Provider newsletter

Winter 2019

Table of contents

Aetna Better Health Implements Early Intervention Services

What are Early Intervention Services (EIS)? Early intervention services (EIS) provides for the early identification and treatment of recipients under the age of three years (36 months) with developmental delays or related conditions. EIS promotes a parent-coaching model intended to support the child in meeting certain developmental milestones.

Early Steps is Florida's early intervention program that provides support to families and caregivers in developing the competence and confidence to help their child learn and develop. The program began December 1, 2018 as a Statewide Medicaid Managed Care (SMMC) plan and Aetna Better Health is covering these services for our members.

Continued on page 2

Aetna Better Health® of Florida

aetna®

86.22.806.1-WI

Aetna Better Health Implements Early Intervention Services

Continued from page 1

What is Aetna Better Health (ABH) plan's responsibilitties?

- Screening and Evaluation services - Screening and/or evaluation is an essential part of the process for determining if a child needs EIS
- Multidisciplinary team meeting, also known as Individualized Family Support Plan (IFSP)- ABH may participate in the multidisciplinary team meetings where the IFSP is developed to facilitate quick and timely authorization of medically necessary services
- Service delivery model
- Targeted Case Management/Care Coordination
- Provider contracting, credentialing and provider reimbursement

For additional information and/or resources please visit **aetnabetterhealth.com/florida/providers/library**

MMA Physician Incentive Program (MPIP)

The MMA Physician Incentive Program (MPIP) is designed to increase compensation for designated physician types who meet certain qualifying criteria, primarily associated with key access and performance measures. Below please find the Aetna Better Health of Florida Qualification Requirements for Region 6, 7 and 11:

Pediatric Primary Care Physician (PCP)

Providers designated by Aetna Better Health of Florida as PCPs (including pediatricians, family practitioners, and general practitioners), regardless of board certification status, with at least 100 assigned Medicaid members under the age of 21 years, at a site recognized as a Patient-Centered Medical Home, on or before September 30, 2018, by one of the following organizations:

- National Committee for Quality Assurance (NCQA), Level 2
- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission (TJC)
- Utilization Review Accreditation Commission (URAC)

PLUS

The site must also achieve the following access and quality measures using HEDIS 2018 specifications within the measurement period January 1, 2017 through December 31, 2017.

Measure	Benchmark to Quality
HEDIS: Children and Adolescent Access to Primary Care Practitioners (3/4 of Age Bands)	Medicaid 50th percentile
ER Utilization	<650 visits/1000 members
After Hours Availability	After 6 p.m. or on Weekends
HEDIS: Lead Screening	Medicaid 50th Percentile

If you have obtained a Patient-Centered Medical Home certification, please be sure to submit a copy of your certification to FLMedicaidProviderRelations@aetna.com for participation in the MPIP program.

Obstetrician/Gynecologist (OB/GYN)

Providers designated by the health plan as OB/GYN physicians practicing within a group with at least 10 deliveries for the health plan's Medicaid members at a site that achieves the following access and quality measures using 2018 HEDIS specifications within the measurement period.

Measure	Measurement Period	Benchmark to Quality
HEDIS: Frequency of Ongoing Prenatal Care	11/6/16-11/5/17	Medicaid 75thPercentile
HEDIS: Postpartum Care	11/6/16-11/5/17	National Medicaid Mean
Florida Medicaid Cesarean Section Rate	CY 2017	<35%

Continued on page 3

MMA Physician Incentive Program (MPIP)

Continued from page 2

Pediatric Specialist

All physicians who are pediatric specialists, regardless of board certification. No additional qualification measures are required.

Important Dental Information

Beginning December 1, 2018, Aetna Better Health will no longer cover dental services. Dental Services are now carved out and members will have to choose between Liberty, MCNA, or Dentaquest for their dental coverage.

Who will pay for the dental services?

Type of Dental Service(s) Provided:	Dental Plan Covers:
Dental Services	Covered when you see your dentist or dental hygienist
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist
Hospital visit for a dental problem	
Prescription drugs for a dental visit or problem	
Transportation to your dental service or appointment	

MMA member dental plans

Dental Insurance Company	Dental Insurance Company Contact Info
LIBERTY Dental Plan of Florida	1-888-352-7924 www.libertydentalplan.com/
DentaQuest, Inc.	1-800-341-8478 www.dentaquest.com/
MCNA Dental Plan	1-800-494-6262 mcna.net

Florida Healthy Kids (FHK) member dental plans

Dental Insurance Company	Dental Insurance Company Contact Info
Argus Dental Plan	1-888-978-9513 argusdental.com/healthykids
DentaQuest, Inc.	1-800-964-7811 dentaquest.com/state-plans/regions/florida
MCNA Dental Plan	1-855-858-6262 mcna.net/en/florida-healthy-kids

Aetna Better Health's Credentialing FAQs

Where do I send my credentialing applications and roster?

All credentialing applications and rosters should be sent by email to **FLMedicaidcredentialing@aetna.com** or by fax to **1-860-607-8854**.

How long does the credentialing process take?

The credentialing process will be complete within 60-days of receipt of your completed application. Please allow at least 45 days before checking on the status by contacting us at **FLMedicaidCredentialing@aetna.com**.

Do all of my providers require credentialing?

All physicians need to be credentialed. Mid-level professionals, such as ARNPs, PAs, and CNMs are not required to be credentialed.

I am credentialed - finally! Now what happens?

Once credentialed updates are made in our central system you will receive notification by mail from the Provider Relations Department.

*If you do not receive status updates by 60 days, please contact **FLMedicaidCredentialing@aetna.com***

Provider Satisfaction Survey - You spoke, and we listened...

Our yearly Provider Satisfaction Survey indicated providers wanted more information regarding:

- Who was their assigned Provider Relations Representative and how to reach them?
- How to obtain assistance with resolving claim payment issues and disputes?
- Improving the New Provider Orientation process

What's new?

- We posted a list of the Provider Relations Representatives and their assigned service areas on the Aetna Better Health Provider Portal, and distributed through Provider Newsletters and Provider Bulletins.
- We have a dedicated Provider Relations claims team that will respond quickly to providers to review and resolve issues promptly.
- We have updated the Provider Manuals and Provider Orientation Toolkit to provide additional information and guidance to providers during orientation sessions

Telemedicine

Aetna Better Health is offering telehealth services in the state of Florida to support our members with receiving healthcare services or in their provider's office. Telehealth is widely viewed as an effective care delivery alternative that can support and complement traditional face-to-face visits for both medical and behavioral care (e.g., face-to-face consultations, assessments or examinations). Aetna's telehealth program seeks to improve our members' health by permitting real-time interactive communication between the member, their primary care provider, care team or other skilled practitioner located at a distant site. Our telehealth program is designed and modeled on the state's regulations which states:

Telemedicine is the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care.

Aetna Better Health of Florida offers telehealth services for both physical health and telebehavioral health services as part of the behavioral health delivery strategy. The use of telehealth can provide increased access to mental health services to children and adults that meet certain criteria.

The Plan's telehealth program will include the following services:

- Provider to member direct service- the core of our programming is to support our members receiving care in the in a state-recognized clinic site via a secure virtual connection.

This program will incorporate the key objectives of our Integrated Care Management program where appropriate including:

- Facilitation of timely access to a continuum of services based on the intensity and complexity of each member's need
- Collaboration with the member, family, community supports, physical health and behavioral health providers to enhance care outcomes
- The telehealth program will allow transformation of medical and behavioral health practices to incorporate the following actions typically in a sequential fashion:
  - Adopt a member-centric care delivery method
  - Improve quality of care on targeted metrics
  - Improve member access to timely care
  - Tailoring care to each individual's needs and desires

Disease Management

At Aetna Better Health of Florida, we strive to improve members' functional status and their ability to self-manage their chronic condition so that they can minimize the extent to which it interferes with their lives, as well as to identify and manage co-morbid conditions as needed. The goal of our disease management program is to reduce longer-term premature morbidity (complications) and mortality of the condition. We promote participation in our disease management programs by identifying and enrolling members with the following diagnoses: Alzheimer's Disease/dementia (Long Term Care Members), asthma, cancer, COPD, diabetes, heart failure, hypertension, mental health and substance use issues. Aetna provides culturally aligned education and / or information specific to members to improve their perceptions of self-management in addition to deploying clinical care managers and community health workers to increase member focused education. To make a referral for disease management, call **1-800-441-5501** and follow the prompts to Case Management.

Accessing our drug formulary

You can gain access to the Aetna Better Health of Florida formularies by visiting our website at **aetnabetterhealth.com/florida**. This can be found under the "For Providers" tab, "Pharmacy" and "Formulary/ Preferred Drug List" areas. This will then lead you to access the Florida Medicaid Preferred Drug List (PDL) and/or the Florida Healthy Kids Formulary Search Tool and formulary document.

Please note the formulary can change at any time. This is due to the ever changing world of medicine. You can find the list of formulary changes on our website under the "For Providers" tab, "Pharmacy" then click on the "Preferred Drug List & Formulary Updates" tab.

If you have any questions in regards to the formulary please feel free to contact us at the toll free numbers below or visit our website.

- Medicaid Provider Relations: **1-800-441-5501**
- Florida Healthy Kids Provider Relations: **1-844-528-5815**

Electronic Prior Authorizations

Aetna Better Health of Florida has partnered with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (ePA) program.

With Electronic Prior Authorization (ePA), you can look forward to:

- Time saving -Decreasing paperwork, phone calls and faxes for requests for prior authorization
- Quicker Determinations - Reduces average wait times, resolution often within minutes
- Accommodating & Secure - HIPAA compliant via electronically submitted requests

No cost required. Let us help get you started. Getting started is easy. Choose ways to enroll:

- Visit the CoverMyMeds website **www.covermymeds.com/main/**
- Call CoverMyMeds toll-free at **1-866-452-5017**
- Visit the SureScripts website **http://surescripts.com/enhance-prescribing/prior-authorization/**
- Call SureScripts toll-free at **1-866-797-3239**

Healthy Behaviors

Aetna Better Health of Florida's Healthy Behaviors programs provide specific interventions aimed at assisting members who use tobacco, have weight management or substance use issues. Members are informed of the availability of Aetna Better Health of Florida's Healthy Behaviors programs (including incentives and rewards) during welcome calls, in their welcome packets and member handbooks, on the member website, in member and disease management newsletters, prenatal and post-partum education mailings, and during outreach telephone calls from the member services and case management staff.

The overarching goal is health promotion to help our members to understand the health risks of their behaviors and elicit changes that positively impact their current and future health and wellness. This will be done through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency and result in members' improved condition management and self-efficacy. To refer a member to our Healthy Behaviors programs, call **1-800-441-5501** and follow the prompts to Case Management.

Our Provider Portal

Aetna Better Health of Florida offers easy access to a variety of functions, web-based tools, and resources at **aetnabetterhealth-florida.aetna.com**. All participating providers may use this resource to access business activity information such as:

- Claim inquiries
- Authorization requirements and information
- Remittance advices
- Member eligibility
- Business forms
- Provider Manual
- Member benefit information
- Other business information or documentation
- Member health alerts

Our secure web portal can be accessed at **aetnabetterhealth-florida.aetna.com**. The Provider Relations team is available to address questions regarding the web site and services. You may contact a representative at **1-800-441-5501** or **1-800-645-7371**. Hours of operation are Monday - Friday 8 a.m. to 6 p.m. ET. Signing up is quick and easy. Please have your Federal Tax Identification Number available.

Aetna Better Health's Timely Filing Guidelines

To avoid payments delays or untimely denials below please find Aetna Better Health's timely filing standards.

Provider / Claim Type	Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **180 days** after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **365 days** after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within **ninety (90) calendar days** after the final determination of the primary payer. (SMMC Contract) (Section VIII)(E)(1)(h)
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare. (SMMC Contract) (Section VIII)(E)(2)(d)(2)
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within **180 days** from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within **thirty-five (35) days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

Special Investigations Unit (SIU) and You

What does it mean when the SIU requests medical records or other information? The very word "investigation" provokes fear and maybe even defensiveness. Everyone wonders why they're being targeted and whether the investigation will be fair. SIU investigations typically occur as a result of data analysis that suggests a provider scores higher than his or her peers in a certain area of service or an unusual pattern of billing is detected. Sometimes cases are opened based on information received from another source. SIU performs due diligence and looks into these situations.

The SIU is responsible for the detection, investigation, reporting, recovery, and prevention of fraud, waste, and abuse. Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Abuse is when a provider engages in practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. Although not formally defined in federal regulations, waste can be defined as treatment or services that are unnecessary, redundant, or ineffective and are contrary to, or not demonstrably associated with, health care quality and outcomes and may result in unnecessary costs. In a nutshell, the SIU is responsible for investigating situations that could cost the Medicaid program money that should not be paid out.

The SIU strives to insure all relevant information is considered and may request material in addition to patient medical records to that end. Most of the identified issues are the result of errors such as improper or incomplete documentation, incorrect understanding of the Medicaid requirements, or use of inappropriate procedure codes or modifiers. Typically, cases are resolved with provider education, corrective action plans, and/or repayment of overpaid amounts if warranted. Providers are given the opportunity to provide additional documentation and information before the final decision is rendered regarding the outcome of cases. SIU endeavors to be fair, impartial, and understanding in the investigation process.

Child health checkup

A child health checkup is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 21. Child health checkups are performed according to a periodic schedule to help children have routine health screenings to identify and correct medical conditions before the conditions become more serious and potentially disabling. Child Health Checkup (CHCUP) is Florida's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

A child health checkup is composed of the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and health status
- Nutritional assessment
- Developmental assessment
- Comprehensive unclothed physical examination
- Dental screening, including dental referral, when required
- Vision screening, including objective testing, when required
- Hearing screening, including objective testing, when required
- Laboratory test, including blood lead testing, when required
- Appropriate immunizations
- Health education, anticipatory guidance
- Diagnosis and treatment
- Referral antd follow-up, as appropriate

HEDIS

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. Results are used for quality assurance and accreditation purposes. All Aetna Better Health providers are contractually obligated to provide medical records necessary to fulfill reporting requirements at no cost to the health plan. We want to be able to reflect the high quality of care you have given to our members that may not have been gone into our claim system. Our goal is to retain the top quality rating of all Medicaid plans in the State of Florida and we need your help in providing timely medical records when requested.

Annual HEDIS Timeline

Medical records are randomly selected across hybrid HEDIS measures through an Auditor approved process 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 all records be sent within five days of receiving the initial request. For large volume providers, Aetna will provide personnel to come onsite 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 soon be sent the specific list of medical records we need including the member's name, date of service, and the measures selected with instructions how to submit. Please feel free to contact **FLMedicaidQualityDept@aetna.com** with any questions.

Coming your way

We are very excited to inform you that our Quality Management Department is growing. Our Outreach Coordinators are calling members in need of preventive care and HEDIS Practice Liaisons to visit their PCPs. We look forward to continuing our partnership and work 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 2019 is expected to be available in April, when enough claims have come in the new year to make these reports valuable. You will be alerted to this by the Quality Team and our new HEDIS Practices Liaisons will be available to deliver and review your GIC reports. We thank you in advance for your quick response to any medical record request you receive and your commitment to our members.

Availability and Accessibility Requirements

Help us ensure your patients have timely and appropriate access to care. We want to remind providers of the required availability and accessibility standards, and ask that you review the standards listed below.

The following can be found in the primary care physician (PCP) contract: "PCPs 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."

After-hours access

The following are acceptable and unacceptable phone arrangements for contacting PCPs after normal business hours.

Acceptable:

Office phone is answered after hours by an answering service, which meet the languages need 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.

Office phone is answered after normal business hours by a recording in which meet the languages need 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.

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, who can return the call within 30 minutes.

Unacceptable:

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

Quick reference guide

Effective January 2019

Health plan main office	Provider & member services phone numbers
1340 Concord Terrace Sunrise, FL 33323	MMA **1-800-441-5501** LTC **1-844-645-7371** FHK **1-844-528-5815**
Hours of operation	**Provider & member services fax numbers**
Monday through Friday 8 a.m. to 7 p.m. EST	Provider services fax: **1-844-235-1340** Member services fax: **1-877-542-6958**
Claims/billing address	**To file a provider appeal**
Aetna Better Health of Florida P.O. Box 63578 Phoenix, AZ 85082-1925	Aetna Better Health of Florida Attn: Medicaid Appeals Coordinator 1340 Concord Terrace Sunrise, FL 33323
Claims payer ID for EDI	**Real time payer ID**
128FL	ABHFL
Claim timely filing – initial & corrected claims	**Claims inquiry / claims research (CICR)**
180 days from date of service or date of discharge	MMA **1-800-441-5501** option 5, 5, 3 FHK **1-844-528-5815** option 5, 4, 3
Fraud & abuse hotline	**Nurse line**
1-888-891-8910	MMA **1-800-441-5501** FHK **1-844-528-5815**
Provider services email address	**CVS mail order phone number**
FLMedicaidProviderRelations@aetna.com	**1-855-271-6603**
Pharmacy helpdesk number	**Web portal**
1-866-693-4445	**aetnabetterhealth-florida.aetna.com**
Prior authorization phone numbers	**Prior authorization fax numbers**
MMA **1-800-441-5501** LTC **1-844-645-7371** FHK **1-844-528-5815**	MMA, LTC, FHK (general services) Fax: **1-860-607-8056** Obstetrics fax: **1-860-607-8726** Pharmacy fax: **1-855-799-2554**
Vendor phone numbers	
Beacon/PsychCare Behavioral Health **1-866-510-0797** eviCore (radiology, pain management, cardio) **1-888-693-3211** Eviti Connect Oncology (MMA only) **1-888-482-8057 (option 2)** HearUSA Hearing **1-800-442-8231 (option 2)**	iCare Vision **1-866-770-8170** Logisticare Transportation (MMA & LTC only) Reservations: **1-866-799-4463** Ride Assist (Where's My Ride) **1-866-799-4464**