# Provider newsletter

Winter 2023

## Where to find important pharmacy information

You can access important pharmacy information on our website, **AetnaBetterHealth.com/Texas**. Once there select "Provider Site", click on "Programs and services", and then click on "Pharmacy".

### Now you can view:

- The preferred drug list
- Medications that require prior authorization, and applicable coverage criteria
- A list and explanation of medications that have limits or quotas.
- Copayment and coinsurance requirements, and the medications or classes to which they apply (CHIP members only).
- Procedures for obtaining clinical PA or PDL PA 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

Effective Sept. 20, 2022, Aetna Better Health of Texas removed clinical PA requirements on preferred ADHD medications. Drugs that require PDL PA (non-preferred products) will still require submission of a PA before coverage.

### In this issue

## Changes to the Texas Medicaid Preferred Drug List

Texas Medicaid publishes the semi-annual update of the Medicaid Preferred Drug List in January and July. The updates are based on the changes presented and recommended at the quarterly Texas Drug Utilization Review Board meetings. The tables below summarize noteworthy changes for the July 2022 update.

Drugs on the Texas Medicaid formulary are designated as preferred, non-preferred, or have neither designation. The preferred drug list includes only drugs identified as either preferred or non-preferred. Drugs on the preferred drug list listed as "preferred" are available to members without prior authorization; however, some could require a clinical prior authorization. Drugs on the preferred drug list that are identified as "non-preferred" require prior authorization. There are certain clinical prior authorizations that all Medicaid managed care organizations (MCO) are required to perform.

### July 2022 preferred drug list updates

| Reviewed Drug Class | Drug Name | Current PDL Status | Recommended Status |
|---|---|---|---|
| Alzheimer's agents | Adlarity (transderm) | Non-reviewed | Non-preferred |
| Calcium channel blockers | Norliqva (oral) | Non-reviewed | Non-preferred |
| Cytokine and cam antagonists | Cibinqo (oral) | Non-reviewed | Non-preferred |
| Fluoroquinolones, oral | Cipro suspension (oral) | Non-preferred | Preferred |
| Fluoroquinolones, oral | Ciprofloxacin suspension (oral) | Preferred | Non-preferred |
| Glucocorticoids, oral | Tarpeyo (oral) | Non-reviewed | Non-preferred |
| Immunosuppressives, oral | Tavneos (oral) | Non-reviewed | Non-preferred |
| Non-steroidal anti-inflammatory drugs (NSAIDs) | Diclofenac sodium (oral) | Non-preferred | Preferred |
| | Ketorolac (oral) | Non-preferred | Preferred |
| | Sulindac (oral) | Non-preferred | Preferred |
| Ophthalmic antibiotics | Vigamox (ophthalmic) | Non-preferred | Preferred |
| Ophthalmic antibiotic-steroid combinations | Tobradex suspension (ophthalmic) | Non-preferred | Preferred |
| Ophthalmics for allergic conjunctivitis | Lastacaft, OTC (ophthalmic) | Non-reviewed | Non-preferred |
| | Olopatadine, OTC (pataday once daily) (ophthalmic) | Non-preferred | Preferred |
| | Olopatadine, OTC (pataday twice daily) (ophthalmic) | Non-preferred | Non-preferred |
| Rosacea agents, topical | Epsolay (topical) | Non-reviewed | Non-preferred |

*(continued on next page)*

| Reviewed Drug Class | Drug Name | Current PDL Status | Recommended Status |
|---|---|---|---|
| Skeletal muscle relaxants | Fleqsuvy (oral) | Non-reviewed | Non-preferred |
| | Lyvispah (oral) | Non-reviewed | Non-preferred |
| Ulcerative colitis | Canasa (rectal) | Non-preferred | Preferred |
| | Mesalamine (Canasa) (AG) (rectal) | Preferred | Non-preferred |
| | Mesalamine (Canasa) (rectal) | Preferred | Non-preferred |
| | Pentasa (oral) | Non-preferred | Preferred |
| Uterine disorder treatments (new PDL class) | Myfembree (oral) | Non-reviewed | Preferred |
| | Oriahnn (oral) | Non-reviewed | Preferred |
| | Orilissa (oral) | Non-reviewed | Preferred |

**Single drug reviews**

| Reviewed Drug Class | Drug Name | Current PDL Status | Recommended Status |
|---|---|---|---|
| Acne agents, topical | Twyneo, cream (topical) | Non-reviewed | Non-preferred |
| Analgesics, narcotics short | Seglentis (oral) | Non-reviewed | Non-preferred |
| Antivirals, orals | Livtencity (oral) | Non-reviewed | Non-preferred |
| Colony stimulating factors | Releuko, syringe (subcutaneous) | Non-reviewed | Non-preferred |
| | Releuko, vial (injection) | Non-reviewed | Non-preferred |
| Gastrointestinal (GI) motility, chronic | Ibsrela, tablet (oral) | Non-reviewed | Non-preferred |
| Hereditary angioedema (HAE) treatments | Takhzyro, syringe (sub-q) | Non-reviewed | Non-preferred |
| HIV/AIDS | Triumeq PD tab suspension (oral) | Non-reviewed | Preferred |
| Opiate dependence treatments | Zimhi (injection) | Non-reviewed | Preferred |

## Community outreach

Our community outreach department can normally be found in the community attending health fairs and community events geared towards educating existing and potential members about our plan. In addition to providing an overview of our plan, community outreach educates our communities on CHIP/Medicaid, Texas Health Steps, and Accelerated Services for Farmworker Children. Our outreach team can also be a great asset to any provider office offering a number of services geared for members to enhance not only their experience with our plan but with the provider as well. Here are a few of the services we offer:

- **Member education** – One-on-one education session with a member that must be conducted in a private room at the provider's office. Community outreach will normally coordinate a date/time with a provider when multiple members are scheduled.
- **Re-enrollment assistance** – Members can call **2-1-1 Texas** or visit **yourtexasbenefits.com/learn/home** to renew their Medicaid benefits.
- **Provider education** – Education sessions for provider offices to assist in the identification of children of migrant farmworkers in order to help them receive the health care services their child/children may need.
- **Farmworker children** – Farmworker children have parents or guardians who meet the state definition of a migratory agricultural worker, generally defined as an individual:

  1. Principal employment is in agriculture on a seasonal basis.
  2. Has been so employed within the last 24 months.
  3. Performs any activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence.
  4. Establishes for the purposes of such employment a temporary abode.

  *Source*: Texas Health and Human Services Commission, Uniform Managed Care Contract Terms & Conditions, Version 1.17, p. 11

- **Farmworker children referral process** – Providers who identify farmworker children members can contact Member Services at **1-888-672-2277** so we can provide additional outreach and assistance if needed.

For more information on our value-added services and programs call **1-877-751-9951**.

## Quality improvement

We want our members to get **quality** care when they need it. "Quality" means great service from our health care providers and doctors. Our Quality Improvement team works to provide services of high quality and value, with a focus on meeting the needs of our members. By working together with our members and health care providers, we can see how we're doing and make any needed changes.

Aetna Better Health of Texas is looking for ways to make our members an providers experience better. Some of the activities we use include:

- Clinical quality surveys
- Member and provider satisfaction surveys
- Accreditation surveys
- Monitoring of Healthcare Effectiveness Data and Information (HEDIS) scores
- Performance improvement projects

The Aetna Better Health of Texas Quality Improvement team will continue to work to find opportunities to advance member and provider experience as well as quality measures.

## Members' cultural and language needs

The Aetna Better Health of Texas membership is diverse and is constantly growing. While most of our members speak English as their primary language, here is an overview of other identified languages spoken by our members. As indicated in the chart below, Spanish is the prevalent non-English language spoken by our members, followed by Vietnamese and Arabic.

| Language | 2021 | | 2022 | |
|---|---|---|---|---|
| | N = 133,590 | | N = 147,665 | |
| | Count | % | Count | % |
| Spanish | 5,599 | 4.2% | 6,417 | 4.35% |
| Vietnamese | 145 | 0.11% | 157 | 0.039% |
| Arabic | 79 | 0.059% | 90 | 0.061% |
| French | 33 | 0.025% | 40 | 0.027% |
| Swahili | 32 | 0.023% | 36 | 0.024% |
| Other | 46 | 0.034% | 74 | 0.05% |

The ability to communicate effectively is important to provide quality health care to patients from different cultural backgrounds. To assist with this, Aetna Better Health of Texas makes its telephonic language interpretation service available to providers to help their interactions with members. These services are free to the member and provider.

For more information, refer to the "Interpreter/translation services" section in your Aetna Better Health of Texas provider manual that can be accessed **here**.

| If you need translation or interpretation services for your patients, contact Member Services at: | | |
|---|---|---|
| **STAR** | **1-800-248-7767** (Bexar) | **1-800-306-8612** (Tarrant) |
| **CHIP** | **1-866-818-0959** (Bexar) | **1-800-245-5380** (Tarrant) |
| **STAR Kids** | **1-844-787-5437** (Dallas and Tarrant) | |

## Coming soon

In an ongoing effort to improve quality of care for members, the Aetna Better Health of Texas Quality team will be requesting medical records from provider groups on a semi-annual basis to monitor documentation of Texas Health Steps and wellness visits. This audit will also include HEDIS measures for Weight Assessment and Counseling for Nutrition and Physical Activity (WCC), Immunizations for Adolescents (IMA), and Well-Child Visits in the First 30 Months of Life (W30) or Child and Adolescent Well-Care Visits (WCV). Once received, the record request will include all information needed as well as a contact for additional questions. We look forward to working with you to improve Texas Health Steps and HEDIS compliance.

## HEDIS® MY2022 data collection is underway

The annual Healthcare Effectiveness Data and Information Set (HEDIS) medical record review is underway and scheduled to start January 2023. Our Aetna Better Health staff or our contracted representatives (Ciox) may be contacting your office to request patient medical records between January and May. We appreciate your understanding and cooperation as we complete required quality reporting with minimal disruption to your practice.

Our HEDIS hybrid medical record requests will be used to review important aspects of care and services on measures such as, controlling high blood pressure, cervical cancer screening, comprehensive diabetes, child and adolescent immunizations, prenatal and postpartum care and weight assessment and counseling for nutrition and physical activity. Most of the data is collected from claims and encounters. Data is also collected and gathered on services provided and member health status form member medical records.

### Why is this necessary?

HEDIS data collection is a nationwide, joint effort among health plans and physicians. Annual medical record review is conducted for reporting to the National Committee of Quality Assurance (NCQA) and to the U.S. Department of Health and Human Service (HHS). Performance measures are developed and maintained by NCQA and is the most widely used set of performance measures utilized by the managed care industry.

Annually, NCQA publishes the Health Plan Ratings which analyzes how plans are rated based on their combined HEDIS, Consumer Assessment of Healthcare Provider and Systems (CAHPS) scores and NCQA Accreditation status. Health plans are evaluated on the quality-of-care patients receive from their health provider, how satisfied patients are with their care and health plans' efforts to keep improving. The 2022 Health Plan Ratings are based on data from calendar year 2021. Plans are rated on a 0- to 5-star scale, with 5 being the highest possible rating.

Our goal is to achieve the five-star status. In 2022, we achieved 3 stars (3.0 in MY2020). We will continue to evaluate, discuss, and implement new initiatives to drive performance in each of the ranking categories.

In efforts to increase HEDIS and CAHPS scores, Aetna Better Health of Texas is working closely with providers to help close gaps in care, conducting member outreach and promoting health wellness and assist in community health events.

**HEDIS MY2021 Health Plan Rating** ★★★

- Patient Experience ★★★
- Prevention ★★★
- Treatment ★★★

## Filing an appeal

When you file a claim appeal, you'll want to be sure it meets these requirements:

- It's a written request to appeal a claim determination.
- You're asking us to further consider the claim based on the original and/or more info you submit.
- Your appeal document includes the word "appeal."

You can appeal in writing by completing an appeal form. Or you can take these steps:

- Submit a copy of the remit/Explanation of Benefits (EOB) page that shows the claim was paid or denied.
- Submit a copy of the remit/EOB for each claim you're appealing.
- Circle all claims you're appealing on the remit/EOB page.
- Tell us the reason for the appeal.
- Tell us about any incorrect info and provide the correct info we should use to reconsider the claim.
- Attach a copy of any supporting info that we requested. For timely filing, include the acceptance report we sent to your claims clearinghouse. Put any supporting info on a separate page — avoid copying it to the other side of the remit/EOB.
- Save a copy of all your documentation.

## Social determinants of health/non-medical drivers of health (SDOH/NMDH)

Vulnerable patients may struggle to prioritize their preventative care and even fail to seek much-needed acute or chronic medical care when they are worried about where their next meal will come from or where they will sleep tonight.

SMI Adviser, a reputable clinical support system for serious mental illness, reports many different potential causes for increased risk of higher SDOH/NMDH. These include low economic status/poverty, unemployment, strained familial relationships, and living in unsafe neighborhoods. Many of the risks for high SDOH/NMDH are social in nature, such as isolation or strained family relationships, while others are physical, such as housing or food insecurity.[1]

Considering that people with SDOH/NMDH are at a greater risk for many illnesses, both physical and mental, it is imperative that close attention be paid to patients coming in for care. Equally important is to be mindful of the patients who fail to come in for regular care, especially if they have made appointments but have not shown up at the scheduled appointment time. Often patients fail to make these appointments due to transportation issues or other extenuating circumstances directly related to the struggles of high SDOH/NMDH.

For resources to help patients with suspected or stated SDOH/NMDH concerns, please contact the Member Services number on the back of the patient's Medicaid card and ask to be referred to a case manager.

**Citations:**

[1] What are the social determinants of health and do they impact people's mental health? *SMI Adviser.* (2022, February 2). Retrieved October 14, 2022, from **smiadviser.org/knowledge_post/what-are-the-social-determinants-of-health-and-do-they-impact-peoples-mental-health**

## Any changes to your demographic information?

Aetna Better Health of Texas strives to ensure provider directory information is as accurate and current as possible for our members. If you are a provider or provider group and need to update demographic information, please contact us at the emails below.

| Contact | Type of Update |
|---|---|
| **ABHTXCredentialing @Aetna.com** | Adding providers, change of physical address, contracting, credentialing, copies of contract or checking credentialing/ contracting status.<br><br>If you have a new provider joining your practice, you must submit a:<br>• Prospective Provider Form<br>• W9<br><br>The application can be found on our website at **AetnaBetterHealth.com/Texas**. |
| **TXproviderenrollment @Aetna.com** | • Request an EFT/ ERA<br>• Submit a delegated roster |

## Provider collaboration approach

Aetna Better Health of Texas' approach to provider collaboration includes a portfolio of value-based programs that support clinical and financial success and aim to achieve the following key objectives:

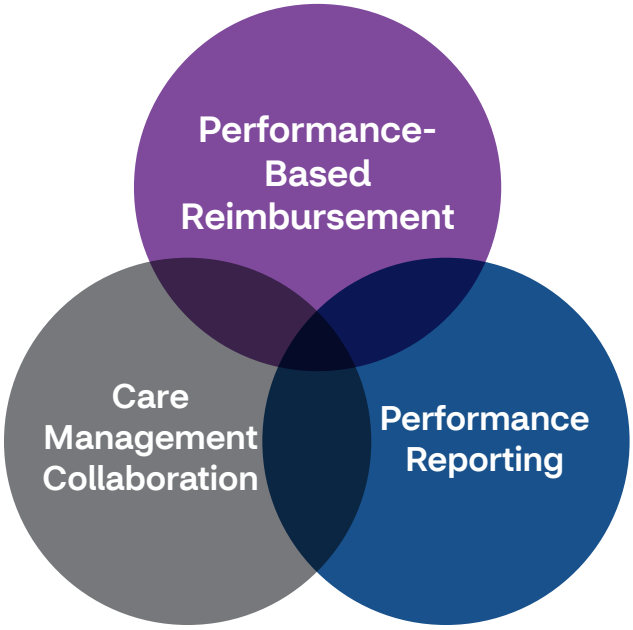
- Growth of Aetna membership
- Increased access to care
- Reduced medical costs
- Improved quality of care and outcomes

### Programs are selected for providers based on:

- Practice size and specialties
- Membership panel and population
- Level of sophistication and engagement
- Clinical and technological capabilities

### Provider collaboration strategy

Aetna's goal is to support providers in their transition from pay-for-volume to pay-for-value by improving access, quality, and affordability in the healthcare ecosystem.




### Performance-based reimbursement

Providers are eligible for incentives tied to both clinical and financial outcomes. Incentive payments are based on performance of selected metrics and targets designed to reduce avoidable utilization and deliver improved care

### Care management collaboration

Care management support is provided through technology, tools, and locally based clinical resources to assist providers in coordinating care for members

### Performance reporting

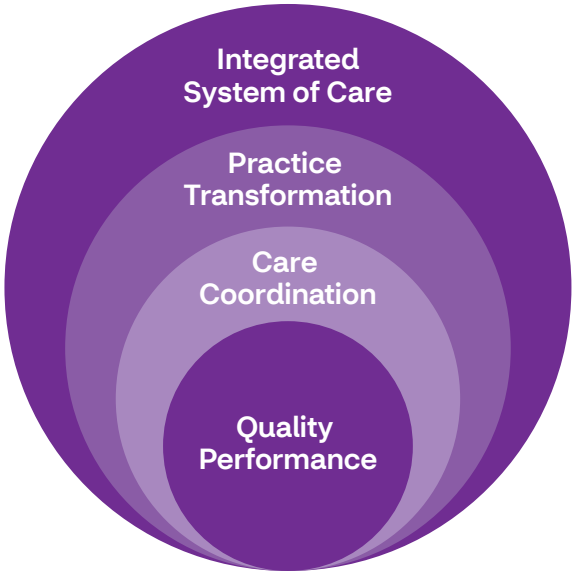
Reporting is available to support providers in understanding their performance and identifying gaps to achieve success.

### Value-based continuum

One goal of these programs is to increase value-based reimbursement to providers as they achieve success in lowering medical costs and improving quality of care.

### Moving providers along the value-based continuum

- Evaluate providers/groups for value-based reimbursement opportunities
  - — Determine provider capabilities, readiness, and engagement
- Increase sophistication in value-based services (VBS) programming as provider capabilities become more robust
  - — Acknowledge care coordination efforts
  - — Reward quality improvements and practice transformation along the continuum
- Adjust value-based contracting terms to include gainsharing
  - — Acknowledge care continuum efforts
  - — Increase accountability through progression to greater risk-sharing

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## Provider collaboration approach *(continued from previous page)*

### Value-based provider programs

**Pay for Quality (P4Q)** Annual bonus program related to quality metrics for providers who do not immediately qualify for our other VBS programs and rewards providers for achieving better performance on a broad spectrum of Healthcare Effectiveness Data and Information Set (HEDIS) and utilization metrics for their Aetna member panel.

**Patient-Centered Medical Home with Pay for Quality (PCMH w/P4Q)** Program for providers whose patients (our members) are best served by a medical home or who have complex needs and require an integrated behavioral health/physical health home. PCMHs/IHHs help to address the complex health needs of the entire community through a highly coordinated system of care including comprehensive primary care, specialty care, acute care, behavioral health integration, and community.

**Shared Savings/Shared Risk** Includes opportunity for providers to earn incentives based on the costs of the services they provide compared to a benchmark. Providers must qualify to earn shared savings incentives by achieving clinical quality outcomes objectives. These arrangements are for those practices serving a larger portion of our Medicaid members and who possess the skills and infrastructure necessary to manage the population and financial risk.

**Bundled Payments** Includes opportunities for specialists not ordinarily participating in primary care incentives to enroll in programming directed toward their specialty

**Full Risk** Rewards providers for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner. Providers who accept full risk payment arrangements are expected to deliver improved clinical outcomes.

## Texas Health Steps tips and reminders

An Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visit, or Texas Health Steps (THSteps) visit in Texas, is a well-child visit designed to be the entryway for comprehensive health care for Medicaid members under the age of 21. It is especially important to perform all age-appropriate screenings and procedures specified on the periodicity schedule.

**Some tips to keep in mind for Texas Health Steps:**

- Follow the THSteps periodicity schedule that can be found in our provider manual and at **www.AetnaBetterHealth.com/Texas/providers/texas-health-steps.html**
- Document the visit in the patient's medical record
- In addition to the comprehensive health history and physical exam, the EPSDT must include:
  - — Developmental health
  - — Nutritional screening
  - — Behavioral health assessments/screenings
  - — Vision/hearing
  - — Up-to-date immunizations
  - — Appropriate lab tests
  - — Dental referral

*References:*

- **hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/texas-health-steps**
- **hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers**

## Help us ensure your Aetna patients have timely and appropriate access to care

We want to remind Aetna Better Health providers of the required availability and accessibility standards. Please review the standards listed below.

| Level of care | Timeframe |
|---|---|
| Emergency services | Upon member presentation at the service delivery site |
| Urgent care appointments | Within 24 hours of request for primary and specialty care |
| Routine primary care | Within 14 days of request for non-urgent, symptomatic condition |
| Routine specialty care | Within 21 days of request for non-urgent, symptomatic condition |
| Adult preventive health physicals/ wellness visits for members over the age of 21 | Within 90 days of request |
| Pediatric preventive health physicals/ well-child checkups for members under the age of 21, including Texas Health Steps services | As soon as possible for members who are due or overdue for services, in accordance with the Texas Health Steps Periodicity Schedule and the American Academy of Pediatrics guidelines, but in no case later than:<br>• 2 weeks of enrollment for members less than 6 months<br>• 60 days of new enrollment for members 6 months – 20 years |
| Prenatal care/first visit | Within 14 days of request. For high-risk pregnancies or new members in the third trimester, appointments should be offered immediately, but no later than 5 days of request. |

## Appointment availability requirements

After-hours access requirements: the following are acceptable and unacceptable phone arrangements for contacting PCPs after normal business hours.

| Acceptable | Unacceptable |
|---|---|
| Office phone is answered after hours by an answering service, in English, Spanish or other languages of the major population groups served, that 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.<br><br>Office phone is answered after normal business hours by a recording in English, Spanish or other languages of the major population groups served, directing the patient to call another number to reach the PCP or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.<br><br>Office phone is transferred after office hours to another location, where someone will answer the phone and be able to contact the PCP or another designated medical practitioner. | Office phone is only answered during office hours.<br><br>Office phone is answered after hours by a recording, which tells the patients to leave a message.<br><br>Office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.<br><br>Returning after-hour calls outside of 30 minutes. |