Aetna Better Health® of Kentucky

# Provider Newsletter

**First Quarter 2019**


Welcome to the Aetna Better Health of Kentucky Quarterly Provider Newsletter! In these issues you will find important updates along with relevant, seasonal health topics that we hope you can use and pass along to all your patients. If you have any suggestions on content, we would love to hear them. Please share any and all feedback with your Network Relations Manager.

## IN THIS ISSUE



**See Page 10 for our current Network Relations Manager Team List.**

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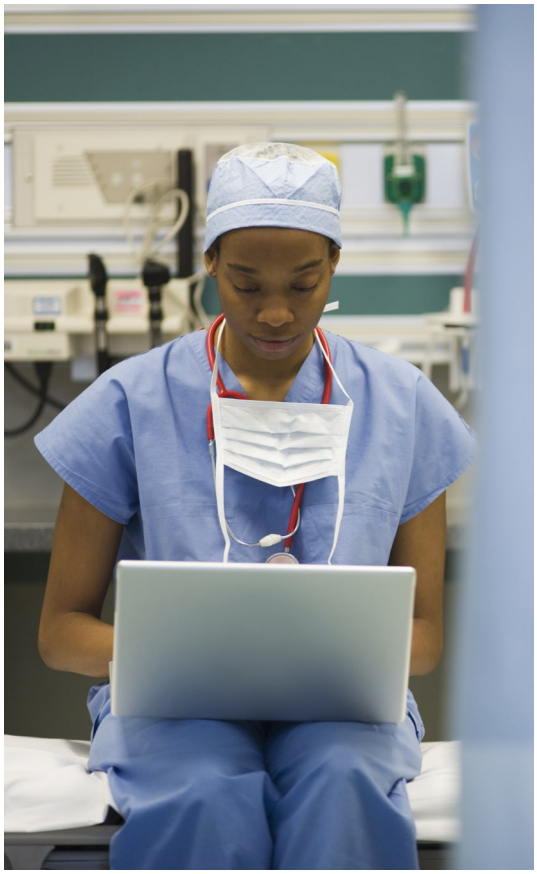
# CONSIDER DEPRESCRIBING



Deprescribing refers to the process of reducing or discontinuing medications, with the goal of minimizing inappropriate use and preventing adverse patient outcomes. The utilization of potentially inappropriate medications is associated with adverse drug events, hospitalizations, and poorer health-related quality of life.[1]

The more medications a person takes, the greater the risk of them having an adverse drug event. While initially prescribed to address legitimate medical conditions, some medications are not intended, nor medically necessary, to be used for the remainder of a patient's lifetime. Diet and lifestyle modifications can improve or sometimes completely resolve some conditions, making the usage of chronic medications no longer necessary for symptom control. The aging process also causes the kidneys and liver to be less efficient metabolizing certain medications, which may necessitate a dosage reduction, change in therapy, or complete discontinuation in order to reduce the risk of an adverse drug event. This is particularly important to consider among elderly patients, since a significant number of hospital stays among older adults are attributed to drug-related complications.

Deprescribing should be a shared decision-making process between the provider and patient or their caregiver. Below are three steps to keep in mind when considering deprescribing:

1. The first step should always include a comprehensive medication history including:
   - assessment of the patient's adherence to their medications
   - weighing overall risks and benefits depending on individual patient factors, including life expectancy, cognitive and functional factors, and impairments the medications may be causing (i.e. increased fall risk or impaired cognition)
   - drug related factors, including daily pill burden, complexity of medication regimen, and potential drug-drug interactions
2. Determine which medications are most important to the patient. Identify potentially inappropriate medications with no clear indication (due to the condition being resolved or uncertainty as to why initially prescribed) and medications with questionable efficacy.
3. Consider whether abrupt discontinuation of the medication is known to cause withdrawal symptoms, and if so ensure a slow dose reduction is made. This is common among many hypertensives, antidepressants, anxiolytics, and pain medications. When a slow dose reduction is required, include specific documentation on the tapering plan and ensure that clear communication is provided to the patient, their caregivers, and other clinicians.

1. Anderson K, Stowasser D, Freeman C, et al. Prescriber barriers and enablers to minimizing potentially inappropriate medications in adults: a systematic review and thematic synthesis. BMJ Open 2014;4:e006544.

## CAHPS SURVEY

The 2019 CAHPS survey is scheduled to be released in February. The survey measures member satisfaction with their health plan.

After reviewing results from the 2018 survey, we found a trend involving questions related to prescriptions and/or OTC medications, specifically when to take them and when not to take them. This was especially evident among the CHIP and child population. We ask for your support in helping us make sure our members know all about their prescribed and recommended OTC medications BEFORE leaving your office.

One recommended way to ensure patient understanding is to ask open-ended questions that assess their understanding of their medication. For example, "I have given you a lot of information, what can you tell me about how to take this medication?"[1]

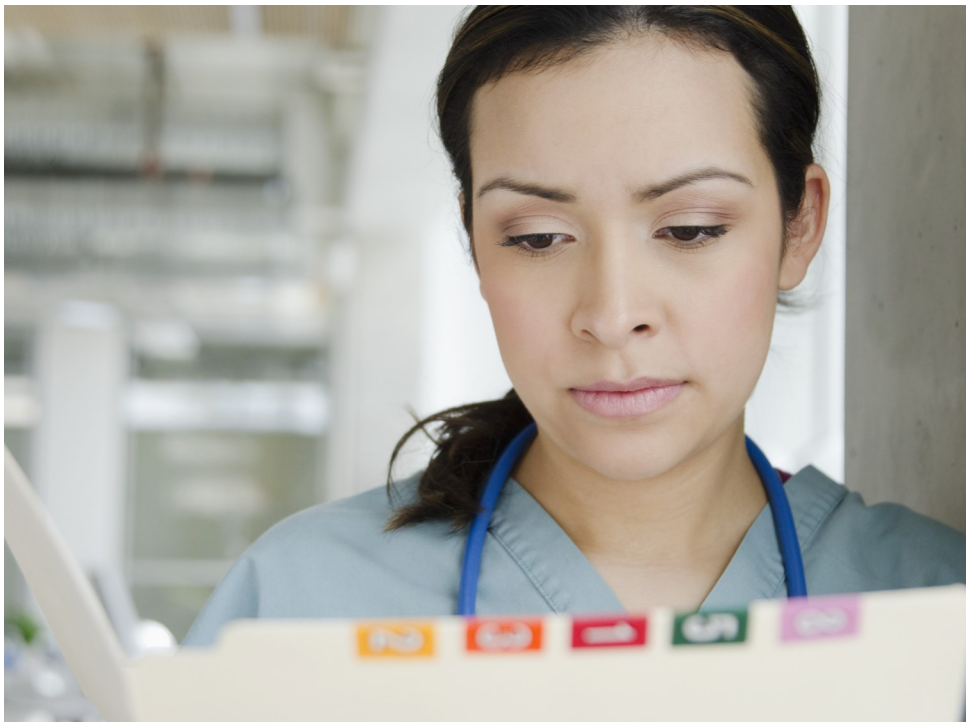
1. Kemp, E., Floyd, M., McCord-Duncan, E., & Lang, F., (2008). Patients prefer the method of "tell back-collaborative inquiry" to assess understanding of medical information. *J Am Board Fam Med. 21*(1): 24-30.

## FLU FACTS

For the 2018-2019 Flu season, flu activity has been increasing in Kentucky.

We encourage our providers to recommend their unvaccinated patients receive a flu shot.

Please click on this link to the Kentucky Medical Association to find helpful flu information: **https://kyma.org/shared/content/uploads/2018/09/Flu-in-Kentucky-Snapshot-July-2018.pdf**



## HEDIS REMINDER



February marks the beginning of our annual HEDIS season. Please be aware that your office may receive a request for medical records from us. We appreciate your cooperation in this important endeavor. You can find helpful HEDIS recorded trainings on our website, **www.aetnabetterhealth.com/Kentucky/providers**.

# FOUR MOMENTS TO PROMOTE ANTIBIOTIC STEWARDSHIP

Antibiotic resistance is an increasingly serious threat to communities, both locally and globally, as bacteria are continuing to develop resistance to routinely prescribed antibiotics. This can lead to higher medical costs, prolonged hospital stays, and increased mortality for our patients. Each year in the United States, at least two million people become infected with bacteria that are resistant to antibiotics; approximately 23,000 people die as a direct result of these infections.[1] It is estimated that antibiotics cause 1 in 5 emergency department (ED) visits for adverse drug events and are the most common cause of ED visits for adverse drug events in children.[2]

Optimizing antibiotic use is vital to help reduce antibiotic associated harm as well as the spread of antibiotic resistance.[3] Clinicians are encouraged to take an organized approach in order promote antibiotic stewardship. The Agency for Healthcare Research and Quality (AHRQ) Safety Program for Improving Antibiotic Use aims to improve antibiotic stewardship by encouraging clinicians to incorporate four moments of antibiotic decision making into their thought process when prescribing antibiotics.[3] These four moments are intended to provide clinicians with a structured approach to improve antibiotic prescribing that can be used in the acute care setting.[3] Applying these four moments of antibiotic decision making can help each time antibiotic therapy is being considered.

**Moment One** • ***Does this patient have an infection that requires antibiotics?*** • Pause and consider if a noninfectious process is more likely. A common scenario in which antibiotics are generally not indicated is asymptomatic bacteriuria.[3] Several studies have shown that bacteriuria is common and that antibiotic treatment of patients with asymptomatic bacteriuria increases the likelihood of subsequent urinary tract infections that are resistant to common antibiotics.[4]

**Moment Two** • ***Have I ordered appropriate cultures before starting antibiotics? What empirical antibiotic therapy should I initiate?*** • Lack of appropriate cultures can lead to prolonged antibiotic therapy when no bacterial infection exists or continuation of broad spectrum antibiotics when narrow spectrum antibiotics could be used which may have a more favorable adverse event profile.[3] Local antibiotic guidelines should be made available at the point of care for common inpatient infectious conditions to ensure that appropriate knowledge is available.

**Moment Three** • ***A day or more has passed.*** • ***Can I stop antibiotics or narrow therapy? Can I change from intravenous to oral therapy?*** • Moment 3 reminds prescribers to perform daily antibiotic reviews for every patient receiving an antibiotic. This can be achieved by having routine verbal discussions by the clinical care team during rounds. Decisions resulting from these daily reviews should be documented in progress notes, including the indication for continued antibiotic therapy, the day of therapy, plans to narrow or switch to oral therapy, and the expected duration of therapy.[3]

**Moment Four** • ***What duration of antibiotic therapy is needed for this patient's diagnosis?*** • An increasing amount of studies support shorter durations of therapy than previously administered for infections such as community-acquired pneumonia, intra-abdominal infections, urinary tract infections, and gram-negative bacteremia.[5] The duration of therapy should be based upon the literature as well as an assessment of the clinical response that the patients has achieved.[3]

**References:**


1. Centers for Disease Control and Prevention. **http://www.cdc.gov/drugresistance/index.html**. Published online August 17, 2016. Accessed January 4, 1019.
2. World Health Organization. **http://www.who.int/mediacentre/factsheets/antibiotic-resistance/en/.** Published online October, 2016. Accessed January 4, 2019.
3. Tamma PD, Miller MA, Cosgrove SE. Rethinking How Antibiotics Are Prescribed: Incorporating the 4 Moments of Antibiotic Decision Making Into Clinical Practice. JAMA. Published online December 27, 2018. Accessed January 7, 2019.
4. Cai T. Nesi G, Mazzoli S, et al. Asymptomatic bacteriuria treatment is associated with a higher prevalence of antibiotic resistant strains in women with urinary tract infections. Clin Infect Dis. 2015;61(11):1655-1661.
5. Spellberg B. The new antibiotic mantra. JAMA Intern Med. 2016:176(9):1254-1255.

## CLINICAL FOCUS

## January - Cervical Cancer Screening Month

Please remember that HPV vaccines can help prevent infection from high risk HPV types that can lead to cervical cancer and low risk types that cause genital warts. The CDC recommends all boys and girls get the HPV vaccine at age 11 or 12 as the vaccines produces a stronger immune response when taken during the preteen years. The vaccine is available for all males and females through age 45. Download facts and resources related to this important initiative at **http://www.nccc-online.org/hpvcervical-cancer/cervical-health-**

## February - American Heart Month

Heart disease is the leading cause of death in the United States. During this month, we encourage our providers to discuss the risks for heart disease with all your patients.

According to the CDC, in 2014 Kentuckians had over 109 instances of mortality from heart failure per 100,000 people. This month, we are shining the spotlight on heart failure and sharing the American Heart Association's Guidelines for targeting HF strategies and preventing re-admission

**https://www.heart.org/en/professional/quality-improvement/target-heart-failure/strategies-and-clinical-tools**

## March - Colorectal Cancer Awareness Month

Bring awareness to colorectal cancer and wear Blue all month, but especially on March 1st. We believe everyone should get screened, the only questions are when, using what method and how often. Find more resources for healthcare professionals at **https://www.ccalliance.org/colorectal-cancer-information/resources-for-healthcare-professionals**

**REMINDER:**
**On March 01, 2019—Wear Blue for Colorectal Cancer Awareness**

### Appropriate utilization of care without conflict of interest nor incentives

Aetna Better Health of Kentucky doesn't reward practitioners, providers, or employees who perform utilization reviews, including those of the delegated entities for not authorizing health care services. No individual is compensated or provided incentives to encourage denials, limited authorization or discontinue medically necessary covered services. Aetna Better Health does not make decisions about hiring, promoting or terminating practitioners or other staff based on the likelihood or on the perceived likelihood that the practitioner or staff member supports, or tends to support, denial of benefits. Individuals shall not participate in the review and evaluation of a case in which he/she has been professionally involved or where his/her judgment might be compromised. Utilization decisions are made based only on appropriateness of care and service and existence of coverage.

# ATTESTATION SUBMISSION FOR MEDICALLY FRAIL

Medically Frail is a Waiver benefit assignment created to identify members who are not able to meet the work requirement of the Kentucky Waiver program, due to specific health conditions. The medically frail attestation process is not an assignment of disability, but rather members are placed in a benefit package which is unique to members with those conditions.

These conditions may qualify a member for the Medically Frail benefit assignment:

- **Disabling mental disorder**
- **Substance use disorder (excluding tobacco and cannabis)**
- **Serious and complex medical condition**
- **Physical/intellectual/developmental disability that impairs one or more activities of daily living (ADL)**
- **Chronic homelessness**

The clinical attestation is a manual process by which the member's PCP or specialist will answer a uniform set of questions about the member and attest that the information provided is accurate. Once submitted it will be scored. There are two methods to submit this information for scoring to the MCO:

1. **Provider portal -** access **http://www.aetnabetterhealth.com/Kentucky** then click "For Providers" and then "provider portal". From there you must log in using your secure log in ID. If you do not have access you will be able to complete a registration form for the secure provider web portal. Sign in securely, then select provider documents, and then at the bottom under "Health Tools" select Provider Deliverable Manager. Now click on "Enter/Upload Deliverable". The attestation/assessment is the same online as it is in the hardcopy. Once the information is submitted, it will be scored, and the score will be available the next day.

2. **The clinical attestation** is a set of questions/assessment of the member's current health status. The medically frail team inputs that information into a system that utilizes the same system to score a member. This is the same algorithm as the online version. If a member meets the criteria, then the member will receive a 12-month assignment for that benefit. Members are reevaluated every twelve (12) months for continued enrollment in that benefit plan. Please fax the attestation to the case management team at **(959) 282-8582**. You may also contact the medically frail team for assistance via email at **KENTUCKY_MEDICALLYFRAILATTESTATION@Aetna.com**.

Medically frail is not disability. Once the waiver goes live, there is no cost share for members assigned the medically frail benefit. They will not have to pay premiums or co-pays once the waiver goes live. Co-pays that are effective **January 01, 2019** are still in effect for members deemed medically frail until the waiver goes live.

Questions about the medically frail process? Simply call **1-855-300-5528** and ask to speak to a medically frail case manager. We are proactively assisting providers with medically frail attestation for the members in their practice. If your office would like further information or a demonstration on the process, simply contact us.

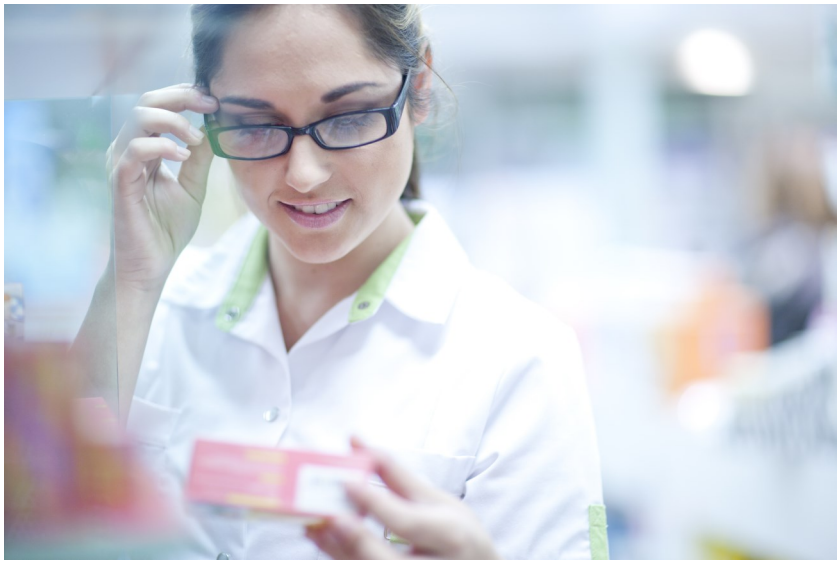
# PHARMACY FORMULARY UPDATES

The following drugs are being removed from the formulary.

These formulary changes are effective **February 01, 2019**.

Please note the formulary alternatives in the second column.

| Non-Formulary Agent | Formulary Alternatives |
|---|---|
| Condylox Gel 0.5% | podofilox solution 0.5%<br>imiquimod cream 5% |
| Elidel 1% cream | tacrolimus 0.1% or 0.03% ointment |
| Humalog<br>Humalog Kwik Pen<br>Novolog<br>Novolog Pen | Admelog<br>Admelog SoloStar |
| Invokana | Steglatro (requires STEP through metformin) |
| Invokamet<br>Invokamet XR<br>Synjardy<br>Synjardy XR | Segluromet (requires STEP through metformin) |
| Flovent Diskus<br>Pulmicort Flexhaler<br>Qvar | Arnuity Ellipta<br>Qvar RediHaler |
| Dulera | Fluticasone – Salmeterol generic<br>Breo Ellipta |
| Trulicity | Ozempic (Step Therapy required)<br>Victoza (Step Therapy required) |



# UTILIZATION MANAGEMENT (UM) PHARMACY REQUIREMENT CHANGES


In addition to formulary updates, we are making the following changes to the UM pharmacy requirements:

| Medication | New UM Pharmacy Requirements |
|---|---|
| Jardiance | Prior authorization required. Trial of Steglatro or Segluromet OR in members with DM2 and established cardiac disease. |
| Flovent HFA | Age limit (maximum 12 years) |
| Breo Ellipta | Age limit (minimum 18 years) |
| Citalopram Sol 10mg/5ml<br>Escitalopram Sol 5mg/5ml<br>Nortriptyline Sol 10mg/5ml | Prior authorization required over 12 years of age. |
| Acyclovir Sus 200mg/5ml<br>Tamiflu/Oseltamivir Sus 6mg/ml | Prior authorization required over 12 years of age. |
| Prednisone Sol 5mg/5ml | Prior authorization required over 12 years of age. |
| Dicyclomine Sol 10mg/5ml<br>Famotidine Sus 40mg/5ml<br>Carafate Sus 1gm/10ml<br>First-Lansoprazole Sus 3mg/ml<br>First-Omeprazole Sus 2mg/ml | Prior authorization required over 12 years of age. |
| Nitrofurantoin Sus 25mg/ml | Prior authorization required over 12 years of age. |
| Abilify Maintena SYN, SDV 300mg, 400mg | QLL 1 EA per 28 days |
| Ondansetron ODT 4mg | QLL 3 EA per day |
| Aristada 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml | QLL 1 syringe per 28 days |
| Aristada 1064mg/3.9ml | QLL 1 syringe per 60 days |
| Aripiprazole tab 2mg, 5mg, 10mg, 15mg, 20mg, 30mg | QLL 1 EA per day |
| Aripiprazole sol 1mg/ml | QLL 25 ML per day |
| Clozapine tab, ODT 25mg | QLL 3 EA per day |
| Clozapine tab, ODT 50mg, 200mg | QLL 4 EA per day |

**Visit our Website - https://www.aetnabetterhealth.com/kentucky**

We invite you to visit our convenient web site, available 24/7 to access provider resources such as:

- Provider manual
- Provider news, to include all fax blast communication
- Access to the web portal
- Quality information

# UTILIZATION MANAGEMENT (UM) PHARMACY REQUIREMENT CHANGES - *Continued*

| Medication | New UM Pharmacy Requirements |
|---|---|
| Clozapine ODT 150mg | QLL 6 EA per day |
| Clozapine tab, ODT 100mg | QLL 9 EA per day |
| Fluphenazine decanoate inj 25mg/ml | QLL 10 ML per 34 days |
| Fluphenazine elixir 2.5/5ml | QLL 80 ML per day |
| Fluphenazine conc 5mg/ml | QLL 8 ML per day |
| Haloperidol tab 0.5mg, 5mg | QLL 5 EA per day |
| Haloperidol tab 20mg | QLL 6 EA per day |
| Haloperidol tab 1mg, 2mg, 10mg | QLL 10 EA per day |
| Haloperidol decanoate inj 100mg/ml | QLL 5 ML per 28 days |
| Haloperidol decanoate inj 50mg/ml | QLL 10 ML per 28 days |
| Haloperidol lactate inj 5mg/ml | QLL 12 ML per 34 days |
| Haloperidol conc 2mg/ml | QLL 1500 ML per 30 days |
| Invega Sustena inj (all strengths) | QLL 1 syringe per 28 days |
| Invega Trinza inj (all strengths) | QLL 1 syringe per 84 days |
| Lithium carbonate cap 600mg | QLL 4 EA per day |
| Lithium carbonate er tab 450mg | QLL 6 EA per day |
| Lithium carbonate tab, cap, er tab 300mg | QLL 8 EA per day |
| Lithium carbonate cap 150mg | QLL 16 EA per day |
| Lithium sol 8meq/5ml | QLL 1200 ML per 30 days |
| Loxapine cap 5mg, 10mg, 50mg | QLL 5 EA per day |
| Loxapine cap 25mg | QLL 10 EA per day |
| Perphenazine tab 16mg | QLL 4 EA per day |
| Perphenazine tab 8mg | QLL 5 EA per day |
| Perphenazine tab 2mg, 4mg | QLL 6 EA per day |
| Prochlorperazine sup 25mg | QLL 2 EA per day |
| Prochlorperazine tab 10mg | QLL 4 EA per day |
| Prochlorperazine tab 5mg | QLL 8 EA per day |
| Risperidone tab, ODT 3mg | QLL 3 EA per day |
| Risperidone tab, ODT 4mg | QLL 4 EA per day |
| Risperidone soln 1mg/ml | QLL 16 ML per day |
| Risperdal Consta inj (all strengths) | QLL 2 vials per 28 days |
| Thioridazine tab 25mg, 50mg | QLL 3 EA per day |
| Thioridazine tab 10mg | QLL 6 EA per day |
| Thioridazine tab 100mg | QLL 8 EA per day |
| Trifluoperazine tab 5mg | QLL 3 EA per day |
| Trifluoperazine tab 1mg, 2mg, 10mg | QLL 4 EA per day |
| Thiothixene cap 1mg, 2mg, 5mg, 10mg | QLL 6 EA per day |

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# Network Relations Manager Contact List

| | |
|---|---|
| **Regions 1 & 2**<br>Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, McCracken Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster<br>**Providers in the state of Indiana** | **Gina Gullo**<br>Network Relationship Manager<br>**502-612-9958**<br>**Rlgullo@aetna.com** |
| **Region 3**<br>Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, Washington | **Connie Edelen**<br>Network Relationship Manager<br>**502-240-2122**<br>**Czedelen@aetna.com** |
| **Region 4**<br>Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne<br>**Providers in the state of Tennessee**<br>**Providers located in any state not otherwise listed** | **Abbi Wilson**<br>Network Manager<br>**270-816-0893**<br>**Wilsona8@aetna.com** |
| **Region 5**<br>Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford | **Sammie Asher**<br>Network Relationship Manager<br>**606-401-1573**<br>**Ashers@aetna.com** |
| **Region 6**<br>Boone, Campbell, , Gallatin, Grant, Kenton, Pendleton<br>**Providers in the state of Ohio** | **Holly Smith**<br>Network Relationship Manager<br>**815-641-7411** |
| **Region 7**<br>Bath, Boyd, Bracken, Carter, Elliot, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan<br>**Providers in the state of West Virginia** | **Jacqulyne Pack**<br>Network Manager<br>**606-331-1075**<br>**Jmpack@aetna.com** |
| **Region 8**<br>Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott ,Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, Wolfe<br>**Providers in the state of Virginia** | **Krystal Risner**<br>Network Relationship Manager<br>**606-687-0310**<br>**Risnerk@aetna.com** |
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| **JoAnn Rose-Marston -** Manager, Network Relations - **859-669-6217 - Jxrose@aetna.com** | |

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