Provider newsletter

Summer 2023

Healthcare Effectiveness Data and Information Set (HEDIS)

We use HEDIS scores to measure our performance, determine quality initiatives and provide educational programs for you and our members. You can use HEDIS scores to monitor your patients' health, identify developing issues and prevent complications.

What is HEDIS used for?

The National Committee for Quality Assurance (NCQA) coordinates HEDIS testing and scorekeeping. The Centers for Medicare & Medicaid Services uses HEDIS scores to monitor a health plan's performance. More than 90% of American health plans use HEDIS scores to compare how well the plan performs in areas like:

- Quality of care
- Access to care
- Member satisfaction with the plan and providers

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HEDIS Reference Tool

Our HEDIS Reference Tool contains information regarding HEDIS measures, definitions, requirements and commonly used codes. For detailed information please review our HEDIS Reference Tool and other HEDIS materials such as educational material and bulletins visit the website at www.aetnabetterhealth.com/florida/providers/hedis.html.

Get to know Availity

Availity is your trusted source for payer information, so you can focus on patient care. If your organization isn't registered with Availity, get started today at Availity.com/provider-portal-registration.

Live webinars for Availity portal users

Once you're registered, sign in at Apps.availity.com/availity/web/public.elegant.login. The Availity Learning Team offers regularly scheduled live webinars on a variety of topics including:

- Prior authorization submission and follow-up training
- Navigating the attachments dashboard and workflow options
- Resources and tips for new administrators on Availity
- Use Availity portal to submit professional claims
- Availity claim status

Tips for finding live webinars

- In the Availity portal, select Help & Training > Get Trained to open your ALC catalog in a new browser tab.
- In the ALC catalog > Sessions tab, browse or search by webinar title and look for live webinar and the date. You can also scroll the months using Your Calendar in the top left of the page.

After you enroll, watch your email inbox for confirmation and reminder emails with information to join and downloadable iCal options.

Can't make a live session?

The ALC catalog includes lots of on-demand options, too. In the ALC catalog, look for courses with a title that ends in recorded webinar, for example, Navigating the Attachments Dashboard and Workflow Options – Recorded Webinar.

Availity Essentials

The Availity Essentials provider portal provides access to robust self-service and online tools to allow more independent and remote providers to easily navigate Aetna's policies, procedures and requirements. Availity allows providers to directly communicate with Aetna's clinical and administrative staff through the Contact Us application. Providers support capabilities offered through Availity include the ability for providers to:

- Claim Submissions
- Claim Status Inquiries
- Appeals & Grievance Appeals
- Appeals & Grievance Status
- Prior Authorization Submission
- Prior Authorization Status
- Payer Space
- Panel Rosters
- Eligibility and Benefits
- Contact Us Messaging
- Specialty Pharmacy Prior Authorization
- Reports & PDM

If you're new to Availity, there are resources to help guide providers on how to navigate the site. Availity is free for all providers and offers a single sign-on for participating payers.

Bookmark this resource for easy access:

- Availity.com/Essentials – 24/7 access to training resources and recorded webinars to view at your leisure

Member rights & responsibilities

We have adopted the Florida Member's Bill of Rights and Responsibilities. Members can request a copy of it from their doctor or from Member Services.

Member rights

1. Members have the right to have their privacy protected.
2. Members have the right to a response to questions and requests.
3. Members have the right to know who is providing services to them.
4. Members have the right to know the services that are available, including an interpreter if they don't speak English.
5. Members have the right to know the rules and regulations about their conduct.
6. Members have the right to be given information about their health.
7. Members have the right to get service from out-of-network providers for emergency services.
8. Members have the right to get family planning services from any participating Medicaid provider without prior authorization.
9. Members have the right to be given information and counseling on the financial resources for their care.
10. Members have the right to know if the provider or facility accepts the assignment rate.
11. Members have the right to receive an estimate of charges for their care.
12. Members have the right to receive a bill and to have the charges explained.
13. Members have the right to be treated regardless of race, national origin, religion, handicap, or source of payment
14. Members have the right to be treated in an emergency.
15. Members have the right to know if medical treatment is for purposes of experimental research and to give their consent or refusal to participate in such research.
16. Members have the right to file a grievance if they think your rights have been violated.
17. Members have the right to information about our doctors.
18. Members have the right to be treated with respect and with due consideration for their dignity and privacy.
19. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
20. Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.
21. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
22. Members have the right to request and receive a copy of their medical records and request that they be amended or corrected.
23. Members have the right to be provided health care services in accordance with federal and state regulations.
24. Members are free to exercise their rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat them.
25. Members have the right to make a complaint about the health plan or the care it provides.
26. Members have the right to file a grievance about any matter other than an adverse benefit determination.
27. Members have the right to appeal a decision the health plan makes.
28. Members have the right to make a recommendation regarding the health plan's member rights and responsibilities.

Member responsibilities

Aetna Better Health of Florida members, their families or guardians are responsible for:

1. Members should provide accurate and complete information about their health.
2. Members should report unexpected changes in their condition.
3. Members should report that you understand your care and what is expected of them.
4. Members should follow the recommended treatment plan.
5. Members should keep appointments.
6. Members should follow their doctor's instructions.
7. Members should make sure their healthcare bills are paid.
8. Members should follow health care facility rules and regulations.
9. Members should understand their health problems and participate in starting equally agreed-upon treatment goals.

Humatrope added to Florida Healthy Kids preferred drug list

Effective 10/1/2023, Humatrope was added to the Florida Healthy Kids preferred drug list (PDL).

This means that there are two preferred growth hormone agents moving forward: Norditropin and Humatrope.

Norditropin and Humatrope require PA for approval. For members to get a non-preferred growth hormone product after this time, they will need to try and fail BOTH Norditropin and Humatrope. There has been a growth hormone shortage since November 2022. The goal of adding Humatrope is to have another preferred formulary option available to FHK members. Once temporary PAs for non-preferred growth hormone drugs start to expire, FHK members will need to switch to Norditropin or Humatrope. If there is some reason that a member cannot use the preferred drugs, this must be documented and submitted with a PA request.

Note: this change applies only to Florida Healthy Kids. Medicaid will continue to follow the Agency for Healthcare Administration (AHCA) preferred drug list and criteria.

Utilization management (UM) criteria, availability, decisions

Utilization management (UM) criteria and availability/ UM decisions is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department includes:

- Preauthorization
- Concurrent review
- Case management too

Medical necessity is based upon clinical standards and guidelines as well as clinical judgment. All clinical standards and guidelines used in the UM program have been reviewed and approved by practicing, participating physicians in our network. You can receive a copy of our clinical standards and guidelines by calling us at **1-800-441-5501**, 8 AM to 7 PM ET.

The medical director makes all final decisions regarding the denial of coverage for services when the services are reviewed via our UM program. The provider is advised that the decision is a payment decision and not a denial of care. The responsibility for treatment remains with the attending physicians. The medical director is available to discuss denials with attending physicians and other providers during the decision process. Notification includes the criteria used and the clinical reason(s) for the adverse decision. It includes instructions on how to request reconsideration as well as a contact person's name, address and phone number.

The policy on payment for services helps ensure that the UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

The UM staff is available to discuss specific cases or UM questions by phone by calling **1-800-441-5501** (Medicaid), **1-844-645-7371** (Comprehensive Long-term Care) or **1-844-528-5815** (Florida Healthy Kids); (TTY: 711), from 8 AM to 7 PM ET. UM staff is available on holidays and weekends by voice mail and fax.

Referrals

The primary care provider (PCP) is responsible for coordinating the provision of specialist services. The specialist and PCP work together to coordinate medical care for the member.

Why are referrals important?

- Support coordination of care between PCP and specialist
- Promote the right care at the right time
- Ensure enrollees receive preventive, primary care services, not just specialty care

No PCP referral is required for the following direct-access services: chiropractic, dermatology (five visits/year), routine podiatric care, optometry, behavioral health and OB/GYN. PCP referrals are required for all other specialist services.

Referrals can be made electronically via our secure portal at AetnaBetterHealth.com/Florida/providers/provider-portal. If a paper version is preferred, it can be downloaded and printed from our website under Authorizations at AetnaBetterHealth.com/Florida/providers/provider-auth.

Specialists will coordinate the provision of specialist services with the PCP in a prompt and efficient manner and furnish a written report within 10 business days of the specialist services. Specialists will refer the member back to the PCP if they determine the member needs the services of another specialist.

Redetermination – Help ensure your patients don't lose their coverage

As you may know, the public health emergency (PHE) related to COVID-19 ended May 11, 2023. States now have 12 months to recertify the eligibility of all Medicaid enrollees.

Those who no longer meet eligibility requirements – or who don't take the steps to confirm their eligibility – will lose their coverage.

Even before the PHE, thousands of people were disenrolled from Medicaid every month for procedural reasons. In many cases, recipients weren't even aware that they needed to recertify their eligibility.

How you can help

Remind your patients to confirm their current contact information with their state Medicaid agency or caseworker. They can visit the website below for more information and to get started.

Also, make note of the phone number for your state's Medicaid enrollment office. It is **850-300-4323**. Keep it handy at your front desk, billing office or anywhere staff can share with patients.

Thank you for supporting us in this effort.

For more information, visit myflfamilies.com/medicaid.

Join Aetna Better Health of Florida's provider network

We are looking to expand our network for long-term and community-based providers. Join our network and become a participating provider for Aetna Better Health of Florida in your service area.

Providers are the cornerstone of our service delivery approach, and the ability to serve our members well is dependent upon the quality of our network, which consists of physicians and physician assistants, hospitals, pharmacies and providers of long-term and community-based services and supports.

We look forward to working with you to provide our members with quality health care services. Should you have any questions, contact our Contracting Department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC) or via email at **FLMedicaidContracting@aetna.com**.