Spring 2022 Provider Newsletter

Reminder: Submitting Expedited (Urgent) Authorization Requests

Aetna's goal is to always provide a prompt response to the requests submitted and we need your help. As a reminder, an expedited request indicates that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Submission of all necessary information helps get our members what they need, while in your care. Please see the provider portal for the necessary Prior Auth forms. It is vital that all lines are filled out in their entirety, including CPT codes, diagnosis codes, and your National Provider Identification (NPI). If not, the case could pend for lack of clinical information. The primary reason for denials within ABH is lack of clinical information received. Please ensure that you are prepared with appropriate clinical during your submission. Please reach out if you are not sure what needs sent or watch for a fax back from us telling you what will help process your case.

Providers can now submit Authorization Requests

As well as check the status through the Availity Essentials Portal!

Availity offers the functionality to check member eligibility, check prior authorization requirements for services, submit an electronic authorization request, and upload clinical documentation to support the request, ALL IN ONE PLACE! Take advantage of this enhanced time-saving feature.

To receive more information on Availity and how to obtain access credentials, please don't hesitate to contact the Provider Experience Team. For registration assistance, please call Availity Client Services at 1-800-282-4548 between the hours of 8:00 am and 8:00 pm Eastern, Monday-Friday (excluding holidays)

To register with Availity, please go to: https://www.availity.com/Essentials-Portal-Registration

HEDIS® Measurement Year (MY) 2021 Data Collection Preparation

HEDIS ("HE-DIS") is an acronym for the Healthcare Effectiveness Data and Information Set. This measurement tool is used by over 90% of the nation's health plans to evaluate their performance in terms of clinical quality and customer service. HEDIS is coordinated and administrated by the National Committee for Quality Assurance (NCQA). It's used by the Centers for Medicare & Medicaid Services (CMS) to monitor the performance of managed care organizations (MCOs).

Our providers play a central role in promoting the health of your patients and our members. You and your office staff can help with the HEDIS process by:

- Offering preventive and chronic condition care within the designated HEDIS time frames
- Documenting all care in the patient's medical record
- Promoting annual wellness visits to your patients
- Using HEDIS approved codes to close gaps in care (ICD 10, CPT, CPT II, Snomed , LOINC, etc.)
- Talking with your health plan contact about submission methods for medical records or data to close gaps in care

Please use this HEDIS quick reference guide for a summary of the HEDIS measures and the commonly used codes. We appreciate your collaboration and attention to closing gaps in care for your patients and our members.

Our MY 2021 HEDIS data collection begins early February 2022 and your offices will be receiving request, mostly via fax, for chart documentation. HEDIS data collection, and the release of information, is permitted under HIPAA and doesn't need patient consent or authorization. This is because the disclosure is covered under quality assessment and improvement activities.

We thank you in advance for responding to our requests and submitting requested medical record documentation. Together, we can accurately measure the quality of care provided to your patients and our members.

If you have any questions, please reach out to our HEDIS Help Line at (855) 750-2389.

What's CAHPS?

CAHPS is a survey that the National Committee for Quality Assurance (NCQA) developed to measure patient satisfaction with their health care. It provides patient perspective of the care they received and includes information about their access to medical services, physicians, specialists and behavioral health providers. The survey also asks about communication with their doctor. We participate in these surveys annually for our adult and child members, and the results help us identify strengths and opportunities for improvement.

The survey focuses on these areas of care:

- Understanding and respect from providers
- Tobacco cessation discussions
- Flu prevention
- Coordination of care

How do you impact CAHPS?

- Understanding the value of the survey
- Engage and listen to patients during their visits
- Enhance perception about thoroughness and appropriateness of care by explaining why tests may be needed and using easy to understand words.
- Ask for their input about their care or treatment plan

Population Health Management

Aetna Medicare Advantage Dual Eligible Special Needs plans (Aetna) maintain Population Health Management (PHM) programs and activities selected to meet the needs of the member population and target their individual risks. These programs are designed to support delivery of care. Each PHM program includes measurable goals that are used to determine program effectiveness. Aetna continues to work collaboratively with provider networks to ensure that the recommended screenings and services are completed for the served membership.

Below are some of the programs we offer to members:

Keeping Members Healthy

Programs are targeted to align with low risk populations. With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy. The PHM program for members is a Flu Vaccination Program that includes educational activities to promote annual flu vaccination.

Managing Members with Emerging Risk

Programs are targeted to align with medium risk populations. Engagement with practitioners focuses on supporting Patient Care Medical Home models to centralize care and patient-driven decision-making. The PHM program for members is a Hepatitis C Program that supports members in completing a prescribed treatment regimen.

Patient Safety and Outcomes Across Settings

Programs are targeted to align with members that experience health services across settings. Engagement with practitioners focuses on communication and collaboration with their patients to share information to prevent duplication and potential for harm. The PHM program for members is Appropriate Use of Acute Care Settings that includes early notification through in-patient alerts.

Managing Multiple Chronic Conditions

Programs are targeted to align with high and intensive risk populations. Engagement with practitioners focuses on maintaining engagement outside of clinic and office visits. The PHM program for members is Life Planning/Advance Directives/Palliative Care that includes providing life planning/advance directive information to members upon enrollment.

Aetna care managers will work with members and providers to ensure that members receive the right care and services that meet members' needs.

Provider Portal

Our enhanced, secure and user-friendly web portal is available at https://medicaid.aetna.com/MWP/ Provider Portal. This HIPAA-compliant portal is available 24 hours a day. It supports the functions and access to information that you need to take care of your patients.

Popular features include:

- **Single sign-on** One login and password allow you to move smoothly through various systems.
- **Personalized content and services.** After login, you will find a landing page customized to you.
- **Real-time data access.** View updates as soon as they are posted.
- **Better tracking.** Know the status of each claim submission and medical prior auth request.
- **eReferrals.** Go paperless. Refer patients to specialists electronically and communicate securely .
- **AutoAuths.** Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- **Detailed summaries.** Find easy access to details about denied prior authorization requests or claims.
- **Enhanced information.** Analyze, track, and improve services and processes.
- **Provider notices/communications.** Review the provider manual and other documents related to members' benefits.

To access the provider portal, please go to https://medicaid.aetna.com/MWP/ Provider Portal

For more information, contact Provider Experience at **1-855-463-0933.**

2022 Quality Improvement Initiatives

Completing the COVID vaccination series, controlling blood pressure, and optimizing hemoglobin A1c levels will continue to be major focus areas for our members in 2022. In order for them to have optimal health outcomes, the health plan and providers must work collaboratively. The plan's approach is to educate members/patients while facilitating their ability to become motivated participants in managing their own health. Since this is a collaborative effort, here are some ways health care providers can assist:

- Provide education that specifically addresses the myths surrounding COVID vaccinations and ensure members/patients are fully vaccinated.
- Support timely and accurate documentation in member/patient medical records.
- Ensure preventive screenings are conducted at recommended intervals.
- Confirm a medication and treatment plan is in place if member/patient biometrics are out of range.

For additional information about COVID: Toolkit for Healthcare Providers | CDC

For additional information about Hypertension: Resources for Health Care Professionals | cdc.gov

For additional information about Diabetes: Health Care Providers | Diabetes | CDC

Complex Care Management Referral Options

Empowerment through care management

Aetna Medicare Advantage Dual Eligible Special Needs plans (Aetna) offers an evidence-based care management program to help our members improve their health and access the services they need. Care managers typically are nurses or social workers. These professionals create comprehensive care plans that help members meet specific health goals.

All members are assigned their own care manager. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a care manager contact the member are:

- Does the member frequently use the emergency room instead of visiting your office for ongoing issues?
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), hypertension, or End Stage Renal Disease (ESRD), yet does not comply with the recommended treatment regimen and would benefit from telemonitoring of these conditions?
- Does the member need help to apply for a state-based long-term care program?
- Does the member live with HIV?
- Is the member pregnant with high-risk conditions?
- Is the member pregnant and over 35 years of age?
- Has the member received a referral to a specialist, but is unsure of the next steps?
- Does the member need information on available community services and resources (e.g. energy assistance, housing assistance)?

What happens to your referral?

After you make a referral, the member's care manager contacts the member. The care manager might also contact the member's caregivers or others as needed.

What will a care manager do?

To help the member learn how to manage their illness and meet their health and other needs, a care manager contacts the member to schedule a time to complete an assessment. The care manager asks the member questions about his or her health and the resources currently being used. Answers to these questions help the care manager determine what kind of assistance the member needs most.

What will a care manager do?

Next, the member and the care manager work together to develop a care plan. The care manager also educates the member on how to obtain what they need. The care manager also may work with the member's health care providers to coordinate these needs. The amount of care management and frequency of contact with the member and others will vary based upon the individual needs of the member.

To make referrals for care management consideration, please call Provider Experience at **1-855-463-0933**. A care manager will review and respond to your request within 3-5 business days.

Clinical Criteria for Utilization Management Decisions

How to Request Criteria

Aetna Medicare Advantage Dual Eligible Special Needs plans (Aetna) medical necessity decisions for requested medical and behavioral services are based upon CMS National Coverage and Local Coverage Determinations, and nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

Aetna uses the following medical review criteria for physical and behavioral health medical necessity decisions which are consulted in the following order:

- National Coverage Determination (NCD) or other Medicare guidance (e.g., Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, Medicare Learning Network (MLN) Matters Articles)
- https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx
- Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC)
- https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx
- Aetna Clinical Policy Bulletins (CPB) available on Aetna.com
- http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html
- Medical Coverage Guidelines (MCG): For inpatient stays, Aetna Medicare uses MCGs as a resource for determining medical necessity for inpatient hospital and long-term acute care hospital (LTACH) stays in conjunction with Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A. Medicare guidelines are very general so MCGs provide condition specific guidance
- https://mcg.aetna.com/
- Pharmacy clinical guidelines
- Aetna Medicaid Pharmacy Guidelines

The criteria and guidelines are disseminated to all affected practitioners, and/or providers, upon request. To request criteria, call Provider Experience at **1-855-463-0933** or visit our website at https://www.aetnabetterhealth.com/virginia-hmosnp/

Pharmacy Benefits

Aetna Medicare Advantage Dual Eligible Special Needs plans' (Aetna) List of Covered Drugs ("the Drug List" or the formulary) is a comprehensive list of covered prescription drugs, over-the-counter drugs, and items at participating network pharmacies. The Drug List and network pharmacies are posted on the plan's website at https://www.aetnabetterhealth.com/virginia-hmosnp/. The Drug List is updated monthly throughout the year, and the date of last change is noted on the front cover of the Drug List. Changes to the plan's Drug List is also posted on the plan's website.

Visit https://www.aetnabetterhealth.com/virginia-hmosnp/ for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at 1-844-362-0934.

The Drug List has detailed information about prior authorization, quantity limitation, step therapy, or formulary exceptions under "Necessary actions, restrictions, or limits on use." To request prior authorization or formulary exception reviews, call Member Services toll-free at 1-844-362-0934. A Member Services representative will work with you to submit a request for prior authorization or formulary exception.

Types of rules or limits:
- Prior approval (or prior authorization)
- Quantity limits
- Step therapy
- If a medication is not on the Drug List (called Formulary Exception)

Aetna D-SNP's formulary covers most drugs identified by Medicare as Part D drugs, and a member's copay may differ depending upon the tier at which the drug resides. The copay tiers for covered prescription medications are listed below. Copay amounts and coinsurance percentages for each tier vary by Aetna D-SNP plan. Consult your plan's Summary of Benefits or Evidence of Coverage for your applicable copays and coinsurance amounts.

Covered drugs are designated the following coverage tiers.
- Tier 1 drugs are Preferred Generic drugs.
- Tier 2 drugs are Generic drugs.
- Tier 3 drugs are Preferred Brand drugs.
- Tier 4 drugs are Non-Preferred drugs.
- Tier 5 drugs are Specialty drugs.

Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Medicare Advantage Dual Eligible Special Needs plans (Aetna) members, you should be aware of the members' rights and responsibilities. Some of the rights members are afforded are as follows:

- A right to receive information about Aetna, our services, our practitioners and providers, and member rights and responsibilities
- A right to be treated with respect and recognition of the member's dignity and right to privacy
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Aetna or the care we provide
- A right to make recommendations regarding Aetna's member rights and responsibilities policy

In addition, our members have the following responsibilities:

- A responsibility to supply information, to the extent possible, that Aetna and our practitioners and providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

For a complete list of member rights and responsibilities visit our website at https://www.aetnabetterhealth.com/virginia-hmosnp/ to see our Member Handbook.

Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

- We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don't reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at 1-855-463-0933, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-855-463-0933.

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

The table below indicates appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/SA) providers.

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Primary Care	Immediate	Within 24 hours	Within 28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
Specialist Care	Immediate	Within 24 hours of referral	Within 28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
OB/GYN	Immediate		Initial Prenatal Care • 1st Trimester: Within 3 weeks • 2nd Trimester: Within 7 calendar days • 3rd Trimester: Within 3 calendar days • High Risk: Within 3 days • Routine Care: Within 3 weeks • Postpartum Care: Within 6 weeks	No more than 45 minutes, except when the provider is unavailable due to an emergency
Behavioral Health	Immediate	Within 24 hours	Within 10 days of the request	No more than 45 minutes, except when the provider is unavailable due to an emergency

In addition to the standards above, Behavioral Health providers are contractually required to offer:

- Follow-up Behavioral Health Medical Management within 3 months of the first appointment
- Follow-up Behavioral Health Therapy within 10 business days of the first appointment
- Next Follow-up Behavioral Health Therapy within 30 business days of the first appointment