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AETNA BETTER HEALTH® OF ILLINOIS
Provider Newsletter Vol. 2

Introducing Our Chief Executive Officer

At Aetna Better Health, we are pleased to introduce Lawrence (Larry) Kissner as our new Chief Executive Officer (CEO). Larry brings the talent and expertise needed to help advance our commitment to serving the health and wellness of our members.

"I am so pleased to be a part of the Aetna Better Health team, and look forward to working with our staff, physicians, volunteers and community partners to continue to improve health care outcomes for our members and provide the excellent, personalized care we are known for. Aetna Better Health is a culture of caring and excellence; it is transforming the health care experience by making life better, one member at a time. We put the needs of our members first, and work with providers to meet them." Lawrence Kissner

Larry comes to Aetna Better Health with more than 30 years of experience in the private insurance industry, including more than 17 years in managed care. Prior to his appointment as CEO, he served as Commissioner of Medicaid within Kentucky's Cabinet for Health and Family Services. As Commissioner, he was responsible for all Medicaid services representing more than 825,000 Kentuckians and managing an annual budget of roughly $8 billion.

He also served as president and CEO of Magnolia Health Plan in Jackson, Mississippi, one of two managed care companies that provide insurance for Medicaid beneficiaries served by that state's coordinated access network program. He served as vice president of sales and marketing for Independence Blue Cross in Philadelphia; president and CEO of UnitedHealthcare of Kentucky; and held a variety of management positions at United Healthcare in Florida.

Larry graduated from the University of Notre Dame with a Bachelor of Business Administration degree where he attended on an athletic scholarship and was a double-sport letterman in football and wrestling.

Larry's passion for Aetna Better Health's members is focused on doing what is right for them and providing the best quality of care. His experience, insight, and proven track record of delivering value for our members and providers informs everything we do at Aetna Better Health and drives our commitment to "Do the right thing for the right reason."

Empowerment through our case management and disease management programs

Aetna Better Health offers an evidence-based case management and disease managements programs to help our members improve their health and access the services they need. Case managers typically are nurses, counselors, or social workers. These professionals create comprehensive care plans that help members meet specific health goals, as well as support psychosocial needs.

Case Management

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 applying 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)?

To make referrals for case management consideration, please call **Member Services at 1-866-600-2139 (MMAI) 1-866-212-2851 (ICP and FHP)**. A case manager will review and respond to your request within 3-5 business days.

Disease management

Our Disease Management (DM) program provides an integrated treatment approach that includes the collaboration and coordination of patient care delivery systems. It focuses on measurably improving clinical outcomes for a particular medical condition. This is accomplished through the use of appropriate clinical resources such as:

- Preventive care
- Treatment guidelines
- Patient counseling
- Education
- Outpatient care
- Telemonitoring

It includes evaluation of the appropriateness of the scope, setting, and level of care in relation to clinical outcomes and cost of a particular condition.

DM Programs available to members include:

- Asthma
- Diabetes
- Depression
- Congestive Heart Failure (CHF)/Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)

For our pediatric Medicaid members, we developed disease management programs for children with asthma and diabetes. Also, all of our DM programs address co-occurring, physical concerns like obesity and hypertension and behavioral health conditions like depression and anxiety. If you have a member who has one of the above listed chronic conditions, you or your staff can make a referral to our Disease Management Program at any time.

To make a referral, please call **Member Services at 1-866-600-2139 (MMAI) 1-866-212-2851 (ICP and FHP)** and ask for Disease Management.

We provide Clinical Practice Guidelines for Asthma, Diabetes, Depression, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. You can get a copy of the guidelines through our web portal at https://www.aetnabetterhealth.com/Illinois.

Utilization management

Aetna Better Health's Utilization Management (UM) Department is committed to delivering quality care that will result in improved outcomes and better health for our members. Continuity of care is accomplished through appropriate coordination with contracted groups and/or primary care physicians in the provision of ambulatory care and inpatient health services.

Clinical Criteria for UM Decisions

Aetna Better Health's UM Department uses criteria or guidelines to make decisions based on medical necessity. These guidelines are developed through technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. The guidelines come from a variety of sources to include:

- Center for Medicare and Medicaid Services (CMS)
- National Coverage Determinations
- Local Coverage Determinations
- CMS Benefit Interpretation Manuals
- Milliman Care Guidelines®
- Apollo Medical Review Criteria
- National Guideline Clearinghouse
- Evidence in the peer-reviewed published medical literature
- Aetna Clinical Policy Bulletins (CPBs)
- Level of Care Utilization System (LOCUS) and Child & Adolescent Level of Care Utilization System (CALOCUS) Guidelines
- American Society of Addiction Medicine (ASAM)

Availability of Criteria

Providers and members have the right to request a copy of a guideline that Aetna Better Health has used to make a treatment authorization decision. Specific criteria or guidelines are available upon request with the following disclosure: "The material provided to you are guidelines used by this plan to authorize, modify, or deny care for the person with similar illnesses or conditions. Care and treatment may vary depending on individual need and the benefits covered under your contract." If you would like to obtain a copy of the criteria, please call **Member Services at 1-866-600-2139 (MMAI) 1-866-212-2851 (ICP and FHP).**

Affirmative Statements about Incentives

UM decisions are based on appropriateness of care and service and existence of coverage. Aetna Better Health does not specifically reward practitioners or individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. Providers and practitioners are not prohibited from acting on behalf of the member. Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care. Practitioners are ensured independence and impartiality in making referral decisions that will not influence:

- Hiring
- Compensation
- Termination
- Promotion
- Any other similar matters

Members' Rights & Responsibilities

Aetna Better Health annually distributes the Members' Rights and Responsibilities Statement to Providers and it is also included in the Provider Handbook you received upon orientation. For your convenience, you can access the Members' Rights and Responsibilities Statement, on our website at: http://www.aetnabetterhealth.com/illinois/members/icp/rights (ICP and FHP) and http://www.aetnabetterhealth.com/illinois/members/premier/rights (MMAI) or by calling 1-866-600- 2139 (MMAI) 1-866-212-2851 (ICP and FHP) to request a copy.

Disability Rights Advocacy Initiative

Aetna Better Health has launched a Disability Rights Advocacy initiative. Each month an email is sent to our team highlighting a disability-rights topic. Prerak Mehta, the Community Liaison Peer Advocate, has led this initiative. As someone with a disability, Prerak provides recovery support and education to members and staff. He provides an alternate perspective of living with a disability. Below is the email sent to Care Mangers in January; its focus is Inclusive Emergency Preparation Management.

In 2010, The Federal Emergency Management Agency (FEMA) developed the Office of Disability Integration. The purpose of the office is to promote an inclusive environment for those with disabilities in the event of an emergent situation. Examples of situations that fall under this category include heavy winter storm where roadways, grocery stores and buildings are closed down, hurricanes, earthquakes etc. FEMA has designed a simple Emergency Preparedness Action Plan that helps promote an inclusive and accessible environment for persons with disabilities. Essentially there are three components that should be included in the plan for emergency management and preparedness for persons with disabilities.

- Including the member in the plan
- Identifying alternative ways to notify an individual of an emergency. This can be a horn, bells or whistles or blinking lights in a home.
- Identifying community or internal resources can help an individual. Examples include: a social-support system as well as community and federal agencies that can provide shelter or emergency-response services.

How does this apply to our members?
Throughout this series we have emphasized establishing a strength-based approach that addresses an individual's abilities as opposed to his or her limitations. As Care Managers, our role is to work with the member to assist in identifying solutions as well as ways to minimize the risks of problems before they occur. Honest, open and informational dialogue regarding an inclusive emergency action plan supports individuals to live in the community of their choice. When members equip themselves with the necessary tools they need to be successful in the community then we have further defined our role as true advocates of the health care delivery system. Additionally, by incorporating an inclusive emergency- management approach, Aetna Better Health strengthens the Aetna culture of inclusion by celebrating diversity.

REMINDER: IMPACT Provider Revalidation-Due Date Extensions

HFS has extended the due dates for provider revalidation. Facility/ Agency/Organizations (FAOs) revalidation has been extended to March 15, 2016.

Based on the above requirement and understanding that FAOs and groups must enter the IMPACT system prior to individual providers; the Department will further extend the revalidation due date for Individual/Sole providers to June 30, 2016.

More information on the IMPACT system plus frequently asked questions, webinars and other training guides are available at the IMPACT website.

For additional questions or assistance, please contact the IMPACT Help Desk:

- Email: IMPACT.Help@Illinois.gov
- Phone: (877) 782-5565 Select option #1.

HPV Vaccine Update

For Health Care Professionals/Clinicians

HPV: You are the Key to Cancer Prevention- HPV Vaccine is Cancer Prevention

What can you do to ensure your patients get fully vaccinated?

- All girls 11 or 12 years old should get 3 doses of HPV vaccine to protect against cervical cancer. All boys 11 or 12 years old should get 3 doses of quadrivalent HPV vaccine to protect against genital warts and anal cancer.
- CDC recommends that adolescent males and females receive HPV vaccines starting at between 11 and 12 years old and may be administered until 18 years of age.. Parents trust your opinion more than anyone else's when it comes to immunizations. Studies consistently show that provider recommendation is the strongest predictor of vaccination.
- Use every opportunity to vaccinate your adolescent patients- Ask about vaccination status when they come in for sick visits and sports physicals
- Patient reminder and recall systems such as automated post cards, phone calls, and text messages are effective tools for increasing office visits.
- Educate parents about the diseases that can be prevented by adolescent vaccines.
- Implement standing orders policies so that patients can receive vaccines without a physician examination or individual physician order.
- Direct parents who want more information on vaccines and vaccine-preventable diseases to visit the CDC website at http://www.cdc.gov/vaccines/teens or to call 800-CDC-INFO.

Aetna Better Health covers the cost of vaccines (including the HPV vaccine) as part of the preventative health care services or well child health care services for our members.

Information adapted from the Centers for Disease Control and Prevention. For more information including Factsheets for Parents in English & Spanish; Free Posters; and Continuing Education including updated CMEs- go to the new HPV Portal for Providers: cdc.gov/vaccines/YouAreTheKey. To stay informed when new resources and tools are published, send an email to request a newsletter: PreteenVaccines@cdc.gov. The CDC can also assist in providing speakers for grand rounds and continuing education events.

Aetna Better Health of Illinois Clinical Quality Committees Look to Expand Membership

Aetna Better Health of Illinois would like to invite independently contracted Providers participating in the Integrated Care Program, Family Health Plan and Premier Plan to become a member of our Quality Management/Utilization Management (QM/UM) and Pharmacy and Therapeutics (P&T) Committee.

The QM/UM Committee is responsible for oversight of the clinical programs including evaluation of the utilization management plan, the care management plan, performance improvement plans, and the quality improvement plan. The committee also provides reviews and recommendations to the Quality Improvement Committee for approval of utilization review guidelines and Clinical Practice Guidelines and is responsible for the evaluation of clinical metrics, including HEDIS®.

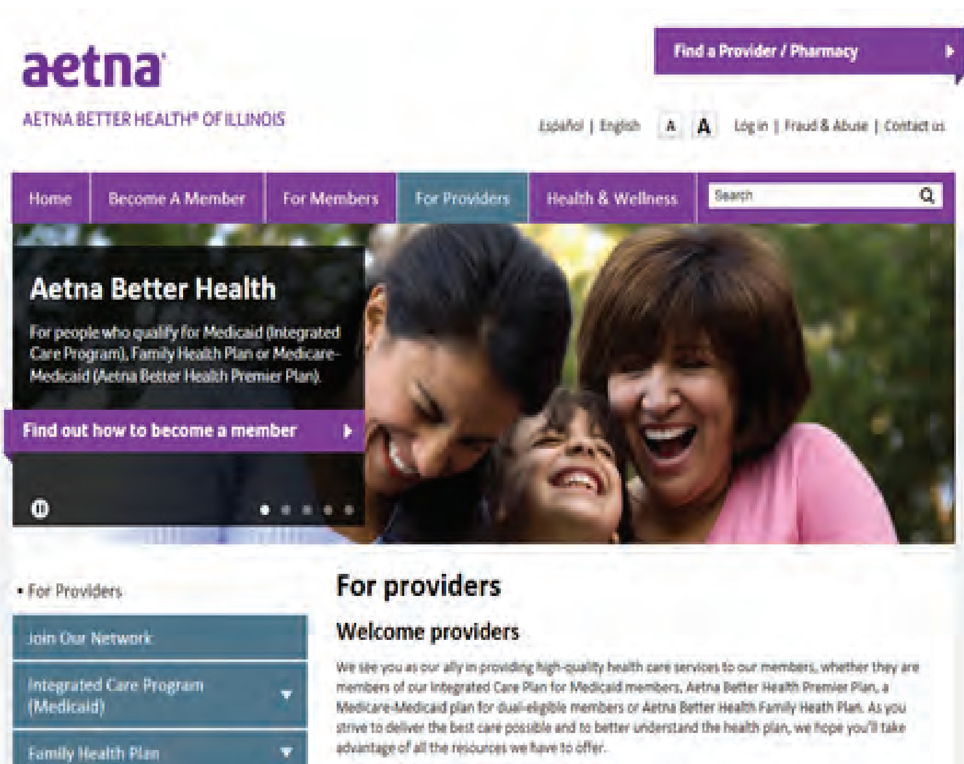
The P&T Committee is responsible for advising and making recommendations regarding the Aetna Better Health Medicaid pharmacy programs. The committee also reviews and assists in the development and maintenance of the Medicaid formularies and reviews member and provider educational materials and programs related to medications and other pharmacy products.

These committees are seeking providers from all specialties who are willing to participate in bi-monthly meetings in Chicago and serve a one-year term. Aetna Better Health will offer an honorarium for your time and participation (and will provide for parking expenses).

If you have questions or would like to receive information about joining the committee, contact Chareese Brown at 312-821-0530 or by email at brownc19@aetna.com. Or, contact Bruce Himelstein, MD, Chief Medical Officer at 312-928-3094 or by email at himelsteinb@aetna.com.

Your Guide to Pharmacy Prior Authorization

Our website provides prescribers with resource tools to educate you on the process and answer questions that you may have. These resource tools can be found on our website – www.aetnabetterhealth.com/Illinois then go to the Provider Tab.



Here are Resource Tools that will assist you in prescribing formulary and non-formulary medication: You can access links to obtain forms and valuable information for the Integrated Care Plan (ICP), Premier Plan (Medicare-Medicaid Plan) and Family Health Plan (FHP).

The Integrated Care Program is a Medicaid plan for adults with a disability ages 19 - 64 or adults 65 and above. It currently serves enrollees in the counties of Boone, DuPage, McHenry, Kane, Kankakee, Lake, Will, Winnebago and Cook. The program is designed to link primary, specialty, community-based and institutional services for Illinois' most vulnerable residents. It focuses on the establishment of a medical home, prevention and wellness services, and community-based supports to manage the full continuum of care for enrollees.

ICP includes Long Term Supports and Services (LTSS), including those in nursing facilities or those who receive Home and Community-Based Services (HCBS) waivers. Waiver services through the Home Services Program (HSP), the Community Care Program (CCP), and the Supportive Living Program (SLP).

The Family Health Plan medical expansion (FHP) consists of families who previously qualified for Temporary Assistance for Needy Families (TANF), which is a program that provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical.

The Aetna Better Health Premier Plan is a Medicare-Medicaid Alignment Initiative (MMAI) which provides coordinated medical care to seniors and to persons with a disability who receive both Medicare and Medicaid. MMAI is a joint initiative of the Federal and State government to improve quality of care for its members. These members are "dual-eligible" for Medicaid and Medicare benefits.

Quick links provide you with answers to frequently asked questions. Plan-specific benefits information for Providers and Members are available in their respective Plan tabs for ICP, FHP, and MMAI. Pharmacy and medical benefits will be different between the Medicaid and MMAI plans. Therefore, different coverage rules and procedures will apply.

Provider Handbook – You can access up to date Provider information and a complete list of department contact information.

Secure Provider Portal – Our HIPPA-compliant web portal is available 24 hours a day. The portal supports the functions an access to information related to:

- Medical Prior-authorization submission and status inquiry
- Claim status inquiry
- Eligibility status inquiry
- Provider search
- Member and provider education and outreach materials

Pharmacy:
The Formulary – The Formulary is a list of drugs chosen by Aetna Better Health and a team of doctors and pharmacists that are generally covered under the plan as long as they are medically necessary. Prescriptions must be filled at a network pharmacy.

TCts, such as prior authorization, step therapy, quantity limits or age limits. The formulary list can change.

Formulary Updates – Formularies may change. Please view updates in the following links.

ICP
http://www.aetnabetterhealth.com/illinois/providers/icp/pharmacy
Premier Plan
http://www.aetnabetterhealth.com/illinois/providers/premier/partd
FHP
http://www.aetnabetterhealth.com/illinois/providers/fhp/pharmacy

Pharmacy Provider search – You can view all of the Aetna Better Health network pharmacies.

Our site also includes links to obtaining information on Step Therapy and Quantity Limits. The step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs.

Specialty Medication Drug List – ICP and FHP utilize CVS Caremark Specialty Pharmacy, as the preferred specialty pharmacy vendor, which offers medication for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis and rheumatoid arthritis, which are not often available at local pharmacies. Specialty medications require prior authorization before they can be filled and delivered. Specialty medications can be delivered to the provider's office, member's home, or other location as requested.

The Premier plan does not restrict members to specific specialty pharmacy, and members can fill covered specialty medications at any network pharmacy that dispenses the specialty medications. Please refer to the Premier Plan's List of Covered Drugs (formulary) and Pharmacy Directory.

Did you know that members are eligible to get mail order prescriptions?

If your members take medicine for an ongoing health condition, they can have their medicines mailed to their home. You can also sign up for automatic refills through Ready Fill. Go to www.caremark.com. CVS will contact you to get the prescriptions. Members can also sign up for service through CVS Caremark by calling 1-855-271-6603 Monday through Friday between 8 am – 8 pm EST.

Over-the-counter-drugs (OTCs) - Aetna Better Health also covers certain OTCs. Some of these may have rules about whether they will be covered. If the rules for that drug are met, Aetna Better Health will cover the drug. All covered over-the-counter drugs must have a prescription for them to be dispensed at the pharmacy and covered at no cost to our members.

The 2016 Illinois PA Guideline Chart can be utilized for ICP and FHP only. This resource tool includes guidelines for pharmacy prior authorization, non-formulary medication, prior authorization and step therapy guidelines and quantity limits. Please follow these links for each program.

Please use the MMAI link and go to the Part D Prescription Drugs tab to retrieve the Prior Authorization Criteria Document, step therapy guidelines and quantity limits.

ICP
http://www.aetnabetterhealth.com/illinois/providers/icp/pharmacy
Premier Plan
http://www.aetnabetterhealth.com/illinois/providers/premier/partd
FHP
http://www.aetnabetterhealth.com/illinois/providers/fhp/priorauth

Prior authorization forms – The above links allows you to click on the drug and download forms, print them out and fax to us.

Need help with prior authorizations?

ICP (Integrated Care Program) and FHP (Family Health Plan)	Call Member Services at 1-866-212-2851 with questions and/or ask how to get forms faxed to you
ICP Pharmacy prior authorizations	Fax Supporting Documents to 1-855-684-5250 or request Pharmacy Prior Authorization over the phone at 866-212-2851
FHP Pharmacy prior authorizations	Fax Supporting Documents to 1-844-242-0908 or request Pharmacy Prior Authorization over the phone at 866-212-2851
ICP and FHP Medical prior authorizations	Fax Supporting Documents to 1-855-684-5259
Aetna Better Health Premier Plan MMAI (Medicare-Medicaid Alignment Initiative)	Call Member Services with questions or request prior authorization over the phone at 1-866-600-2139
Premier Plan Pharmacy Coverage Determination form (Pharmacy prior authorization form)	Fax documents to 1-855-365-8109
Premier Plan medical prior authorizations	Fax Supporting Documents to 1-855-320-8445

Tips for requesting authorizations

- Remember to always verify member eligibility for all programs
- Complete the appropriate prior authorization forms for pharmacy or medical requests.
- Complete appropriate pharmacy prior authorization forms for ICP, FHP and The Premier Plan.
- Please call **Member Services for assistance with required forms: 1-866-212-2851 (ICP and FHP) or 1-866-600-2139 (MMAI)**
- Attach all clinical supporting documentation when submitting.

Can't find the drug you would like to prescribe or need information about prior authorization requirements?

- Use the Non-Formulary Prior Authorization Form for ICP, FHP, and MMAI.
- Please call Member Services at the numbers above. They can help with medical and pharmacy prior authorization requests.