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AetnaBetterHealth.com/Maryland

Aetna Better Health® of Maryland

## Opportunities to connect with other providers.

**By Stacy Babani, Communications Consultant**

A strong provider network drives membership! With this in mind, Aetna Better Health of Maryland has set out to engage providers (both in- and out-of-network) by holding forums, symposiums and networking events. These events allow team members to enhance relationships, raise brand and benefit awareness, and potentially grow the provider network.

For example, the health plan has established a collaborative partnership with One World Health Care to implement monthly provider events titled "Meet the Docs." These monthly social programs are held at various locations throughout Howard County and offer opportunities for over 300 medical providers and staff to network with the health plan and with each other.

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## In this issue.



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# ‘Meet the Docs’ enhances provider relationships.

*Continued from front page*

After attending one of the recent events, a provider gave some feedback: “My patients and I love working with Aetna Better Health of Maryland. I am so appreciative that the health plan invited me to attend this function. Being able to attend a social function after-hours allowed me to delve deeper into my partnership with the health plan without all the distractions of a busy office. Plus, I was able to learn more about provider initiatives and member benefits.”

To learn more about these provider networking events or how to adopt a similar program at your health plan, reach out to Paris Gibson at **GibsonP2@Aetna.com**.

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# After Hours Appointment Availability Study.

On a quarterly basis, Aetna Better Health® of Maryland completes an after-hours appointment availability study of our provider network. To ensure members receive medical care in a timely manner, primary care providers (PCPs) and specialists that participate with managed care organizations (MCOs), are required to maintain the following after hours availability standards:

**After Hours Requirements**
1.Telephone is answered by the office staff, answering service, or voicemail
2. Answering machine/service or voicemail provides a telephone number to contact an on-call physician
3. Answering machine/service or voicemail indicates that the on-call physician will return the call within one (1) hour of receiving the message
4. Answering machine/service or voicemail refers the caller to the emergency room only for a true emergency

Source: COMAR 10.67.05.07

Details of the after-hours appointment availability standards can be found in our Provider Manual on our health plan website. As a reminder, when our health plan contacts your office to complete the study, the representative will identify themselves as an Aetna Better Health® of Maryland employee. Because this study is completed after your office has closed, we do not anticipate any impact to your normal operations.

If you have any questions about this letter or the after-hours appointment availability study, please feel free to contact our Provider Relations department at (866) 827-2710 or e-mail us at MarylandProviderRelationsDepartment@aetna.com.

## Happy 1st Anniversary to our Diabetes Prevention Program.

HealthChoice managed care organizations (MCOs) have joined together to provide a national Diabetes Prevention Program (DPP) lifestyle change program for HealthChoice enrollees. The Centers for Disease Control and Prevention (CDC) lifestyle change program aims to prevent or delay the onset of type 2 diabetes. We have several virtual classes already in progress and several more scheduled to begin in early 2021. This evidence-based program will teach your patients how to eat healthy, add physical activity into their daily lives, deal with stress and learn ways to cope with challenges. The DPP meetings run for a year, with weekly meetings for the first six months and monthly meetings for the latter six months, all led by a trained lifestyle coach. To be eligible for referral to a CDC-recognized lifestyle change program, patients must:

• Be at least 18 years old
• Be overweight (body mass index of 25 or more; 23 or more if Asian)
• Not be pregnant
• Have no previous diagnosis of type 1 or type 2 diabetes
• Have a blood test result in the prediabetes range within the past year, such as:
- Hemoglobin A1C: 5.7–6.4%
- Fasting plasma glucose: 100–125 mg/dL
- Two-hour plasma glucose (after a 75-gram glucose load): 140–199 mg/dL
• Have a previous clinical diagnosis of gestational diabetes

The DPP not only benefits your patients, it can also benefit your practice by helping reinforce the important advice that you give them. You can trust that your patients are receiving evidence-based information, and their increased knowledge may even save you time during office visits. Refer your patients today! For more information, please contact: WellnessandPrevention@Aetna.com

## Member rights and responsibilities.

Aetna Better Health members, their families and guardians have the right to information related to their treatment or treatment options in a manner and language appropriate to the member's condition and ability to understand. To access the specific member rights and responsibilities, call our Provider Relations staff toll-free at **1-866-827-2710 (TTY: 711)**. Check the **AetnaBetterHealth.com/Maryland** website for the full list of these rights and responsibilities.

## How we make coverage decisions.

Utilization Management decision-making criteria can be found on our website, **AetnaBetterHealth.com/Maryland**. Or call **1-866- 827-2710 (TTY: 711)** and request that a copy of the UM criteria be mailed to you. You can also call to request a free copy of any UM guideline, codes, records, benefit provision, protocol or document used to make a specific UM decision.

## Discover our community development events.

We enjoy meeting our members in the communities where they live, work and play.

**Let's connect.** To learn more about our community development team and how our partnership can help you, reach out to us today at **OutreachMD@Aetna.com** or **1-866-827-2710 (TTY: 711)**.

## It's that time again.

### Annual HEDIS medical record collection.

HEDIS is a performance measurement requirement administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.

All Aetna Better Health providers are contractually obligated to provide medical records necessary to fulfill reporting requirements. We want to be able to reflect the high quality of care you have given to our members that may not have gone into our claim system.

### Annual HEDIS timeline

Medical records are randomly selected across hybrid HEDIS measures and then requested from provider offices in early February to the end of April. In order to minimize disruption of provider operations and increase efficiency of this process, we request that all records be sent within five days of receiving the initial request.

For large volume providers, Aetna will provide personnel to come on-site to assist with record retrieval. We have staff ready to receive remote electronic medical record system access, if available, as well.

If members are selected that are assigned to your panel, you will be sent the specific list of medical records we need, including the member's name, date of service and the measures selected, with instructions on how to submit.

### Coming your way

We look forward to continuing our partnership and working with you to develop strategies to address any barriers to care you may have experienced. As a reminder, the first Gap in Care (GIC) report for 2020 is expected to be available in April, when enough claims have come in the new year to make these reports valuable.

We thank you in advance for your quick response to any medical record requests you receive and your commitment to our members.

## What is EPSDT?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services.

Aetna recommends that all children under the age of 21 be cared for by a primary care provider (PCP) who is EPSDT-certified. While not mandatory, it is preferred to ensure that our members receive the quality of care they deserve.

**Early:** Assessing and identifying problems early.

**Periodic:** Checking children's health at periodic, age-appropriate intervals.

**Screening:** Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems.

**Diagnostic:** Performing diagnostic tests to follow up when a risk is identified.

**Treatment:** Control, correct or reduce health problems found

### EPSDT services

States are required to provide comprehensive services and furnish all Medicaid-coverable, appropriate and medically

necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic and treatment services.

**Screening services:**

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health education (anticipatory guidance, including child development, healthy lifestyles, and accident and disease prevention)

**Vision services:** At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary. For additional information, visit the Vision and Hearing Screening Services for Children & Adolescents page at **Medicaid.gov/Medicaid/Benefits/EPSDT/V-And-H/Index.html**.

**Dental services:** At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

**Hearing services:** At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. For additional information, visit the Vision and Hearing Screening Services for Children & Adolescents page at **Medicaid.gov/Medicaid/Bene its/EPSDT/V-And-H/Index.html**.

## Other necessary health care services

States are required to provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat,correct, or reduce illnesses and conditions discovered, regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

## Diagnostic services

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay, and there should be follow-up to ensure that the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to ensure that comprehensive care is provided.

## Treatment

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

# Integrated Care Management program.

Our Care Management department provides support to members based on each individual's risks and unmet needs. These care needs are assessed by licensed nurses, social workers and counselors, as well as nonclinical professionals. We use a bio-psychosocial (BPS) model to help us identify what care our members need. The Care Management staff performs a health risk assessment to determine the member's medical, behavioral health and bio-psychosocial needs.

Care managers work with the member, member's family, PCP, psychiatrist, substance abuse counselor and any other health care team member to achieve a quality-focused, cost-effective care plan. Care managers educate members on their specific disease and how to prevent worsening of their illness or any complications. The goal is to maintain or improve their health status.

**The Care Management program provides services to the following populations, but is not limited to:**

- Pregnant and postpartum outreach
- High-risk pregnancy outreach
- Children with special health care needs
- Children in state-supervised care
- Individuals with a physical or developmental disability
- Behavioral health/substance abuse
- Disease management of conditions such as asthma, diabetes, heart failure, COPD, sickle cell anemia, hepatitis C and HIV/AIDS

If you have concerns about one of your patients and would like to refer them to the Care Management program, call **1-866-827-2710 (TTY: 711)** and ask for the Care Management department or email the Care Management department at **AetnaBetterHealthMDCM@Aetna.com**.

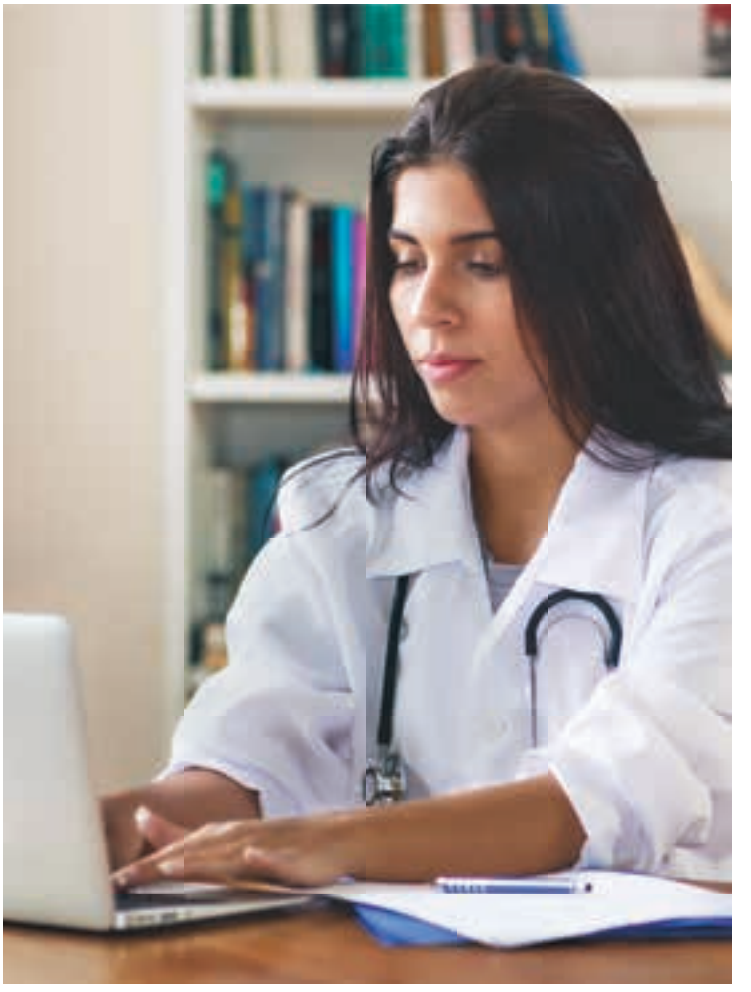
## Appeals and grievances.

A **dispute** is defined as an expression of dissatisfaction with any administrative function, including policies and decisions based on contractual provisions inclusive of claim disputes. The dispute will be reviewed and processed according to the definitions provided, but not limited to resubmissions (corrected claims and reconsiderations), appeals, complaints and grievances. Provider claim disputes do not include pre-service disputes that were denied due to not meeting medical necessity. Pre-service denials are processed as member appeals and are subject to member policies and time frames.

A **resubmission** is a request for review of a claim denial or payment amount on a claim originally denied because of incorrect coding or missing information that prevents Aetna Better Health from processing the claim. Resubmissions should be submitted with both a corrected claim and the additional information needed to process the claim (e.g., NDC denial issues, claims that require medical records review). **Resubmissions must be submitted within 60 days of the last claim rejection to the Grievances & Appeals mailing address (Aetna Better Health of Maryland, P.O. Box 81040, 5801 Postal Road, Cleveland, OH 44181).**

An **appeal** is a dissatisfaction with the resolution of a reconsidered disputed claim or a request to review a denial of payment that does not meet the resubmission requirements. **Appeals should be submitted within 90 business days of the claim's denial.**

Visit **AetnaBetterHealth.com/Maryland/providers/grievance** for more information.



### Reminder.

All provider appeals should be sent to:
Aetna Better Health of Maryland
Attn: Grievances & Appeals
P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181

## Member education opportunities.

For assistance with member education opportunities, please contact Aetna Better Health Member Services at **1-866-827-2710 (TTY: 711)**.

Also visit our website for additional information at **AetnaBetterHealth.com/Maryland/wellness/care**.

## Fraud, Waste and Abuse.

Know the signs — and how to report an incident.

Health care fraud means receiving benefits or services that are not approved. Fraud can be committed by a provider, member or employee. Abuse is doing something that results in needless costs. Waste goes beyond fraud and abuse. Activities that are considered fraud, waste and abuse by members, doctors or any health care professional hurt everyone. Most waste does not involve a violation of law.

You can learn more and report fraud, waste or abuse by going online at **AetnaBetterHealth.com/Maryland/fraud-abuse**.

**Nondiscrimination notice:** This information can always be found on our website at **AetnaBetterHealth.com/Maryland**.

## Check out our website.

**AetnaBetterHealth.com/Maryland**

What you can find:

- Information about member rights and responsibilities
- Provider handbook
- Provider directory
- Pharmacy/prescription and other health information
- Information about our care management program, utilization management program and our quality programs
- Clinical Practice Guidelines
- Affirmative Action and nondiscrimination information

If you do not have internet access, give us a call at **1-866-827-2710 (TTY: 711)** and we can send you a copy of the written information you need.

**Contact us**

Aetna Better Health® of Maryland
509 Progress Drive, Suite 117,
Linthicum, MD 21090-2256

**1-866-827-2710**
Hearing-impaired MD Relay: **711**

This newsletter is published as a community service for the providers of Aetna Better Health® of Maryland. HealthChoice is a program of the Maryland Department of Health. Models may be used in photos and illustrations.