Healthy Practices

A quarterly publication for MVP Health Care® Providers.

Spring 2022
Volume 18 Number 2

Access, Convenience, and Value

Introducing Scarlet Health® for In-Home Lab Test Collection

MVP Health Care® (MVP) is collaborating with BioReference Laboratories to provide MVP Members an easy way to complete their medically necessary lab testing. MVP is utilizing Scarlet Health, BioReference's on-demand, fully integrated digital solution that offers specimen collection at a convenient location of your patients' choosing such as their home or workplace. With Scarlet,® MVP Members facing barriers such as transportation challenges, reduced mobility, or a lack of childcare can have their blood, urine, and COVID-19 PCR specimens safely collected from the comfort of their homes.

As we learned in the recent MVP podcast: *Exploring the Virtual-to-Physical Care Continuum* (see article below), patients desire availability, which is a component of access, convenience, and value. Scarlet gives patients an easy option to stay current with their laboratory testing which may not only lower costs but may also lead to improved health outcomes and happier patients. When you tell your patients about Scarlet, you not only give them the choice of convenience and peace of mind, you may also reduce the unfilled lab test gap.

Providers who want to make this part of their regular workflow may email **hello@scarlethealth.com** for more information. However, patients can still take advantage of this service even if you're not set up with Scarlet Health. Simply enter the order for laboratory testing and give your patient a copy of the test order. Your patient can upload the lab order on Scarlet's website and schedule the mobile test collection.

Once the lab testing is complete, the lab test results will be sent to the ordering provider via fax or electronic ordering system. Patients may access their test results via the secure, HIPAA-compliant BioReference Patient Portal.

See the insert in this newsletter or visit **mvphealthcare.com/providers/scarlet** to learn more and access instructions for how patients can get started with Scarlet.

Telemedicine Podcast: Part 2

Virtual-To-Physical-Care Continuum

Last quarter, MVP launched Part 1 of our podcast with Dr. Kim Kilby, Vice President, Medical Director for Health and Well-Being at MVP, and Dr. Tucker Slingerland, CEO of Hudson Headwaters Health Network in upstate New York. Together, they discussed telehealth in general, and how we can all work together to achieve an optimal virtual-to-physical care continuum in the future.

We are proud to present Part 2. In the conclusion of their conversation, we'll hear about how in person visits and virtual care can work together for the best patient care. The doctors also discussed other challenges and foreseeable changes as health care continues to adapt to our ever-changing environment. Access both podcasts at **mvphealthcare.com/providers/podcast**.

Let's Deliver
health insurance built around

We welcome your comments.

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Customer Care Center for Provider Services

1-800-684-9286

Updated Contact Information for DME Requests

Effective immediately, please call the MVP Customer Care Center for Provider Services at **800-684-9286** for calls related to Durable Medical Equipment (DME) inquiries. MVP has discontinued the use of the former DME phone number, 800-452-6966, as of April 1, 2022.

Cybersecurity: Protect Your Data Against Threats

MVP places great importance on information security to protect against internal and external threats. Our cybersecurity strategy prioritizes detection, analysis, and incident response to cyber threats, vulnerability management, and resilience against cyber incidents. MVP continuously strives to meet and exceed the industry's information security best practices and applies controls to protect our Provider partners and our Members. As a strategic partner, we want to remind you of some basic questions to ask yourself before clicking on emails that come from an unknown source:

- Do you recognize the sender's email address?
- If you know the sender, were you expecting this email?
- Does the message contain poor spelling or grammar?
- Does the message ask for personal information?
- Does the offer seem too good to be true?
- Did you initiate the action?
- Are you being asked to send money?
- Does the message make unrealistic threats?
- Does the message appear to be from a government agency like the IRS?
- Does anything look off?

Please be sure to remind your staff to ask themselves these questions and to stay vigilant against cyberattacks.

Electronic Claims Submission Update

As part of your agreement with MVP, Providers that are enabled to submit claims electronically must do so. To ensure the claims submission and remittance process is as easy for Providers as possible, MVP is reviewing and enhancing its digital strategy and capabilities related to these processes. Providers are encouraged to take advantage of the many digital options available which helps to streamline the process—through our online claims keying tool, direct 837 submission to MVP, or through a billing service or clearinghouse of your choice.

As a result of this review, we are updating our list of preferred clearinghouses to ensure our Providers receive the highest quality service from these vendors. Over the next few months, you may receive a notification from your clearinghouse stating MVP has ended its relationship with them. However, this will not impact your ability to submit claims to MVP. Providers can use any claims clearinghouse vendor and the claims will be submitted to MVP. Regardless of if MVP is contracted with a specific clearinghouse, your submission process does not need to change, and the service, including response times, should not be impacted.

There are many ways to submit claims to MVP—the use of a clearinghouse is just one way. MVP also encourages providers to receive remittance electronically, which helps to expedite payment. Learn more about how to submit claims and receive remittance electronically at **mvphealthcare.com/providers/education**, then select *Claims and Electronic Remittance Advice.*

Best Practice for Coding and Documentation of Obesity

Per ICD-10 guidelines and the American Hospital Association's (AHA) Coding Clinic, the best practice for coding and documenting obesity disease requires providers to apply a primary code of the type of obesity disease and only use a BMI code as a secondary diagnosis code. While BMI codes should be captured, they should never be used as the primary code and are not intended for use as a primary diagnosis. If the provider documents BMI only, and there is no mention of the associated condition, the BMI status code will not be captured. Review tips for making coding obesity easier, by visiting **mvphealthcare.com/providers**, select *Reference Library,* then select *ICD-10 Updates and FAQs.* If you have any coding questions or concerns, contact the MVP Senior Risk Mitigation Coordinator, Mary Ellen Reardon at **585-279-8583** or email **mreardon@mvphealthcare.com**.

The information, including but not limited to, text, graphics, images and other material contained in this publication is for informational purposes only and no warranty or representation is made that the information is error-free. The information contained in this publication may include inaccuracies and/or errors, or be outdated as changes may occur at any time without notice. The purpose of this publication is to promote broad provider understanding and knowledge of various general health plan topics. Please contact MVP Professional Relations Staff with any questions, concerns, or comments that you have concerning any information in this publication.

Helping to Improve Patient Outcomes

Authorization to Disclose Information

MVP strives to create the best experience for our Members, your patients. Collaboration between providers can make a positive impact on their overall health by helping to close communication gaps, identify potential health issues before they arise, and provide more comprehensive care. MVP encourages providers to work with their patients to sign releases of information to offer a more integrative approach to treatment. MVP Case Managers (CMs) help to coordinate care by educating Members on completing an MVP authorization to disclose form, which can be found by visiting **mvphealthcare.com/members**, then select *Forms,* then *Authorization.* This will allow the MVP CM to coordinate important health information with the identified provider and ensure the best health outcomes for our Members.

Provider Availability to Members

MVP Participating Providers must ensure that there is 24/7 coverage for Members. PCPs may use a back-up call service, provided that a physician is always available to back up the call service. PCPs agree that, in the case of an absence, they will arrange for patient care to be delivered by another provider and ensure the covering provider participates with MVP. If arrangements are made with a non-participating physician, it is the responsibility of the participating physician to ensure that the non-participating physician will:

- Accept MVP's fee as full payment for services delivered to MVP Member patients
- Accept the MVP peer-review procedures
- Seek payment only from MVP for covered services provided to Members and at no time bill or otherwise seek compensation for covered services from MVP Members, except for the applicable co-payments
- Comply with MVP utilization management and quality improvement procedures

Note: Providers who are not contracted for Government Program lines of business are considered non-participating for Government Program plan types (Medicaid Managed Care, HARP, and Child Health Plus). When submitting the insurance claim to MVP, the covering provider should indicate "covering for Dr. 'X'" in box 19 of the CMS-1500 claim form.

MVP Code of Ethics and Business Conduct Summary

MVP provides this Code of Ethics and Business Conduct Summary as part of its commitment to conducting business with integrity and in accordance with all federal, state, and local laws. This summary provides MVP's network Providers, vendors, and delegated entities (Contractors) with a formal statement of MVP's commitment to the standards and rules of ethical business conduct. All MVP Contractors are expected to comply with the standards as highlighted below. Contractors may access MVP's Corporate Code of Ethics and Business Conduct by visiting **mvphealthcare.com/providers**, then select *Reference Library,* then select *Learn about MVP Policies,* then select *Corporate Code of Ethics and Business Conduct.*

Protecting Confidential and Proprietary Information

It is of paramount importance that MVP's Member and proprietary information be always protected. Access to proprietary and Member information should only be granted on a need-to-know basis and great care should be taken to prevent unauthorized uses and disclosures. MVP's Contractors are contractually obligated to protect Member and proprietary information.

Complying with the Anti-Kickback Statute

As a Government Programs Contractor, MVP is subject to the federal anti-kickback laws. The anti-kickback laws prohibit MVP, its employees, and Contractors from offering or paying remuneration in exchange for the referral of Government Programs business.

Reviewing the Federal and State Exclusion, Preclusion, and Identification Databases

MVP and its Government Programs Contractors are required to review the applicable federal and/or state exclusion, preclusion, and identification databases. These database reviews must be conducted to determine whether potential and current employees, Contractors, and vendors are excluded or precluded from participation in federal and state sponsored health care programs. The federal and state databases are maintained by the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (HHS), the Office of Inspector General (OIG), the General Services Administration (GSA), the New York State Office of Medicaid Inspector General (OMIG), the Social Security Administration Death Master File (SSADMF) and the National Plan and Provider Enumeration System (NPPES).

Prohibiting the Acceptance of Gifts

MVP prohibits employees from accepting or soliciting gifts of any kind from MVP's current or prospective vendors, suppliers, providers, or customers that are designed to influence business decisions.

Detecting and Preventing Fraud, Waste, and Abuse (FWA)

MVP has policies and processes in place to detect and prevent fraud, waste, and abuse (FWA). These policies outline MVP's compliance with the False Claims Act and other applicable FWA laws and regulations. These laws and regulations prohibit MVP and its Contractors from knowingly presenting or causing to present a false claim or record to the federal government, the State Medicaid program, or an agent of these entities for payment or approval. Contractors may access MVP's policy for Detecting and Preventing FWA online here under the Learn about MVP Policies section. MVP's Special Investigations Unit (SIU) is instrumental in managing the program to detect, correct, and prevent FWA committed by providers, Members, subcontractors, vendors, and employees. The SIU maintains a toll-free, 24-hour hotline, **1-877-835-5687**, where suspected fraud, waste, and abuse issues can be reported directly by internal and external sources.

Providing Compliance Training, Fraud, Waste, and Abuse (FWA) Training and HIPAA Training

To prevent and detect FWA, all MVP's Contractors that support its Medicare products and who are first tier, downstream, or related entities (FDRs) are required to provide general compliance training and FWA training to their employees, subcontractors, and downstream entities upon hire, annually, and as changes are implemented. The Centers for Medicare and Medicaid Services (CMS) provides a Medicare Parts C and D FWA and general compliance training program. This online program is available through the CMS Medicare Learning Network. Entities who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare Program or through accreditation as a supplier of DMEPOS are deemed to have met the FWA training requirement. However, these entities must provide general compliance training. MVP's Contractors that support its Medicaid products are also required to provide general compliance and FWA training to their employees, subcontractors, and downstream entities upon hire, annually and as changes are implemented. In addition, Contractors who handle MVP Protected Health Information are required to provide HIPAA Privacy, Security, and Breach Prevention trainings to their employees.

Reporting Suspected Violations

MVP provides an Ethics and Integrity Hotline for reporting suspected violations of the Code or of its legal requirements. The Ethics and Integrity Hotline, **1-888-357-2687**, is available for employees, vendors, and Contractors to report suspected violations anonymously. Reports of suspected fraud, waste, and abuse may also be reported anonymously by contacting the Ethics and Integrity Hotline. EthicsPoint manages MVP's confidential reporting system and receives calls made to the Hotline. EthicsPoint triages reports in a secure manner to MVP's Compliance Office. The Compliance Office promptly and thoroughly investigates all allegations of violations. All MVP Contractors are required to report actual or suspected non-compliance and FWA that impacts MVP using the hotlines referenced above. Contractors are protected from intimidation and retaliation for good faith participation in MVP's Compliance Program.

MVP HEALTH CARE

Provider Policies and Payment Policies Effective April 1, 2022

MVP Provider Policies and Payment Policies includes revisions on operational procedures, plan type offerings, and clinical programs. The policies are designed to serve as a reference tool for Providers and facilities. The following policies have been updated, with an effective date of April 1, 2022, and are posted at **mvphealthcare.com/policies**.

PROVIDER POLICY UPDATES EFFECTIVE APRIL 1, 2022

- Behavioral Health Policy
- Claims
- Contacting MVP
- Provider Responsibilities

PAYMENT POLICY UPDATES EFFECTIVE APRIL 1, 2022

- After-Hours
- Allergy Testing and Serum Preparation Claims
- Audiology Services
- Arthroscopic, Endoscopic, and other Non-Gastrointestinal Scope Procedures
- Consistency of Denials
- Default Pricing
- Home Infusion
- Interpreter Services
- Infusion Policy
- JW Modifier
- Laboratory Services
- Mental Health and Substance Use Disorder
- Mid-Level Payment Policy
- Multiple Surgery, VT Only
- NDC Policy
- Preventive Payment Policy
- Radiology
- Transitional Care Management
- Viscosupplementation of the Knee: Non-Coverage for Medicaid Manage Care (MMC) Plans (new policy)

Improving Behavioral Health Follow-Up Care

Follow-up Care After Emergency Department Visits

According to the US National Institutes of Health, 50% of all hospital admissions are a direct result of Emergency Department (ED) visits. Timely follow up care with the patient after an ED visit may be the key to reducing return ED visits as well as improving overall population health outcomes.

Behavioral Health ED Visits

For ED visits due to a Behavioral Health event, such as mental illness, alcohol dependence, or substance use disorders, studies have demonstrated the benefits of timely follow-up care such as decreased suicidal ideation, reduced ED readmissions, and improved medication adherence.[1] Furthermore, the American Medical Association has found that follow-up care for people with Behavioral Health conditions not only lead to fewer repeat ED visits, but also improved physical and mental function, and increased compliance with follow-up instructions.

Implementing Best Practices for Follow-Up Care

Reach out to your patients to schedule a follow-up appointment as soon as you are notified of their ED visit. Utilize your health information exchange (HIE) to gain more information on ED discharges or collaborate with hospital ED's to obtain data exchange reports on your patients seen in the ED for better care coordination. If available, offer your patients options for telemedicine services for follow-up care, including:

- Telephone visits
- Telehealth visits
- Online Assessment (e-visits or virtual check-ins)

Providers can improve the transition of care by connecting Members with appropriate Behavioral Health care providers in their area or working with Members to sign information sharing agreements that facilitate integrated health care between providers. For more information on follow-up care after ED visits for Behavioral Health events, visit **mvphealthcare.com/providers**, select *Reference Library,* and then *HEDIS Provider Reference Guides.*

MVP Behavioral Health Care Program

MVP's Behavioral Health care program connects Members to licensed Behavioral Health clinicians who are available for support calls, to help improve their daily quality of life, and to help them better understand their Behavioral Health condition. If you are treating MVP Members who may benefit from this program, refer them to MVP Case Management at **1-866-942-7966**, Monday–Friday 8:30 am–5 pm.

[1]Source: Psychiatry Online: ps.psychiatryonline.org/ doi/10.1176/appi.ps.201500104

Provider Excellence Program

The MVP Provider Excellence Program provides our physicians and MVP Members relevant quality and cost data to help them make informed health care decisions.

Why is it important?

- Creates awareness of high-performing Providers within the MVP network
- Provides additional support to strategic Provider groups
- In the future, the results may inform MVP products and program benefits

What is the value to MVP Members?

- Encourages Members to consider using a high value Provider
- Encourages Members to consider all relevant factors when choosing a Provider and to speak with their Primary Care Physician (PCP) when selecting a specialist

Currently, MVP publicly reports the top 15% of Provider groups for Family Medicine and Internal Medicine specialties that are in-network and contracted in New York State, only. MVP evaluates quality and cost efficiency information using a methodology that is consistent with national standards and incorporates feedback from health care professionals in our network.

To learn more, visit **mvphealthcare.com/providerexcellenceprogram**. To request the full methodology, email **ProviderExcellence@mvphealthcare.com**.

A Woman's Health Journey

Whether it's keeping up with routine screenings or needing specialized diagnosis and treatment, women face complex health decisions at every stage in life.

Adolescence

Establishing a strong foundation during early childhood and adolescence will make it easier to help them manage changes, both physical and behavioral, as they grow into adulthood.

- Starting at birth, girls should see their pediatrician or PCP for routine well-child visits
- It's important that girls select a gynecologist and start annual well-woman exams once in their teens
- HPV is the leading cause of cervical cancer. Adolescent girls should get the HPV vaccine series completed between nine and 13 years old

Teens and Young Adult

Working with younger female patients to develop and maintain healthy habits may help them stay physically and mentally fit as they get older. Implement office procedures to ensure your female patients keep regular checkups, health screenings, and immunizations.

- One in four young female adults will be diagnosed with an STD. Women who are 16–24 years old and sexually active should have at least one test for chlamydia each year
- Cervical cancer can be found with regular pap tests. Women should be screened for cervical cancer every three years starting at age 21
- Women in reproductive years are recommended to seek contraception and family planning counseling

From early childhood to older adulthood, the provider-patient relationship that fosters open-communication and coordination of care increases the likelihood that women will be more involved in their health care, improving overall health outcomes.

Mature Adult

Promoting self-care becomes especially important during this phase of a woman's life. Along with the demands of everyday responsibilities, women are going through changes that can raise their risk of high blood pressure, heart disease, and diabetes.

- Use annual well-care or well-woman visits to discuss stress, depression, anxiety, or other mental health issues
- Begin scheduling breast and colorectal cancer screenings at age 40 and 45, respectively, unless risk factors indicate earlier screenings
- One in four women die from heart disease—talk about health screenings that are age or lifestyle appropriate such as blood pressure readings and hemoglobin A1C testing to help prevent or manage chronic care conditions

Older Adult

In addition to chronic conditions like heart disease and diabetes, this is the time to speak with your female patients about good bone health.

- One in two women will have an osteoporosis-related bone break; 33% of women will be diagnosed with osteoporosis by age 75
- 46% of older women take five or more prescription drugs. Make sure you know all their medications, and if they're causing side effects.
- Work with your older patients on a fall prevention plan including appropriate exercises for balance and strength and hearing and vision checks
- Starting at age 65, women should complete an osteoporosis screening every two years

MVP HEALTH CARE

Quality Corner

Spotlight on Medication Adherence

Medication adherence is a critical aspect for managing chronic conditions such as diabetes and hypertension. Despite its importance, medication nonadherence continues to be a serious problem and a leading driver of poor health outcomes.

Strategies for Improving Medication Adherence:

- Ensure open and ongoing communication between you and your patient, with the goal of achieving optimal health outcomes. For example, when ordering the initial prescription, educate the Member on the benefits and potential side effects
- Leverage all visits, including annual wellness and sick visits to conduct medication reconciliation. Patients fail to take their medications about 50% of the time. Medication reconciliation creates an opportunity to discuss adherence, stress the risk factors associated with non-adherence, and help improve compliance with instructions
- Assess if the Member is eligible for a longer-term supply of their medication. Not only does it mean fewer trips to the pharmacy and possible cost-savings for the Member, but studies have also shown that adherence is 20% higher when the individual has a 90-day supply versus a 30-day

There are countless reasons for medication nonadherence, and no easy solutions. The best approach for improving adherence is by working collaboratively with the Member and their pharmacists, specialists, and entire health care team.

MVP Supports the Following Services to Help Improve Medication Adherence With Your Patients

CVS® Caremark Mail Service Pharmacy

MVP Members who have prescription drug coverage may be able order up to a 90-day supply of their maintenance medications through this program. To find out if a medication is available from CVS Caremark Mail Service Pharmacy, visit **mvphealthcare.com/providers**, select Pharmacy, then select *MVP Formularies,* and the select the appropriate formulary; if a drug or drug class has an asterisk (*) next to it, that drug or all drugs in that class are available through mail service program.

SimpleDose™ from CVS Pharmacy®

SimpleDose is a convenient and simple medication management solution for your patients taking multiple medications. Eligible medications are presorted into easy-to-open packets based on dose, date, and time. There is no additional cost to enroll. Free nationwide delivery to the Member's home or any CVS Pharmacy location is included. SimpleDose™ can only be filled for 30-day supplies. If you have a Member who would like to learn move, visit **CVS.com/SimpleDose** or call **1-800-753-0596**.

Medication Therapy Management Program

Eligible MVP Medicare Advantage Members can speak with an MVP pharmacist privately over the phone to review their medications for safety and check if lower-cost alternatives are available. The Medication Therapy Management Program (MTMP) also helps to ensure that Members understand why they have been prescribed a medication and the importance of taking it exactly as prescribed. To find out if a Member is eligible for MTMP, call MVP at **1-866-942-7754**, Monday–Friday, 8:30 am–5 pm Eastern Time.

Medical Policy Updates

Below is a recap of the Medical Policies that went into effect February 1, 2022. All policies are reviewed at least once annually. For more detailed information on these changes, please review **mvphealthcare.com/Fastfax** or visit **mvphealthcare.com/Providers** and *Sign In* to your account, and select *Resources,* then *Medical Policies.*

MEDICAL POLICY NAME
Adult Day Care Service
Bariatric Surgery
Benign Prostatic Hyperplasia (BPH) Treatments
Colorectal Cancer Genetic Testing
Continuous Glucose Monitoring
Dental Care Services Accidental Injury
Dental Care Services Medical Services for Complications of Dental Problems
Dental Care Services Facility Services for Dental Care
Dental Care Services Prophylactic Dental Extractions
Endoscopy (Colonoscopy)
Ground Ambulance/Ambulette Services
Investigational Procedures
Needle-free Insulin Injectors
Neuropsychological Testing
Oncotype DX Test
Phototherapy, Photochemotherapy, Excimer Laser Therapy
Power Mobility Devices
Tissue-Engineered Skin Substitutes

Pharmacy Policy Updates

Below is a recap of the Pharmacy and Formulary updates that went into effect from January 1 to February 1, 2022. All policies are reviewed at least once annually. For more detailed information on these changes, please review updates at **mvphealthcare.com/FastFax.**

EFFECTIVE JANUARY 1, 2022

PHARMACEUTICAL POLICY NAME	STATUS
Crohn's Disease Select Agents	**Updated**
Dupixent	**Updated**
Quantity Limits for Prescription Drugs (effective October 1, 2021)	**Updated**
Mulpleta/Doptelet	**Updated**
Prostate Cancer	**Updated**
Radicava	**Updated**
Zulresso	**Reviewed/No changes**
Palforzia	**Reviewed/No changes**
Formulary Exception for Non-Covered Drug (External)	**Reviewed/No changes**
Infliximab	**Updated**
Growth Hormone Therapy	**Updated**
Ulcerative Colitis, Select Agents	**Updated**
SGLT2 Inhibitors Medicaid	**New**
Multiple Sclerosis Agents	**Updated**
Select Oral Antipsychotics	**Reviewed/No changes**
GABA-Receptor Modulators (formerly Xyrem)	**Updated**
Movement Disorder	**Updated**
Select Hypnotics	**Updated**
Respiratory Syncytial Virus/Synagis	**Reviewed/No changes**
Spravato	**Updated**
Nuedexta	**Reviewed/No changes**
Gabapentin ER	**Reviewed/No changes**
Spinal Muscular Atrophy	**Reviewed/No changes**
Oral Allergen Immunotherapy Medications	**Updated**
Agents for Female Sexual Dysfunction	**Reviewed/No changes**
Ankylosing Spondylitis Drug Therapy	**Updated**
Rheumatoid Arthritis Drug Therapy	**Updated**
Psoriatic Arthritis Drug Therapy	**Updated**

EFFECTIVE FEBRUARU 1, 2022

PHARMACEUTICAL POLICY NAME	STATUS
Doryx/Oracea (doxycycline)	**Reviewed/No changes**
Antibiotic/Antiviral (Oral) Prophylaxis	**Updated**
Government Programs Over the Counter (OTC) Drug Coverage (For MVP Medicaid, Child Health Plus, and select Essential Plan Members Only)	**Updated**
Compounded (Extemporaneous) Medications	**Updated**

Formulary Updates

COMMERCIAL, MARKETPLACE, AND MEDICAID

New Drugs (recently FDA approved, prior authorization required, Tier 3, non-formulary for MVP Medicaid)

DRUG	COMMERCIAL	MEDICAID	MEDICARE
Nexviazyme	Medical	Medical	Non-Formulary
Welireg	Tier 3	Non-Formulary	Non-Formulary
Loreev XR	Tier 3	Non-Formulary	Non-Formulary
Exkivity™ (mobocertinib)	Medical	Non-Formulary	Medical Part D- Tier 5, if RxCui becomes available
Tivdak™ (tisotumab vedotin-tftv)	Tier 3	Medical	Medical Part D- Tier 5, if RxCui becomes available
Livmarli™ (maralixibat)	Tier 3	Non-Formulary	Non-Formulary
Qulipta™ (atogepant)	Tier 3	Non-Formulary	Non-Formulary
Skytrofa™ (lonapegsomatro-pin-tcgd)	Tier 3	Non-Formulary	Non-Formulary
Tavneos™ (avacopan)	Tier 3	Non-Formulary	Non-Formulary
Trudhesa™ (dihydroergota-mine)	Tier 3	Non-Formulary	Non-Formulary
Lybalvi™ (olanzapine/ samidorphan)	Tier 3	Non-Formulary	Non-Formulary
Opzelura Cream™ (ruxolitinib)	Tier 3	Non-Formulary	Non-Formulary
Scemblix®	Tier 3	Non-Formulary	Medical
(asciminib)	Tier 3	Non-Formulary	Part D- Tier 5, if RxCui becomes available
Besremi® (ropeginterferon alfa-2b)	Tier 3	Non-Formulary	Non-Formulary
Voxzogo™ (vosoritide)	Tier 3	Non-Formulary	Non-Formulary
Fyarro™ (sirolimus)	Medical	Medical	Medical
Livtencity™ (maribavir)	Tier 3	Non-Formulary	Non-Formulary
Tyrvaya™ (varenicline)	Tier 3	Non-Formulary	Non-Formulary
Eprontia™ Oral Solution (topiramate)	Tier 3	Non-Formulary	Tier 5
Vuity™ Solution (pilocarpine)	Tier 3	Non-Formulary	Non-Formulary
Elyxyb™ Solution (celecoxib)	Tier 3	Non-Formulary	Non-Formulary

DRUGS REMOVED FROM PRIOR AUTHORIZATION: COMMERCIAL AND EXCHANGE

Myfembree (Non-formulary for Medicaid)
Truseltiq (Non-formulary for Medicaid)
Lumakras (Non-formulary for Medicaid)

DRUG EXCLUSION COMMERCIAL, EXCHANGE, AND MEDICAID

Dextenza

Miscellaneous Updates

COMMERCIAL AND EXCHANGE FORMULARY EFFECTIVE JANUARY 1, 2022

DRUG	ACTION
Aimovig, Emgality, and Ajovy	Move from Tier 3 to Tier 2
Stelara and Tremfya	Move from Tier 3 to Tier 2 for Psoriatic Arthritis. Prior authorization still required.
Zeposia	Move from Tier 3 to Tier 2 for Ulcerative Colitis. Prior authorization still required.
Nurtec ODT	Quantity limit increase to 16 tablets per 30 days
Bystolic	Move to Tier 3
Zolpidem ER (generic)	Add a quantity limit of 30 tablets per 30 days

MEDICAID FORMULARY EFFECTIVE JANUARY 1, 2022

DRUG	ACTION	NOTES
Segluromet and Steglatro	Move to preferred Tier 2	
Invokamet, Invokamet XR, Invokana, and Xigduo XR to Excluded status	Exclude	
Farxiga	Add prior authorization, Tier 2	New policy
Advair HFA and Symbicort	Exclude	
Fasenra pen	Move to preferred Tier 2/specialty	
Norditropin Injection (ALL formulations)	Move to preferred Tier 2/specialty	Growth Hormone Therapy policy updated
Viokace and Zenpep	Move to preferred Tier 2	
Movantik	Move to preferred Tier 2	
Nurtec	Move to preferred Tier 2	Quantity limit of 15 tablets/30 days remains the same. Will only require prior authorization if exceeding the quantity limit.
Sofosbuvir-velpatasvir (generic Epclusa)	Move to preferred Tier 2 with a quantity limit of 84 tablets/year	Quantity reflects standard 12 weeks of therapy
Truvada	Move to non-formulary	
Nurtec ODT	Quantity limit increase to 16 tablets per 30 days	
Bystolic Diclegis and Chantix	Move to non-formulary	
Zolpidem ER (generic)	Add a quantity limit of 30 tablets per 30 days	
Nurtec ODT	Quantity limit increase to 16 tablets per 30 days	
Bystolic, Diclegis and Chantix	Move to non-formulary	
Zolpidem ER (generic)	Add a quantity limit of 30 tablets per 30 days	

MVP HEALTH CARE

Back on Track with Annual Wellness Visits (AWV)

The world may have changed due to the pandemic, but the importance of annual wellness visits has not. Even prior to COVID-19 people may have justified not seeing their PCP annually with reasons like “I never get sick” or “I don’t have any risk factors”. However, in today’s times, it’s vital that Members recognize that preventive care, including annual wellness visits, is an investment in their health.

Routine annual visits, regardless of the Member’s state of health, allow the PCP to build a comprehensive picture of the Member’s health risks, goals, and barriers. Implementing an integrated approach with your patients that includes physical, behavioral, and social factors encourages Members to be active players in their health care and empowers them to make well-informed decisions appropriate for their own health journey.

Annual visits also provide a good opportunity to remind your patients of any other services they may need, such as:

- Are they due for a colorectal cancer screening (COL) and would they be a candidate for home screening such as Cologuard®?
- Are they due for breast cancer screening (BCS) or a bone mineral density test and can you get that appointment set up before the visit is over to ensure better compliance?
- Remind them if they need a HbA1c lab testing, kidney health evaluation, or retinal screening
- Review immunizations they may be due for; identify any that can be given during the wellness visit to ensure better compliance
- Would they benefit from support services or referrals for healthy living such as weight management, behavioral health treatment, or tobacco cessation?

Continue to utilize telehealth services when appropriate and make sure that Members keep upcoming appointments with outreach calls or letter reminders. Specify what they need to do or have available at the time of the visit, such as medications, list of other health care providers, blood pressure readings, etc.

While the last two years have been challenging for everyone it is still crucial that plans and Providers work together now to educate, facilitate, and remind Members why annual wellness visits and preventive care are necessary.

Medicare Members who complete their AWV:

- 15% more likely to complete COL
- 17% more likely to complete BCS
- 4% more likely to compete HbA1c test

Source: Carrot Health Portfolio Analysis, October 2021

19% Medicaid Members, 10% HARP Members are non-compliant for an ambulatory or primary care visit.

93% of Medicaid Members who are children have two or three open gaps in care. 100% of this population are non-compliant for their annual dental visit and well-care visit.

Source: MVP Health Care, October 2021

Healthy Practices

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MVP IN THE COMMUNITY

Capital Roots

In February 2022, Team MVP helped produce a donor mailing that included over 570 letters and brochures highlighting Capital Roots’ mission. Capital Roots works to reduce the impact of poor nutrition on public health in New York’s Capital Region by organizing community gardens, providing healthy food access, offering nutritional and horticultural education for all ages, and coordinating urban greening programs in Albany, Rensselaer, Schenectady, and southern Saratoga Counties.

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