

*in*Touch



MARICOPA
HEALTH PLAN
managed by
THE UNIVERSITY OF ARIZONA
HEALTH PLANS

A newsletter for Providers associated with Maricopa Health Plan,
University Healthcare Group & University Care Advantage

Important Conversations to Have with Patients

Time is a valuable commodity, especially when it comes to patient care. Asking patients the right questions could help facilitate a more meaningful and productive visit. Sometimes uncomfortable topics are avoided by patients, yet they are nevertheless important. Using **SOURCE** as a reminder will help to maximize the provider-patient experience. After all, your patient is the best **SOURCE** of information about their healthcare needs.

Screenings: Encourage members to have preventive screenings including breast cancer screening, colorectal cancer screening, cholesterol screening, glaucoma testing, bone density testing, etc., according to age and gender guidelines.

Organize Medications: Review the patient's current medications. If possible, replace medications with a high risk of serious side effects with safer drug choices. Also, encourage adherence with maintenance medications for hypertension, diabetes and cholesterol.

Urinary Incontinence: This can be a difficult topic for patients to bring up with their physician. Find out if the patient has experienced problems with the leakage of urine. If yes, consider recommending bladder training, exercises, medication, and/or surgery.

Risk of Falling: Determine if the patient had a fall or problems with balance or walking in the past 12 months. The patient may benefit from having their blood pressure taken in a lying or standing position, an exercise or physical therapy program, a vision or hearing test, or even prescribing a cane or walker.

Chronic Conditions: Members with hypertension, heart disease, diabetes, rheumatoid arthritis, chronic obstructive pulmonary disease, etc., require extra care. Be sure to allow sufficient time for monitoring disease specific criteria in addition to routine preventative care.

Exercise: Discuss level of physical activity; encouraging patients to initiate, increase or maintain an exercise program. Don't forget to calculate the patient's Body Mass Index (BMI) as part of the overall assessment.

University Care Advantage has many **resources** available to assist you including Medical Directors, Case Managers and Pharmacists.



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1. Why does the entire claim need to be resubmitted when only one line was denied? Can't we just send in a correction for that one line?

When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim. For example: a provider submits a three-line claim. Lines 1 and 3 are paid, but line 2 is denied. When resubmitting the claim, the provider should resubmit all three lines. If only line 2 is resubmitted, the system will recoup the payment for lines 1 and 3.

2. Is there any additional information that we need to include on a resubmitted claim?

Yes, for a CMS 1500 you should enter an "A" in field 22 and the original claim number of the denied claim in the field labeled "Original Ref. No." To resubmit a denied UB-04 claim, write the word "resubmission" and the original claim number of the denied claim in the "Remarks" field 84. On an ADA claim, enter the original claim number of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No.", field 2.

3. This month there were recoupments for services that we have always billed that way. Why are they taking back our money?

Check billing to see if there were any errors in coding or if required information was omitted. Under certain circumstances, UAHP may find it necessary to recoup, or take back, money previously paid to a provider. Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments. Upon completion of the recoupment, the plan will send an EOB explaining the action, date of the action, recipient, date of service, date of original remittance advice, and the reason for recoupment. If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), the provider will be afforded additional time to provide justification for re-payment. In the case of recoupments, the time frame for submission of a clean claim differs from the time frame for submission of initial claims. The time span allowed for submission of a previously recouped claim is sixty (60) days from the date of the recoupment EOB.



REMINDER:

Formulary Changes

Effective October 15, 2011, two significant formulary changes were implemented for University Family Care, Maricopa Health Plan, and University Healthcare Group. Advair and Symbicort will now require step therapy. The member must have had at least two fills for an inhaled corticosteroid and one fill for a short-acting beta agonist in the previous 130 days in order to receive Advair or Symbicort without prior authorization. Members who have filled Advair or Symbicort in the previous 130 days will be able to continue therapy without a prior authorization. Also, carisoprodol has been removed from the formulary. Alternatives include cyclobenzaprine, methocarbamol, and tizanidine.

Avoiding Medicare & Medicaid Fraud & Abuse

In our last edition, we discussed the False Claims Act (FCA) [31 U.S.C. §§ 3729-3733], and how you can do your part to help prevent Medicare and Medicaid Fraud, Waste, and Abuse. In this edition, we will be addressing the Anti-Kickback Statute (AKS) [42 U.S.C. § 1320a-7b(b)].

The AKS is a criminal law that prohibits the knowing and willful payment of “remuneration” to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. **In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime.** The statute covers the payers of kickbacks – those who offer or pay remuneration – as well as the recipients of kickbacks – those who solicit or receive remuneration. Each party’s intent is a key element of their liability under the AKS.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the Civil Monetary Penalties Law (CPML), physicians who pay or accept kickbacks also face penalties of up to \$50,000 per kickback plus three times the amount of the remuneration.

Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to bona fide employees.

As a physician, you are an attractive target for kickback schemes because you can be a source of referrals for fellow physicians or other health care providers and suppliers. You decide what drugs your patients use, which

specialists they see, and what health care services and supplies they receive.

Many people and companies want your patients’ business and would pay you to send that business their way. Just as it is illegal for you to take money from providers and suppliers in return for the referral of your Medicare and Medicaid patients, it is illegal for you to pay others to refer their Medicare and Medicaid patients to you.

Kickbacks in health care can lead to:

- Overutilization (Waste)
- Increased program costs
- Corruption of medical decision making
- Patient steering
- Unfair competition

The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect money from your patients. Routinely waiving these copays could implicate the AKS and you may

not advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts fail. It is also legal to provide free or discounted services to uninsured people.

Besides the AKS, the Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5)) also imposes civil monetary penalties on physicians who offer remuneration to Medicare and Medicaid beneficiaries to influence them to use their services.

The government does not need to prove patient harm or financial loss to the programs to show that a physician violated the AKS. A physician can be guilty of violating the AKS even if the physician actually rendered the service and the service was medically necessary. **Taking money or gifts from a drug or device company or durable medical equipment (DME) supplier is not justified by the argument that you would have prescribed that drug or ordered that wheelchair even without a kickback.**





Advance Directives Reminder from The University of Arizona Health Plans Quality Management Department

Advance Directives are written documents stating how a member wants medical decisions made, if they lose the ability to make decisions for themselves. It is the policy of The University of Arizona Health Plans (UAHP) to establish advance directive standards to ensure all adult members are provided with information about formulating advance directives, and to ensure all adult members are informed of their advance directive rights. In addition, UAHP wants to ensure that all contracted facilities and contracted Primary Care Providers (PCPs) are aware of the AHCCCS mandates regarding advance directives.

Each facility contracted with UAHP (i.e., hospital, nursing facility, home health agency, hospice, or other organization which provides personal care) must comply with federal and state law regarding advance directives for adult members. This includes development of written policies, the rights adult members have to make decisions about their medical care, the right to accept or refuse medical care, and the right to execute an advance directive. If the organization has a conscientious objection to carrying out an advance directive, it must be explained in these policies.

Written information must be provided to adult members regarding each individual's rights under state law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives, including any conscientious objections. There must be documentation in the member's medical record that the information has been provided and **whether or not an advance directive has been executed**. Providers cannot discriminate against a member because of his or her decision to execute, or not to execute, an advance directive. Executing an advance directive cannot be a condition for provision of care.

Providers must educate their staff on issues concerning advance directives, including notification of services to direct care providers, such as home health care, of any advanced directives executed by members to whom they are assigned to provide services. Facilities are encouraged to provide a copy of the member's executed advance directive, or documentation of refusal, to the member's PCP for inclusion in the medical record. All contracted PCPs must comply with the above requirements.

UAHP will provide written information to all adult members that describe the following:

- A member's rights under state law, including a description of the applicable law;
- The organizational policy regarding the implementation of those rights, including a statement of any limitations regarding the implementation of advance directives as a matter of conscience;
- The member's right to file a complaint/grievance, related to advance directives, directly with AHCCCS;
- Notification of changes to the State's advanced directive laws no later than 90 days after the effective date of the change.

If you have questions, please call Carol Burks, RN Clinical Performance and Monitoring Manager/Manager Quality of Care and Credentials, with The University of Arizona Health Plans Quality Management Department at (520) 874-2760.



Urgent Care and Emergency Room Use

Primary Care Providers (PCPs) are asked to educate members on the differences between urgent and emergent conditions. Members are to contact their PCP before visiting an emergency room or calling an ambulance, unless they have a life-threatening emergency. Information regarding appropriate use of the emergency room is below.

The emergency room is for emergencies!

Examples of non-emergencies are:

- Sprained ankle
- Minor burns
- A minor allergic reaction
- Rashes
- Flu
- Sore throat with a fever
- Earache

What is an emergency? Emergencies are a threat of your life. Emergencies can cause death if not taken care of quickly.

Examples of emergencies are:

- Extreme shortness of breath
- Poisoning
- Bleeding that will not stop
- Fainting
- Chest pains
- Seizures

Please let the member know that if they are experiencing any of these signs, to go the nearest emergency room or call 911 immediately.

Tobacco Cessation

- Members must be at least 18 years of age
- Enrollment in the Arizona Smokers' Helpline (ASHline) (800) 556-6222 is encouraged
- Medications will be provided on formulary for a total of 12 consecutive weeks during a six month time period
- Medications for tobacco cessation on the formulary include:
 - Nicotine patches
 - Nicotine gum
 - Nicotine lozenges
 - Nicotine spray
 - Bupropion SR
 - Chantix

Members can only receive one product at a time.





Team Up with Influenza and Pneumococcal Vaccines

The 2011-12 flu season has already begun. To get off to a good start, health care professionals should lead the way by getting vaccinated. It is especially important for people with a high risk of serious complications to be vaccinated early. These include young children, pregnant women, people with chronic health conditions, and people 65 years of age and older. Ultimately, everyone six months of age and older should be vaccinated.



As a provider, please talk to your patients about the seasonal flu vaccine. Your personal recommendation can be a key factor in increasing the number of people who choose to get the flu shot. If you don't administer flu vaccines in your office, The University of Arizona Health Plans members can be vaccinated at Mollen Immunization Clinics or any participating network pharmacy.

Vaccinating against pneumococcal disease is another important consideration for your patients. The following are the recommendations from the Centers for Disease Control and Prevention (CDC) on who should receive the vaccine:

- Anyone 65 years of age and older
- Adults 19 – 64 with any of the following conditions:
 - Chronic illnesses such as lung, heart, liver or kidney disease, asthma, diabetes or alcoholism
 - Conditions that weaken the immune system, such as HIV/AIDS, cancer or damaged/absent spleen
 - Cochlear implants or cerebro-spinal fluid leaks
- Adults 19-64 who smoke cigarettes



It's a fact that having the flu increases the chances of getting pneumococcal disease. Therefore, it makes sense to team patients up with both the influenza and pneumococcal vaccines. This will ensure patients have protection against two deadly diseases. Early intervention promotes the best patient outcomes.

EPSDT Form Submittal

The University of Arizona Health Plans (UAHP) would like to remind you that a copy of the AHCCCS-approved EPSDT form or the electronic version must be submitted to UAHP on a monthly basis.

By submitting the EPSDT tracking form, you are complying with AHCCCS requirements and helping UAHP to accurately calculate EPSDT participation for needed compliance.

To avoid missed opportunities for an EPSDT visit, UAHP encourages providers to assess a child's need for an EPSDT screening at every clinical encounter in case the EPSDT interval has lapsed. Providers may offer an EPSDT visit to children when they present for:

- Other preventative care (e.g. sports physical)
- Lab follow-up
- Sick visit
- Prescription refill

If an EPSDT screening is performed during a sick visit, don't forget to include the sick diagnosis code on the claim and add modifier 25 so you can bill the EPSDT screening with that sick visit.



Please do not attach the EPSDT forms to your claims. The EPSDT forms can be sent to:

Maricopa Health Plan
Attn: Christine Schween,
MHP EPSDT Assistant
2701 E. Elvira Rd
Tucson, AZ 85756



Member Transportation

How does an AHCCCS member get to a doctor's appointment if they don't have a way of getting there?

Maricopa Health Plan (MHP) is contracted with Medical Transportation Brokerage of Arizona (MTBA) to provide transportation for MHP members.

What services does MTBA provide?

Services include transportation to and from doctor's appointments, pharmacy pickup, urgent care, and outpatient surgery.

MHP members that utilize transportation frequently may qualify for an unlimited bus pass, which will entitle them to general transportation for the approved period. Those members will be required to use their bus pass for all of their medical transportation needs unless approved otherwise by the Health Plan.

MTBA also provides blanket transportation for MHP members with reoccurring routine dialysis or cancer treatments.

The only transports that MTBA is not delegated to handle are trips to and from the emergency room. In a true emergency situation, MHP members will need to dial 911 and utilize emergency transportation.

How does it all work?

When a MHP member or a provider office calls The University of Arizona Health Plans Customer Care Center, they are first prompted to select their language of choice. Once that is established, the MHP member or provider office is given a second set of options including "Transportation." When selecting the transportation option, they are transferred directly to MTBA's call center.

MTBA has two call centers, one in Phoenix and one in Tucson. Both call centers are staffed by specially trained representatives who are familiar with medical transportation, Health Plan policy, and HIPAA. MTBA currently employs over 70 Customer Service Representatives (CSR's) and they are still growing their staff to meet our member's needs!

Call the Customer Care Center at 1-800-582-8686 to set-up transportation for a MHP member today!

Diabetes Testing Supplies

Blood glucose testing supplies are available through the pharmacy benefit for members of The University of Arizona Health Plans. Current covered products include TrueTrack and Accu-Chek products. Coverage for blood glucose testing supplies is as follows:

Standard Coverage

- Not requiring insulin therapy
 - 100 strips and lancets every 3 months
- Requiring insulin therapy
 - 100 strips and lancets every month

Exception Criteria (prior authorization required)

- Not requiring insulin therapy
 - During adjustment of medications, may receive up to 100 strips and lancets per month for 2 months only
 - If experiencing frequent episodes of hypoglycemia (*more than 5 times weekly*), despite education and regimen adjustment, may receive up to 200 strips and lancets every 3 months
- Requiring insulin therapy
 - During adjustment of intensive insulin therapy (*more than 3 injections per day of short-acting and long-acting insulin*), or initiation of an insulin pump, may receive up to 200 strips and lancets per month for 2 months only
 - If receiving intensive insulin therapy (*more than 3 injections per day of short-acting and long-acting insulin*), or on an insulin pump, may receive 150 strips and lancet per month. Managing physician must submit plan and instructions for patient.
- Alternative amounts of blood glucose testing supplies may be requested by provider based on medical necessity.

HEDIS

(Healthcare Effectiveness Data and Information Set)

is a set of standardized performance measures designed to ensure that consumers have the information they need to reliably compare the performance of healthcare plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA). HEDIS measures to pay particular attention to and to assist us with collection of accurate data are listed here. It is of great importance to document in the member's record when the following measure, exam/screening is ordered and the results.



Breast Cancer Screening:

Description: Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.

Metric: The percentage of female MA enrollees ages 40 to 69 (denominator) who had one or more mammograms during the measurement year or the year prior to the measurement year (numerator).

Exclusions: (optional) Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies.

Diabetic Retinal Exams:

Description: Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.

Metric: The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).

Colorectal Screening:

HEDIS Label: Colorectal Cancer Screening (COL)

Description: Percent of plan members aged 50-75 who had appropriate screening for colon cancer.

Metric: The percentage of MA enrollees aged 50 to 75 (denominator) who had one or more appropriate screenings for colorectal cancer (numerator). Fecal Occult Blood Test in the office, colonoscopy within the last 10 years etc.

Exclusions: (optional) Members with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the member's history.

Cholesterol Management for Patients with Cardiovascular Conditions (CMC):

Description: Percent of plan members with heart disease who have had a test for bad (LDL) cholesterol within the past year.

Metric: The percentage of members 18-75 years of age who were discharged alive for Acute Myocardial Infarction (AMI), coronary

artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year (denominator), who had an LDL-C screening test performed during the measurement year (numerator).

Physical Activity in Older Adults (PAO):

Description: Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.

Metric: The percentage of sampled Medicare members 65 years of age or older (denominator) who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity (numerator).

Adult BMI:

Label for Data: Checking to see if members are at a healthy weight

HEDIS Label: Adult BMI Assessment (ABA)

Description: Percent of plan members with an outpatient visit who had their Body Mass Index (BMI) calculated from their height and weight and recorded in their medical records.

Metric: The percentage of members 18-74 years of age (denominator) who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year (numerator).

Exclusions: (optional) Members who have a diagnosis of pregnancy.

Functional Status Assessment:

Label for Stars: Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living (Special Needs Plans only)

Label for Data: Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living (Special Needs Plans only)

HEDIS Label: Care for Older Adults (COA) – Functional Status Assessment

Description: Percent of plan members whose doctor has done a functional status assessment to see how well they are able to do activities of daily living (such as dressing, eating, and bathing). (This information about the yearly assessment is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan

designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one functional status assessment during the measurement year (numerator).

Pain Screening:

Label for Data: Yearly Pain Screening or Pain Management Plan (Special Needs Plans only)

HEDIS Label: Care for Older Adults (COA) – Pain Screening

Description: Percent of plan members who had a pain screening or pain management plan at least once during the year. (This information about pain screening or pain management is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)

Metric: The percentage of Medicare Advantage Special Needs Plan enrollees 66 years and older (denominator) who received at least one pain screening or pain management plan during the measurement year (numerator).

Controlling Blood Pressure:

Label for Data: Controlling Blood Pressure

HEDIS Label: Controlling High Blood Pressure (CBP)

Description: Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.

Metric: The percentage of MA members 18–85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) during the measurement year (numerator).

If you have questions, please call
Beth Brenner, RN, Manager Quality &
Performance Indicators, with The University
of Arizona Health Plans Quality Management
Department at (520) 874-5509.

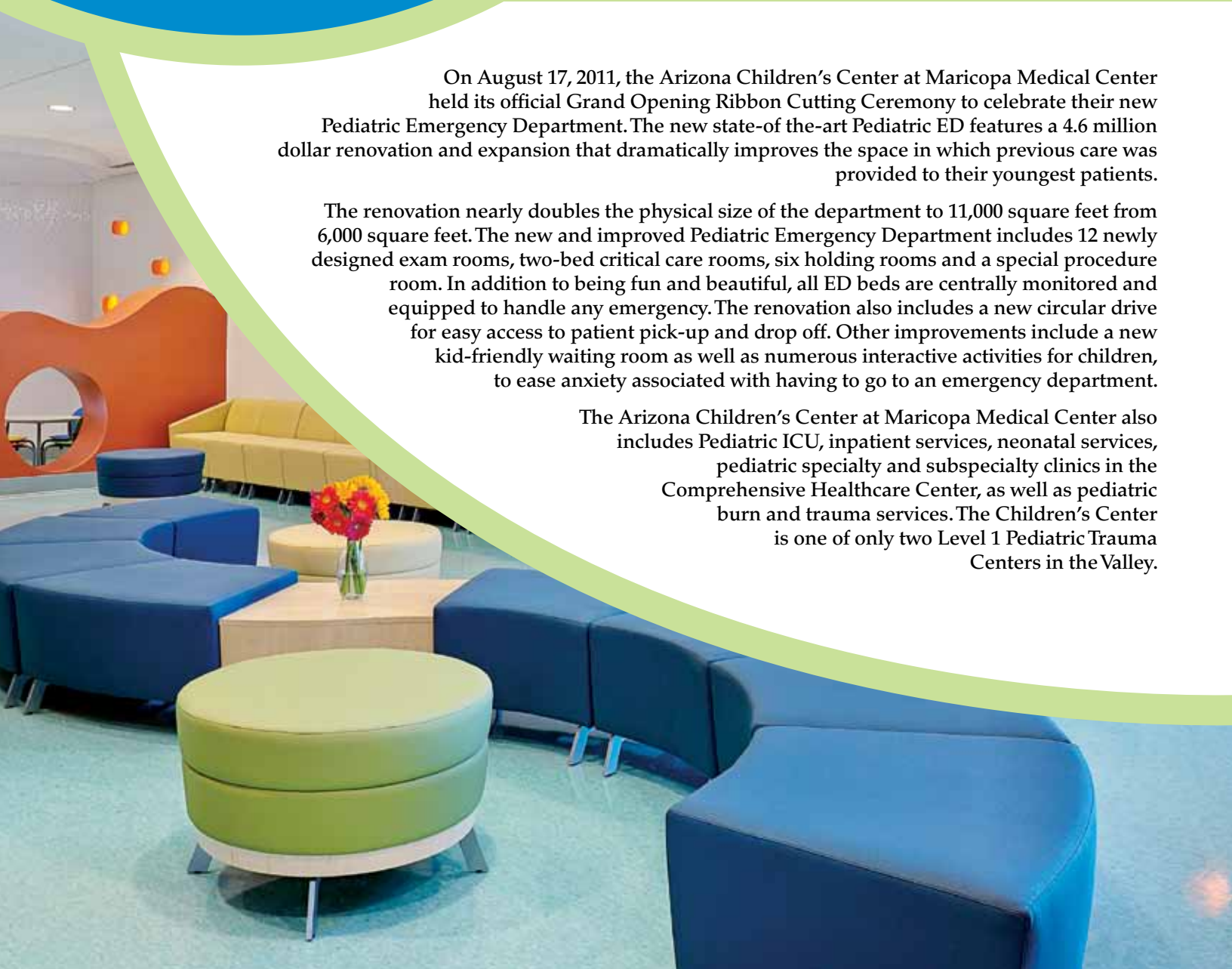
Arizona Children's Center at Maricopa Medical Center Officially Opens New Pediatric Emergency Department



On August 17, 2011, the Arizona Children's Center at Maricopa Medical Center held its official Grand Opening Ribbon Cutting Ceremony to celebrate their new Pediatric Emergency Department. The new state-of-the-art Pediatric ED features a 4.6 million dollar renovation and expansion that dramatically improves the space in which previous care was provided to their youngest patients.

The renovation nearly doubles the physical size of the department to 11,000 square feet from 6,000 square feet. The new and improved Pediatric Emergency Department includes 12 newly designed exam rooms, two-bed critical care rooms, six holding rooms and a special procedure room. In addition to being fun and beautiful, all ED beds are centrally monitored and equipped to handle any emergency. The renovation also includes a new circular drive for easy access to patient pick-up and drop off. Other improvements include a new kid-friendly waiting room as well as numerous interactive activities for children, to ease anxiety associated with having to go to an emergency department.

The Arizona Children's Center at Maricopa Medical Center also includes Pediatric ICU, inpatient services, neonatal services, pediatric specialty and subspecialty clinics in the Comprehensive Healthcare Center, as well as pediatric burn and trauma services. The Children's Center is one of only two Level 1 Pediatric Trauma Centers in the Valley.



2012 | Medicare Advantage Special Needs Plan Benefits

University Care Advantage is A Medicare Advantage Special Needs Plan that is available to individuals who are entitled to Medicare Part A, enrolled in Medicare Part B and AHCCCS and who reside within Pima, Pinal, Santa Cruz, Cochise, and Maricopa counties.

University Care Advantage is dedicated to our Model of Care and the personalized support that we offer our members. We are happy to announce that effective January 1, 2012, University Care Advantage, will have enhanced supplemental benefits.

University Care Advantage provides personal support to all of our members:

- Medicaid/Medicare full coordination of benefits
- Case Management Team – an experienced team of specialized RNs that assist in the transition of our member's care
- Golden Touch Program – may assist members with community based cost savings programs
- Exceptional Customer Care Team
- Expert Enrollment Team

No additional costs to our members

Contact your Provider Relations Representative for additional information.

\$1500 Plan Limit for Comprehensive Dental Every Year*

Oral Exam	1 oral exam six months
Cleanings	1 cleaning every six months
Dental X-rays	1 dental x-ray every year
Fluoride Treatments	1 fluoride treatment every year
Comprehensive Dental	No Copay or Coinsurance

\$1000 Plan Limit for Hearing Aid(s) Every Year*

Hearing Exam	0% of the cost for up to 1 supplemental routine hearing exam every year
Hearing Aid(s)	\$0 copay for up to 1 hearing aid(s) every year

\$200 Plan Limit for Eye Wear Every Year*

Routine Eye Exam	1 supplemental eye exam per year
Contacts	0% of the cost for up to 1 pair of contacts every year
Eye Glasses	0% of the cost for up to 1 pair of glasses every year

Mail Order Maintenance Medications

One of the most important ways members can manage their health is by taking medications as directed. As such, University Care Advantage (UCA) is requesting provider support for a new quality initiative to improve medication adherence among Medicare Part D beneficiaries, 18 years of age and older, for the following drug therapies:

- Medication Adherence for Oral Diabetes Medications: biguanides, sulfonylureas, thiazolidinediones, and dipeptidyl peptidase-4 (DPP-4) inhibitors
- Medication Adherence for Hypertension: angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medications
- Medication Adherence for Cholesterol: statin cholesterol medications

We are asking providers to encourage members to use the mail order program. Through Express Scripts Pharmacy, members can order maintenance medications for home delivery. The service is safe, reliable and convenient for members.

To facilitate the mail order program, providers need to:

- Prescribe formulary drugs
- Write scripts for a 90-day supply

Once the mail order program is initiated, it will be sustained through the auto refill component.

We believe the mail order program will benefit the member and the provider. By working together, we can improve medication adherence and overall patient outcomes.

