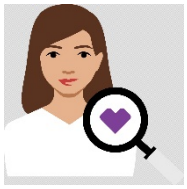


New Medicare Plan: Aetna Assure Premier Plus (HMO D-SNP)

On January 1, 2021, Aetna launched Aetna Assure Premier Plus (HMO D-SNP), a new Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in the 10 New Jersey counties of Bergen, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union. Aetna Assure Premier Plus (HMO D-SNP) is a Medicare Advantage managed care plan option for individuals with Medicare and full NJ FamilyCare/Medicaid coverage. This plan covers all Medicare and Medicaid services including prescriptions drugs, behavioral health, Managed Long Term Services and Supports (MLTSS) and additional supplemental benefits at $0 cost sharing for all members.

Network participation for the FIDE D-SNP network was developed in one of two ways…

- Automatic enrollment for providers participating in the Medicare Advantage network
- Deeming of providers participating in the Medicaid network through contract addendum

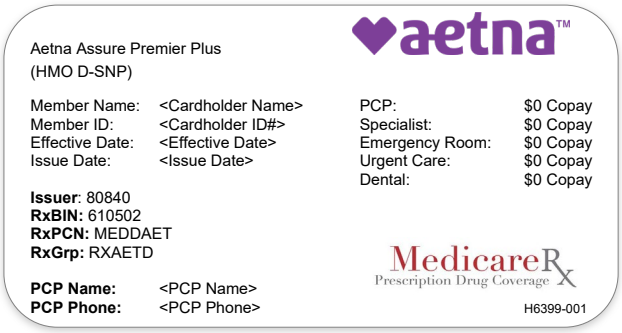
As a participating provider in this new plan, we wanted to ensure that you were aware of the following:

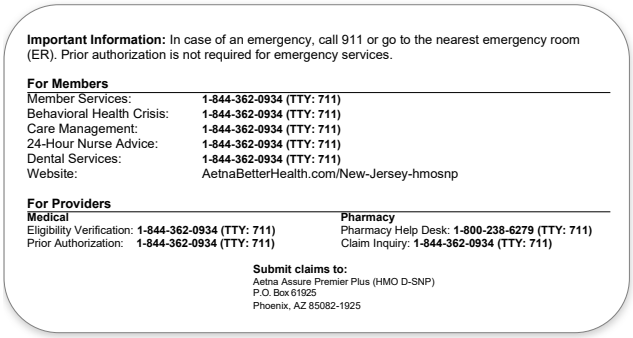
- Key plan features
  - $0 cost sharing for all plan covered services and prescription drugs
  - One member ID card to access all covered services
  - All members have a dedicated Aetna care manager
  - No referrals for specialists
  - In-network primary care provider selection is required
- Using the member's ID number from the plan ID card, you will need to submit **one claim**. Your claims will automatically be processed first under the Medicare benefits and then under the Medicaid benefits. Use submitter ID #46320 when submitting claims. Members should not be balanced billed for any covered benefit.
- You can use the provider portal to access, eligibility, panel rosters, claims status, and much more. Simply use the Medicaid Web Portal or select Aetna Better Health in Availity to see all the ways that we support you.

Below are additional resources for you and your office staff

- Aetna Assure Premier Plus (HMO D-SNP) plan website: www.aetnabetterhealth.com/new-jersey-hmosnp/find-provider
- Provider Manual: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/PROVIDER_MANUAL_4-1-21.pdf
- Provider FAQ: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/PROVIDER_FAQ.pdf
- Provider Orientation: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/PROVIDER-ORIENTATION-KIT.pdf
- You can reach the designated care manager for an Aetna Assure Premier Plus (HMO D-SNP) member by calling **844-362-0934 (711)** Monday to Friday, 8:00 AM to 5:00 PM.

Member ID Card Image





If you have any questions, please call Aetna Assure Premier Plus (HMO D-SNP) at **844-362-0934 (711)** Monday to Friday, 8:00 AM to 5:00 PM.

Financial Liability for Payment for Services

Balance billing enrollees is prohibited under the Aetna Assure Premier Plus (HMO D-SNP). 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 Assure Premier Plus (HMO D-SNP). 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 Assure Premier Plus (HMO D-SNP), and must indemnify the enrollee for payment of any fees that are the legal obligation of Aetna for services furnished by providers that have been authorized by Aetna Assure Premier Plus (HMO D-SNP) to service such enrollees, as long as the enrollee follows Aetna Assure Premier Plus (HMO D-SNP) rules for accessing services described in the approved enrollee Evidence of Coverage (EOC).
- 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

---

Electronic Visit Verification (EVV)

EVV is a web-based system that verifies when provider visits occur and documents the precise time services began and end. It ensures that people receive their authorized services. The 21st Century Cures Act mandate requires EVV for all personal care services with an “in-home” visit. In New Jersey, this includes:

- Personal Care Assistance services delivered by an agency
- Individual Supports, Community Based Supports, and In-home Respite delivered through DDD programs
- Respite and Home-Based Supportive Care delivered through MLTSS

Self-Directed personal care services (the Personal Preference Program and self-directed services coordinated through the NJ Division of Developmental Disabilities) will also require EVV.

The 21st Century Cures Act requires that states use EVV to collect six data points:

- Type of Service
- Person Served
- Dates of Service
- Location of Service
- Name of Caregiver
- Times of Service

Agency providers that do not demonstrate a good faith effort toward EVV compliance and do not align with the EVV compliance expectations outlined in the State of New Jersey Department of Human Services Division of Medical Assistance & Health Services (DMAHS) will be at risk of not receiving new referrals for PCA services beginning July 1, 2021.

All EVV mandated services will be submitted and billed through HHAeXchange as of July 1, 2021. Aetna providers can now use the HHA portal to both enter EVV data and to submit claims to us. Aetna encourages providers to begin submitting through HHAeXchange today to ensure compliance by July 1, 2021

For questions and issues, please contact HHA:

- NJ Client Support Email: NJSupport@hhaexchange.com
- Need help with EDI? EDISupport@hhaexchange.com

To submit questions or concerns about EVV, please email New Jersey's EVV Mailbox at: mahs.evv@dhs.state.nj.us DMAHS will monitor the mailbox and respond to inquiries.

Other resources

- Link to is the overall resource page for all functions within HHAX (including videos on the billing process). https://mlsupport.hhaexchange.com/knowledge-base/provider-portal-resource-center/

ConnectCenter to Replace Emdeon Office

We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health. ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims. You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until 05/31/2021. After that date, most of your Emdeon Office account will be deactivated, leaving access to old claims by logging in directly to the Reporting & Analytics feature. Click here to get started.

Here are a few improvements you can look forward to with ConnectCenter:

- Claims users no longer need to choose between data entry of claims and upload of 837 files. All users may do both
- Secondary and tertiary claims can be submitted
- Institutional claims are supported
- Claims created online are fully validated in real-time so that you can correct them in real-time
- Whether you upload your claims or create them online, you claim reports are integrated with the claim correction screen for ease in follow-up
- Dashboard and work list views makes managing your billing to-do list a snap
- On-shore customer support available through online chat, as well as by phone

If you wish to retain access to old claims after May 31st, please take the following steps to establish a Reporting & Analytics account that can be accessed independently of Emdeon Office

1. Go to https://access.emdeon.com/ and select the Forgot Password link

2. Provide your email address and the same Username you use to access the Emdeon Office Aetna Better Health Portal
3. Once your new password is emailed to you, please make note of the Username, Password and access.emdeon.com URL for use in future access to Reporting & Analytics

If you are unable to obtain a new password as described above, please contact customer support for assistance at (877) 667-1512, option 2.

Availity Provider Portal

You told us you wanted one efficient workflow to communicate with payers, so we teamed up with Availity® to streamline the process. We are excited to announce that Aetna Medicaid is now on the Availity Provider Portal, the same platform used by Aetna Commercial and Medicare. That means you only need access to one website to interact with all Aetna products, using your secure Availity username and password. Simply select Aetna Better Health from your list of payers to submit claims and view your Aetna Assure Premier Plus Membership.

On the Availity portal, providers can use:

- Payer Spaces
- Claims Submission Link (Change HealthCare)
- Contact Us messaging
- Claims status inquiry
- Appeals and Grievances
- Grievance submission
- Appeal submission
- Grievance and Appeals status
- Panel Roster-Panel Lookup
- Reports
- Prior Authorization
- Eligibility and Benefits

Coming soon to Availity…

- Remit PDF
- Enhanced Panel Roster
- Enhanced G&A tool

For registration assistance, please call Availity Client Services at 1-800-282-4548 between the hours of 8:00am and 8:00pm Eastern, Monday-Friday (excluding holidays).

Appointment Availability Standards

The following table 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.

- Baseline physicals for new adult members within 180 calendar days of initial enrollment
- Baseline physicals for new children members and adult clients of DDD within 90 days of initial enrollment
- Routine physicals within 4 weeks for routine physicals needed for school, camp, work or similar

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventative & Routine Care	Wait Time in Office Standard
Primary Care Physician (PCP)	Immediate	Within 24 hours	Within 72 hours	Within 28 days	No more than 45 minutes, except when Provider is unavailable due to an emergency
Specialty Referral	Immediate	Within 24 hours of referral	Within 4 weeks or shorter as medically indicated	Within 28 days	No more than 45 minutes, except when Provider is unavailable due to an emergency
Dental Care	Within 48 hours	Within 3 days of referral	Within 30 days of referral	Routine Care within 28 days	No more than 45 minutes, except when Provider is unavailable due to an emergency
Mental Health/Substance Abuse (MH/SA)	Immediate	Within 24 hours	Within 10 days of the request	Within 10 days of request	No more than 45 minutes, except when Provider is unavailable due to an emergency
Lab and Radiology Services	Immediate	Within 48 hours		Within 3 weeks for routine appointments	No more than 45 minutes, except when Provider is unavailable due to an emergency
OB/GYN	Immediate		Prenatal Care: 1. Within 3 weeks of positive pregnancy test (home or laboratory) 2. Within 3 days of identification of high-risk 3. Within 7 days of request in first and second trimester 4. Within 3 days of first request in third trimester		No more than 45 minutes, except when Provider is unavailable due to an emergency
Pediatric	Immediate		Within 3 months of enrollment		