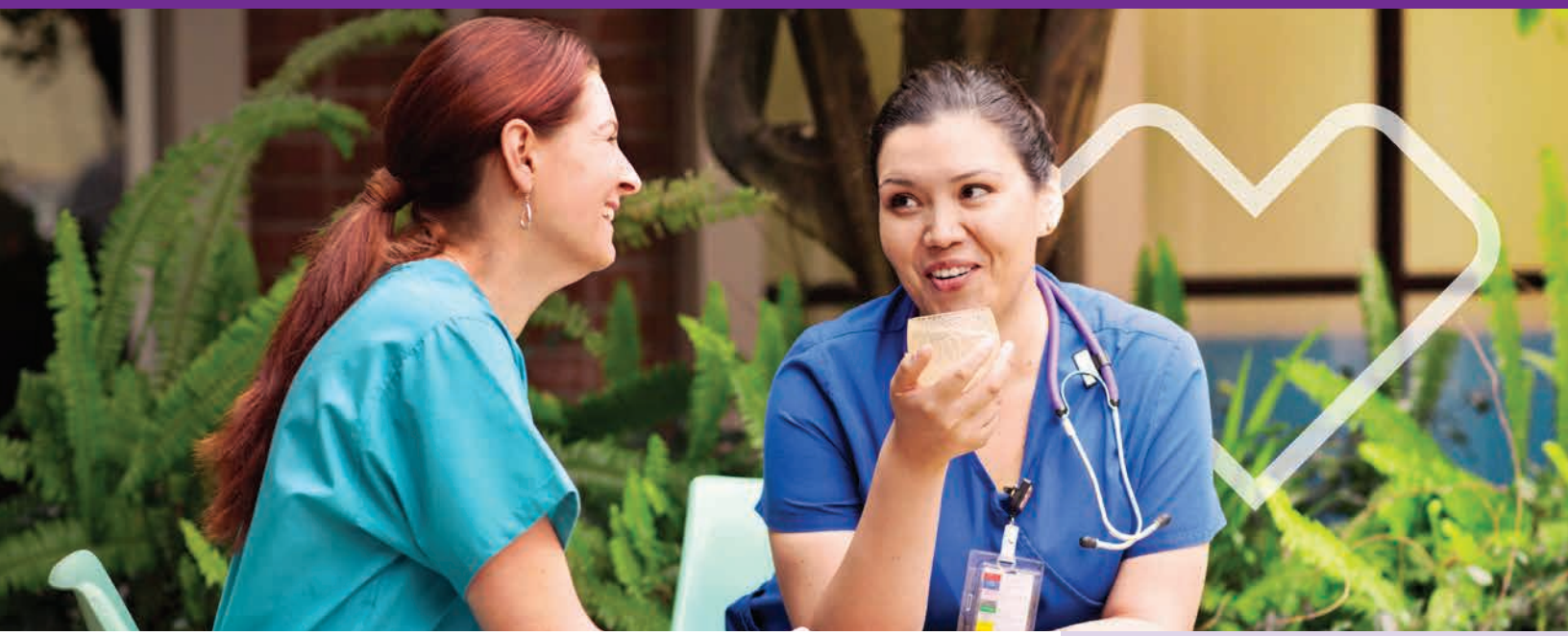
Provider newsletter

Spring 2021



National Developmental Disabilities Awareness Month - March 2021

#DDawareness2021

In 1987, President Ronald Reagan proclaimed March as National Developmental Disability Awareness Month. The campaign seeks to raise awareness about the inclusion of people with developmental disabilities in all facets of community life, as well as awareness of the barriers that people with disabilities still sometimes face in connecting to the communities in which they live.

Intellectual and developmental disabilities, also referred to as IDD, includes several conditions that are due to mental and/or physical impairments. Most developmental disabilities begin before a baby is born, but some can happen after birth because of injury, infection, or other factors. IDD begins during the developmental period, up to age 22, and usually lasts throughout a person's lifetime. Persons with an IDD may have problems with major life activities such as: language, mobility, learning, self-help, and independent living.

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Most developmental disabilities are thought to be caused by a complex mix of factors. These factors include genetics; parental health and behaviors (such as smoking and drinking) during pregnancy; complications during birth; infections the mother might have during pregnancy or the baby might have very early in life; and exposure of the mother or child to high levels of environmental toxins, such as lead. Developmental disabilities occur among all racial, ethnic, and socioeconomic groups. According to the Centers for Disease Control and Prevention (CDC), recent estimates in the United States show that about one in six, or about 17%, of children aged 3 through 17 years have one or more developmental disabilities, such as:

- Autism spectrum disorder
- Cerebral palsy
- Hearing loss
- Intellectual disability
- Vision impairment
- Learning disability
- Other developmental delays

As reported by the Texas Council of Community Centers, Texas is home to more than 485,000 children and adults with IDD. Texas HHSC data shows that approximately 35 percent of Texans with IDD have a co-occurring mental health diagnosis and require additional community supports and services. Each county has a Local Intellectual and Developmental Disability Authority (LIDDA), which serves as the point of access for community-based supports and services for persons with IDD. The LIDDA offers targeted case management and connects the person to needed services: life skills training, job support, specialized therapies, in-home support services, respite, and community residential services.

There are several resources in Texas to support your patient or member with IDD. Please visit the websites below for information, education, and resources to support Texans with IDD.

Agency	Website
LIDDA (Local IDD Authority)	**https://apps.hhs.texas.gov/contact/la.cfm**
Navigate Life Texas	**www.navigatelifetexas.org/en**
Texas Parent to Parent	**www.txp2p.org**
The ARC of Texas	**www.thearcoftexas.org**
Mental Health Texas	**https://mentalhealthtx.org**
Texas Council of Community Centers	**https://txcouncil.com/intellectual-developmental-disabilities**

Where to find important pharmacy information

You can access important pharmacy information on **AetnaBetterHealth.com/Texas.**

Once you access **AetnaBetterHealth.com/Texas**, select "For Provider" and then "Pharmacy" to find:

- Preferred Drug list – there's also a link to the vendor drug website **www.txvendordrug.com/formulary/prior-authorization/mco-clinical-pa**
- A list of preferred pharmaceuticals, including any restrictions and/or preferences
- Medications that require prior authorization, and applicable coverage criteria
- Medications that require step therapy, including the medications that must be tried/failed prior to coverage
- A list and explanation of medications that have limits or quotas
- Copayment and coinsurance requirements, and the medications or classes to which they apply. No copays except on CHIP.
- Procedures for step-therapy, prior authorization, generic substitution, preferred-brand interchange
- Information on the use of pharmaceutical management procedures
- Criteria used to evaluate new medications for inclusion on the formulary
- A description of the process for requesting a medication coverage exception

Availity is here

On February 25, we transitioned from our current provider portal to Availity. We are excited to share the functionality of our new system.

Provider portal benefits include:

- Payer spaces
- Change healthcare claim submission link
- Contact us and messaging
- Claim status inquiry
- Grievance submission
- Appeals submission
- Grievance and appeals status
- Provider data management
- Ambient (business intelligence reporting)
- Clear claim
- ProPAT
- Provider intake
- Dynamo (case management)

If you are already registered in Availity, upon logging into Availity, you will simply select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

If you are not registered, we recommend that you do so immediately.

- Click **here** to learn more about Availity portal registration
- Click **here** to register
- For registration assistance, call Availity Client Services at **1-800-282-4548** Monday-Friday, 8 AM to 8 PM ET (excluding holidays)

For access to the following features, you will still need to use the secure provider portal:

- Prior auth
- Eligibility and benefits
- Panel roster
- Remit PDF

Secure provider web portal log-in

- Provider portal registration form
- Provider portal instructions

Access to care

OBGYN/Prenatal Care – STAR Program Thresholds		
Level/Type of Care	**Time to Treatment (Calendar Days)**	**Threshold**
Low-Risk Pregnancies	Within 14 calendar days	85%
High-Risk Pregnancies	Within 5 calendar days	51%
New Members in the Third Trimester	Within 5 calendar days	51%

Vision Care Threshold		
Level/Type of Care	**Standard**	**Threshold**
Specialist physician access: ophthalmology, therapeutic optometry	Members must be allowed to have access without a PCP referral to eye health care services from a network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.	99.0%

Primary Care Provider Thresholds				
Standard	**STAR Child**	**STAR Adult**	**CHIP**	**STAR+PLUS**
Preventive health services – within 90 calendar days	99.0%	99.0%	99.0%	99.0%
Routine primary care – within 14 calendar days	99.0%	95.8%	90.7%	87.2%
Urgent care – within 24 hours	99.0%	99.0%	99.0%	99.0%

Behavioral Health Provider Thresholds				
Standard	**STAR Child**	**STAR Adult**	**CHIP**	**STAR+PLUS**
Initial outpatient behavioral health visit (child and adult) within 14 calendar days	75%	79%	83%	89%

Reminder when submitting appeals

If your office staff is given permission to act on behalf of the member by submitting an appeal – please ensure the member has provided your staff with the documentation necessary to act on their behalf.

COVID-19 news and updates

Please visit our website at **AetnaBetterHealth.com/Texas/providers/covid-19** for the latest news and updates regarding COVID-19 news, updates and webinars.

Provider notification: prior auth RFI changes

Notification of incomplete prior authorization requests

Effective immediately, we will require all essential information when reviewing prior authorization requests. An incomplete prior authorization (PA) request is a request for a service that is missing information needed to decide medical necessity. Aetna Better Health of Texas will notify the requesting provider and Member, in writing, of missing information no later than three business days after the prior authorization receive date.

Incomplete prior authorization request

If any of the information is missing, illegible or incomplete, Aetna Better Health of Texas will contact the provider in writing to obtain the information necessary to resolve the incomplete PA request. Our plan's written request for additional information will include:

- A statement that Aetna Better Health of Texas has reviewed the PA request and is unable to make a decision about the requested services without the submission of additional information
- A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete
- An applicable timeline for the provider to submit the missing information
- Information on how the provider may contact Aetna Better Health of Texas.

Essential information required by HHSC UMCM 3.22

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider's national provider identifier (NPI)
- Service Requested-Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) or Current Dental Terminology (CDT)
- Service requested stand and end date(s)
- Quantity of service units requested based on the CPT, HCPCS or CDT requested
- Rending/servicing provider
- Rendering/servicing provider national provider identifier (NPI)

Aetna Better Health of Texas uses the date that the complete request form is received to determine the start date for services. Previous submission dates with missing or incomplete information are not considered when determining the start date of service.

If the information requested is not received within three business days from the date that the plan sent the notice to the provider and the PA request will result in an adverse benefit determination. Aetna Better Health will refer the incomplete PA request to the medical director with all information received in the initial PA request. The determination should be completed within three business days of the referral to the medical director.

Coverage determination

Prior to issuing an adverse determination, a medical director will offer a peer-to-peer review to discuss the member's plan of treatment and the clinical basis for the medical necessity determination. Aetna Better Health of Texas will allow one business day or a reasonable timeframe before an adverse determination is issued. Final determination will be made within three business days after the date missing information is provided to Aetna Better Health of Texas.

If services are not approved based on medical necessity, Aetna Better Health of Texas will send the appropriate notice of action to the member and the requesting/ordering provider. The notice will include an explanation of the determination and the member's internal appeal rights and state fair hearing/external independent review rights and process.

For additional information on the prior authorization process, please review our provider manual and prior authorization tools:

- **Provider Manual**
- **Prior Authorization in provider portal**

Office hours of operation parity

The state of Texas requires us to ensure that network practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. Additionally, if the practitioner serves only Medicaid enrollees, hours offered to Medicaid managed care enrollees must be comparable to those for Medicaid fee for service enrollees. As a contracted Medicaid managed care organization, Aetna Better Health of Texas also adheres to these requirements.

The National Committee for Quality Assurance (NCQA) reviews Aetna Better Health of Texas practitioner materials such as contract templates, the practitioner manual and practitioner newsletters for language that the practitioner's hours of operation are not less for Medicaid patients than for non-Medicaid patients.

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 **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 call your Provider Relations Representative at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) or **1-844-787-5437** (STAR Kids).

Medical Management department

Aetna Better Health's Medical Management department is responsible for integrating systems for managing, monitoring, evaluating, and improving the utilization of care and services members receive. The program is designed to assist members, practitioners, and providers in the appropriate utilization of care/service delivery systems, assess satisfaction with the processes, and discover opportunities to optimize members' health outcomes.

Our Utilization Management (UM) department bases medical necessity decisions only on appropriateness of care and service and the existence of coverage. We do not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage decisions that result in under-utilization.

Utilization Management

The purpose of the Utilization Management program is to manage the use of health care resources so members receive the most medically appropriate and cost-effective health care that will improve their medical and behavioral health outcomes. The utilization management department consists of clinical and non-clinical staff members.

The Utilization Management department is responsible for monitoring the use of designated services before the services are delivered to confirm that they are:

- Provided at an appropriate level of care and place of service
- Included in the defined benefits, and are appropriate, timely, and cost-effective
- Properly documented to facilitate accurate and timely reimbursement

The Aetna Better Health of Texas Utilization Management staff has expertise in physical, behavioral health care services. Staff receives training to combine clinical skills with service techniques to support our utilization management processes. Our staff receives initial and ongoing training on a regular basis, but no less than annually.

Our utilization management function identifies both over- and under-utilization patterns for inpatient and outpatient services. This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population. Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The Utilization Management department has a toll-free voicemail phone line available 24 hours a day, 7 days a week. The utilization management department conducts outgoing communications with practitioners and providers regarding authorizations from 8 AM to 5 PM CT. The telephone help line will have staff to respond to practitioner and provider questions about authorization. It can be accessed by calling Member Services at **1-800-306-8612** (Tarrant Medicaid), **1-800-248-7767** (Bexar Medicaid), **1-800-245-5380** (Tarrant CHIP), **1-866-818-0959** (Bexar CHIP) and **1-844-787-5437** (STAR Kids).

Member Services can also provide callers with TDD/TTY and language assistance services for providers and members who need them. Aetna Better Health of Texas requires utilization management staff to identify themselves by name, title, and organization name when initiating or returning calls regarding UM inquiries. And upon request, verbally facility personnel; the attending physician and other ordering practitioners/providers of specific utilization management requirements and procedures.

Important fax numbers for you to know

- Prior authorizations: fax requests to **1-866-835-9589**
- Concurrent review: fax requests to **1-866-706-0529**

Integrated Care Management program

The Aetna Better Health of Texas's Integrated Care Management (ICM) is designed to identify our most bio-psycho-socially complex and vulnerable members with whom we have an opportunity to make a significant difference. The care management program is "integrated" as it reflects our belief that care management must address the member's medical, behavioral and social needs in an integrated fashion and must address the continuum of acute, chronic and long term services and supports needs. Case managers assist members in coordinating medical and/or behavioral health services as well as those available in the community.

Our ICM department consists of non-clinical and clinical employees who are trained in motivational interviewing. Our care managers would like to collaborate with you to help members improve their health and sustain improvement over time. Using available information we employ clinical algorithms and case manager judgment to recommend a level of care management that is best suited to address the member's needs.

Intensive care management

Intensive care management is intended for people with complex conditions to help them receive coordinated care, based on a customized approach to each individual's unique circumstances.

Supportive care management

Supportive care management includes problem-solving interventions that focus on improving access to, and effectiveness and safety of, standard health care for individual members.

Population health

This level of care management offers basic educational outreach and includes individualized services to members who require routine screening, monitoring, and follow-up. Low risk pregnant members and low risk members with chronic conditions are assigned to population health.

There are multiple ways we consider members for care management services. Information sources include but are not limited to:

- Enrollment data from the state
- Predictive modeling tools
- Claim/encounter information including pharmacy data if available
- Data collection through the utilization management processes
- Hospital or facility admissions and discharges
- Health risk appraisal tools.

We may also receive referrals from our health information line, members, caregivers, providers or practitioners to outreach members appropriate for care management and assign members to the appropriate level of ICM.

Integrated Care Management (ICM) Program is a benefit for all Medicaid, CHIP, and CHIP perinate members. A care manager can assist you in locating in-network specialists to meet member needs as well as arrange transportation to get them to appointments. To request care management services, call Member Services and ask to talk to a care manager.

A source for identification of members for case management is the monthly Consolidated Outreach Risk Evaluation (CORE) report, a predictive modeling tool. The CORE is based on three risk metrics:

1. General risk score
2. Emergency department (ED) risk
3. Inpatient (IP) risk

Additionally, disease conditions are identified for each member on the CORE, including asthma, chronic pain, substance abuse, congestive heart disease, cardiovascular disease, diabetes, and behavioral health diagnoses.

Other members are enrolled in case management via referrals from providers and post-discharge planners and internal referrals, as well as health risk assessments from the state enrollment broker.

You can refer your Aetna Better Health patients for care management service by calling Member Services at **1-800-306-8612** (Tarrant Medicaid), **1-800-248-7767** (Bexar Medicaid), **1-800-245-5380** (Tarrant CHIP), **1-866-818-0959** (Bexar CHIP) and **1-844-787-5437** (STAR Kids).