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Aetna Better Health® of Michigan

Zantac® alternatives

As you may have already heard, many retailers have pulled Zantac® and its generic equivalent, ranitidine, off their shelves due to a recent Product Alert from the U.S. Food and Drug Administration (FDA) that ranitidine products may contain an impurity known as NDMA (N-nitrosodimethylamine), which is a probable human carcinogen. The source of this impurity is currently under investigation by FDA.

FDA has advised that patients who are taking prescription ranitidine or using an over-the-counter version and want to stop using it should discuss alternatives with their health care provider. There are alternatives to Zantac® and ranitidine available in both prescription and over-the-counter form. These alternatives are Pepcid® (famotidine) and Tagamet® (cimetidine).

Key points:

- Ranitidine is more widely known by the brand name Zantac®.
- Ranitidine is an H2 blocker that is taken to provide heartburn relief.
- There is a risk that some ranitidine products may contain a potentially cancer-causing chemical.
- FDA is still investigating whether the chemical is at a high enough level to be a health risk.
- FDA has not stated that patients should stop taking ranitidine and advised that patients should speak to their doctor and pharmacist if they would like to change to an alternative.
- Alternative H2 blockers are Pepcid® (famotidine) and Tagamet® (cimetidine).

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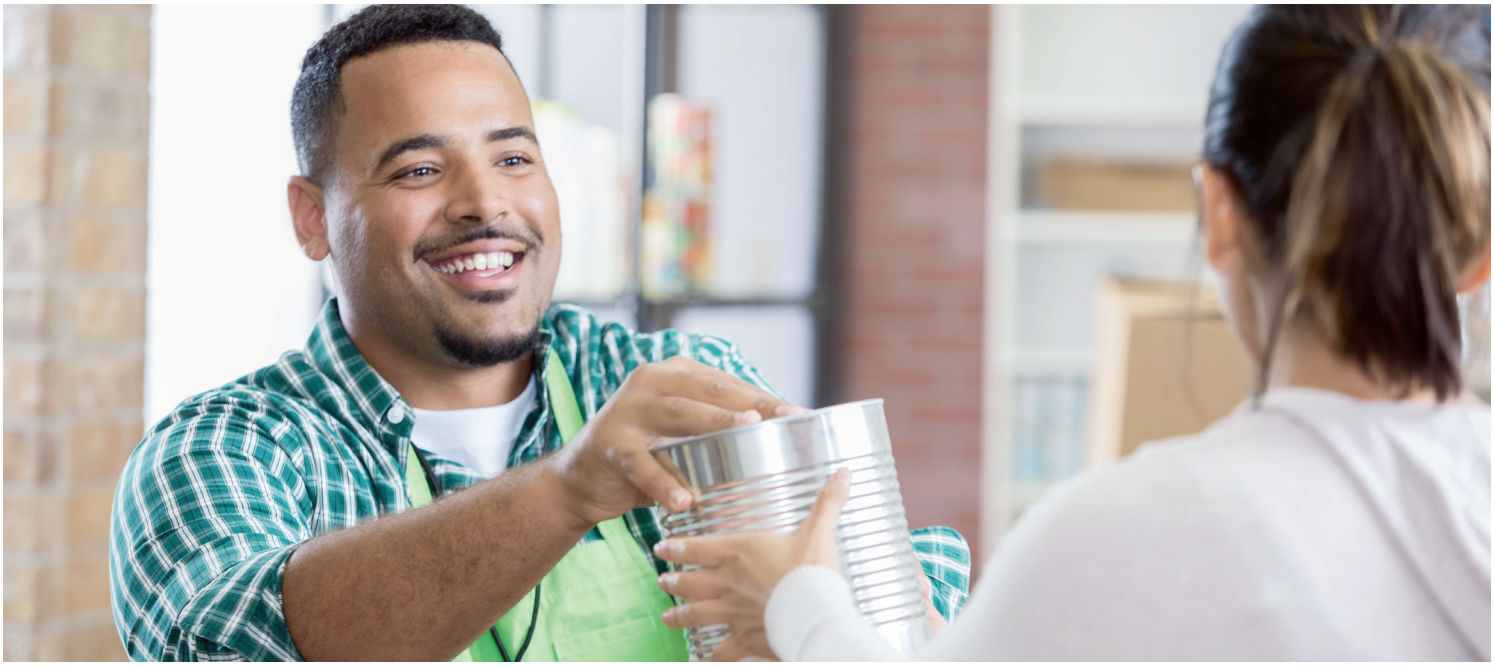

January 2020 Healthy Michigan Plan work and activity requirements

Beginning January 2020, to keep Healthy Michigan Plan (HMP) coverage, some Aetna Better Health HMP members will be required to complete and report 80 hours of work or activities every month. The work or activities could include:

- Having a job or income
- Being a student
- Looking for a job
- Volunteering (this activity can only be used for three months each calendar year)
- Doing job training
- Participating in a tribal employment program
- Participating in rehab (substance abuse)
- Doing vocational training
- Doing an internship

Anyone who is 19 to 62 years old and enrolled in the HMP will be required to report work or activities unless they are exempt (excused). Someone may be exempt (excused) for up to one year, and the exemption can be renewed. In some cases, the Michigan Department of Health and Human Services (MDHHS) will already know someone is exempt (excused) and will apply the exemption automatically.

Members can be exempt (excused) if they are:

- Pregnant or were pregnant in the last two months
- Medically frail
- The main caretaker for a family member under 6 (one parent per household)
- A full-time student
- Under age 21 and were in Michigan foster care
- In prison or jail in the last 6 months
- Getting State of Michigan unemployment benefits
- Getting temporary or permanent disability payments from a private insurer or the government
- Experiencing a medical condition that limits work, approved by a doctor
- Caring for a dependent who has a disability and who has a doctor's order for full-time care (one claim per household)
- Caring for a person who cannot make decisions for themselves
- Able to demonstrate a good cause circumstance such as experiencing a disability, hospitalization or serious illness

To claim an exemption, fill out and send MDHHS the exemption form MSA-1905 by Jan. 31, 2020. The form can be found online by going to **michigan.gov/healthymiplan** and clicking on the link that says "Changes are coming to the Healthy Michigan Plan in January 2020."

Members who are covered through HMP should have received a letter in September or October. The letter either lets members know that they are required to report work or activities or that they are excused from reporting work or activities.

Pharmacy benefits

Prescription drugs are often an important part of your patients' health care. Aetna Better Health of Michigan's members have the right to certain prescription drug benefits.

Aetna Better Health of Michigan covers prescription drugs and certain over-the-counter drugs when presented with a prescription at a pharmacy.

To find out if a drug is covered, you can check our formulary. A formulary is a list of drugs that Aetna Better Health covers. The formulary is available on our website at **aetnabetterhealth.com/michigan**. You can use the prescription drug search tool to find out if a drug is covered. You may also request a printed copy of this formulary by calling Provider Services. If you have any questions about a drug that is not listed, please call the Pharmacy Helpdesk toll-free at **1-866-314-3784 (TTY: 711)**, 24 hours a day, 7 days a week.

If a drug is not listed on the formulary, a pharmacy prior authorization (PA) request form must be completed. You or your staff can complete this form. You must demonstrate why a formulary drug will not work for your patient. Please include any medical records needed for the request.

The pharmacy prior authorization form is available on our website, or you can make a request by telephone at **1-866-314-3784** or via fax at **1-855-799-2551**.

Aetna Better Health of Michigan members must have their prescriptions filled at a network pharmacy.

PA process

Aetna Better Health of Michigan's pharmacy PA process is designed to approve drugs that are medically needed. We require doctors to obtain a PA before prescribing or giving out the following:

- Injectable drugs provided by a pharmacy
- Nonformulary drugs that are not excluded under a state's Medicaid program
- Prescriptions that do not follow our guidelines (like quantity limits, age limits or step therapy)
- Brand-name drugs, when a generic is available

Aetna Better Health of Michigan's medical director decides if a drug is denied or approved using our guidelines. The medical director may need additional information before making a decision. This information may include the following:

- Drugs on the formulary have been tried and do not work (step therapy).
- No other drugs on the formulary would work as well as the drug requested.
- The request is accepted by the U.S. Food and Drug Administration (FDA) or is accepted by nationally noted experts.
- For brand-name drug requests, a completed FDA MedWatch form documenting failure or issues with the generic equal is required.

Adult immunization schedule

Aetna Better Health of Michigan is as committed to promoting routine adult vaccinations as we are about the needed childhood immunizations.

In fact, routine adult vaccinations are all covered under our member benefits, including the pharmacy benefit with a prescription. These vaccines can then be administered by a pharmacist certified to provide vaccinations in the store.

Vaccine coverage

Aetna Better Health of Michigan covers the following vaccines through pharmacy:

Vaccine	Age(s)	Vaccine	Age(s)
Flu (trivalent, quadrivalent)	19 and older	Tetanus, diphtheria toxoids	19 and older
FluMist	19 and older	HPV	19 to 26 years
Fluzone HD (high dose)	65 and older	Measles, mumps, rubella	19 and older
Pneumonia	19 and older	Tetanus, diphtheria, pertussis	19 and older
Herpes zoster	50 and older	Hepatitis B	19 and older

Key CDC recommendations

All adults should receive a **flu vaccine** each year; it is especially important for people with chronic health conditions, pregnant women, and older adults.

Measles, mumps, rubella should be up-to-date in all adults. Measles outbreaks have been reported in the U.S. in 2019, and measles is highly contagious.

Every adult should get the **Tdap** vaccine once if they did not receive it as an adolescent to protect against pertussis (whooping cough), and then a **Td** (tetanus, diphtheria) booster shot every 10 years. In addition, women should get the Tdap vaccine each time they are pregnant, preferably at 27 through 36 weeks.

HPV is recommended for adults up to age 26 if they were not vaccinated as pre-teens or teens.

Adults over 50 years of age should be vaccinated against **herpes zoster**.

A full adult vaccination schedule, as well as recommendations for special situations, can be found on the CDC website: **cdc.gov/vaccines/schedules/hcp/imz/adult.html**.

Resistance to tuberculosis drugs

Resistance rates have remained stable for the last 20 years. In 2017, the most common form of resistance was to isoniazid (INH), occurring in 9.3% of cases with susceptibility results. Multi-drug resistance is still rare. To keep resistance low, it is important to select a dosing and administration strategy that will maximize probability of member adherence and completion of the regimen.

Tuberculosis treatment

The American Thoracic Society (ATS), CDC and the Infectious Diseases Society of America (IDSA) recommend a four-drug combination for treatment of active disease: rifampin (RIF), INH, pyrazinamide (PZA) and ethambutol (EMB), abbreviated as RIPE.

The preferred schedule is two months on the daily RIPE regimen for induction and four months on RIF + INH for maintenance. Some groups may require longer durations of maintenance, but shorter durations are not recommended. Pyridoxine (vitamin B_6) is recommended to prevent neuropathy while on INH.

Latent disease may be treated with RIF and/or INH.

See links in references for details on special populations and when to use other dosing frequencies.

Standard dosing recommendations for tuberculosis treatment

Drug	Preparation	Population	Daily	1 day/ week	2 days/week	3 days/week
Isoniazid	Tablets (50 mg, 100 mg, 300 mg)	Adults	300 mg	900 mg	900 mg	900 mg
		Children	10–15 mg/kg	N/A	20–30 mg/kg	N/A
Rifampin	Capsule (150 mg, 300 mg)	Adults	600 mg	N/A	600 mg	600 mg
		Children	10–20 mg/kg	N/A	10–20 mg/kg	N/A
Rifabutin	Capsule (150 mg)	Adults	300 mg	N/A	Not recommended	Not recommended
		Children	Appropriate dosing for children is unknown. Estimated at 5 mg/kg.			
Rifapentine	Tablet (150 mg)	Adults	N/A	10–20 mg/kg	N/A	N/A
		Children	Active TB: for children ≥12 years of age, same as adults, once weekly. Not FDA-approved for treatment of active TB in children <12 years old.			
Pyrazinamide*	Tablet (500 mg)	Adults	1,000, 1,500 or 2,000 mg	N/A	1,500, 2,500 or 3,000 mg	2,000, 3,000 or 4,000 mg
		Children	30–40 mg/kg	N/A	50 mg/kg	N/A
Ethambutol*	Tablet (100 mg, 400 mg)	Adults	800, 1,200 or 1,600 mg	N/A	1,200, 2,000 or 2,400 mg	2,000, 2,800 or 4,000 mg
		Children	15–25 mg/kg	N/A	50 mg/kg	N/A

*Dosed in adults based on 3 weight ranges: 40–55 kg, 56–75 kg, 76–90 kg

Sources:

1. *Full ATS/IDSA/CDC guidelines: cdc.gov/tb/publications/guidelines/pdf/clin-infect-dis.-2016-nahid-cid_ciw376.pdf*
2. *Guideline highlights: cdc.gov/tb/topic/treatment/guidelinehighlights.htm*
3. *Statistics: cdc.gov/tb/publications/factsheets/statistics/tbtrends.htm*
4. *Latent TB in children: cdc.gov/tb/topic/treatment/children.htm*
5. *Latent TB in women of child-bearing age: cdc.gov/tb/topic/treatment/pregnancy.htm*

Quality improvement program

The results are in

It is important to us that our doctors and staff provide high-quality services and health care. We have a quality improvement program to make sure that happens. We check provider office hours and appointment wait times to make sure patients are getting the care they need quickly. We also use doctor and member surveys to let us know how we are doing. The results of these and other quality reports are on our website at **aetnabetterhealth.com/michigan**.

If you want copies of any of our reports, call Provider Services toll-free at **1-866-314-3784**. We will be glad to send them to you.

How we make coverage decisions

When making coverage decisions, Aetna Better Health of Michigan follows the health care rules of MCG® (Milliman Care Guidelines). Aetna Better Health of Michigan uses these rules to determine the type of treatments that will be covered for members. Providers can obtain the criteria to make coverage decisions by calling Provider Services at **1-866-314-3784 (option 4)**. Specific criteria will be made available upon your request.

Aetna Better Health of Michigan's staff and its providers must make health care decisions based on the proper care and service rules, including member eligibility. There are no rewards or financial incentives for providers or staff for the denial or reduction of services.

OB-GYNs: LARC reimbursement

Effective since Oct. 1, 2018, separate reimbursement is available for long-acting reversible contraception (LARC) devices when the device is provided immediately postpartum in an inpatient hospital setting prior to discharge. Individual practitioners will continue to receive payment for their professional services related to the immediate postpartum LARC insertion procedure if billed separately from the professional global obstetric procedure codes and the hospital facility. Payment for the LARC will be made in accordance with the Practitioner Medicaid fee schedule in effect on the date of service for the procedure code billed.

IUD procedures
58300-58301

IUD device
S4989, J7300

LARC procedures
S4981, 11976, 11980, S4989

LARC device
J7296-J7298, J7306, J7307

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 of **aetna.com**. Once on the page, click "See Our Medicare Compliance FDR Program Guide" or "See Our Office Manual" under "Need More Information on the Medicare FDR Program?"

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.

Access to our clinical staff

If Aetna Better Health members need access to a nurse during normal business hours, 8 a.m. to 5 p.m., they can call Member Services at **1-866-316-3784** and ask to be connected to a nurse.

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

Language translation is also provided to members for free by calling **1-866-316-3784**. Providers can access language translation by calling **1-866-314-3784**.

2019 HEDIS® medical record review season

In February, Aetna Better Health of Michigan will begin collecting medical records for the annual Healthcare Effectiveness Data and Information Set (HEDIS®) reporting requirements. We will be conducting HEDIS® medical record reviews on members enrolled with Aetna Better Health of Michigan in 2019 to measure the quality of care provided to our members.

Our Provider Relations team will be contacting your office to do one of the following:

- Request remote access to your electronic medical record (EMR) system
- Schedule an on-site visit
- Request medical records be faxed, uploaded to the provider portal or securely emailed

Aetna does not typically reimburse for medical records when required for quality projects such as HEDIS®. Please check with your Provider Relations representative or review your provider contract with Aetna if there are questions regarding this.

When the medical record review project starts, we will send you a request for the information we need. The request will include:

- **A Member Pull List,** which identifies the members who may have been seen in your office and which HEDIS® measures apply to each member.
- **The Medical Record Documentation Guide,** which outlines the required medical record data needed for each measure — match the Measure Key in the Member Pull List to the corresponding Measure Key in the Medical Record Documentation Guide to see what documentation is required.

HEDIS® data collection is a time-sensitive project. Medical records should be made available on the date of the on-site review or, in the case of fax/mail, by the date requested. Typically, data collection begins in February and concludes at the end of April. It is imperative that you respond to a request for medical records within five business days to ensure that we are able to report complete and accurate rates to state and federal regulatory bodies, as well as the National Committee for Quality Assurance (NCQA). Thanks in advance for your assistance and cooperation.

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS® measures is permitted and the release of this information requires no special patient consent or authorization. Please be assured that our members' personal health information is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers.

Tuberculosis: A brief review

According to the Centers for Disease Control and Prevention (CDC), in 2017 there were a total of 9,105 tuberculosis (TB) cases (incidence: 2.8 cases per 100,000 people). California, Texas and New York reported higher incidence rates and had the highest case counts. Common risk factors include diabetes, substance abuse, HIV, homelessness and incarceration. 13% of U.S. TB cases can be attributed to recent transmission and not a re-activation of latent disease.

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
1333 Gratiot Ave., Suite 400
Detroit, MI 48207

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.

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.

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