Population Health Management

Aetna Better of Ohio 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:

Keeping Members Healthy
Programs are targeted to align with low risk populations. With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy. The PHM program for members is a Flu Vaccination Program that includes educational activities to promote annual flu vaccination.

Managing Members with Emerging Risk
Programs are targeted to align with medium risk populations. Engagement with practitioners focuses on supporting Patient Care Medical Home models to centralize care and patient-driven decision-making. The PHM program for members is a Hepatitis C Program that supports members in completing a prescribed treatment regimen.

Patient Safety and Outcomes Across Settings
Programs are targeted to align with members that experience health services across settings. Engagement with practitioners focuses on communication and collaboration with their patients to share information to prevent duplication and potential for harm. The PHM program for members is Appropriate Use of Acute Care Settings that includes early notification through in-patient alerts.

Managing Multiple Chronic Conditions
Programs are targeted to align with high and intensive risk populations. Engagement with practitioners focuses on maintaining engagement outside of clinic and office visits. The PHM program for members is Life Planning/Advance Directives/Palliative Care that includes providing life planning/advance directive information to members upon enrollment.

Aetna Better Health of Ohio care managers will work with members and providers to ensure that members receive the right care and services that meet members' needs.

Diabetes Self-Management Education (DSME)

It can be overwhelming for a patient to receive a Diabetes diagnosis. There are so many questions with a new diagnosis, but the provider will offer support and guidance to the patient on how to manage and live with their condition. Although the provider will give information, the provider is not the only way for the patient to receive Diabetes information.

The provider can help the patient navigate their Diabetes diagnosis by referring the patient to Diabetes Self-Management Education (DSME). This 10-hour education series can re-enforce the provider's teachings by discussing how and when to check blood sugar, reducing risks for other health problems, and being physically active. The patient can take these courses in-person or virtually. No one should manage Diabetes alone. Through provider support, Diabetes Self-Management Education, and patient compliance, the patient can successfully manage their life and condition.

Please click here for more information

Financial Liability for Payment for Services

Balance billing enrollees is prohibited under the MyCare Ohio plan. In no event should a provider bill an enrollee (or a person acting on behalf of an enrollee) for payment of fees that are the legal obligation of Aetna Better Health of Ohio. This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Providers must make certain that they are:

- Agreeing not to hold enrollees liable for payment of any fees that are the legal obligation of Aetna Better
- Health of Ohio, and must indemnify the enrollee for payment of any fees that are the legal obligation of Aetna Better Health of Ohio for services furnished by providers that have been authorized by Aetna Better Health of Ohio to service such enrollees, as long as the enrollee follows Aetna Better Health of Ohio's rules for accessing services described in the approved enrollee Evidence of Coverage (EOC) and or their Enrollee Handbook.
- Agreeing not to bill an enrollee for medically necessary services covered under the plan and to always notify enrollees prior to rendering services.
- Agreeing to clearly advise an enrollee, prior to furnishing a non-covered service, of the enrollee's responsibility to pay the full cost of the services.
- Agreeing that when referring an enrollee to another provider for a non-covered service, provider must make certain that the enrollee is aware of his or her obligation to pay in full for such non-covered services

Provider Portal

Our enhanced, secure and user-friendly web portal is available at https://www.aetnabetterhealth.com/ohio/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.

To access the provider portal, please go to https://www.aetnabetterhealth.com/ohio/providers/portal

For more information, contact Provider Services at **1-855-364-0974.**

Complex Care Management Referral Options

Empowerment through care management
Aetna Better Health of Ohio offers an evidence-based care management program to help our members improve their health and access the services they need. Care 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 care 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 care 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), hypertension, or End Stage Renal Disease (ESRD), yet does not comply with the recommended treatment regimen and would benefit from telemonitoring of these conditions?
- Does the member need help to apply for a state-based long-term care program?
- Does the member live with 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 care manager contacts the member. The care manager might also contact the member's caregivers or others as needed.

What will a care manager do?

To help the member learn how to manage their illness and meet their health and other needs, a care manager contacts the member to schedule a time to complete an assessment. The care 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 care manager work together to develop a care plan. The care manager also educates the member on how to obtain what they need. The care manager also may work with the member’s health care providers to coordinate these needs. The amount of care management and frequency of contact with the member and others will vary based upon the individual needs of the member.

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

Clinical Criteria for Utilization Management Decisions

How to Request Criteria

Aetna Better Health of Ohio 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 & DME MAC)
  - 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 criteria, call Provider Services at 1-855-364-0974 or visit our website at https://www.aetnabetterhealth.com/ohio/

Pharmacy Benefits

Aetna Better Health of Ohio'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/ohio. 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/ohio for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at 1-855-364-0974.

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 1-855-364-0974. 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 of Ohio does not charge member copays for covered prescription and OTC drugs as long as Aetna Better Health of Ohio's rules are followed, and drugs are filled at a network pharmacy.

Covered drugs are designated 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.

Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Better Health of Ohio 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 health care
- 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 https://www.aetnabetterhealth.com/ohio/ to see our Member Handbook.

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet the Ohio Department of Medicaid (ODM) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

The table on the below shows appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/SA) providers.

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Primary Care	Same Day	Within 2 calendar days	Within 3 weeks	No more than 60 minutes
Specialist Care	Immediate	Within 2 calendar days	Within 3 weeks	No more than 60 minutes
OB/GYN	Immediate	Within 2 calendar days	Initial Prenatal Care • 1st Trimester: Within 3 weeks • 2nd Trimester: Within 7 calendar days • 3rd Trimester: Within 3 calendar days • High Risk: Within 3 days • Routine Care: Within 3 weeks • Postpartum Care: Within 6 weeks	•
Behavioral Health	**Potentially suicidal individual:** immediate treatment **Non-life threatening emergency:** within 6 hours	Within 48 hours		No more than 60 minutes
EPSDT (Early Periodic Screening Diagnosis & Treatment)				No more than 60 minutes
Physical Therapy	Within 24 hours	Within 72 hours		No more than 60 minutes
Occupational Therapy	Within 24 hours	Within 72 hours		No more than 60 minutes
Sports Medicine	Within 24 hours	Within 72 hours		No more than 60 minutes
Audiology				No more than 60 minutes

Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

- We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don't reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at 1-855-364-0974, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-855-364-0974.