Provider newsletter

Spring 2023

Member advocates

Our member advocate team can normally be found working with members to ensure that they have the best healthcare experience possible. In addition to providing an overview of our plan, member advocates educate our members on benefits available for STAR/CHIP/STAR Kids coverage, Texas Health Steps, renewal and Accelerated Services for Farmworker Children. Here are a few additional services our outreach team offers:

- **Questions about coverage** – Our member advocate team can assist members in obtaining answers to questions about their coverage.
- **Re-enrollment assistance** – Call **2-1-1 Texas** or visit **https://yourtexasbenefits.com/Learn/Home**
- **Member Advisory Group meetings** – Our member advocate team schedules quarterly STAR Member Advisory Group meetings and welcomes all STAR members to attend.
- **Member Baby Shower program** – Our Maternity Care Program provides lots of great information to help with pregnancy. Visit: **www.aetnabetterhealth.com/texas/wellness/women/pregnancy**.
- **Diapers for Dads program** – Our Maternity Care Program also offers information to help soon-to-be fathers. Visit our website at: **www.aetnabetterhealth.com/texas/wellness/women/pregnancy**.

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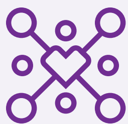
- **CVS HealthHUB™ events** – Our member advocate team schedules weekly health events at local CVS HealthHUBs to provide member education on STAR/CHIP/STAR Kids coverage, Texas Health Steps, renewal, services for farmworker children and the latest on COVID-19 and vaccination incentives.

To get connected with a member advocate, members can call the number on the back of their member ID card. They can also leave a message at **1-800-327-0016** in our member advocate mailbox and we will return the call within one to two business days.

Members who are deaf or hard of hearing can call **1-800-735-2989**.

For information on our value-added services please visit:

- **What Does Medicaid Cover? | Aetna Medicaid Texas**
- **What Does STAR Kids Cover? | Aetna Medicaid Texas**
- **What Does CHIP Cover? | Aetna Medicaid Texas**



Community outreach

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

- **Member education** – One-on-one education session with a member that must be conducted in a private room at the provider's office. Community outreach will normally coordinate a date/time with a provider when multiple members are scheduled.
- **Re-enrollment assistance** – Members can call **2-1-1 Texas** or visit **yourtexasbenefits.com/learn/home** to renew their Medicaid benefits.
- **Provider education** – Education sessions for provider offices to assist in the identification of children of migrant farmworkers in order to help them receive the health care services their child/children may need.
- **Farmworker children** – Farmworker children have parents or guardians who meet the state definition of a migratory agricultural worker, generally defined as an individual:
  1. Whose principal employment is in agriculture on a seasonal basis.
  2. Who has been so employed within the last 24 months.
  3. Who performs any activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence.
  4. Who establishes for the purpose of such employment a temporary abode.

  Source: Texas Health and Human Services Commission, Uniform Managed Care Contract Terms & Conditions, Version 1.17, p. 11
- **Farmworker children referral process** – Providers who identify farmworker children members can contact Member Services at **1-888-672-2277** so we can provide additional outreach and assistance if needed.

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

Appeals and Grievances

Filing a complaint

Both in-network and out-of-network providers may file verbal complaints with us, so that we can resolve them outside of the formal complaint and appeal process. Provider complaints could be based on things such as:

- Policies and procedures
- One of our decisions
- A disagreement about whether a service, supply or procedure is a covered benefit, is medically necessary or is done in the appropriate setting
- Any concern other than an adverse benefit determination

Some provider complaints are subject to the member complaint process. In these cases, we transfer them. These include complaints from a provider on behalf of a member with written consent (except for an expedited request).

Filing an appeal

When you file a claim appeal, be sure it meets these requirements:

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

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

- Submit a copy of the remit/explanation of benefits (EOB) page that shows the claim was paid or denied.
- Submit a copy of the remit/EOB for each claim you're appealing.
- Circle all claims you're appealing on the remit/EOB page.
- Tell us the reason for the appeal.
- Tell us about any incorrect information and provide the correct information we should use to reconsider the claim.
- Attach a copy of any supporting information that we have asked for. For timely filing, include the acceptance report we sent to your claims clearinghouse. Put any supporting information on a separate page – don't put it on the other side of the remit/EOB.
- Save a copy of all your documentation.

Where to find important pharmacy information

You can access important pharmacy information on **AetnaBetterHealth.com/Texas**. Once you access the website, select "Provider Site", click on "Programs and services" and then click on "Pharmacy" to find:

- Preferred Drug List
- Medications that require prior authorization and applicable coverage criteria
- A list and explanation of medications that have limits or quotas
- Copayment and coinsurance requirements along with the medications or classes to which they apply (CHIP members only)
- Procedures for obtaining clinical prior authorization or PDL prior authorization, generic substitution, preferred brand interchange
- Pharmaceutical management procedures
- Criteria used to evaluate new medications for inclusion on the formulary
- The process for requesting a medication coverage exception

Medicaid Applied Behavior Analysis (ABA) Services for Children and Youth With Autism

To find an LBA, you can use TMHP's Online Provider Look-up tool at opl.tmhp.com.

This guide can help you use the Online Provider Look-up tool, and it includes your health plan's directory:
Medicaid LBA_OPL_MCO directories

Other Medicaid Autism Services

Medicaid covers many services for children with autism, including:

- Case management/care coordination (with parent permission).
- Early Childhood Intervention.
- Medical nutrition counseling provided by a licensed dietitian.
- Occupational, physical and speech therapy.
- Outpatient behavioral health services.
- Physician services, including medication management.

TEXAS
Health and Human Services

What is ABA?

ABA is one of many services available for Medicaid members, age 20 or younger, who have a diagnosis of autism spectrum disorder (ASD).

ABA is a treatment approach provided by specialists called licensed behavior analysts (LBAs).

If your child is eligible, ABA can help:

- Encourage positive and adaptive behaviors.
- Apply skills across everyday settings so they can improve their health, safety or independence.

How can you get ABA services for your child?

Your child will need an evaluation to determine if they qualify for Medicaid ABA services. To learn more, call:

- Your child's primary care provider. (They will have to check the criteria needed for the diagnosis of ASD in Texas Medicaid.)
- Your health plan using the phone number on the back of your health plan ID card.
- The Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 800-925-9126.

How ABA Services Work

ABA services can be delivered in the home, community or in a clinic by an LBA.

When you meet with an LBA:

- They'll work with your child and your family to create a treatment plan. Your child and family will learn strategies to use at home and in the community — wherever your family goes.
- They can coordinate with your child's therapists and other providers up to twice a year to ensure a team approach to your child's treatment.

Your involvement is needed. ABA works best when parents and caregivers use the training and strategies in their daily lives.

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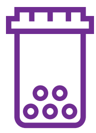

Changes to the Texas Medicaid Preferred Drug List

Texas Medicaid publishes the semi-annual update of the Medicaid Preferred Drug List in January and July. The updates are based on the changes presented and recommended at the quarterly Texas Drug Utilization Review Board meetings. The tables below summarize noteworthy changes for the January 2023 update.

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

January 2023 Preferred Drug List updates

Reviewed Drug Class	Drug Name	Current Status	Recommended Status
Antimigraine agents, other	Ubrelvy (oral)	Non-preferred	Preferred
Bladder relaxant preparations	Myrbetriq (oral)	Non-preferred	Preferred
Bladder relaxant preparations	Myrbetriq granules (oral)	Non-preferred	Preferred
Glucagon agents	Gvoke pen (subcutaneous)	Non-preferred	Preferred
Glucagon agents	Gvoke syringe (subcutaneous)	Preferred	Non-preferred
Intranasal rhinitis agents	Ryaltris (nasal)	Not reviewed	Non-preferred
Movement disorders	Tetrabenazine (oral)	Preferred	Non-preferred
Movement disorders	Xenazine (oral)	Non-preferred	Preferred
Pulmonary arterial hypertension agents, oral and inhaled	Tadliq suspension (oral)	Not reviewed	Non-preferred
Stimulants and related agents	Dyanavel XR tablet (oral)	Not reviewed	Non-preferred
Stimulants and related agents	Quillichew ER (oral)	Preferred	Non-preferred
Stimulants and related agents	Xelstrym (transdermal)	Not reviewed	Non-preferred
Anticonvulsants	Zonisade (oral)	Not reviewed	Preferred
Anticonvulsants	Ztalmy (oral)	Not reviewed	Preferred
Antidepressants, other	Auvelity (oral)	Not reviewed	Non-preferred
Benign prostatic hyperplasia treatments	Entadfi (oral)	Not reviewed	Non-preferred
Colony stimulating factor	Fylnetra (subcutaneous)	Not reviewed	Non-preferred
Cytokine and cam antagonists	Skyrizi on-body (subcutaneous)	Not reviewed	Non-preferred

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Changes to the Texas Medicaid preferred drug list *(continued from previous page)*

Reviewed Drug Class	Drug Name	Current Status	Recommended Status
Cytokine and cam antagonists	Sotyktu (oral)	Not reviewed	Non-preferred
Multiple sclerosis agents	Tascenso ODT (oral)	Not reviewed	Preferred
Urea cycle disorders, oral	Pheburane (oral)	Not reviewed	Non-preferred

Care Management/ Service Coordination

Sometimes, managing a chronic condition or multiple conditions can become overwhelming. To offer support, a doctor, hospital discharge planner or other provider may refer an Aetna Better Health of Texas member to Care Management/Service Coordination. Additionally, a nurse on our health information line may refer members. However, members don't need to wait for a referral if they need help. Members can self-refer by calling and asking for Care Management/Service Coordination:

Medicaid (STAR) **1-800-248-7767** (Bexar)

Medicaid (STAR) **1-800-306-8612** (Tarrant)

STAR Kids **1-844-787-5437**

CHIP **1-800-248-7767** (Bexar)

CHIP **1-800-306-8612** (Tarrant)

TTY **1-800-735-2939**

After a member joins care management/service coordination, they receive a welcome letter to explain how our services can help. They also get a call from a case manager/service coordinator.

Our case managers/service coordinators can:

- Help members understand their covered benefits.
- Show them how to get specialty, behavioral health or hospital services.
- Talk with their doctors and other agencies to ensure they get needed services.
- Teach them more about their disease or condition.
- Help them locate community resources to meet their needs.

Member rights and responsibilities

Aetna Better Health of Texas maintains policies and procedures that formally address a member's rights and responsibilities. The policies reflect federal and state laws as well as regulatory agency requirements.

We annually inform our members of their rights and responsibilities in the member handbook, member newsletter and community mailings, when applicable. They are also posted to our website at **AetnaBetterHealth.com/Texas**.

Aetna Better Health of Texas ensures that a member can exercise their rights without adversely affecting treatment by participating providers. Members' rights and responsibilities are monitored through our quality management process for tracking grievances and appeals as well as through member surveys. Issues are reviewed by our service improvement committee and reported to the quality management oversight committee.

For additional information regarding member rights and responsibilities, visit our website or contact your assigned provider relations representative.

Availability of utilization management criteria

Aetna Better Health of Texas employees make clinical decisions regarding members' health based on the most appropriate care and service available. We make medical necessity determinations based on established criteria. The criteria used to make determinations are available to practitioners at any time by contacting the utilization management department to obtain a mailed copy. The national criteria are available on our website at **www.AetnaBetterHealth.com/Texas/providers/clinical-guidelines-policy-bulletins.html**.

Aetna clinical policy bulletins are available on the main Aetna website at **www.aetna.com/health-care-professionals/clinical-policy-bulletins.html**.

Join our Provider Advisory Group and Clinical and Administrative Advisory Committee

Your opinion matters. Every year, we host meetings to talk about what's working and what needs improvement. We'd love to have you attend. Join us and tell us what you think. Contact your provider relations representative and/or provider web portal. You can provide valuable feedback to help improve quality management activities, policy and operational changes. We work to ensure participation and representation from across the state.

Our group meets regularly and includes providers who serve members with:

- A Medicaid plan
- Very low incomes
- Special needs

Membership is representative of the network's:

- Specialty mix
- Geographic locations
- Provider ages/generations and genders
- Experience levels
- Advanced provider mix

Board objective

The objective of both the Provider Advisory Group and the Clinical and Administrative Advisory Committee is to improve our plan's performance by promoting:

- Active provider involvement
- Effective communication
- Provider leadership development of health plan initiatives

Each provider receives a $200 stipend for their participation when they attend each meeting. There are four meetings a year. If you are interested in joining the committee, contact your provider relations representative.

Checklist for Texas Health Steps Medical Checkup

It is important that children and adolescents enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to encourage healthy development. Texas Health Steps services must be rendered on or after the due date in accordance with federal and state EPSDT guidelines. Please review Texas Health Steps components and proper documentations with your team.

A comprehensive medical checkup must include the following age-appropriate services as set out in the Texas Health Steps periodicity schedule:

- Comprehensive health and developmental history, including nutritional and mental health screening.
- Comprehensive unclothed physical examination, including measurements and sensory screening (vision and hearing).
- Laboratory tests, including age- and risk-based tests for lead screening, anemia, dyslipidemia and type 2 diabetes
- Immunizations indicated in the recommended childhood and adolescent immunization schedule.
- Health education/anticipatory guidance
- Dental referral every six months until a dental home is established

For additional resources including the complete Texas Health Step medical periodicity schedule and quick reference guide, please visit our website at **www.AetnaBetterHealth.com/Texas/providers/texas-health-steps.html**.

Decreasing potentially preventable admissions (PPAs)

What is a PPA?

Texas Health and Human Services (HHSC) defines PPA as "facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination[1]." Adequate monitoring and follow-up, medication management, care coordination and attention to quality can all have a positive impact and reduce the number of PPAs a patient has.

In 2021, the cost of preventable admissions across Texas for Medicaid programs came to $313,362,717. This enormous cost illustrates the severity of the problem of preventable admissions, but it also represents an opportunity to improve.

What can providers do?

Providers can help reduce PPAs first by identifying any patients who are at higher risk. This is often patients with complex conditions and chronic diseases, especially neuromuscular or cardiovascular conditions. Other patterns that can reflect higher risk include patients living with siblings (without a parent in the household), younger patients and patients using public insurance, self-pay or more than one kind of insurance[2]. HHSC also recommends providers identify and avoid unnecessary services as this can have a great impact on quality and efficiency, thus reducing cost[1].

Aetna Better Health of Texas recommends that providers identify patients at high risk and ensure they are receiving regular checkups and any needed specialty appointments. PCPs can make a huge impact by coordinating care with specialty providers for their patients with complex conditions. Medication management and reconciliation should be given special consideration when coordinating care with multiple providers. Additionally, it is recommended that providers streamline and organize preventative care. This will have a great impact on overall cost and can reduce the number of appointments a patient might need to attend for treatment of their condition.

References:

[1]Texas Healthcare Learning Collaborative. (n.d.). Retrieved Feb. 7, 2023, from **thlcportal.com**

[2]Hudson, S. M., Mueller, M., Hester, W. H., Magwood, G. S., Newman, S. D., & Laken, M. A. (2014, April). At-risk characteristics for hospital admissions and ED visits. *Journal for specialists in pediatric nursing: JSPN*. Retrieved Feb. 14, 2023, from **www.ncbi.nlm.nih.gov/pmc/articles/PMC4020806**

Any changes to your demographic information?

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

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

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

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

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

Provider Relations Representatives

Our provider relations representatives are based in the communities they serve, fostering personal relationships and a high level of responsiveness. They engage with providers in a variety of ways to provide proactive, prompt and collaborative communication. If you do not know your assigned representative please email **ABHTXCredentialing@aetna.com** and a provider relations representative will connect with you.

Appointment availability requirements

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

Acceptable	Unacceptable
Office phone is answered after hours by an answering service, in English, Spanish or other languages of the major population groups served, that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.	Office phone is only answered during office hours.
Office phone is answered after normal business hours by a recording in English, Spanish or other languages of the major population groups served, directing the patient to call another number to reach the PCP or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.	Office phone is answered after hours by a recording, which tells the patients to leave a message.
Office phone is transferred after office hours to another location, where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.	Office phone is 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.