ConnectiCare

December 2018 - In this issue

What's new for 2019?

Here's what you need to know about programs, services and Medicare Advantage plan updates that will go into effect Jan. 1, 2019. Also, learn about changes to preventive services coverage, ID cards and pharmacy preauthorization requirements.

Medicare Advantage dual special needs plan

In 2019, we will offer a special needs plan (SNP) for Medicare beneficiaries who also qualify for full Medicaid benefits through Connecticut's HUSKY program.

Medicare Special Needs Plans (SNP) are Medicare Advantage plans that serve individuals with specific characteristics, chronic conditions or disabling conditions. The state of Connecticut will cover some Medicare costs, depending on the individual's eligibility.

Our special needs plan is known as the Passage Dual (HMO SNP) plan. Like our other Passage products, members with this special needs plan are required to get referrals from their Passage primary care providers (PCPs) to see certain specialists in our ConnectiCare network.

Referral requirements for the Passage HMO SNP plan are similar to the commercial Passage plans sold to individuals under 65 and offered by employers. ConnectiCare review and approval of referrals are not required. Referrals are effective on the "Start Date" entered by the Passage PCP.

However, referrals for Passage HMO SNP plan members can only be submitted to us by faxing this form to 866-706-6929, attention ConnectiCare, Passage Dual (HMO SNP) plan referrals. Specialists who need to check Passage HMO SNP referrals have to call Medicare provider services at 1-877-224-8230 from 8 a.m. to 6 p.m. Monday through Friday.

Treatment of Passage HMO SNP plan members will follow the same ConnectiCare Medicare Advantage policies and procedures, including preauthorization request, medical and pharmacy policy criteria and other ConnectiCare policies and procedures. Claim and appeal submissions will also be the same as all other ConnectiCare Medicare plans.

Providers will need to call Medicare provider services to check benefits and eligibility of our Passage HMO SNP members. Our Passage HMO SNP members will have member ID numbers that start with K and will have the following Member ID card:

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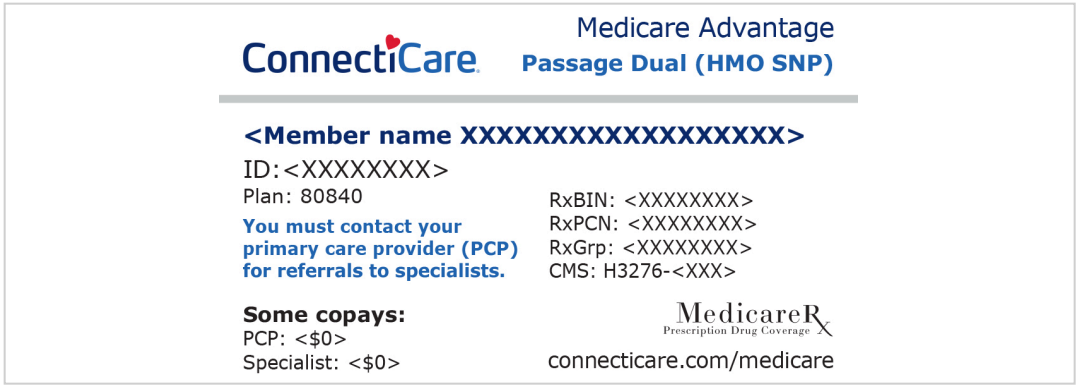
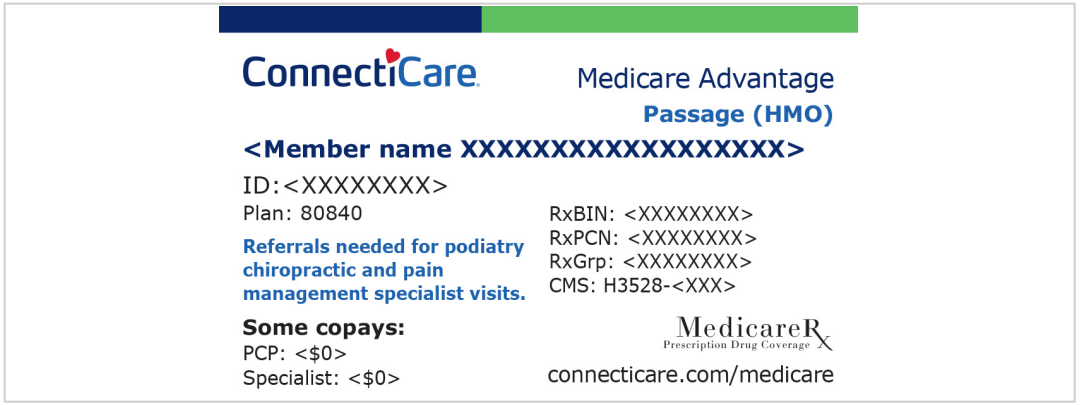


As part of our special needs plan, we will be offering a Model of Care training for providers, as required by the Centers for Medicare & Medicaid Services (CMS). The training serves as a vital quality improvement tool and integral component to help make sure the unique needs of a SNP member are identified and addressed. It also helps providers deliver coordinated and quality care to your patients. Stay tuned for more details about the model of care training.

Updated Medicare ID card for Passage Plan 1 (HMO)

As we mentioned in the October 2018 *Office Visit*, members with Medicare Advantage Passage Plan 1 (HMO) will have new cards for 2019 to reflect the reduction of specialists that will need referrals.

As of Jan. 1, 2019, only podiatry, chiropractic and pain management specialist treatment will require referrals for members with Medicare Advantage Passage Plan 1 (HMO). Below is an image of the new Passage Plan 1 (HMO) member ID card.



Where you submit and view referrals for Passage Plan 1 (HMO) members will remain the same:

- Passage PCPs can continue to submit referrals through our website, connecticare.com/providers, or through your electronic medical record (EMR) system.
- Passage specialists can view referrals for these members through our website, connecticare.com/providers.

Please note, there are no changes to our other ID cards for Medicare Advantage plans (except the one for our special needs plan) and commercial plans.

Preventive services updates

The following changes to our preventive services coverage will go into effect Jan. 1:

- **Diagnostic mammography, including 3-D mammography, covered as preventive**
  Starting Jan. 1, 2019, *diagnostic* mammography, including breast tomosynthesis services (3-D mammography), will be covered as a preventive service with no member cost-share for eligible members under our Connecticut commercial plans. Age and frequency requirements must be followed as part of the routine, preventive annual mammography coverage.

  Under the annual routine mammography coverage in our commercial plans, **one** screening or diagnostic service is allowed per year for members 40 years of age and older as a preventive service.

  This will apply to fully-insured individual and employer-sponsored commercial plans that are new and renewing after Jan. 1, 2019. This may also apply to some members with self-insured plans. Please check the provider website for benefits and eligibility.

  For members with employer-sponsored ConnectiCare of Massachusetts Inc. plans, we will cover diagnostic mammogram services as part of the routine mammography coverage with no member cost-share for eligible members. However, diagnostic and screening breast tomosynthesis will remain as non-covered services.

- **Physical exams for Medicare Advantage members**
  Starting in 2019, we will only cover the first physical exam claim we receive for the calendar year. If patients undergo another physical exam in the same calendar year, the claim will be denied. We ask our members' primary care providers and ob/gyns to coordinate care and remind their Medicare patients that they are only covered for one physical exam with no cost-share per calendar year.

- **Vitamin D coverage**
  Starting Jan. 1, we will no longer cover prescription or over-the-counter Vitamin D supplements under the preventive services guidelines for members age 65 or older. This change is consistent with changes made by the federal government.

Advanced opioid management program

In response to the national opioid epidemic, we will launch in January 2019 a new, advanced opioid management program engaging pharmacies, prescribing health care providers and members.

The goal is to help members safely treat their medical conditions while limiting the potential for drug misuse or abuse.

The program will:

- Monitor a member's cumulative morphine equivalent dose (MEqD), across all opioid claims history, and identify for further clinical review any dose that exceeds more than 200 MEqD in the past 180 days
- Set a seven-day supply limit for the first fill of short-acting opioids
- Provide real-time alerts to dispensing pharmacists about any concerns related to the member's clinical safety or medication use
- Have a trained opioid neuroscience pharmacist contact a member each time he/she fills:
    - two or more different short-acting opioids within 30 days
    - two or more long-acting opioids within 21 days as prescribed by two or more providers
    - three or more different opioids or a 3-drug combo
- Use case management and utilization management to ensure drugs are being filled and used properly
- Direct members, if applicable, to one treating provider to get prescriptions and better coordinate care

This program will apply to all ConnectiCare members.

Please be aware that Express Scripts, our pharmacy benefit manager, may

Please be aware that Express Scripts, our pharmacy benefit manager, may send letters to you and your patients under this program.

Pharmacy updates

The following pharmacy updates will go into effect Jan. 1, 2019:

- **Eye medications requiring preauthorization**
  We will require preauthorization for the eye medications listed below for members with commercial plans:
  - Dexycu
  - Eylea
  - Iluvien
  - Jetrea
  - Lucentis

This policy is consistent with the preauthorization process now in place for your ConnectiCare Medicare Advantage patients.

Preauthorization requests must be submitted to ConnectiCare. Use the provider form found on our website and send it to us in one of two ways:

- Fax: 1-800-249-1367
- Mail: ConnectiCare
  Attn. Pharmacy Services
  175 Scott Swamp Road
  Farmington, CT 06032-3124

Coverage for specialty drugs used to treat bleeding disorders

We will only cover specialty drugs used to treat bleeding disorders if they are filled through Accredo Specialty Pharmacy, our exclusive medical specialty provider. Accredo will bill ConnectiCare for the drugs under the member's medical benefit.

Members who are currently getting drugs filled by another provider will need to get new prescriptions sent to Accredo on or before Jan. 1, 2019. If any of your patients are affected by this change, Accredo will contact you to get new prescriptions. We have already notified members.

New commercial policy to go into effect Feb. 1, 2019

The following policy will go into effect Feb. 1, 2019, for our commercial plans:

- **Administrative Policy: Use of Non-Participating Provider Advance Member Notification Policy**

  This policy — which providers are required to follow after Feb. 1, 2019 — tries to make sure our members are given advance notice before they receive care or services from an out-of-network physician, facility and/or other health care provider that may lead to higher out-of-pocket costs for the members. This policy won't apply to emergency situations or when providers or the member received preauthorization from us to obtain care and/or services to use an out-of-network provider.

  Under this policy, members will need to acknowledge they have been notified about and agree to using out-of-network providers by signing this Non-Participating Advance Member Notification Form. A copy of this signed form should be given to the member and a copy must be retained in the provider's records.

Reducing the risk of falls: prevention begins with you

During winter, we know about the risk of falling on ice- or snow-covered walkways and driveways. But for people age 65 and older, a fall can be costly, devastating and life-changing.

The risk for our Medicare population doesn't just exist outdoors. The dangers also lurk indoors. As their doctors, you can help!

Millions of people ages 65 and older — or more specifically, one out of four older adults — fall each year, according to the Centers for Disease Control and Prevention. This doubles their chance of falling again, but many don't tell their doctors.

Through our ongoing "Ask Away" campaign, we are educating our Medicare members about their fall risk and how to limit it. We are encouraging them to talk to their doctors about the topic.

Here's how you can help

- Ask your older adult patients if they have fallen since their last visit.
- Talk to them about the consequences of falls, such as injuries, fractures, loss of the ability to live independently, limited mobility and decreased quality of life.
- Discuss the risk factors such as age, lack of activity, prescription drugs, hearing or visual impairments and unsafe home environment, including tripping hazards.
- Conduct a "timed get up and go" test during the patient's annual wellness visit.
- Evaluate the fall risk and provide education, including recommendations and treatment such as an exercise program to improve balance, an eye exam, medication review, vitamin D and a bone mineral density test, if the patient is due.
- Suggest the use of a cane or walker and physical therapy, when needed, and follow up to make sure the patient is not having trouble following your

suggestions and recommendations.

Please remember, ConnectiCare offers the SilverSneakers® program* at no cost to our Medicare Advantage members. For more information about fall prevention, please check out these CDC online resources.

**Members of our Medicare Advantage special needs plan as well as some of our employer group Medicare plans do not have the SilverSneakers benefit.*

Reminders about caring for our Medicare Advantage members

Please keep the following in mind as you provide care and services to our Medicare Advantage members:

- **Follow the Medicare Outpatient Observation Notice (MOON) requirements**
  Hospital providers must give written and verbal notice to Medicare Advantage members when they are receiving observation services as outpatients for more than 24 hours.

  This notice is called the Medicare Outpatient Observation Notice (MOON). It informs Medicare beneficiaries (including Medicare Advantage plan members) that they are receiving outpatient observation services and are not admitted as inpatient of a hospital or critical access hospital (CAH).

  All hospitals and CAHs have been required to provide this notice since March 2017. For more information, visit the Centers for Medicare & Medicaid Services (CMS) website.

- **Do not bill patients who are designated as Qualified Medicare Beneficiaries (QMBs)**
  Federal law prohibits all Original Medicare and Medicare Advantage providers and suppliers from billing individuals enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances. Providers who inappropriately bill individuals enrolled in QMB are violating their Medicare Provider

Agreement and may be subject to sanctions.

This applies to all Medicare providers, regardless of whether they accept Medicaid.

The QMB program is a Medicaid program that exempts Medicare beneficiaries from having to pay their Medicare cost-shares. If providers want to get paid a patient's cost-share, the bill of service may be submitted to Medicaid for reimbursement.

For more information, check out this Medicare Learning Network resource.

Also as a reminder:

- **Our contracts require** all our Medicare providers to see all our Medicare Advantage members, including those who are eligible for both Medicare and Medicaid (often called "dual eligible").
- **The Centers for Medicare & Medicaid Services (CMS) forbids** Medicare providers from discriminating against patients based on "source of payment," which means providers cannot refuse to serve members because they receive assistance with Medicare cost-sharing from a State Medicaid program.

Medical record reviews start this month

Ciox Health (formerly known as ArroHealth) may contact your office from now through April to retrieve and review the medical records of your patients who have ConnectiCare commercial plans.

We are required to submit accurate and complete member diagnosis data to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS).

Ciox will call your offices to coordinate a convenient chart retrieval method and set the date when records are needed. Please respond to Ciox's request for records promptly.

As our partner and "business associate," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Ciox is fully HIPAA-compliant and is required to protect, preserve and maintain the confidentiality of any protected health information (PHI) obtained from clinical records provided by medical practices.

We appreciate your help. If you have questions, call our provider services at 1-800-828-3407.

ConnectiCare in the community

'Tis the season for giving. Here are a few highlights of our recent community outreach.

Our President, Eric Galvin spoke on a panel last month at the Connecticut Insurance and Financial Services (CT IFS) Insurance Market Summit about new customer expectations. Eric also took the 'baton' and will be the new chair of the CT IFS.

Members and employees came together on Saturday, Dec. 1 to sort food at the Connecticut Food Bank as part of our "Good Deeds with ConnectiCare" program. The group sorted 14,000 pounds of food for area feeding programs. Good Deeds with ConnectiCare is a volunteer program that brings together our members and employees in service to create healthier communities.

ConnectiCare was proud to support the HYPE (Hartford Young Professionals and Entrepreneurs) Tons of Toys event on Dec. 6. It was a wonderful night, and more than 1,700 toys were donated to the YMCA of Greater Hartford!

Much more to see! Follow us on social media to stay up to date:

Facebook | LinkedIn | Twitter

Recent provider headlines

Check out the latest Provider News & Headlines:

- Flu is here: time to get your patients in for shots
- Improving your Medicare Advantage patients' mental health
- Alzheimer's support group held monthly at ConnectiCare center in Manchester
- Information you need for the 2018-2019 flu season
- Use the right sleep study codes for payment
- Claims edits that go into effect Nov. 27, 2018
- Update on UConn study on 3Ds
- In-office laboratory reimbursement policies updated
- Stay in-network when referring patients to skilled nursing facilities or home health care services
- A reminder about 'turnaround' times for non-urgent pre-service organization determinations
- Gonal-F is preferred infertility hormone treatment
- Has any of your information changed? Let us know.
- Specialist "eConsults" now available to ConnectiCare's PCPs
- Hospital readmission policy updated
- HEDIS updated technical specifications for Controlling High Blood Pressure (CBP)
- Answers to questions about preauthorization through Magellan Healthcare

Keep in Touch