Quick Links: Aetna Better Health of Illinois Provider Site, Provider Portal, Notices, Resources, Contact Us

COVID-19 Provider Education

Aetna has posted a comprehensive "What you need to know about Coronavirus, Provider Guide" to our COVID-19 website **here**. This site is updated daily with FAQs, updates and education catered to providers for everything COVID-19 related. Information on Aetna's guidelines on the waiver of prior authorization requirements, covered telehealth services and billing guidance, and behavioral health services can all be referenced here. The site also provides daily updates and insight on what education and resources are being shared and distributed to members for provider awareness.

Claims and configuration project updates

Our newly featured way to communicate with you as a provider was rolled out in our Summer 2019 newsletter. To reiterate, this feature includes active updates on processing issues as well as the role you as the provider can have in remediating these issues. This process is accessible on our website under **Claim and Configuration Projects**. We hope the increased communication will strengthen our relationship with you and allow us to better resolve the system issues at-hand.

Proprietary

Ensure you are enrolled as a participant in the Opioid Treatment Program (OTP)

On 12/27/2019, CMS released a HPMS memo titled "Addressing Continuity of Care for Dually Eligible Enrollees Currently Receiving Opioid Treatment Program Services through Medicaid". This memo outlines the implementation of the Medicare Opioid Treatment Program (OTP) benefit effective January 1, 2020. Medicare became the primary payer for dually eligible enrollees who may previously have obtained these services through Medicaid.

This change from Medicaid to Medicare is significant in that most OTP providers are not Medicare certified providers. CMS wants to ensure continuity of care for dual eligible enrollees and ensure payment is made to OTP providers, during this transition. This will allow OTP providers time to become certified with Medicare for OTP Services. To become OTP Medicare Certified please refer to this comprehensive OTP Medicare Enrollment Fact Sheet provided by CMS:

https://www.cms.gov/files/document/otp-medicare-enrollment-fact-sheet.pdf

Appointment availability standards & timeframes

Appointments must be scheduled in accordance with the *minimum appointment availability standards*. This is subject to the acuity and severity of the presenting condition and the enrollee's past and current medical history. Aetna's Provider Services Department routinely monitors compliance and seeks Corrective Action Plans (CAP), such as panel or referral restrictions should providers not comply with the accessibility standard. These standards are set to benefit the patient. Providers are contractually obligated to meet standards determined by Illinois Healthcare and Family Services (HFS) and the National Committee for Quality Assurance (NCQA) to ensure timely access to care, accounting for the urgency of and need for the respective services.

The table below indicates the standard appointment wait times for Primary Care Providers (PCP),

Provider type	Emergency Appointment Time Frame	Urgent appointment timeframe	Preventive & Routine appointment timeframe	Appointment wait time (office setting)
Primary Care	Immediately upon member's request	Within 48-hours of member's request	Within 6-weeks of member's request; Not applicable for: routine physical examinations, regularly scheduled visits to monitor chronic medical conditions if the schedule calls for visits less frequently than once every six calendar days	No more than 60 minutes
Specialty Care				
Primary Care	Same Day	Within 2 calendar days	Within 3 weeks	No more than 60 minutes
Specialty Referral	Immediate	Within 2 calendar days	Within 3 weeks	No more than 60 minutes

Behavioral Health Clinics, and Specialists, such as Obstetrics and Gynecologist (OB/GYNs).

Proprietary

OB/GYN	Immediate	Within 72 hours	Within 2 weeks Prenatal Care: First Trimester: within 14 calendar days of request Second Trimester: within 7 calendar days of request Third Trimester: within 3 business days of request	No more than 60 minutes
Oncologist and other High Impact Specialist	Immediate	Within 2 days	Within 3 weeks	No more than 60 minutes
Physical Therapy	Within 24 hours	Within 72 hours	Within 2 weeks	No more than 60 minutes
Occupational Therapy	Within 24 hours	Within 72 hours	Within 2 weeks	No more than 60 minutes
Sports Medicine	Within 24 hours	Within 72 hours	Within 2 weeks	No more than 60 minutes
Behavioral Health	**Potentially suicidal individual:** immediate treatment **Non-life-threatening urgent*:** within 6 hours	Urgent- No Immediate danger**: Within 48 hours	Initial visit within 10 business days of official request	No more than 60 minutes

*No immediate danger to self or others and/or if not addressed within 6 hours may escalate to: extreme anxiety, parent child issues, passive suicidal ideation, excess drug or alcohol usage
**No immediate danger to self or others and/or if not addressed within 48 hours may escalate to: follow-up to a crisis stabilization, escalating depression, escalating anxiety, escalating drug/alcohol usage, escalating behavioral issues in children.

Behavioral health providers are contractually required to offer:

Provider Type	Follow-up BH Medication Mgt.	Follow-up BH Therapy	Next Follow-up BH Therapy
Behavioral Health	Within 3 months of first appointment	Within 10 business days of first appointment	Within 30 business days of first appointment

Quality Management/Utilization Management (QMUM) Committee

We continually look for consistent external provider representation during the health plan's QMUM Committee meetings. During the committee meetings you will have the opportunity to review the plan's performance with respect to various quality related metrics, provide feedback and collaborate with not only the plan staff and leadership, but also other providers on best practices. This forum allows for robust strategy discussions on improvement of processes between the health plan and contracted provider networks in order to improve members' health outcomes. The committee meets every other month via teleconference. If you interested in becoming a voting members of the Aetna Better Health of Illinois Premier Plan QMUM Committee please contact Anya Alcazar, Director of Quality Management at alcazara@aetna.com for more information.

Collaboration with plan's Quality Management team

The health plan's Quality Management staff has begun working in partnership with providers on improving health outcomes for the served members. This initiative is a cross-functional effort to continue to collaborate with our provider networks. This forum also allows for a deep dive into the most up to date care recommendations as captured through HEDIS reporting, review of provider performance regarding access and availability to care captured through the CAHPS survey and the plan's Access and Availability to Care survey along with provider panel reconciliations. We look forward to working in tandem with you in order to improve the health of our members.

Population health management

Aetna Better Health Premier Plan maintains Population Health Management (PHM) programs and activities selected to meet the needs of the member population and target their individual risks. These programs are designed to support delivery of care. Each PHM program includes measurable goals that are used to determine program effectiveness. Aetna continues to work collaboratively with provider networks to ensure that the recommended screenings and services are completed for the served membership.

Below are some of the programs we offer to members along with evaluations of their impact:

Keeping members healthy

With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy such as:

- **Breast cancer screenings**
- **Colorectal cancer screenings**
- **Annual adult-well visits**

The program continues to demonstrate increased rates of screenings for the target population with an improved rate of compliance for the breast cancer (BCS) and colorectal cancer (COL) screenings. The plan continues to work on improving member's annual provider visit and overall outpatient utilization.

	Healthy Adults		H2018	H2019	YOY Improvement %	Goal Met Y/N
Keeping Members Healthy	Clinical	BCS	50.2%	54.3%	8.2%	Y
		COL	34.8%	42.1%	21.0%	Y
		AAP	85.9%	86.2%	0.3%	N
	Utilization	Outpatient utilization-AMBA	8068.06	8302.90	2.9%	Y

Managing members with emerging risk

Members who have diabetes or high blood pressure are educated in how to manage their condition. Members can learn:

- **How to take care of their diabetes or high blood pressure**
- **How to watch their blood sugar or blood pressure**
- **Why it is important to take medications and how they work**
- **Healthy habits and lifestyle**

Diabetes and hypertension are the most prevalent physical health conditions representative of the population regardless of members' risk. Goal of this program is to ensure proper condition management to reduce the risk of migrating to a higher risk due to poor condition management and/or development of condition related complications or co-morbidities through the completion of recommended screenings, ensuring conditions are well controlled through evidence-based parameters, education on medication adherence, nutritional and physical activity support. Evaluation of this program includes the assessment of the HEDIS comprehensive diabetes care (CDC) and controlling blood pressure (CBP) measures along with medication adherence rates. Based on the results this program has positive impact on the members' health with ongoing improvement in recommended screenings and medication adherence.

	Living with Diabetes		H2018	H2019	YOY Improvement %	Goal Met Y/N
Managing Members with Emerging risk	Clinical	A1 C testing	92.5%	89.5%	-3.2%	N
		A1C <8	50.1%	52.6%	4.8%	Y
		Eye Exam	62.3%	66.9%	7.4%	Y
		SCR for Nephropathy	91.5%	91.2%	-0.3%	N
		BP 140/90	55.7%	62.0%	11.3%	Y
	Utilization	Med Adherence PDE	80.0%	83.0%	3.7%	Y

	Living with HTN		H2018	H2019	YOY Improvement %	Goal Met Y/N
Managing Members with Emerging risk	Clinical	CBP	61.1%	57.4%	-6.0%	N
	Utilization	Med adherence - RAS	78.0%	80.0%	2.6%	Y

Patient safety and outcomes across settings

For members who were recently in a hospital, Aetna will help them meet their discharge needs. Our case managers will work with members, their support systems and their providers to help them arrange for necessary and timely follow-up appointments with the right providers. We will work with members to make sure they understand the medications that they were prescribed when leaving the hospital and help them obtain any other health services they may need to assist them on their road to recovery.

This program demonstrated success for the served population. It is imperative to continue to foster successful transition of care (TOC) by ensuring members follow up timely with their providers which is considered to be within 30 days of discharge (HEDIS TRC member engagement) and to ensure proper medication reconciliation (HEDIS MRP) which demonstrates coordination and continuity of medical care. Successful transition of care also positively impacts the probability of an all-cause readmission within 30 days of the initial discharge (HEDIS PCR).

	TOC		H2018	H2019	YOY Improvement %	Goal Met Y/N
Member Safety	Clinical	TRC member engagement	57.7%	64.0%	11.0%	Y
		MRP	19.7%	28.0%	42.2%	Y
	Utilization	PCR	21.1%	18.7%	-11.2%	Y

Managing multiple chronic conditions

A case manager will work with members, their doctors and other providers to ensure they receive the right care and services that meet their needs. The case manager will help members who:

- **Go to the Emergency Room frequently**
- **Have trouble getting medications and other things providers have ordered**
- **Need information about a disease or treatment**
- **Need help with activities of daily living**

The plan focuses on the evaluation of proper services and care for members with high ED utilization. Goal of the program is to ensure access and availability to outpatient care, identification of barriers to self-care, proper condition management, medication adherence and working with members to address any existent Social Determinants of Health that contribute to high ED utilization. The plan evaluated this program through the assessment of the HEDIS annual outpatient provider visit (AAP) and HEDIS ED utilization rate.

Managing Members with Chronic Conditions	ER Diversion program		H2018	H2019	YOY Improvement %	Goal Met Y/N
	Clinical	AAP	85.9%	86.2%	0.3%	N
	Utilization	ED HEDIS	785.49	745.47	-5.1%	Y

*Aetna Better Health Premier Plan case managers will work with members and providers to ensure that members receive the right care and services that meet members' needs.

Provider Portal

Our enhanced, secure and user-friendly web portal is available at:

https://www.aetnabetterhealth.com/illinois/providers/portal

This HIPAA-compliant portal is available 24 hours a day. It supports the functions and access to information that you need to take care of your patients.
Popular features include:

- **Single sign-on.** One login and password allow you to move smoothly through various systems.
- **Personalized content and services.** After login, you will find a landing page customized to you.
- **Real-time data access.** View updates as soon as they are posted.
- **Better tracking.** Know immediately the status of each claim submission and medical prior authorization (PA) request.
- **eReferrals.** Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- **AutoAuths.** Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- **Detailed summaries.** Find easy access to details about denied PA requests or claims.
- **Enhanced information.** Analyze, track, and improve services and processes.
- **Provider notices/communications.** Review the provider manual and other documents related to members' benefits.

For more information, contact Provider Services at **1-866-600-2139 (TTY: 711).**

Complex case management referral options

Empowerment through case management

Aetna Better Health Premier Plan offers an evidence-based case management program to help our members improve their health and access the services they need. Case managers typically are nurses or social workers. These professionals create comprehensive care plans that help members meet specific health goals.

All members are assigned their own case manager. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a case manager contact the member are:

- **Does the member frequently use the emergency room instead of visiting your office for ongoing issues?**
- **Has the member recently had multiple hospitalizations?**
- **Is the member having difficulty obtaining medical benefits ordered by providers?**
- **Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), yet does not comply with the recommended treatment regimen?**
- **Does the member need help to apply for a state-based long-term care program?**
- **Does the member have HIV?**
- **Is the member pregnant with high-risk conditions?**
- **Is the member pregnant and over 35 years of age?**
- **Has the member received a referral to a specialist, but is unsure of the next steps?**
- **Does the member need information on available community services and resources not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)?**

What happens to your referral?

After you make a referral, the member's case manager contacts the member. The case manager might also contact the member's caregivers or others as needed.

What will a case manager do?

To help the member learn how to manage their illness and meet their health and other needs, a case manager contacts the member to schedule a time to complete an assessment. The case manager asks the member questions about his or her health and the resources currently being used. Answers to these questions help the care manager determine what kind of assistance the member needs most.

Next, the member and the case manager work together to develop a care plan. The case manager also educates the member on how to obtain what they need. The case manager also may work with the member's health care providers to coordinate these needs. The amount of case management and frequency of contact with the member and others will vary based upon the individual needs of the member.

To make referrals for case management consideration, please call Provider Services at **1-866-600-2139 (TTY: 711)**. A case manager will review and respond to your request within 3-5 business days.

Clinical criteria for Utilization Management decisions

How to request clinical criteria?

Aetna Better Health Premier Plan's medical necessity decisions for requested medical and behavioral services are based upon CMS National Coverage and Local Coverage Determinations, and nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

Aetna uses the following medical review criteria for physical and behavioral health medical necessity decisions which are consulted in the following order:

- **National Coverage Determination (NCD) or other Medicare guidance (e.g., Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, Medicare Learning Network (MLN) Matters Articles)**
  https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical- index.aspx
- **Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DMEMAC)**
  https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx
- **Aetna Clinical Policy Bulletins (CPB) available on Aetna.com**
  http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html
- **Medical Coverage Guidelines (MCG): For inpatient stays, Aetna Medicare uses MCGs as a resource for determining medical necessity for inpatient hospital and long-term acute care hospital (LTACH) stays in conjunction with Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A. Medicare guidelines are very general so MCGs provide condition specific guidance**
  https://mcg.aetna.com/
- **Pharmacy clinical guidelines**
- **Aetna Medicaid Pharmacy Guidelines**

*The criteria and guidelines are disseminated to all affected practitioners, and/or providers, upon request.

To request the criteria, call Provider Services at **1-866-600-2139 (TTY: 711)** or visit our **website**

Pharmacy Benefits

Aetna Better Health Premier Plan's List of Covered Drugs ("the Drug List" or the formulary) is a comprehensive list of covered prescription drugs, over-the-counter drugs, and items at participating network pharmacies. The Drug List and network pharmacies are posted on the plan's website at www.aetnabetterhealth.com/illinois. The Drug List is updated monthly throughout the year, and the date of last change is noted on the front cover of the Drug List. Changes to the plan's Drug List is also posted on the plan's website.

Visit aetnabetterhealth.com/Illinois for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at **1-866-600-2139 (TTY: 711)**.

The Drug List has detailed information about prior authorization, quantity limitation, step therapy, or formulary exceptions under "Necessary actions, restrictions, or limits on use." To request prior authorization or formulary exception reviews, call Member Services toll-free at **1-866-600-2139 (TTY: 711)**. A Member Services representative will work with you to submit a request for prior authorization or formulary exception.

Types of rules or limits:

- **Prior approval (or prior authorization)**
- **Quantity limits**
- **Step therapy**
- **If a medication is not on the Drug List (called Formulary Exception)**

Aetna Better Health Premier Plan does not charge member copays for covered prescription and OTC drugs if Aetna Better Health Premier Plan's rules are followed, and drugs are filled at a network pharmacy.

Covered drugs are designated to the following coverage tiers:

- **Tier 1 drugs are Medicare Part D prescription brand name and generic drugs.**
- **Tier 2 drugs are Medicare Part D prescription brand name and generic drugs.**
- **Tier 3 drugs are Non-Medicare Part D prescription and over-the-counter drugs.**

Clinical practice guidelines

On at least bi-annual basis the health plan reviews and adopts most up to date evidence based Clinical Practice Guidelines targeting the needs of the served membership. Approved and adopted guidelines can be located on the health plan's website: https://www.aetnabetterhealth.com/illinois/providers/resources/clinical-practice

Currently, the plan's adopted guidelines include the following care management of:

- **Asthma**
- **Coronary Artery Disease**
- **Congestive Heart Failure**
- **Chronic Obstructive Pulmonary Disease**
- **Diabetes Mellitus**
- **HIV/AIDS**
- **Hypertension**
- **Adult preventive care inclusive of immunizations**
- **Prenatal, Postpartum and Inter-conceptual Care**
- **Behavioral health inclusive of mental health and substance abuse**
- **Tobacco Cessation**
- **Psychotropic Medication Management**
- **Clinical Pharmacy Medication Review**
- **Coordination of Community Support for members in the HCBS waiver programs**
- **Community reintegration and support**
- **Long-term care Residential Condition of Services**

Coordination and continuity between behavioral healthcare and medical care

On an ongoing basis Aetna evaluates the coordination and continuity between behavioral healthcare and medical care in order to ensure seamless and comprehensive care delivery to the served membership. There are various performance metrics that the plan evaluates on a regular basis and includes and continually works towards improvement of information and practice flow. Information that the plan evaluates includes six (6) elements:

- **Data exchange of information between behavioral health (BH) providers and physical health providers (PH).**
- **Data on the appropriateness of treatment and/or referrals to appropriate BH providers**
- **Data on BH and PH provider adherence to prescribing guidelines**
- **Data on issues around the management of multiple conditions where there are both PH and BH conditions along with management across the continuum of care**
- **Data on opportunities regarding issues that could be preventable if appropriate primary or secondary programs were developed and implemented**
- **Data on specific issues around the continuity and coordination of services for members with severe and persistent mental illness**

The most recent evaluation based on implemented interventions identified opportunities for improvement ensure that our members with BH conditions get quality comprehensive care.

- Exchange of information – Only 74% of sampled members during the BH member satisfaction survey reported that their BH and PH providers share information about their health and treatment options.

Measure	2017 results	2018 results		2019 results	Goal	Goal Met Y/N
My BHCP and PCP share information about my health and treatment plan.	90%	67%		74%	85%	N
I see my BHCP and PCP at the same location.	64%	64%		64%	85%	N

- Appropriateness of treatment and/or referrals to appropriate BH providers – the plan evaluated this through the assessment of the HEDIS Follow up with an appropriate provider post ED visit with a principal diagnosis of mental illness within 7 and 30 days (FUM) of the visit measure. Plan results demonstrated that 41% of members that visited an ED with a principal diagnosis of mental illness followed up timely within 7 days with an appropriate provider and only 49% followed up within 30 days.

Measure	2017 results	2018 results		2019 results	Goal	Goal Met Y/N
FUM 7 days	50%	32%		41%	39%	Y
FUM 30 days	58%	52%		49%	57%	N

- BH and PH providers' adherence to prescribing guidelines – the plan evaluated this through the assessment of the HEDIS Antidepressant Medication Management, acute phase and continuation phase (AMM) measure. Results demonstrated that only 68% of members who were prescribed antidepressant and who filled their prescription remained on the treatment plan for at least 84 days (12 weeks) and only 44% remained on their antidepressant treatment plan for 180 days (6 months).

Measure	2017 results	2018 results		2019 results	Goal	Goal Met Y/N
AMM - acute phase	81%	66%		68%	75%	N
AMM - continuation phase	78%	45%		44%	60%	N

- Management of multiple conditions where there are both PH and BH conditions – the plan evaluated this through the assessment of the HEDIS Diabetes monitoring for people with cardiovascular diseases and schizophrenia (SMD) measure. Results demonstrated that only 69% of members with a documented cardiovascular condition and schizophrenia had diabetes screenings completed which include LDL-C and HbA1c tests at least once a year.

Measure	2017 results	2018 results		2019 results	Goal	Goal Met Y/N
SMD rate	74%	83%		69%	75%	N

- Opportunities regarding issues that could be preventable if appropriate primary or secondary programs were developed and implemented. The plan evaluated its BH related readmissions within 30, 60 and 90 days. Hypothesis behind this element is that preventive programs to benefit members with BH admissions would be to have an onsite BH provider provide follow up services immediately post discharge to ensure successful transition of care. The most recent results demonstrate an increase in the 30-day BH readmission and a decrease in the 60 and 90 days BH readmissions.

Mea sure	2017 results	2018 results	2019 results
30 day BH readmission rate	17%	27%	30%
60 day BH readmission rate	21%	34%	28%
90 day BH readmission rate	25%	38%	27%

- Specific issues around the continuity and coordination of services for members with severe and persistent mental illness – the evaluated performance in this by assessing the HEDIS Diabetes screening for people with schizophrenia or bipolar disorders who are using antipsychotic medications (SSD) measure. Results indicated that only 77% of members with either schizophrenia or bipolar disorder who are taking antipsychotics medications where screened for diabetes which includes a glucose test of HbA1c test at least once a year.

Measure	2017 results	2018 results	2019 results	Goal	Goal Met Y/N
SSD rate	78%	84%	77%	84%	N

As the results above demonstrate, there are additional opportunities for improvement to ensure coordination and continuity of care between BH and PH providers. The health plan reviews and adopts the most up to date Clinical Practice Guidelines which include the management of BH conditions, pharmacology management, etc. at least every two (2) years and places the information on the plan's website. Communication regarding treatment plans amongst providers is at the forefront on ongoing quality improvement across the industry with evidence based positive impact on the members' health.
If you have additional questions regarding the above please contact Aetna Better Health of Illinois Quality Management department at QMQuestions@aetna.com.

Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Better Health Premier Plan members, you should be aware of the members' rights and responsibilities. Some of the rights members are afforded are as follows:

- **A right to receive information about Aetna, our services, our practitioners and providers, and member rights and responsibilities**
- **A right to be treated with respect and recognition of the member's dignity and right to privacy**
- **A right to participate with practitioners in making decisions about their healthcare**
- **A right to a candid discussion of appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage**
- **A right to voice complaints or appeals about Aetna or the care we provide**
- **A right to make recommendations regarding Aetna's member rights and responsibilities policy**

In addition, our members have the following responsibilities:

- **A responsibility to supply information (to the extent possible) that Aetna and our practitioners and providers need in order to provide care**
- **A responsibility to follow plans and instructions for care that they have agreed to with their practitioners**
- **A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible**

For a complete list of member rights and responsibilities visit our website at **www.AetnaBetterHealth.com/Illinois** to see our Member Handbook.

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IL-20-04-03