Spring 2023 Provider Newsletter

Aetna Better Health Premier Plan MMAI

What is Availity?

Availity is a single log-in, multi-payer provider portal with self-service tools and provider-initiated transactions in one convenient location. Once registered, providers can simply add the Aetna instances to their registration at any time.

Aetna and Availity

Availity operates Aetna's provider portal for multiple lines of business, including Commercial, Medicaid, Medicare, and DSNP/MMP products. There are now two instances of Availity for Aetna products: "Aetna" instance is for Medicare/Commercial, and the "Aetna Better Health" instance is for Medicaid/DSNP/MMP. Providers will need add both instances to their Availity profile to access our entire population. Availity will eventually replace the Aetna Better Health Medicaid Web Portal.

Uses of Availity

Availity allows providers to verify member eligibility and benefit coverage, submit claims and subsequent disputes, encounters, submit appeals and grievances, and update their rosters. Learn about the additional functions in one of the training options offered by Availity.

How to receive training?

Did you know that in addition to Availity Client Services, Availity offers a wide range of training sessions for all users via the Availity Essentials Provider Portal? You can simply click on the "Help & Training" dropdown to access both upcoming sessions as well as pre-recorded webinars.

Who can the provider call for assistance?

Call Availity directly at **1-800-AVAILITY (282-4548)**. Monday through Friday from 8 a.m. to 8:00 p.m. ET (excluding holidays). Availity can also be reached through direct messaging when available. Availity should be contacted for any connectivity or account concerns. Any concerns with an Aetna decision or information on Availity should be directed to the respective provider services.

Retrospective Review Primer

A retrospective review is when the service has started. If the Date of service is before the request comes in then it is considered a Retrospective case. For example the service started on 3/20 and your request is received by the plan on 3/22 that would be a retrospective review. Post Service requests are not processed as Expedited or Urgent requests.

A retrospective review cannot be performed in the following instances:

- A claim for the service/treatment has been submitted to the health plan
- The retrospective review request is made more than 180 days beyond the actual date of the service/treatment

Decisions will be made and you will be notified within thirty (30) calendar days of receipt of the request.

Alternative Formats and Languages

If you wish to make or change a standing request to receive all materials in a language other than English or in an alternate format, you can call Aetna Better Health Premier Plan MMAI Member Services at **1-866-600-2139 (TTY: 711)**, 24 hours a day, 7 days a week.

MOOP & Cost-Share Claims

This document is to provide a summary of two regulatory changes that impact Medicare medical providers. Both of these changes take effect on January 1, 2023.

Maximum Out Of Pocket (MOOP)

The MOOP limit for dual members will now be tracked based on the accrual of all Medicare Part A & B cost sharing in the plan, whether those cost sharing amounts are paid by the member, other secondary insurance, or not paid at all. As a reminder, once MOOP is met Aetna will pay 100% of Medicare A&B covered services for the remainder of the calendar year.

Prior to 2023, MOOP for dual members was tracked by calculating cost share amounts paid by the member. CMS projects this change will increase payment to providers serving DSNP and MMP members by $8 billion over 10 years.

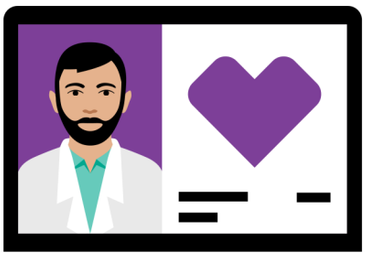
Regulatory Citation: 42 CFR § 422.100 and 422.101

Medicaid Enrollment for Cost-Share Claims

State Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers if the provider or supplier otherwise meets all Federal Medicaid enrollment requirements. Even if a provider or supplier is of a type not recognized as eligible to enroll in the State Medicaid program or is located out of state.

This change means, the provider does not have to become part of the Medicaid provider network or see Medicaid patients. If the provider or supplier chooses not to enroll with Medicaid, the state is not required to process their cost-share claims. In other words, the payment from Aetna would be payment in full.

Regulatory Citation: 42 CFR § 455.410(d)



Updating Rosters and Provider Details

One of the functions available within Availity is updating provider demographics and roster information. Due to Availity serving multiple payers, providers can update their profiles on the Provider Data Management (PDM) page and have quarterly updates sent to all participating payers. In the page you can update service locations, location ADA compliance, update contact information, modify NPIs for the business, provide hospital affiliations, and correct provider profiles. You can reach the PDM by clicking on “My Providers” on the main page.

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 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.

Advance Directives

Having the Conversation with Your Patient

A patient’s comfort in contemplating, completing or even discussing an advance directive can greatly depend on what the physician has to say and offer.

Your contract requires documentation in the patient’s medical record of whether the individual has completed an advance directive.

Having a conversation around advance directives with patients can be an awkward conversation in large part because many patients only see the advance directive process in terms of suffering and death. As the healthcare provider, you should approach advance care planning from the perspective of living well and quality of life. Approaching the sub-ject in this way would allow members to engage in discussing what matters most to them so their wishes will be honored. You may start the conversation by asking about the types of treatments to consider if the member becomes very ill, is unable to recognize family, is unable to perform self-care or is unlikely to get better.

Advance Directives (continued)

Advance directives are considered legal documents that take effect when someone is no longer able to speak for himself or herself. They ensure that your medical preferences are properly carried out by your health care provider. Advance directives include a living will and durable power of attorney for healthcare (DPA).

You should know that the AMA has developed training materials and ethical guidelines that provide understanding as to what patients want and physicians are able to provide. You can find those guidelines at **ama-assn.org**.

Additionally, Medicare offers payment for a voluntary advance-care planning (ACP) consultation offered by the physician or other qualified health professional when done face- to-face with the patient, family member(s) and/or surrogate.

For additional information on the medical records audit components refer to your provider manual

Sources: AMA. "Advance directives: How to talk with patients about them." Retrieved from ***https://www.ama-assn.org/delivering-care/patient-support-advocacy/advance-directives-how-talk-patients-about-them***

"Advance Directives: Having the Talk." Retrieved from ***https://www.webmd.com/palliative-care/features/advance-directives-having-the-talK***

"Billing and coding: Advance Care Planning" ***https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58664***

"Advance directives- State of New Jersey Dept of Health ***https://www.nj.gov/health/advancedirective/ad/***

Preventing Falls with Members

Each year, between 700,000 to a million fall incidents happen within a hospital setting. Up to a 1/3 of these may be preventable. Aetna Assure Premier Plus wants to provide several tools and resources to prevent falls for members, both inside your offices or in the patient's home.

Providers can mitigate fall risks by:

Including fall risk screenings yearly or following a recent fall

Evaluating patient's footwear, gait, strength and balance

Review a patient's medication and home hazard risks

Educate patients on their risk factors and community resources

For more information for offices, please see the CDC's **Stopping Elderly Accidents, Deaths, & Injuries (STEADI) website**. You can find information on medications linked to falls, materials for member distribution, standardized assessments, and staff training and continuing education.

For information specifically catered to facilities, see the Agency for Healthcare Research and Quality's **Hospital Fall Prevention Program** which provides facility-centric training and toolkit to assist facilities mitigate fall risks.

Population Health Management

Aetna Medicare-Medicaid Plans maintains 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.

Cognitive Impairment Program

This program is targeted towards members and/or their caregivers who are either formally diagnosed with mild to severe cognitive impairments or are identified with positive findings for cognitive impairment. The focus is on member safety (medication, home safety, driving, financial, wandering), supporting a least restrictive residential setting, and working towards an optimal quality of life for the member and the caregiver.

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

Continuous Glucose Monitoring (CGM)

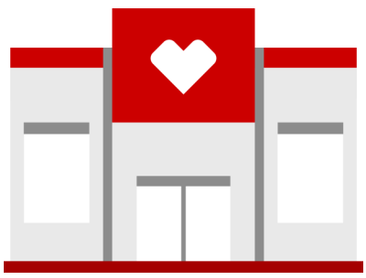
Aetna Better Health Premier Plan MMAI is working to reduce the long-term sequelae of diabetes. In addition, to working with our diabetic members chronic condition management including to have their hemoglobin A1c checked at least once a year, the plan is encouraging our providers to consider continuous glucose monitoring (CGM) systems for their patients with diabetes that would benefit from this. In general, individuals with diabetes are most appropriate for CGM when they:

- require at least 3 insulin administrations per day or use an insulin pump; and
- require frequent adjustment of insulin regimen based on their blood glucose levels.

In addition, individuals who suffer from frequent episodes of hypoglycemia may also be appropriate candidates. CGM allows you and your patients to see the fluctuations in blood glucose levels throughout the day, providing a more real-time view of their glycemic control. **CGMs do not require prior authorization.** For additional information, please refer to the following:

https://diabetes.org/tools-support/devices-technology

Updating Rates for Critical Access Hospital



Aetna Better Health Premier Plan MMAI always strives to provide prompt and accurate payment. Aetna is asking for Critical Access Hospitals to forward any updated rate and fee schedule documentation to Aetna as soon as they receive them.

This will allows Aetna to update claim rates as soon as possible. Completing rate adjustments in a timely fashion helps avoid claim readjudication or recoupment. Your assistance is greatly appreciated.

EFT/ERA Registration

Aetna Better Health Premier Plan MMAI is partnering with Change Healthcare to introduce the new EFT/ERA Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

What is EERS?
EERS will offer providers a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Providers will be able to use the Change Healthcare tool to manage ETF and ERA enrollments with multiple payers on a single platform.

How does it work?
EERS will give payees multiple ways to set up EFT and ERA in order to receive transactions from multiple payers. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts. Providers who currently use Change Healthcare as a clearinghouse will still need to complete EERS enrollment, but providers who currently have an application pending with Change Healthcare will not need to resubmit. Once enrolled, payees will have access to the Change Healthcare user guide to aid in navigation of the new system.

How and when do I enroll?
All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit **https://payerenrollservices.com/.**

Complex Care Management Referral Options
Empowerment through care management

Aetna Medicare Medicaid Plans offer 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 Services at **1-866-600-2139**. A care manager will review and respond to your request within 3 -5 business days.

Pharmacy Benefits

Aetna Medicare Medicaid 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/illinois/providers/premier/partd**. 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/illinois/providers/premier/partd** for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at **1-866-600-2139**.

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 **1-866-600-2139**. 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 MMP'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 MMP 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.

Cultural Competency Training

Providers and their office staff are responsible for ensuring all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all patients. This includes those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Providers should ensure to address and document that patients are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages from all staff members. Providers should also honor members' beliefs, be sensitive to cultural diversity, and foster respect for members' cultural backgrounds.

Aetna conducts initial cultural competency training during Provider orientation meetings. If you have not previously completed Cultural Competency training or annual re-training, please take a moment to watch the video below:

How Effective Healthcare Communication Contributes to Health Equity

and visit: **thinkculturalhealth.hhs.gov/**

Additionally, Aetna's Quality Interactions© course series is available to Provider who wish to learn more about cultural competency. This course is designed to help you:

· Bridge cultures

· Build stronger patient relationships

· Provide more effective care to ethnic and minority patients

· Work with your patients to help obtain better health outcomes

To access the online cultural competency course, please visit:

hrsa.gov/culturalcompetence

Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Medicare Medicaid Plan (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

Members' Rights and Responsibilities (Continued)

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/illinois/providers/premier/handbook** to see our Handbook.

Electronic Submission of Pharmacy Prior Authorizations

We are committed to making sure our providers receive the best possible information, and the latest technology and tools available.

We have partnered with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (ePA) program.

With Electronic Prior Authorization (ePA), you can look forward to:

- Time saving: Decreasing paperwork, phone calls and faxes for requests for prior authorization
- Quicker Determinations: Reduces average wait times, resolution often within minutes
- Accommodating & Secure:
- HIPAA compliant via electronically submitted requests.
- Getting started is easy. Choose ways to enroll:
- Visit the **CoverMyMeds® website**
- Call CoverMyMeds® toll-free at **866-452-5017**
- Visit the **SureScripts website**
- Call SureScripts toll-free at **866-797-3239**

No cost required! Let us help get you started!

Aetna Better Health Premier Plan MMAI

- PCN: MEDDADV
- Group: RX8815
- BIN: 610591

Clinical Criteria for Utilization Management Decisions

How to request criteria

Aetna Better Health Premier Plan MMAI 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:

1. 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)
2. Medicare Coverage Database (**link**)
3. Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC) (**link**)
4. Aetna Clinical Policy Bulletins (CPB) available on Aetna.com (**link**)
5. 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 (**link**)
6. Pharmacy clinical guidelines
7. Aetna Medicaid Pharmacy Guidelines

To request criteria, call Provider Experience at **1-866-600-2139** or visit our website at **https://www.aetnabetterhealth.com/illinois/providers/**

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 **1-866-600-2139**, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling **1-866-600-2139**. Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.

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	Urgent Appointment	Routine Appointment	Appointment Wait Time
Primary Care	Immediate	24 hours	28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
Specialist	Immediate	24 hours of referral	28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
OB/GYN	Immediate	24 hours	Initial Prenatal Care **1st Trimester:** 3 weeks **2nd Trimester:** 7 calendar days **3rd Trimester:** 3 calendar days **High Risk:** 3 days **Routine Care:** 3 weeks **Postpartum Care:**	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 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