AETNA BETTER HEALTH® OF ILLINOIS
Provider Newsletter Volume 6

www.aetnabetterhealth.com/illinois
With questions or concerns, please contact Provider Services at 866-212-2851 "Option 2"

November 2016

Important news about Members' privacy

Aetna Better Health of Illinois has drafted reminders to members in our Member Newsletter about their privacy. Aetna Better Health staff will never ask members for their DEBIT or CREDIT CARD information. We reminded them that if someone calls claiming to be from Aetna Better Health of Illinois and asks for their debit or credit card number, hang up and call Member Services at 866-212-2851 immediately.

Managed Long Term Supports and Services (MLTSS) - our newest membership!

In our last Provider Newsletter, we included information about the MLTSS program. Below are highlights from what was discussed:

The MLTSS program is for adults and older adults with disabilities, ages 21 and over, who are eligible for Medicaid and Medicare. As of June, 2016, individuals who had previously opted out of the Medicare Medicaid Alignment Initiative (MMAI) received notification that they must select a health plan to coordinate their Long Term Service and Supports (LTSS). This means that those who elected not to select a health plan for MMAI must now select one to manage their LTSS benefits. Members will receive their Medicaid waiver services through Aetna Better Health, along with a few extra benefits. MLTSS is a mandatory program; individuals must select a health plan to manage their LTSS benefits (Behavioral Health, Waiver Services, Nursing Facility care, Transportation).

However..

Because Members can opt out of MLTSS at ANY time and select to be enrolled in the Medicare Medicaid Alignment Initiative, we've included a quick comparison guide of the two programs (MMAI and MLTSS). We've also included the link to the HFS provider notice for MLTSS MEDI eligibility verification.
https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160831a.aspx

Covered Benefit	Medicare Medicaid Alignment Initiative (MMAI)	Medicaid Managed Long Term Services and Supports (MLTSS)
Medicare Part A and Part B medical services. Some examples include: • Hospital stays, • Doctor office visits, • Specialty care, • Clinic visits, • X-ray and other radiology services, • Chiropractic care, and • Ambulance services.	Yes	Not covered by MLTSS *MLTSS enrollees get Medicare Part A and B services through Original Medicare or Medicare Advantage*
Medicare Part D prescription drugs	Yes	Not covered by MLTSS *MLTSS enrollees get Medicare prescription drugs through Medicare Advantage or Medicare Part D*
Medicaid-covered drugs, including over-the-counter drugs	Yes	Not covered by MLTSS *MLTSS enrollees get Medicaid-covered drugs through Medicaid fee-for-service*
Medicare and Medicaid-covered mental health services	Yes	MLTSS includes Medicaid-covered outpatient mental health services, such as services provided by Community Mental Health Center (CMHCs) and Federally Qualified Health Center (FQHCs) *MLTSS enrollees get Medicare-covered mental health services through Original Medicare or Medicare Advantage*
Medicare and Medicaid-covered substance abuse services	Yes	MLTSS includes Medicaid-covered substance abuse services *MLTSS enrollees get Medicare-covered substance abuse services through Original Medicare or Medicare Advantage*
Non-emergency transportation to Medicare and Medicaid-covered health care services	Yes	Yes
Nursing home care	Yes	Yes
Supportive living	Yes	Yes
HCBS Waiver services. Some examples include: • homemaker services, • personal assistant services, • emergency home response system, • adult day services, and • home delivered meals. *Note: MMAI and MLTSS plans only cover HCBS Waiver Services provided through the following Waiver programs:* • Persons with Disabilities (Home Services Program), • Persons with Brain Injury (Home Services Program), • Persons with HIV or AIDs (Home Services Program), • Persons who are Elderly (Community Care Program), or • Supportive Living Facilities.	Yes	Yes
Care management, including a Care Coordinator, regardless of the enrollee's health status Extra benefits	Yes	Yes
See each MMAI and MLTSS health plan's extra benefits at http://enrollhfs.illinois.gov/	Yes	Yes

ScreenABLE: Prevention Screening is Important for Women with Disabilities

By Susan Magasi, PhD

Cancer can be scary, but screening and early detection have been shown to improve outcomes for breast, cervical, colorectal and lung cancer. Disability status does not protect women from getting cancer, yet women with disabilities in Illinois are at 22% less likely to be screened for breast cancer and are 43% less likely to be screened for cervical cancer. Issues such as lack of accessible examination equipment, the perception that healthcare providers do not understand the healthcare and accommodation needs of people with disabilities, people's history of previous poor qualitative care and treatment fatigue all serve as barriers to screening. You can play a pivotal role in closing the gap and make sure that your patients with disabilities are receiving the age appropriate screenings in accordance with the most up to date guidelines.

The Centers for Disease Control (http://www.cdc.gov/cancer/dcpc/prevention/screening.htm) has guidelines on when people should get different types of cancer screenings.

Here are some tips to share with your patients with disabilities to help make sure they get the screenings that they need.

- Be proactive: Ask your healthcare providers about what screenings are right for you
- Don't let fear get in your way: Talk to your healthcare providers about your concerns and ask them to explain the process to you in advance so you know what to expect
- When scheduling a screening appointment, let the clinical team know what kinds of assistance and accommodations you need
    - Some common requests include, sign language interpreters, help filling out forms, dressing assistance, extra time, adjustable examination equipment, positioning assistance
- You are never required to bring someone with you, but you can if it makes you feel more comfortable
- Work with your healthcare provider during the screening to help them learn how to best help you
- Know what to expect: Ask your healthcare provider when nad how you will get your results

Remember: Women with disabilities are important and are ScreenABLE.

Men, too! Even though our research was with women, it is important for men to get appropriate screenings as well. Susan Magasi is an assistant professor at the University of Illinois at Chicago in the Departments of Occupational Therapy and Disability Studies. Her work focuses on healthcare disparities among people with disabilities and is funded by the American Cancer Society Illinois Division (#266888) and the ChicagoCHEC (U54CA203000).

The Great American Smoke Out- 'Nobody Quits Like Chicagoland!'

The Great American Smoke Out takes place every year on the third Thursday of November. The American Cancer Society marks this day by encouraging people who smoke to use the date to make a plan to quit. Please support this initiative by sharing the following message with your patients who are interested in quitting: If you smoke, you can use this day or any day to take the next step in creating a healthier life and to help lessen your chance of cancer.

If you are ready to quit and need assistance, you may contact the Illinois Tobacco Quitline- a free resource for tobacco users who want to quit for good. Their registered nurses, respiratory therapists, and certified tobacco treatment counselors are on call 7 days a week from 7:00 AM to 11:00 PM to answer all your tobacco related questions and provide the support you need to break the habit. Habla espanol? They serve a diverse client base, with Spanish-speaking counselors and live translation services for more than 200 languages. The Illinois Tobacco Quitline is sponsored by the Illinois Department of Public Health and the American Lung Association of Illinois. For more information you may call them directly or go to their website:

- 1-886-QUIT-YES/1-886-784-8937
- www.Quityes.org

HFS/CMS Mandatory Prescriber Enrollment

Beginning February 1st, 2017, HFS and CMS will implement a policy only prohibiting reimbursement for prescriptions that are written by prescribers who are enrolled with (CMS) Medicare FFS or have a valid opt-out affidavit on file and (HFS) enrolled in the IMPACT program. Prescribing providers should verify appropriate enrollment to ensure there is no disruption to payment for prescriptions provided to members. These requirements for enrollment will not be delayed.

Starting February 1st, 2017, CVS will provide MMAI members a provisional supply – up to 90 days – when filling prescriptions written by prescribers who are not enrolled per the requirements. In an effort to assist providers comply with these new requirements per HFS and CMS, Aetna Better Health will send notification to prescribing providers who are not registered with either respective agency after a claim has been submitted. Although at this time the plan is not to reject claims submitted by providers who are not yet enrolled, providers should verify appropriate enrollment under the assumption that this requirement will go live in the coming months.

Notice – providers should not solely use notification from Aetna Better Health as primary source verification of enrollment status with either HFS or CMS. Providers should contact HFS IMPACT and/or Medicare Administrative Contractor (MAC) in a geographic area to verify appropriate enrollment.

Provider Mailing

Aetna Better Health of Illinois consistently provides opportunities to promote efficiency and HIPPA compliance in the sharing of member information and PHI. We would like to take the opportunity to emphasize the importance for network providers to send the below sensitive information to the appropriate addresses listed below. This will help to ensure that information is received and processed in the most appropriate manner.

Issue Type

Aetna (Provider Claim Disputes):

Aetna Better Health
Attention: Provider Disputes or Appeals
333 West Wacker Drive
Mail Stop F646
Chicago, IL 60606

Aetna (New Day Claim Submission & Resubmission):

Aetna Better Health
PO Box 66545
Phoenix, AZ 85082

Member Appeal:

Aetna Better Health
Appeals and Grievance Manager
333 West Wacker Drive, Suite 2100
Mail Stop F646
Chicago, IL 60606

Further clarification to the difference between issue type can be obtained through the provider handbook or by contacting the provider services department. We sincerely appreciate your assistance!

Vaccines for Children Program

Effective October 1st, 2016, the Illinois Department of healthcare and Family Services sent information to the provider community regarding changes to the Vaccines for Children (VFC) program. Previously, All Kids participants ages 0 through 18 eligible under Illinois' State-funded only program, or Title XXI [21] or the Social Security Act, were eligible to receive free VFC vaccines through an Intergovenmental Agreement between HFS and DPH. Effective October1st 2016, children who have the state's Title XXI [21] and State Funded All Kids eligibility are no longer eligible to receive vaccines through the federal VFC program – these vaccinations will be reimbursed by the assigned MCO as of the Date of Service of the member. Participants through age 18 with Title XIX[19] coverage continue to be eligible for vaccination through the VFC program.

To ensure correct reimbursement, providers must verify a child's eligibility status through use of an eligibility system that will provide the Title XXI [21] and State-Funded information. The HFS MEDI system returns this information with verification of eligibility.

<table>
<tr><td rowspan="2">All Kids Program
(Children can be enrolled in a MCO or have a traditional medical program eligibility where a provider bills HFS directly a fee for each service, FFS)</td><td>Medicaid – Title XIX [19]</td><td>VFC vaccine</td></tr>
<tr><td>CHIP – Title XXI [21]
or
State-Funded</td><td>Private Stock Vaccine</td></tr>
</table>

Long Term Care Billing Guidelines

HFS released provider notice on 04/19/2016 detailing new monthly billing requirements for Long Term Care Services effective July 1st, 2016. Long Term Care Facilities include Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Supportive Living Program (SLP), and Specialized Mental Health Rehabilitation Facilities (SMHRF). Implementation of these new monthly billing requirements was further delayed beginning with service dates on and after October 1st, 2016. Specific information on new requirements including billing guidelines, COS Crosswalk, and coding can be found on the HFS LTC Direct billing webpage.

HEDIS Performance Guide

HEDIS performance is based on claims data received from the provider and/or medical record review. Aetna Better Health of Illinois captures claim level data to determine adherence with HEDIS criteria. The following billing guide has been provided to assist providers in accurately reporting those services that demonstrate services rendered to members that satisfy HEDIS measures.

PBH - Persistence of Beta-Blocker Treatment After a Heart Attack

Measure Definition:

The percentage of members 18 years of age and older in 2016 who were hospitalized and discharged from July 1, 2015 to June 30, 2016 with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Billing Reference		
Description	**ICD-9 CM**	**ICD-10 CM**
AMI	**410.X1**	**I21.01-I21.4**

Beta-Blocker Medications		
Description	**Prescriptions**	
Noncardioselective beta-blockers	**Carvedilol**	**Pindolol**
	Labetalol	**Propranolol**
	Nadolol	**Timolol**
	Penbutolol	**Sotalol**
Cardioselective beta-blockers	**Acebutolol**	**Bisoprolol**
	Atenolol	**Metoprolol**
	Betaxolol	**Nebivolol**
Antihypertensive combinations	**Atenolol-chlorthalidone**	**Hydrochlorothiazide-metoprolol**
	Bendroflumethiazide-nadolol	**Hydrochlorothiazide-propranolol**
	Bisoprolol-hydrochlorothiazide	

Measure Exclusion Criteria:
Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member's history through 179 days after discharge:

Codes to Identify Exclusions		
Description	**ICD-9 CM**	**ICD-10 CM**
History of Asthma	**493**	**J45.20-J45.998**
COPD	**493.20-493.22, 496**	**J44.0, J44.1, J44.9**
Obstructive Chronic Bronchitis	**491.20-491.22**	
Hypotension	**458**	**I95.0-I95.9**
Heart Block>1 degree	**426.0, 426.12, 426.13, 426.2-426.4, 426.51-426.54, 426.7**	**I44.1-I44.7, I45.10-I45.3, I45.6, I49.5**
Sinus Bradycardia	**427.81, 427.89**	**R00.1**
Chronic Respiratory Conditions Due to Fumes/Vapors	**506.4**	**J68.4**

Disease-modifying Anti-rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
Help your patients receive Rheumatoid Arthritis (RA) treatment

Patients 18 years and older diagnosed with RA and prescribed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD). This measure excludes patients who are pregnant or HIV positive.

Next Steps

- Contact your patient for a medication review.
- Discuss with your patient on the importance of taking DMARDs.
- Coordinate care with your patient's Rheumatologist and other specialists.

Annual Monitoring for Patients on Persistent Medications (MPM)

Aetna Better Health recommends annual monitoring for patients who are 18 years of age and older and receiving ambulatory medication therapy for the following therapeutic agents: Digoxin, Diuretics and ARB/ACE Inhibitors.

Next Steps

- Determine lab test needed
- Contact your patient to refer for an evaluation for treatment and medication review.
- Please coordinate care with physicians and refer to specialists, if necessary.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Aetna Better Health recommends women ages 67-85 who have suffered a fracture receive either a bone mineral density test (BMD) or a prescription for a drug to treat osteoporosis in the 6 months after the fracture.

Next Steps

- Please refer these patients for a BMD and ensure they receive osteoporosis treatment within the 6 months after the fracture.
- Discuss prescriptions used to prevent and treat osteoporosis.

Medication Reconciliation Post-Discharge (MRP)

A medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Listed below are the criteria to show complete medication reconciliation:

Documentation in the medical record **must include** evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria:

- Documentation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications were reviewed (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the patient's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.