Provider Newsletter

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Spotlight: Seven tips to improve your 2020 HEDIS® scores

We are your partners in care and want to help you improve your HEDIS scores. Here are eight tips to get you started:

1. **Take advantage of your electronic medical records (EMR).** If you have EMR, use care gap "alerts."
2. **Avoid missed opportunities.** Many patients may not return to the office for preventive care, so make every visit count. Schedule follow-up visits before patients leave.
3. **Improve office management processes and flow**. Review and evaluate appointment hours, access, scheduling processes, billing, and office/patient flow.
4. **Remind your patients of their appointments**. Call patients 48 hours before their appointments to remind them about their appointments and anything they will need to bring.
5. **Gather the right data**. Train your medical staff to collect and document adult BMI and child BMI percentiles.
6. **Get patients to ask questions.** Promote the use of Ask Me Three® to elicit questions from your patients and make the most of each visit. The program gives patients three questions to ask at each visit.
7. **Ensure patients understand what they need to do.** This improves the patient's perception that there is good communication with their provider.

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Keeping directory information up to date

Help us keep your practice information updated in the directory. Having a correct listing is a prerequisite for proper handling of your claims and is important in ensuring uninterrupted care for our members. The following elements are critical to the accuracy of your listing:

- Street address
- Phone number
- Ability to accept new patients
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory.

Update your directory information by submitting the spot check form online, available at this link: www.medicaid.aetna.com/MWP/myaccount/viewProviderDocuments.

Access and availability standards

We use accessibility/availability standards based on requirements from NCQA, state, and federal regulations. These standards are communicated to providers and members via newsletter, our website, and as part of the provider manual.

Federal law requires that participating providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid fee-for-service members.

Providers who do not meet these access standards are provided recommendations for improvements in order to meet the set standard.

... continued

The timely access standards for for PCPs, behavioral health providers, and prenatal providers can be reviewed in the chart below.

Provider	Appointment	Availability standard
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
Behavioral Health	Non-life-threatening emergency	Within 6 hours
	Urgent care	Within 48 hours
	Initial visit routine care	Within 10 working days
Prenatal	First trimester	Seven calendar days
	Initial second trimester	Seven calendar days
	Third trimester and high risk	Three working days from date of referral or immediately, if an emergency exists

Continuity and coordination of care

Improve your patients' outcomes by coordinating with other health care providers.

Our recent research in continuity and coordination of care indicates that health care outcomes are far better when PCPs, specialists, and behavioral health providers work in partnership with each another to meet our members' health care needs.

We expect this collaboration will positively impact the overall health and wellbeing of our members. Aetna Better Health of Virginia has identified that continuity and coordination of care for our members is an area where we have room for improvement.

Therefore, we encourage our behavioral health providers and specialists to keep PCPs informed about member treatment, such as:

- Hospitalizations.
- Assessments.
- Recommended treatment plans.

Our members may either self-refer or directly access services without referral from their PCP. As a result, we encourage PCPs to discuss specialty and behavioral health care with their members to help coordinate needed services.

Interpreter and translation services is a covered benefit

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the health plan, the provider is financially responsible for associated costs.

For more information, refer to the "Health Literacy" section in your Aetna Better Health provider manual. To request interpreter and translation services, please call **1-800-279-1878** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus).

Integrated Care Management Program

Aetna Better Health of Virginia's Integrated Care Management (ICM) program implements a population-based approach to specific chronic diseases or conditions while engaging the member on an individual basis. All Aetna Better Health of Virginia members with identified conditions are auto-enrolled in the chronic condition program based on claims data. The chronic conditions managed include:

- Diabetes.
- COPD.
- Asthma.
- Coronary artery disease.
- Depression.
- Congestive heart failure.

The primary goal of our ICM program is to assist our members and their caregivers to better understand their conditions, update them with new information, and provide them with assistance from our staff to help them manage their disease. Members who do not wish to participate can call member services to disenroll from the program at any time.

Services we offer

Services for those with chronic conditions include but are not limited to:

- Coordination of care assistance.
- Disease-specific education and support.
- Assistance in receiving community-based services.

In addition to helping members who have special medical needs, we have care management programs for high-risk pregnancies and opioid management, as well as for pregnant women with substance use disorder and their babies.

Members can be referred to the ICM program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers. We encourage you to refer patients who would benefit from chronic condition management.

Need to get in touch with a care manager?

Please call Member Services at **1-800-279-1878** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus). We are here to help and look forward to joining you on our members' journey to better health.

Clinical Practice Guidelines

Aetna Better Health of Virginia's Clinical Practice Guidelines and Preventive Services Guidelines are based on nationally recognized recommendations and peer-reviewed medical literature. The guidelines consider the needs of enrollees, opportunities for improvement identified through our QM Program, and feedback from participating practitioners and providers. Guidelines are updated as appropriate, but at least every two years.

Where to learn more

More information about our practice guidelines, are on our website at www.aetnabetterhealth.com/virginia.

Simply scroll down and select **Practice Guidelines** on the left-hand menu.

Our Population Health Management

Aetna Better Health of Virginia's Population Health Management (PMH) program recognizes that health is more than the just optimal delivery of clinical care. It's also about the well-being of the total population within communities, including social determinants of health, such as socio-cultural background, economic factors, and the reduction of barriers pertaining to access to food, safety, and other resources.

Our PHM programs meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals.

Latest provider manual

Our provider manual is reviewed annually, at a minimum, and is updated as needed. Your provider manual is your primary information source and an effective guide to your participation with us. It is located on our website under the **For Providers** tab.

Monitoring metabolic risks of anti-psychotic medications

Metabolic changes in patients with schizophrenia who receive antipsychotic agents can contribute to the development of metabolic syndrome and increase the risk for type 2 diabetes mellitus and cardiovascular disease. Some antipsychotic treatments (such as olanzapine/Zyprexa) can cause significant increases in body weight and adiposity (4-10 kg). Increased adiposity has been associated with decreases in insulin sensitivity which may contribute to increases in plasma glucose concentrations and lipid levels[1]. As a result, it is important that metabolic functions and risk factors are systematically monitored.

Consensus guidelines from the American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists and the North American Association of for the Study of Obesity recommend the following[2]:

- At baseline, assess the patient's and/or family history of obesity, diabetes, cardiovascular disease, dyslipidemia, or hypertension.
- Assess and document the patient's BMI at baseline, at four, eight, and 12 weeks, and at least every three months thereafter, or more often as indicated.
- Assess and document the patient's fasting glucose, fasting lipid profile, and blood pressure at baseline and after three months of treatment. If the results are normal after three months of treatment, glucose and blood pressure monitoring is recommended annually. If the lipid profile is normal after three months, follow-up monitoring is recommend at least every five years.

Children and adolescents prescribed concurrent antipsychotics are at high risk for developing metabolic syndome. There is a lack of evidence supporting concurrent use. Because of this, guidelines caution against their use[3]. Additionally, the use of multiple concurrent antipsychotics in children and adolescents is a HEDIS measure for quality of care[4].

References

1 Newcomer, J. W. (2004). Metabolic risk during antipsychotic treatment. ***Clinical Therapeutics, 26***(12), 1936-1946.
2 American Diabetes Association. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. ***Diabetes Care, 27***(2), 596-601.
3 Correll, C. U., Kratochvil, C. J., & March, J. S. (2011). Developments in pediatric psychopharmacology: focus on stimulants, antidepressants, and antipsychotics. ***The Journal of Clinical Psychiatry, 72***(5), 655-670.
4 National Committee for Quality Assurance. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC). Retrieved from, https://www.ncqa.org/hedis/measures/use-of-multiple-concurrent-antipsychotics-in-children-and-adolescents

Login to our provider portal, today!

Our free provider portal allows you to access critical information securely online wherever and whenever you need it. This innovative tool is available to connect you directly with up-to-date information, including:

- Eligibility verification
- Claims inquiries
- Prior authorization information and requests
- Remittance advice
- And other helpful information

If you haven't yet registered, registering is easy:

1. Visit **aetnabetterhealth.com/virginia**
2. Click "For Providers"
3. Select "Provider Portal," then "Login" to get started

Healthy babies, healthy moms

To make sure our new mothers stay well and complete their postpartum follow-up visit in a timely manner (21-56 days after delivery), we offer them a maternity incentive program.

Each new mom is also sent a postpartum packet in the mail. This packet gives members detailed information on when to schedule postpartum visits with their provider in order to promote a healthy outcome after delivery.

To learn more about our maternity incentive program and request a sample postpartum packet for your office, contact your Provider Relations representative.

Important Note: Updates to Appeals & Grievances

We are in the process of updating our Appeals & Grievances address. These new addresses will be put into place **effective March 26, 2020**. Please see the new address below:

Member Appeals & Grievances:
Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Provider Appeals & Grievances:
Aetna Better Health of Virginia
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Help stop fraud!

Fraud, waste, and abuse are widespread in the health care industry and generally result in the increase of health care costs. Aetna Better Health is dedicated to fighting fraud, waste, and abuse through its Fraud Prevention Program. This program is designed to detect and eliminate health care fraud, waste, and abuse.

The most common types of health care fraud, waste, and abuse are:

- Billing for services never provided
- Billing for more expensive services than were actually provided
- Incorrectly stating a diagnosis to get higher payments
- Performing unnecessary services to get higher payments
- Misrepresenting non-covered procedures as medically necessary
- Selling or sharing a member's identification number for the purpose of filing false claims

If you believe you have information relating to health care fraud, waste, and abuse, please contact our Fraud Prevention Department. Our Fraud Prevention Department will review the information and will maintain the highest level of confidentiality as permitted by law.

To report suspected fraud or abuse, contact us:

- Toll-free FWA Hotline is **1-844-317-5825**
- Email **reportfraudabuseVA@aetna.com**

You can help support our mission to reduce and eliminate fraud in the health care industry by following a few simple guidelines:

- Be careful when providing health care information, including a member's identification number.
- Inform your patients to be cautious of "free" medical treatments in which the patient is required to provide them with health care information.
- Aetna Better Health receives bills from providers to pay. This includes doctor visits, inpatient and outpatient services, and equipment and supplies, etc. There will be times when a member receives a letter telling them how we paid for these services. If a member receives a letter, it's important they know to fill it out and return it as soon as possible in the postage paid envelope provided.
- Understand the benefit plan and what types of treatments, drugs, services, etc. are covered.

How to request prior authorization

If a service you are providing our member needs prior authorization, please call:

Program	Phone number	FAX
Medallion/FAMIS	1-800-279-1878	1-877-817-3707
CCC Plus	1-855-652-8249	1-877-817-3707
HMO-SNP	1-855-463-0933	1-833-280-5224

You may also request a prior authorization online. Visit **aetnabetterhealth.com/virginia**. Select For Providers, then Provider Portal. When requesting a prior authorization, please include:

- Member's name and date of birth
- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service

Emergency services do not require prior authorization; however, notification is required the same day. For post stabilization services, hospitals may request prior authorization by calling our Prior Authorization department. All out-of-network services must be authorized. Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

Cultural Competency

Culture is a major factor in how people respond to health services. If affects their approach to:

- Coping with illness
- Accessing care
- Taking steps to get well

Patient satisfaction and even positive health outcomes are directly related to good communication between a member and his or her provider.

A culturally competent provider communicates effectively with patients and understands their individual concerns. It's incumbent on providers to make sure patients understand their care regimen. Each segment of our population requires special sensitivities and strategies to embrace cultural differences.

Training resources for our providers
As part of our cultural competency program, we encourage our providers to access information on the Office of Minority Health's web-based A Physician's Guide to Culturally Competent Care. The American Medical Association, American Academy of Family Physicians, and the American College of Physicians endorse this program, which provides up to 9.0 hours of category 1 AMA credits at no cost.

Learn more about our HMO SNP plan

Interested providers and offices are encouraged to contact Russ Barbour, Director of DSNP, at 804-968-5146.

Aetna Better Health of Virginia (HMO SNP) is a Medicare Special Needs Plan, which means our plan benefits and services are designed for people with special health care needs. Our plan offers additional benefits and services not covered under Medicare, such as dental, hearing aids, and contact lenses.

Aetna Better Health of Virginia (HMO SNP) is available to people who have Medicare and who receive Medicaid assistance from the Commonwealth Coordinated Care Plus (Medicaid).

Additionally, please visit us on the web at **aetnabetterhealth.com/virginia-hmosnp**.

Member Rights and Responsibilities

As a provider to our members, it is important that you know our members rights and responsibilities. To view:

- Medallion and FAMIS
- CCC Plus

Visit **aetnabetterhealth.com/virginia/providers/member-rights** on our website.

Thank you for providing our members with the highest quality of care!