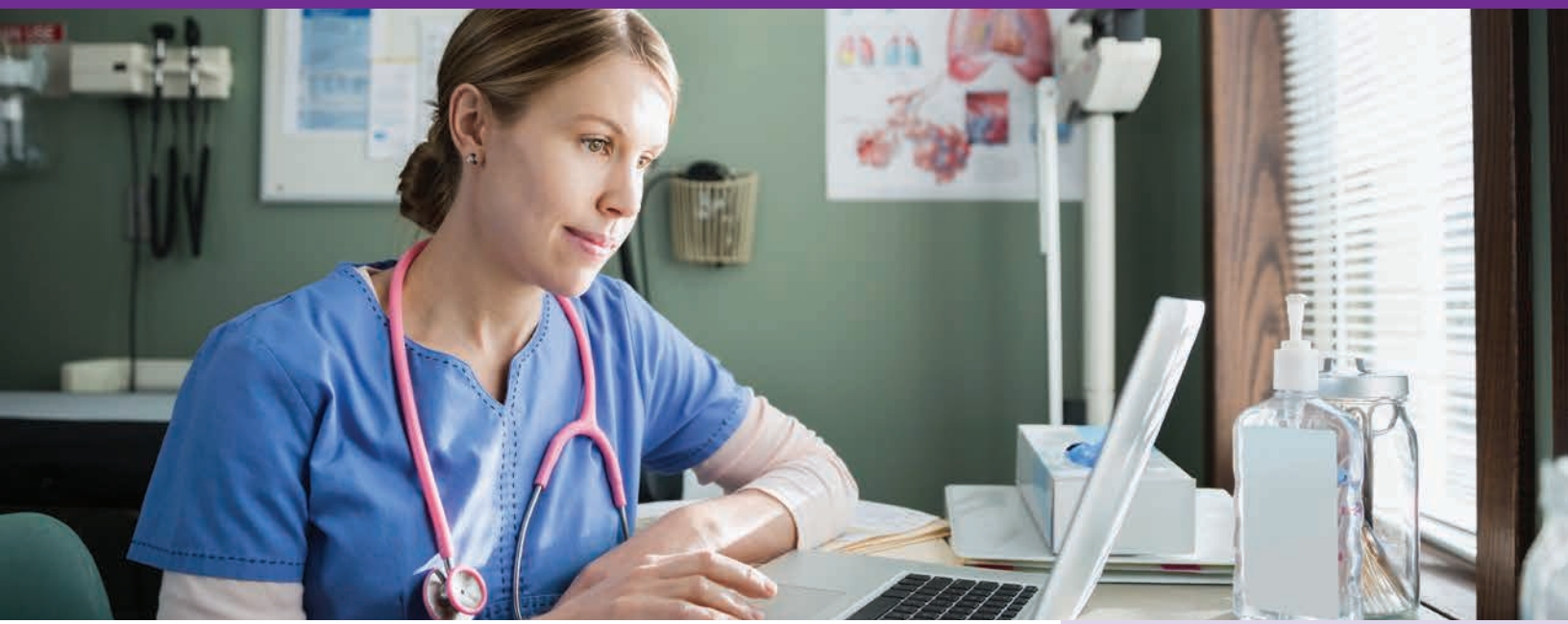
Provider newsletter

Spring 2022



VaxCare – a platform for driving vaccine access and adherence

VaxCare is a comprehensive solution that simplifies, optimizes, and automates your vaccine program. Our fully integrated platform eliminates vaccine purchasing, manual work, and financial risk while providing visibility in every step of the process.

This means more money for your practice, more time with your patients – and increased community immunization rates. With VaxCare, all that's left for you to do is take care of your patients.

Here's how it works:

- We handle the headache of vaccine purchasing, providing unlimited inventory at no cost and automatically replenishing your stock when the supply gets low. New vaccines on the schedule? We'll get them for you.
- We automate your workflow, eliminating manual tasks and costly errors.
- We ensure you're paid for every qualifying dose and provide the end-to-end visibility you need to keep your vaccine program profitable.

(continued on next page)

In this issue

VaxCare *(continued from previous page)*

- Our new mobile hub, fast-track developed in response to the pandemic, is a hand-held device that allows practices to administer vaccines anywhere – curbside, drive-throughs, or vaccination fairs. The mobile hub does not require wi-fi, removing the need for internet connection.

For more information visit **vaxcare.com**.

Care Management

Sometimes, managing a chronic condition or multiple conditions can become overwhelming. To offer support, a doctor, hospital discharge planner or other provider may refer an Aetna Better Health of Texas member to Care Management. Or a nurse on our health information line may refer them. However, they don't need to wait for a referral if they need help.

Members can self-refer by calling and asking for Care Management:

Medicaid (STAR) **1-800-248-7767** (Bexar)
Medicaid (STAR) **1-800-306-8612** (Tarrant)
STAR Kids **1-844-787-5437**
CHIP **1-800-248-7767** (Bexar)
CHIP **1-800-306-8612** (Tarrant)
TTY **1-800-735-2939**

After a member joins care management, they'll get a welcome letter that will explain how our services can help. They'll also get a call from a case manager.

Our case managers can:

- Help members understand their covered benefits
- Show them how to get specialty, behavioral health, or hospital services
- Talk with their doctors and other agencies to ensure they get needed services
- Teach them more about their disease or condition
- Help them locate community resources to meet their needs

Availability of utilization management criteria

Aetna Better Health of Texas employees make clinical decisions regarding members' health based on the most appropriate care and service available. We make medical necessity determinations based on established criteria. The criteria used to make determinations are available to practitioners at any time by contacting the utilization management department to obtain a mailed copy.

The national criteria are made available on our website at **https://www.aetnabetterhealth.com/texas/providers/clinical-guidelines-policy-bulletins.html**.

Aetna clinical policy bulletins are available on the main Aetna website at **https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html**.

Pharmacy Corner

You can access important pharmacy information on our website, **AetnaBetterHealth.com/Texas**. Select "Provider Site" and then "Programs and Services" and select "Pharmacy benefits" to find the Preferred Drug list.

There's also a link to the vendor drug website at **www.txvendordrug.com**.

Keeping members healthy through Texas Health Steps

Texas Health Steps (THSteps) is an important state-mandated program to make sure members receive the care they need, especially before any concerns become long-term health issues. These screenings provide routine physicals or well-child checkups at specified age ranges which include immunizations.

As a reminder, members should receive health checkups regularly on or before the following ages: 1 month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 24 months; 30 months; 3 years; 4 years; 5 years; 6 years; 8 years; and once a year for ages 6-20.

A complete list of components required to meet the THSteps regulations can also be found on our website **www.aetnabetterhealth.com/texas/providers/texas-health-steps.html**.

Applied behavioral analysis (ABA) services

In alignment with Texas Medicaid's decision to cover treatment services for members with Autism, Aetna Better Health of Texas began offering applied behavioral analysis (ABA) services to our members aged 0-20 with a qualifying autism spectrum disorder (ASD) diagnosis (ICD 10 code F84.0) This change went into effect Feb. 1, 2022, and the benefit will be part of the Texas Health Steps Comprehensive Care Program (THSteps-CCP).

This new benefit is available in Dallas, Tarrant, and Bexar services areas to all Aetna Better Health of Texas STAR and STAR Kids members aged 0-20 with a qualifying ASD diagnosis who meet medical necessity criteria for ABA treatment services. CHIP and CHIP perinate populations are not part of this benefit expansion

For members to have services covered by this new Medicaid benefit, they need to qualify according to the Texas Medicaid criteria and receive services through a network of Medicaid ABA providers.

Autism services include a comprehensive service array:

- Applied behavior analysis (ABA)
- Case management/care coordination
- Early childhood intervention (ECI)
- Nutrition (when provided by a licensed dietitian)
- Occupational therapy (OT)
- Outpatient behavioral health services
- Physician services, including medication management
- Physical therapy (PT)
- Speech-language pathology (SLP or ST)

For any questions, please contact your provider rep directly or Provider Services at:
1-800-248-7767 (Bexar)
1-800-306-8612 (Tarrant)
1-844-787-5437 (STAR Kids)

Member rights and responsibilities

Aetna Better Health of Texas maintains policies and procedures that formally address a member's rights and responsibilities. The policies reflect federal and state laws as well as regulatory agency requirements.

We annually inform our members of their rights and responsibilities in the member handbook, member newsletter and community mailings, when applicable. They are also posted to our website at **AetnaBetterHealth.com/Texas**.

Aetna Better Health of Texas ensures that a member can exercise their rights without adversely affecting treatment by participating providers. Members' rights and responsibilities are monitored through our quality management process for tracking grievances and appeals as well as through member surveys. Issues are reviewed by our service improvement committee and reported to the quality management oversight committee.

For additional information regarding member rights and responsibilities, visit our website or reach out to your assigned provider relations representative.

Access to care standards and availability

Primary care providers (PCP) provide covered services in their offices during normal business hours and are available and accessible to members, including telephone access, 24 hours a day, 7 days per week, to advise members requiring urgent or emergency services. If the PCP is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating physicians must be arranged.

If a member is referred to another PCP who is not on record as a covering provider, a referral must be submitted to the Aetna Better Health Prior Authorization unit to prevent a delay in payment.

PCPs must be accessible to covered persons via one of the following methods:

- Office phone answered by answering service, with calls returned by PCP within 30 minutes;
- Office phone answered by recording in each language of the major population groups served by the PCP, with a recording giving the PCP's or another participating provider's direct number, which must be answered (referring the covered person to another recording is not acceptable);
- Office phone transferred to another location that answers and contacts the PCP or another designated participating provider, with the call to be returned within 30 minutes.

PCPs may not have a phone message that directs the covered person to simply leave a message or to go to the emergency room for any service needed, although direction to go to the emergency room for emergency care is appropriate.

Provider appointment standards

Provider type	Emergency services	Urgent care	Non-urgent	Routine care	Standard wait time in office
Primary care provider (PCP)	Same day	Within 24 hours	Within 72 hours	Within 14 days	No more than 30 minutes
Specialty referral	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 4 weeks	No more than 30 minutes
Dental care	Within 48 hours	Within 3 days of referral		Within 30 days of referral	No more than 45 minutes
Mental health/ substance abuse (MH/SA)	Same day	Within 24 hours		Within 14 days	No more than 45 minutes
Lab and radiology services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

Prenatal care

Members shall be seen within the following timeframes
3 weeks of a positive pregnancy test (home or laboratory)
3 days of identification of high-risk
7 days of request in first and second trimester
3 days of first request in third trimester

(continued on next page)

Access to care standards and availability *(continued from previous page)*

Level/type of care	Time to treatment (calendar days)
Low-risk pregnancies	Within 14 calendar days
High-risk pregnancies	Within 5 calendar days
New members in the third trimester	Within 5 calendar days

Initial pediatric appointments	Within 3 months of enrollment
Supplemental Security Income (SSI) and Texas Care (ABD & Disabled members)	Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.
Maximum number of intermediate/limited patient encounters: 4 per hour for adults and children.	

Physicals	
Baseline physicals for new adult members	Within 180 calendar days of initial enrollment.
Baseline physicals for new children members and adult clients of DDD	Within 90 days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine physicals	Within 4 weeks for routine physicals needed for school, camp, work, or similar.

7 After-hours coverage

Acceptable after-hours coverage:

- The office telephone is answered after hours by an answering service, which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.
- The office telephone is answered after normal business hours by language appropriate recording directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the covering provider's phone. Another recording is not acceptable
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

- The office telephone is only answered during office hours;
- The office telephone is answered after hours by a recording, which tells the patients to leave a message;
- The office telephone is answered after hours by a recording which directs patients to go to an emergency room for any services needed; and
- Returning after-hours calls outside of 30 minutes.