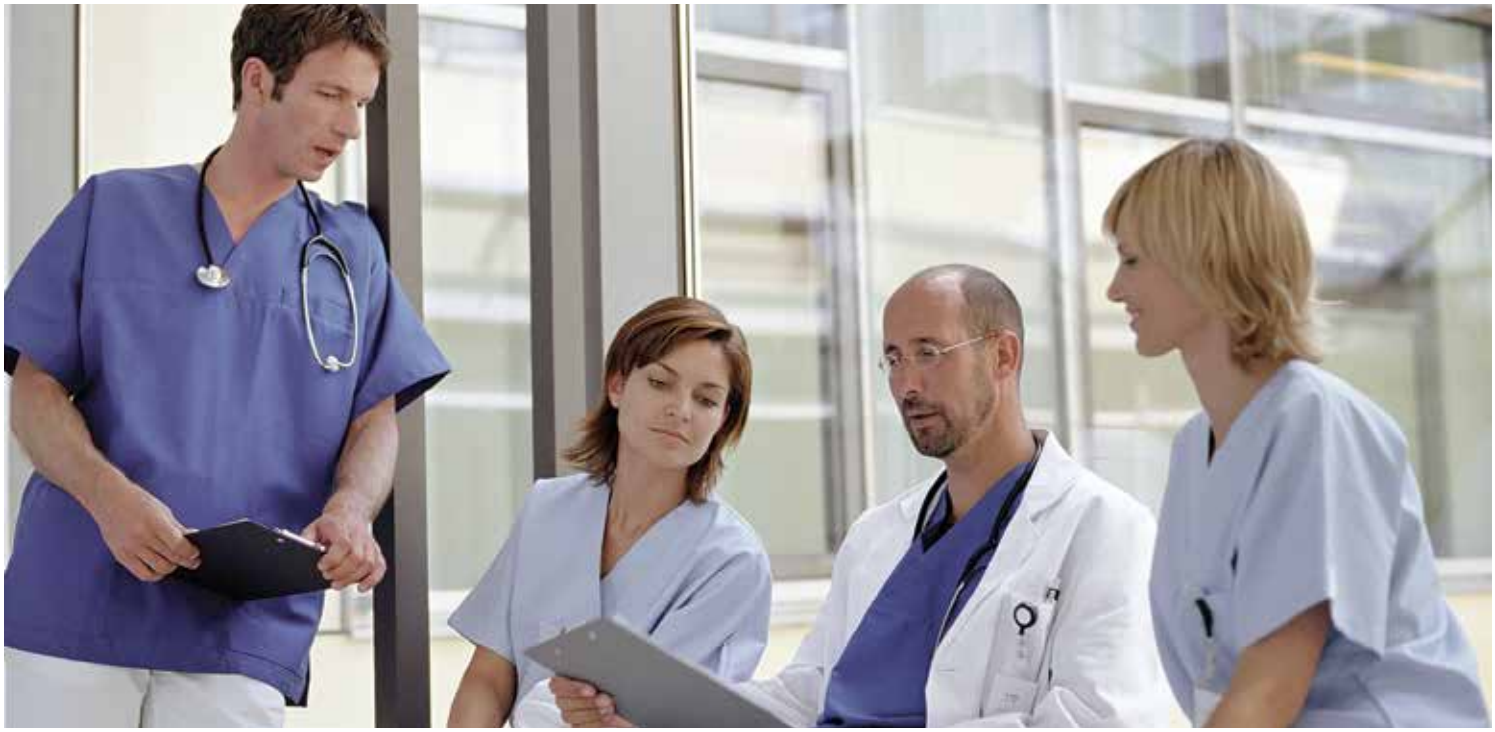
Due to these changes, we are taking this time to communicate to our providers that based on the ICD-10 coding guidelines, new diagnosis coding policies will be implemented:

- **ICD-10-CM Laterality policy for Diagnosis-to-Modifier comparison.**
- **ICD-10-CM Laterality policy for Diagnosis-to-Diagnosis comparison**

Our policies are to support the unique attributes to the ICD-10-CM code set for the reporting regarding laterality that have been built into code descriptions. Some ICD-10-CM codes specify whether the condition occurs on the left or right, or is bilateral. For example: if no bilateral code is provided and the condition is bilateral, then codes for both left and right should be assigned. If the side is not identified in the medical record, then the unspecified code should be assigned.

For additional information please reference your current ICD-10 Manual and the CMS Medicare Learning Network document, ICD-10–CM Classification Enhancement at the following link: https://www.cms.gov/Medicare/Coding/ICD10/downloads/icd-10quickrefer.pdf

If you have questions about this communication, please contact your Provider Account Representative.



PREFERRED PHARMACY NETWORK

As a reminder, Cigna Medicare Advantage plans now offer a preferred pharmacy network. Our PDP (Part D only) plans utilized a preferred network in 2016 and will continue to do so in 2017. The preferred pharmacy network supports affordability for patients while helping to improve health outcomes. By negotiating with many of our contracted pharmacies, we were able to either lower or maintain drug copays for patients who utilize this preferred network. Most patients filling their medications at these pharmacies will experience lower copays than when using a standard pharmacy in our network[1]. Performance on medication adherence metrics is a component of the agreement with pharmacies in our preferred network. This increased focus from our preferred network pharmacies, coupled with the reduced copays at these pharmacies, should help improve your patients' medication adherence.

The preferred network includes several large and regional chains in addition to local pharmacies. The following is a list of some of the over 32,000 retail pharmacies that are participating in our preferred pharmacy network for 2017 (up-to-date pharmacy directories can be accessed at https://www.cigna.com/medicare/medicare-advantage/pharmacy-options):

Patients can also find network pharmacies in their area by going to www.cignahealthspring.com and hitting the "Find a Pharmacy/Drug" button. This will direct them to a geo-coded system that will identify preferred and standard network pharmacies near a specific address.

Cigna patients still have the option of filling their prescriptions at either preferred or standard network pharmacies. The copay difference has been communicated to them by mail.

[1] The preferred network pharmacy copay difference does not apply to patients in Cigna-Healthspring TotalCare, Primary, or Traditions plans. Also, patients who receive a low-income subsidy (LIS) may not see a copayment difference as their copayments are set by CMS. The copay difference also does not apply to Tier 5 – Specialty Drugs.

PNEUMONIA VACCINATION UPDATE

The CDC issued an update on pneumococcal vaccination of adults 65+ in 2014. The recommendation was that adults 65+ be vaccinated with both Prevnar 13® (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM197 Protein])[1] and the Pneumovax 23 (Pneumococcal Polysaccharide vaccine 23 valent), based on the findings of the Advisory Committee on Immunization Practices (ACIP)[2].

Cigna hospital admission statistics have shown pneumonia to be one of the top three causes for admission. In an effort to address this serious health problem in the 65+ population, Cigna supports the updated ACIP recommendations. The CDC recommendations for adults 65+ had a change in 2016 as follows:

Pneumococcal Vaccine- naïve* adults aged ≥ 65	Adults previously vaccinated with PPSV23 at age ≥ 65	Adults previously vaccinated with PPSV23 before age 65 years who are now aged ≥ 65
Administer Prevnar 13® first	Administer Prevnar 13® *(at least 1 year after the most recent dose of PPSV23)*	Administer Prevnar 13® *(at least 1 year after the most recent dose of PPSV23)*
12 months later† Administer dose of PPSV23‡ *(or during the next visit)*		12 months later†, administer subsequent dose of PPSV23‡ *(no sooner than 5 years after the most recent dose of PPSV23)*

* Pneumococcal vaccine naïve or unknown vaccine history.
† Minimum interval between sequential administration of Prevnar 13® and PPSV23 is 12 months
‡ The 2 vaccines (Prevnar 13® and PPSV23 should not be coadministered)

Prevnar 13® is indicated for active immunization for the prevention of disease caused by *Streptococcus pneumoniae* serotypes 1,3,4,5,6A,6B,7F,9V,14,18C,19A,and 23F. Effectiveness of Prevnar 13® when administered < 5 years after the PPSV vaccine is given are unknown.

Changes in the 2016 adult immunization schedule for the pneumonia vaccines from the 2015 schedule included the following new ACIP recommendations:

> Interval change for 13-valent pneumococcal conjugate vaccine (PCV13) followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23) from "6 to 12 months" to "at least 1 year" for adults aged ≥ 65 years who do not have immunocompromising conditions, anatomical or functional asplenia, cerebrospinal fluid leaks, or cochlear implants (1). The interval for adults aged ≥ 19 years with any of these conditions is at least 8 weeks (2)[3].

Both pneumonia vaccines are a covered benefit for Cigna patients.
The billing code for each vaccine is:

Vaccine	CPT Code
Prevnar 13®	90670
PPSV23	90732

For further information, links to the referenced article in the CDC report are provided below:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm
http://www.cdc.gov/mmwr/volumes/65/wr/mm6504a5.htm

If you have additional questions, please feel free to contact your Network Operations representative.

[1] Prevnar 13® (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM197 Protein]) prescribing Information Wyeth Pharmaceuticals. Inc.; 2014
[2] Tomczyk S, Bennett NM, Stoecker C, et al; Centers for Disease Control and Prevention (CDC). Use of 13- valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults aged ≥65 years: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Morb Mortal Wkly Rep. 2014;63(37): 822-825.
[3] http://www.cdc.gov/mmwr/volumes/65/wr/mm6504a5.htm

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