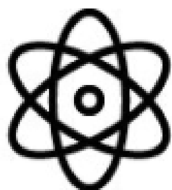
Aetna Better Health Premier Plan MMAI
Fall 2021 Provider Newsletter



Population Health Management

Aetna Better Health Premier Plan MMAI 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

With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy such as:

- Breast cancer screenings
- Colorectal cancer screenings
- Annual adult-well visits

Managing Members with Emerging Risk

Members who have diabetes or high blood pressure are educated in how to manage their condition. Members can learn:

- How to take care of their diabetes or high blood pressure
- How to watch their blood sugar or blood pressure
- Why it is important to take medications and how they work
- Healthy habits and lifestyle

Patient Safety and Outcomes Across Settings

For members who were recently in a hospital, Aetna will help them meet their discharge needs. Our care managers will work with members, their support systems and their providers to help them arrange for necessary and timely follow-up appointments with the right providers. We will work with members to make sure they understand the medications

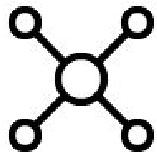
that they were prescribed when leaving the hospital and help them obtain any other health services they may need to assist them on their road to recovery.

Managing Multiple Chronic Conditions

A care manager will work with members, their doctors and other providers to ensure they receive the right care and services that meet their needs. The care manager will help members who:

- Go to the Emergency Room frequently
- Have trouble getting medications and other things providers have ordered
- Need information about a disease or treatment
- Need help with activities of daily living

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



Financial Liability for Payment for Services

Balance billing enrollees is prohibited under the Aetna Better Health Premier Plan MMAI. In no event should a provider bill an enrollee (or a person acting on behalf of an enrollee) for payment of fees that are the legal obligation of Aetna Better Health Premier Plan MMAI. This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Providers must make certain that they are:

- Agreeing not to hold enrollees liable for payment of any fees that are the legal obligation of Aetna Better Health Premier Plan MMAI, and must indemnify the enrollee for payment of any fees that are the legal obligation of Aetna Better Health Premier Plan MMAI for services furnished by providers that have been authorized by Aetna Better Health Premier Plan MMAI to service such enrollees, as long as the enrollee follows Aetna Better Health Premier Plan MMAI's rules for accessing services described in the approved enrollee Evidence of Coverage (EOC) and or their Enrollee Handbook.
- Agreeing not to bill an enrollee for medically necessary services covered under the plan and to always notify enrollees prior to rendering services.
- Agreeing to clearly advise an enrollee, prior to furnishing a non-covered service, of the enrollee's responsibility to pay the full cost of the services.
- Agreeing that when referring an enrollee to another provider for a non-covered service, provider must make certain that the enrollee is aware of his or her obligation to pay in full for such non-covered services

Provider Portal

Our enhanced, secure and user-friendly web portal is available at https://www.aetnabetterhealth.com/illinois/providers/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 immediately the status of each claim submission and medical prior authorization (PA) request.
eReferrals. Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
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 PA 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://www.aetnabetterhealth.com/illinois/providers/portal

For more information, contact Provider Services at **1-866-600-2139.**

Complex Care Management Referral Options

Empowerment through care management

Aetna Better Health Premier Plan MMAI 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 not covered by Medicaid (e.g. energy assistance, SNAP, 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.

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.

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:

- 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 Services at 1-866-600-2139 or visit our website at https://www.aetnabetterhealth.com/illinois/providers/

Pharmacy Benefits

Aetna Better Health Premier Plan MMAI's 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.

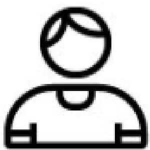
Visit https://www.aetnabetterhealth.com/illinois/providers/premier/partd for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at 1-866-600-2139.

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 Better Health Premier Plan MMAI does not charge member copays for covered prescription and OTC drugs as long as Aetna Better Health Premier Plan MMAI's rules are followed, and drugs are filled at a network pharmacy.

Covered drugs are designated the following coverage tiers.
• Tier 1 drugs are Medicare Part D prescription brand name and generic drugs.
• Tier 2 drugs are Medicare Part D prescription brand name and generic drugs.
• Tier 3 drugs are Non-Medicare Part D prescription and over-the-counter drugs.



Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Better Health Premier Plan MMAI members, you should be aware of the members' rights and responsibilities. Some of the rights members are afforded are as follows:

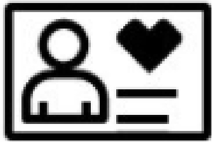
- A right to receive information about Aetna, our services, our practitioners and providers, and member rights and responsibilities
- A right to be treated with respect and recognition of the member's dignity and right to privacy
- A right to participate with practitioners in making decisions about their 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/illinois/members/premier/materials to see our Member Handbook.



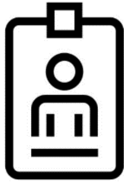
Affirmative Statement

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 1-866-600-2139, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-866-600-2139.



Submitted Expedited (Urgent) Authorization Requests

The goal of Aetna Better Health Premier Plan MMAI 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.

Submit Authorization Requests through the Web-based Application Availity

You no longer have to log in to update portals, waste time filling out PA forms, faxing in clinical information, or waiting in a phone queue to request an authorization. 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 contact the Provider Experience Team.

Appointment Availability Standards

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 Illinois Healthcare and Family Services (HFS) and 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 tables below indicate appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Behavioral Health/Substance Use Disorder (SUD) providers.

Provider Type	**Emergency Care**	**Urgent Care**	**Non-Urgent**	**Preventative & Routine Care**	**Wait Time in Office Standard**
Primary Care	Same day	Within 24 hours	Within 72 hours	Within 28 calendar days	No more than 45 minutes
Specialty Referral (Includes high-volume specialty care)	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 28 calendar days	No more than 45 minutes
Oncology and High Impact Specialists	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 28 calendar days	No more than 45 minutes
Behavioral Health/SUD	Immediately	Within 24 hours	Within 24 hours	Initial visit: Within 10 business days of original request	No more than 45 minutes

Additionally, Behavioral Health providers are contractually required to offer:

Provider Type	Follow-up Behavioral Health Medication Management	Follow-up Behavioral Health Therapy	Next Follow-up Behavioral Health Therapy
Behavioral Health	Within 3 months of first appointment	Within 10 business days of the first appointment	Within 30 business days of first appointment

Providers must comply with the following prenatal care appointment access standards:

Provider Type	Positive Pregnancy	High Risk	First Trimester	Second Trimester	Third Trimester
OB/GYN	Within 3 weeks of positive pregnancy	Within 3 days of identification of high risk	Within 7 calendar days of request	Within 7 calendar days of request	Within 3 business days of request