Aetna Better Health® of Maryland

# Connection

Winter 2019

## 'Meet the Docs' enhances provider relationships

**By Stacy Babani, Communications Consultant**

A strong provider network drives membership! With this in mind, Aetna Better Health of Maryland has set out to engage providers (both in- and out-of-network) by holding forums, symposiums and networking events. These events allow team members to enhance relationships, raise brand and benefit awareness, and potentially grow the provider network.

For example, the health plan has established a collaborative partnership with One World Health Care to implement monthly provider events titled "Meet the Docs." These monthly social programs are held at various locations throughout Howard County and offer opportunities for over 300 medical providers and

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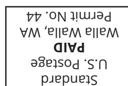


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## ‘Meet the Docs’ enhances provider relationships

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staff to network with the health plan and with each other.

After attending one of the recent events, a provider gave some feedback: “My patients and I love working with Aetna Better Health of Maryland. I am so appreciative that the health plan invited me to attend this function. Being able to attend a social function after-hours allowed me to delve deeper into my partnership with the health plan without all the distractions of a busy office. Plus, I was able to learn more about provider initiatives and member benefits.”

To learn more about these provider networking events or how to adopt a similar program at your health plan, reach out to Paris Gibson at **GibsonP2@aetna.com**.

## Dealing with holiday depression

The holiday season can be a time full of joy, cheer, parties and family gatherings. But for many people, it is a time of self-evaluation, grieving the loss of loved ones, loneliness, reflection on past failures and anxiety about an uncertain future — hence leading to holiday depression.

**Symptoms of holiday depression:**

- Headaches
- Excessive drinking
- Overeating
- Difficulty sleeping
- And others

As you care for patients during this season, please screen them for symptoms of depression or acute anxiety.

Remind them of ways to stave off the holiday blues that may descend at this time:

- **Begin a new tradition.** Try planning a family outing or vacation, instead of spending the holidays at home.
- **Don’t give in to holiday pressures.** Feel free to leave an event if you aren’t comfortable. Be willing to tell others, “I'm not up for this right now.”
- **Volunteer.** Helping others can be very helpful for you too. For example, you might try:
  - Helping at a shelter or soup kitchen
  - Organizing a gift drive
  - Helping an elderly neighbor with a yard or house task
- **Get back to nature.** Going for a walk in the park or the woods helps many people relax and feel better when they are feeling overwhelmed.
- **Exercise.**

Encourage patients to practice self-care during the holidays by eating a healthy diet, maintaining a regular sleep pattern and sticking to an exercise program. As little as 30 minutes of cardiovascular exercise can provide an immediate mood boost similar to the effects of an antidepressant medication.

Be prepared to refer members, if needed, to a mental health specialist. If their feelings of sadness during the holidays are accompanied by suicidal thoughts, encourage them to do one of the following immediately:

- Call **911**.
- Go immediately to a hospital emergency room.
- Call the National Suicide Prevention Lifeline at **1-800-273-TALK** (**1-800-273-8255**).

With self-care, the holidays can be a joyful time for all of our members.

## Diabetes Prevention Program

Effective Sept. 1, 2019, HealthChoice managed care organizations (MCOs) will provide the national Diabetes Prevention Program (DPP) lifestyle change program to HealthChoice enrollees. The Centers for Disease Control and Prevention (CDC) lifestyle change program aims to prevent or delay the onset of type 2 diabetes.

This evidence-based program will teach your patients how to eat healthy, add physical activity into their daily lives, deal with stress and learn ways to cope with challenges. The DPP runs for a year, with weekly meetings for the first six months and monthly meetings for the latter six months, all led by a trained lifestyle coach.

To be eligible for referral to a CDC-recognized lifestyle change program, patients must:

- Be at least 18 years old
- Be overweight (body mass index of 25 or more; 23 or more if Asian)
- Not be pregnant
- Have no previous diagnosis of type 1 or type 2 diabetes

- Have a blood test result in the prediabetes range within the past year, such as:
  - Hemoglobin A1C: 5.7–6.4%
  - Fasting plasma glucose: 100–125 mg/dL
  - Two-hour plasma glucose (after a 75-gram glucose load): 140–199 mg/dL
- Have a previous clinical diagnosis of gestational diabetes

The DPP not only benefits your patients, it can also benefit your practice by helping reinforce the important advice that you give them. You can trust that your patients are receiving evidence-based information, and their increased knowledge may even save you time during office visits. Refer your patients today!

For more information, please contact:
LyAvia Patterson, MPH, Prevention and Wellness Coordinator
**443-457-5344**
**pattersonL3@aetna.com**

## Member rights and responsibilities

Aetna Better Health members, their families and guardians have the right to information related to their treatment or treatment options in a manner and language appropriate to the member's condition and ability to understand. To access the specific member rights and responsibilities, call our Provider Relations staff toll-free at **1-866-827-2710 (TTY: 711)**. Check the **aetnabetterhealth.com/maryland** website for the full list of these rights and responsibilities.

## ePREP is a success!

Maryland Medicaid's electronic Provider Revalidation and Enrollment Portal (ePREP) is a huge success! ePREP is the one-stop shop for provider enrollment, re-enrollment, revalidation, information updates and demographic changes.

Aetna Better Health of Maryland's provider enrollment via ePREP has exceeded 85% since ePREP's go-live. This is a great way to ensure timely updates.

## Discover our community development events

We enjoy meeting our members in the communities where they live, work and play. Here are some of the events scheduled for the coming months:

| Event name | Date/time | Location | Address |
|---|---|---|---|
| **Family Market Distribution** | Dec. 18, 2019, 4 to 6 p.m. | Port Town/Rogers Heights ES | 4301 58th Ave., #1900 Bladensburg, MD 20710 |
| **Farmers Market** | Dec. 21, 2019, 8 a.m. to noon | Capital Food Bank–SHABACH | 3600 Brightseat Road Landover, MD 20785 |

**Let's connect.** To learn more about our community development team and how our partnership can help you, reach out to us today at **outreachmd@aetna.com** or **1-866-827-2710 (TTY: 711)**.

## Affirmative statement about Utilization Management (UM) coverage decisions

Aetna Better Health of Maryland makes Utilization Management (UM) decisions based only on appropriateness of care and service and existence of coverage. We do not reward practitioners, employees or other individuals for issuing denials of coverage. Any financial incentives Aetna Better Health of Maryland may provide to UM decision makers do not encourage them to make decisions that result in underutilization of services. We also do not use employee incentives or disincentives to encourage barriers to care and service.

When making coverage decisions, Aetna Better Health of Maryland follows the health care rules of the State of Maryland's HealthChoice program. These rules determine the type of treatments that will be covered for members. Providers can obtain the criteria to make coverage decisions upon request by calling Provider Experience at **1-866-827-2710 (TTY: 711)** and pressing *****.

The HealthChoice program's definition of "medically necessary" means that the service or benefit is:

- Directly related to diagnostics, preventive, curative, palliative, habilitative or ameliorative treatment of an illness, injury, disability or health condition
- Consistent with current accepted standards of good medical practice
- The most cost-effective service that can be provided without sacrificing effectiveness or access to care
- Not primarily for the convenience of the member, the member's family or the provider

Aetna Better Health of Maryland's staff and its providers must make health care decisions based on the appropriate care and service rules, including member eligibility.

## 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.

All Aetna Better Health providers are contractually obligated to provide medical records necessary to fulfill reporting requirements. We want to be able to reflect the high quality of care you have given to our members that may not have gone into our claim system.

### Annual HEDIS timeline

Medical records are randomly selected across hybrid HEDIS measures 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 that all records be sent within five days of receiving the initial request.

For large volume providers, Aetna will provide personnel to come on-site 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 be sent the specific list of medical records we need, including the member's name, date of service and the measures selected, with instructions on how to submit.

### Coming your way

We look forward to continuing our partnership and working 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 2020 is expected to be available in April, when enough claims have come in the new year to make these reports valuable.

We thank you in advance for your quick response to any medical record requests you receive and your commitment to our members.

# What is EPSDT?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services.

Aetna recommends that all children under the age of 21 be cared for by a primary care provider (PCP) who is EPSDT-certified. While not mandatory, it is preferred to ensure that our members receive the quality of care they deserve.

**Early:** Assessing and identifying problems early

**Periodic:** Checking children's health at periodic, age-appropriate intervals

**Screening:** Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems

**Diagnostic:** Performing diagnostic tests to follow up when a risk is identified

**Treatment:** Control, correct or reduce health problems found

## EPSDT services

States are required to provide comprehensive services and furnish all Medicaid-coverable, appropriate and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic and treatment services.

**Screening services:**

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health education (anticipatory guidance, including child development, healthy lifestyles, and accident and disease prevention)

**Vision services:** At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary. For additional information, visit the Vision and Hearing Screening Services for Children & Adolescents page at **medicaid.gov/medicaid/benefits/epsdt/v-and-h/index.html**.

**Dental services:** At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

**Hearing services:** At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. For additional information, visit the Vision and Hearing Screening Services for Children & Adolescents page at **medicaid.gov/medicaid/benefits/epsdt/v-and-h/index.html**.

## Other necessary health care services

States are required to provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered, regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

## Diagnostic services

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay, and there should be follow-up to ensure that the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to ensure that comprehensive care is provided.

## Treatment

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

## Integrated Care Management program

Our Care Management department provides support to members based on each individual's risks and unmet needs. These care needs are assessed by licensed nurses, social workers and counselors, as well as nonclinical professionals. We use a bio-psychosocial (BPS) model to help us identify what care our members need. The Care Management staff performs a health risk assessment to determine the member's medical, behavioral health and bio-psychosocial needs.

Care managers work with the member, member's family, PCP, psychiatrist, substance abuse counselor and any other health care team member to achieve a quality-focused, cost-effective care plan. Care managers educate members on their specific disease and how to prevent worsening of their illness or any complications. The goal is to maintain or improve their health status.

**The Care Management program provides services to the following populations, but is not limited to:**

- Pregnant and postpartum outreach
- High-risk pregnancy outreach

- Children with special health care needs
- Children in state-supervised care
- Individuals with a physical or developmental disability
- Behavioral health/substance abuse
- Disease management of conditions such as asthma, diabetes, heart failure, COPD, sickle cell anemia, hepatitis C and HIV/AIDS

If you have concerns about one of your patients and would like to refer them to the Care Management program, call **1-866-827-2710 (TTY: 711)** and ask for the Care Management department or email the Care Management department at **aetnabetterhealthmdcm@aetna.com**.

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## Nondiscrimination notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If a member needs a qualified interpreter, written information in other formats, translation or other services, call the number on the member's ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address:
Attn: Civil Rights Coordinator
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Telephone: **1-888-234-7358 (TTY: 711)**

Email: **MedicaidCRCoordinator@aetna.com**

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave., SW Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **1-800-537-7697 (TDD)**.

## Appeals and grievances

A **dispute** is defined as an expression of dissatisfaction with any administrative function, including policies and decisions based on contractual provisions inclusive of claim disputes. The dispute will be reviewed and processed according to the definitions provided, but not limited to resubmissions (corrected claims and reconsiderations), appeals, complaints and grievances. Provider claim disputes do not include pre-service disputes that were denied due to not meeting medical necessity. Pre-service denials are processed as member appeals and are subject to member policies and time frames.

A **resubmission** is a request for review of a claim denial or payment amount on a claim originally denied because of incorrect coding or missing information that prevents Aetna Better Health from processing the claim. Resubmissions should be submitted with both a corrected claim and the additional information needed to process the claim (e.g., NDC denial issues, claims that require medical records review). **Resubmissions must be submitted within 60 days of the last claim rejection to the Claims mailing address (P.O. Box 61538, Phoenix, AZ 61538).**

An **appeal** is a dissatisfaction with the resolution of a reconsidered disputed claim or a request to review a denial of payment that does not meet the resubmission requirements. **Appeals should be submitted within 90 business days of the claim denial.**

You may also be asked to complete and submit the dispute form with any appropriate supporting documentation. This form can be found on the Aetna Better Health of Maryland website in the "Provider" section. If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department.

## Member education opportunities

For assistance with member education opportunities, please contact Aetna Better Health Member Services at **1-866-827-2710 (TTY: 711)** and ask for the Special Needs Coordinator.

Also visit our website for additional information at **aetnabetterhealth.com/maryland/wellness/care**.

Encourage your patients to stop by our Health Education tables at the following locations:

- Dec. 9, 11 a.m., BMS Belair Edison
- Dec. 10, 10 a.m., BMS St. Agnes
- Dec. 18, 10 a.m., Park Heights Community Health Alliance

## Reminder

**All provider appeals should be sent to:**
Aetna Better Health of Maryland
Attn: Grievances & Appeals
509 Progress Drive, Suite 117
Linthicum, MD 21090

**Claims should be sent to:**
Aetna Better Health of Maryland
P.O. Box 61538
Phoenix, AZ 85082-1538
This includes corrected/resubmission claims. If claims are not sent to the correct location, it can cause a delay in the process and result in a denial due to the submission's being untimely.

# Fraud, Waste and Abuse

## Know the signs — and how to report an incident

Health care fraud means receiving benefits or services that are not approved. Fraud can be committed by a provider, member or employee. Abuse is doing something that results in needless costs. Waste goes beyond fraud and abuse. Activities that are considered fraud, waste and abuse by members, doctors or any health care professional hurt everyone. Most waste does not involve a violation of law.

Everyone has a right and duty to report suspected fraud, waste and abuse. An example of provider fraud is billing for services, procedures and/or supplies that were not provided. Abuse is treatment or services that do not agree with the diagnosis. Hostile or abusive behavior in a doctor's office or hospital is also abuse. Suspected use of altered or stolen prescription pads is an example of member fraud. An example of abuse would be a member asking the transportation driver to take him or her to an unapproved location.

It is your responsibility to report members or providers you suspect are committing fraud or abuse. Your assistance in notifying us with any potential fraud or abuse occurrence is vital and is critical to maintaining high quality health outcomes for you.

If you suspect a colleague, member or other individual of fraud, waste or abuse, report it. Combating fraud, waste and abuse is everyone's responsibility; failure to comply with these laws could result in civil and criminal penalties, including sanctions imposed by government entities and exclusion from future participation in Medicaid and any services provided by the state and federal government.

- You can anonymously call the Aetna Better Health of Maryland Special Investigations Fraud, Waste and Abuse Hotline at **1-855-877-9735 (TTY: 711)** to report these types of acts right away.
- You can also report fraud, waste or abuse by going online at **aetnabetterhealth.com/maryland/fraud-abuse**.
- You can also report suspected fraud, waste or abuse to the Maryland Medicaid Fraud Control Unit (MFCU) at the Office of the Maryland Attorney General by calling **1-888-743-0023**.
- Or write confidentially to:
  Aetna Better Health of Maryland
  509 Progress Drive, Suite 117
  Linthicum, MD 20910

**Remember**, you do not have to leave your name when you report fraud, waste or abuse.

## Need the latest information?

We update our website on a regular basis. Please visit our website for the most up-to-date information on:

- Clinical Practice Guidelines updates
- Preventive care guidelines
- Pharmacy restrictions and formulary updates
- Fraud, waste and abuse contact information
- HEDIS collection dates, etc.

If you do not have access to the internet, call **1-866-827-2710** and a paper copy can be mailed to you.

**Contact us**

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**1-866-827-2710**
Hearing-impaired MD Relay: **711**

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MD-19-10-04