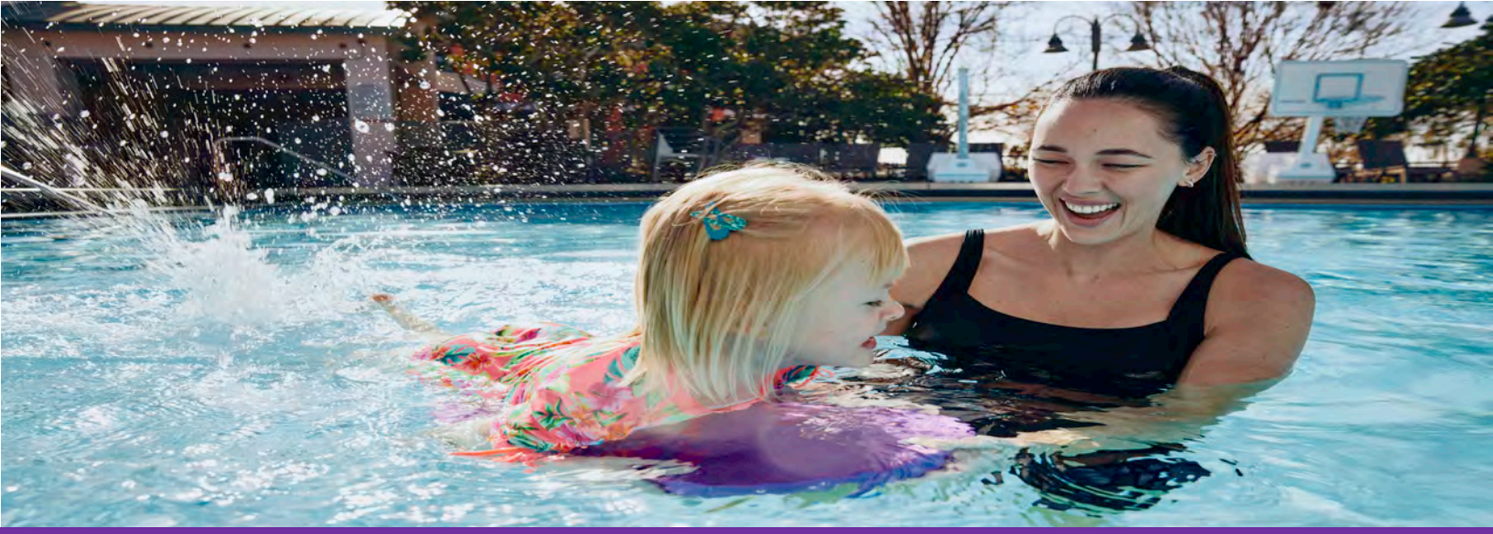


# Summer 2024 Provider Newsletter

**Aetna Better Health® of Virginia (HMO D-SNP) Aetna Medicare Assure Premier (HMO D-SNP) Aetna Medicare Assure Value (HMO D-SNP)**

## 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 standards. Providers are contractually required to meet 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 below indicates 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.

| | Primary Care | Specialist | OB/GYN | Behavioral Health |
|---|---|---|---|---|
| **Emergency** | Immediate | Immediate | Immediate | Immediate |
| **Urgent** | 24 Hours | 24 Hours | 24 Hours | 24 Hours |
| **Non-Urgent** | 72 Hours | 28 Days | 28 Days | 10 Days |
| **Routine** | 28 Days | 28 Days | 28 Days (non-perinatal) | 10 Days |
| **Perinatal** | N/A | N/A | 1st Trimester: 3 Weeks<br>2nd Trimester: 7 Days<br>3rd Trimester: 3 Days<br>High Risk: 3 Days<br>Routine: 3 Weeks<br>Postpartum: 6 weeks | N/A |
| **Wait Time** | No more than 45 minutes, except when the provider is unavailable due to an emergency | No more than 45 minutes, except when the provider is unavailable due to an emergency | No more than 45 minutes, except when the provider is unavailable due to an emergency | No more than 45 minutes, except when the provider is unavailable due to an emergency |

In addition to the standards above, Behavioral Health providers are required to offer:

- Follow-up Behavioral Health Medical Management within 3 months of the first appointment
- Follow-up Behavioral Health Therapy within 10 business days of the first appointment
- Next Follow-up Behavioral Health Therapy within 30 business days of the first appointment

## After Hours Phone Access

Provider expected response time for after-hours call back will be:

- Fifteen (15) minutes for crisis situations
- Thirty to forty-five (30-45) minutes for non-emergent symptomatic issues
- Same day for non-symptomatic concerns

Acceptable answering practices and staffing after-hours includes:
1) Telephone is answered by physician, office staff, answering service, or voice mail.
2) If using an answering service either:
• Connects the caller directly to the provider
• Contacts the PCP on behalf of the caller and the provider returns the call
• Provides a telephone number where the covering provider can be reached
3) The provider's answering machine message provides a telephone number to contact the covering provider.

## Balance Billing

Providers may not bill members for any Medicare or Medicaid covered services. Members are not responsible for Medicare cost sharing under CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays included as part of Medicare Advantage benefit plans.

## Dental Benefits

The membership has dental benefits included within their plan. Primary care providers should include discussions of dental health during their wellness visits and remind members to utilize their dental benefits by receiving their semi-annual cleanings and visit with a participating dentist. For more information on their dental plan, please review the provider handbooks for further information.

## Availity

### What is Availity?

Availity is a single login, multi-payer provider portal with self-service tools and provider-initiated transactions in one convenient location. Once registered, providers can simply add the Aetna instances to their registration at any time.

### Aetna and Availity

Availity operates Aetna's provider portal for multiple lines of business, including Commercial, Medicaid, Medicare, and DSNP/MMP products. There are now two instances of Availity for Aetna products: "Aetna" instance is for Medicare/Commercial, and the "Aetna Better Health" instance is for Medicaid/DSNP/MMP. Providers will need add both instances to their Availity profile to access our entire population. Availity will eventually replace the Aetna Better Health Medicaid Web Portal.

**Uses of Availity**
Availity allows providers to verify member eligibility and benefit coverage, submit claims and subsequent disputes, encounters, submit appeals and grievances, and update their rosters. Learn about the additional functions in one of the training options offered by Availity.

**How to receive training?**
Did you know that in addition to Availity Client Services, Availity offers a wide range of training sessions for all users via the Availity Essentials Provider Portal? You can simply click on the "Help & Training" dropdown to access both upcoming sessions as well as pre-recorded webinars.

**Who can the provider call for assistance?**
Call Availity directly at **1-800-AVAILITY (282-4548)**. Monday through Friday from 8 a.m. to 8:00 p.m. ET (excluding holidays). Availity can also be reached through direct messaging when available. Availity should be contacted for any connectivity or account concerns. Any concerns with an Aetna decision or information on Availity should be directed to the respective provider services.

## Quality Program

The Quality Management (QM) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service. A multidimensional approach enables the plan to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and providers. The QM Program is essential to ensure all medical care and service needs of our members are met and also ensure continuous improvement occurs with the quality of care and services being provided.

The QM Program addresses issues related to quality management and quality performance measures to ensure both state and national compliance. Annually, the health plan evaluates the effectiveness of the QM programs identifying specific opportunities for improvement.

**Quality goals:**

- Develop and maintain quality improvement processes, structures and resources in support of the organization-wide commitment to provision of quality healthcare for all members
- Development of effective methods to measure outcome of care and services provided to members, as well as interventions to achieve continuous and measurable improvements
- Continuous collaboration with appointed entities to develop and implement structures and programs fostering coordination and continuity of care
- Compliance with applicable federal, state, regulatory, contractual and accreditation requirements (HEDIS, CAHPS, HOS)
- Ensuring adequate accessibility to care and services
- Monitor and ensure members receive seamless, continuous and appropriate attention throughout the continuum of care
- Ensure members have access to appropriate care management programs, including Case Management and Disease Management
- Coordinate, monitor and report QM activities to appropriate committees

- Conduct root cause analysis for benchmarks or goals unmet
- Implement and monitor programs designed to improve the quality and safety of members through member and provider education

In an effort to meet these general goals, the QM Program implements and tracks a variety of QI activities that address the quality and safety of clinical care and quality of service throughout the year. These activities are described within the program evaluation including results compared to performance goals, trending of measures when appropriate, barrier analysis, opportunities for improvement and interventions.

- Ensure effective credentialing and recredentialing processes for providers who comply with state, federal and accreditation requirements
- Ensure the confidentiality of members is maintained at all times
- Analyze member and provider satisfaction survey results and implement effective interventions to address areas of dissatisfaction
- Oversight of all delegated activities to ensure compliance with all state, federal and accrediting organizations
- Promote improved continuity and coordination of care between medical and behavioral healthcare
- Develop and implement programs based on population analysis and incorporate culturally and linguistically appropriate services

Aetna evaluates the overall effectiveness of the QM Program utilizing the aforementioned findings to determine the adequacy of QM Program resources, QM committee structure, practitioner participation and leadership involvement. Where needed, changes to the QM Program for the subsequent year are made.

If you would like more information on our QM Program, please call Member Services or our Provider Network**.** It is very important to us that all members get access to the highest quality care and services possible. We want providers to know that not only do we listen to their feedback but try to find a way to implement that feedback.

## Notice of New Aetna Better Health of Virginia® Medicaid Claims and Encounters Front End Edits

The Virginia Department of Medical Assistance Services (DMAS) is required by the United States Code of Federal 42 CFR § 438 Subpart H to verify that all providers, provider groups, and affiliations who wish to provide services to Medicaid participants have their enrollment verified. This requirement applies to contracted Managed Care Organizations (MCOs), as well [aligns to rules 438.6 (b)(1) and 438.6(b)(2)].

In Virginia, DMAS requires contracted MCOs to verify that all Providers, Provider Groups, and their affiliates who wish to provide services to Medicaid participants have their Medicaid Enterprise System (MES) enrollment completed and verified using the State's Provider Service Solution module, PRSS, prior to rendering services to Medicaid members.

Aetna's Virginia plans have prepared clean claim edits to ensure compliance with the State of Virginia DMAS rules and edits. Aetna Better Health of Virginia will being enforcement of these edits as of July, 1st, 2023. This letter is being sent to ensure your medical office is

also preparing to ensure compliance. Together, we can reduce the impact and disruption to billing operations. The clean claim edits will deny claims when an effective Medicaid ID cannot be found on the State of Virginia MES registry for any of the following provider categories:

| **Professional Claims - 837P or CMS-1500** | **Institutional Claims - 837I or UB04** |
|---|---|
| Billing Provider 2010AA/Box 33A | Billing Provider 2010AA or Box 56 |
| Rendering Provider 2310B/2420A or Box 24J | Rendering Loop 2310D/2420C or Box 79 with 82 Qualifier |
| Referring Provider 2310A/2420F or Box 17B with DN Qualifier | Referring Loop 2310F/2420D or Box 79 with DN Qualifier |
| Ordering/Prescribing Provider 2420E or Box 17B with DK Qualifier | N/A |
| Supervising Provider 2310D/2420D or Box 17B with DQ Qualifier | N/A |
| N/A | Attending Provider 2310A or Box 76 |
| N/A | Operating Loop 2310B/2420A or Box 77 |
| N/A | Other Operating Loop 2310C/ 2420B or Box 78 with ZZ Qualifier |

Providers are responsible for resolving any State registration issues and are not permitted to balance bill the Medicaid subscriber. Aetna Providers of Medicaid patients must be registered with the State of Virginia's MES, using their National Provider Identifier (NPI), Taxonomy Code Practice address and Billing address. Registration must occur prior to rendering services to the plan's membership. Atypical providers are not required to have a National Provider ID (NPI). The Health Plan will perform edits based on the Medicaid ID submitted using the G2 qualifier in the rendering and/or billing loops.

In April 2022, the Virginia Department of Medical Assistance Services (DMAS) launched a new portal to manage provider enrollment – the Provider Services Solution (PRSS). Medicaid providers will use the PRSS portal, located on the MES website **https://virginia.hppcloud.com** to complete enrollment. All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act.

Providers can initiate enrollment through the new PRSS enrollment site. Go to "Enroll as a new provider or check your enrollment status." Only one enrollment application is necessary in PRSS, even if a provider participates with more than one Managed Care Organization (MCO). Once approved, providers will need to create a PRSS portal online account to revalidate their enrollment, make changes to personal or business information, and check member eligibility. You can find helpful training resources on the MES website **https://vamedicaid.dmas.virginia.gov/provider**.
Note: Those network providers currently enrolled as fee-for-service in Medicaid do not need to re-enroll in PRSS.

As of July 1st, 2023, Providers will be required to submit claims with the Billing and/or Rendering, Provider Taxonomy codes that are consistent with the registered specialty and services being rendered. Aetna Better Health of Virginia will reject the claim if the taxonomy code is not submitted for either the Billing or Rendering NPI. Aetna Better Health of Virginia strongly encourages sending the taxonomy codes associated to the Referring and Attending Provider types when included on the claim. Please follow the billing guidelines outlined in:

- **www.wpc-edi.com** when submitting EDI 837I/837P Claims
- **www.nucc.org** when submitting Professional CMS-1500 Claim Forms
- **www.nubc.org** when submitting Institutional UB-04 Claim Forms

## Retrospective Review Primer

A retrospective review is when the service has started. If the Date of service is before the request comes in then it is considered a Retrospective case. For example, the service started on 3/20 and your request is received by the plan on 3/22 that would be a retrospective review. Post Service requests are not processed as Expedited or Urgent requests.

A retrospective review cannot be performed in the following instances:

- A claim for the service/treatment has been submitted to the health plan
- The retrospective review request is made more than 180 days beyond the actual date of the service/treatment

Decisions will be made and you will be notified within thirty (30) calendar days of receipt of the request.

## Alternative Formats and Languages

If you wish to make or change a standing request to receive all materials in a language other than English or in an alternate format, you can call Aetna Member Services at **1-855-463-0933 (TTY: 711)**, 24 hours a day, 7 days a week.

## MOOP & Cost-Share Claims

This document is to provide a summary of two regulatory changes that impact Medicare medical providers.

**Maximum Out Of Pocket (MOOP)**

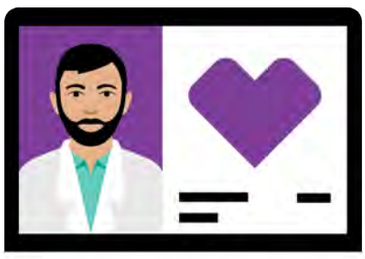
The MOOP limit for dual members will now be tracked based on the accrual of all Medi- care Part A & B cost sharing in the plan, whether those cost sharing amounts are paid by the member, other secondary insurance, or not paid at all. As a reminder, once MOOP is met Aetna will pay 100% of Medicare A&B covered services for the remainder of the calendar year.

Prior to 2023, MOOP for dual members was tracked by calculating cost share amounts paid by the member. CMS projects this change will increase payment to providers serving DSNP and MMP members by $8 billion over 10 years.
Regulatory Citation: 42 CFR § 422.100 and 422.101

**Medicaid Enrollment for Cost-Share Claims**

State Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers if the provider or supplier otherwise meets all Federal Medicaid enrollment requirements. Even if a provider or supplier is of a type not recognized as eligible to enroll in the State Medicaid program or is located out of state.

This change means, the provider does not have to become part of the Medicaid provider network or see Medicaid patients. If the provider or supplier chooses not to enroll with Medicaid, the state is not required to process their cost-share claims. In other words, the payment from Aetna would be payment in full.
Regulatory Citation: 42 CFR § 455.410(d)



## Updating Rosters and Provider Details

One of the functions available within Availity is updating provider demographics and roster information. Due to Availity serving multiple payers, providers can update their profiles on the Provider Data Management (PDM) page and have quarterly updates sent to all participating payers. In the page you can update service locations, location ADA compliance, update contact information, modify NPIs for the business, provide hospital affiliations, and correct provider profiles. You can reach the PDM by clicking on “My Providers” on the main page.

## Reminder: Submitting Expedited (Urgent) Authorization Requests

Aetna’s goal is to always provide a prompt response to the requests submitted and we need your help. As a reminder, an expedited request indicates that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

Submission of all necessary information helps get our members what they need, while in your care.  Please see the provider portal for the necessary Prior Auth forms.  It is vital that all lines are filled out in their entirety, including CPT codes, diagnosis codes, and your National Provider Identification (NPI).  If not, the case could pend for lack of clinical information.  The primary reason for denials is lack of clinical information received.  Please ensure that you are prepared with appropriate clinical during your submission.  Please reach out if you are not sure what needs sent or watch for a fax back from us telling you what will help process your case.

## Provider portal

Our enhanced, secure and user-friendly web portal is available at aetnabetterhealth.com/virginia-hmosnp/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 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 prior authorization 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 **aetnabetterhealth.com/virginia-hmosnp/providers/portal.** For more information, contact Provider Services at **1-855-463-0933.**

## Population Health Management

Aetna plans 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.

**Cognitive Impairment Program**

This program is targeted towards members and/or their caregivers who are either formally diagnosed with mild to severe cognitive impairments or are identified with positive findings for cognitive impairment. The focus is on member safety (medication, home safety, driving, financial, wandering), supporting a least restrictive residential setting, and working towards an optimal quality of life for the member and the caregiver. Aetna care managers will work with members and providers to ensure that members receive the right care and services that meet members' needs.

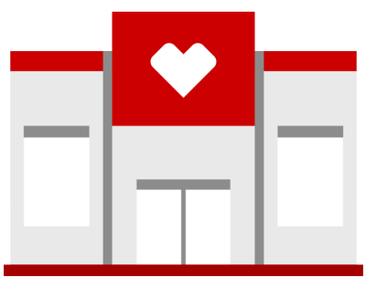
## Continuous Glucose Monitoring (CGM)

Aetna is working to reduce the long-term sequelae of diabetes. In addition, to working with our diabetic members chronic condition management including to have their hemoglobin A1c checked at least once a year, the plan is encouraging our providers to consider continuous glucose monitoring (CGM) systems for their patients with diabetes that would benefit from this. In general, individuals with diabetes are most appropriate for CGM when they:

- require at least 3 insulin administrations per day or use an insulin pump; and
- require frequent adjustment of insulin regimen based on their blood glucose levels.

In addition, individuals who suffer from frequent episodes of hypoglycemia may also be appropriate candidates. CGM allows you and your patients to see the fluctuations in blood glucose levels throughout the day, providing a more real-time view of their glycemic control. **CGMs do not require prior authorization.** For additional information, please refer to the following:
https://diabetes.org/tools-support/devices-technology

## Updating Rates for Critical Access Hospital



Aetna always strives to provide prompt and accurate payment. Aetna is asking for Critical Access Hospitals to forward any updated rate and fee schedule documentation to Aetna as soon as they receive them.

This will allow Aetna to update claim rates as soon as possible. Completing rate adjustments in a timely fashion helps avoid claim readjudication or recoupment. Your assistance is greatly appreciated.

## EFT/ERA Registration NEW!

Aetna is partnering with ECHO Health, Inc. to introduce the new EFT/ERA Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

**What is EERS?**

EERS will offer providers a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Providers will be able to use ECHO Health, Inc. to manage ETF and ERA enrollments with multiple payers on a single platform.

**How does it work?**
Please complete the ERA/EFT **enrollment form.** Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health, Inc. supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process. If you need assistance, contact ECHO Health, Inc. at allpayer@echohealthinc.com or 888.834.3511

**How and when do I enroll?**
All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit the ECHO Health, Inc. **Portal Guide.**

## Complex Care Management Referral Options
## Empowerment through care management

Aetna plans offer 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 (e.g. energy assistance, 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.

**What will a care manager do?**
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 **1-855-463-0933**. A care manager will review and respond to your request within 3 -5 business days.

## Pharmacy Benefits

Aetna'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 **https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/snp-prescriptions**. 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 **https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/snp-prescriptions** for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at **1-855-463-0933**.

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 **1-855-463-0933**. 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 MMP's formulary covers most drugs identified by Medicare as Part D drugs, and a member's copay may differ depending upon the tier at which the drug resides. The copay tiers for covered prescription medications are listed below. Copay amounts and coinsurance percentages for each tier vary by Aetna MMP plan. Consult your plan's Summary of Benefits or Evidence of Coverage for your applicable copays and coinsurance amounts.

Covered drugs are designated the following coverage tiers.
- Tier 1 drugs are Preferred Generic drugs.
- Tier 2 drugs are Generic drugs.

- Tier 3 drugs are Preferred Brand drugs.
- Tier 4 drugs are Non-Preferred drugs.
- Tier 5 drugs are Specialty drugs.

## Electronic Submission of Pharmacy Prior Authorizations

We are committed to making sure our providers receive the best possible information, and the latest technology and tools available. We have partnered with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (ePA) program. With Electronic Prior Authorization (ePA), you can look forward to:

- Time saving: Decreasing paperwork, phone calls and faxes for requests for prior authorization
- Quicker Determinations: Reduces average wait times, resolution often within minutes
- Accommodating & Secure:
- HIPAA compliant via electronically submitted requests.
- Getting started is easy. Choose ways to enroll:
- Visit the **CoverMyMeds® website**
- Call CoverMyMeds® toll-free at **866-452-5017**
- Visit the **SureScripts website**
- Call SureScripts toll-free at **866-797-3239**

**No cost required! Let us help get you started!**

**Aetna HMO D-SNP**
PCN: MEDDADV
Group: RXAETD
BIN: 610502

## Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Medicare Medicaid Plan (Aetna) 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/virginia-hmosnp/providers/hmo-snp-pr/snp-manual** to see our manual.


## Advance Directives Having the Conversation with Your Patient

A patient's comfort in contemplating, completing or even discussing an advance directive can greatly depend on what the physician has to say and offer.

***Your contract requires documentation in the patient's medical record of whether the individual has completed an advance directive***.

Having a conversation around advance directives with patients can be an awkward conversation in large part because many patients only see the advance directive process in terms of suffering and death. As the healthcare provider, you should approach advance care planning from the perspective of living well and quality of life. Approaching the subject in this way would allow members to engage in discussing what matters most to them so their wishes will be honored. You may start the conversation by asking about the types of treatments to consider if the member becomes very ill, is unable to recognize family, is unable to perform self-care or is unlikely to get better.

Advance directives are considered legal documents that take effect when someone is no longer able to speak for himself or herself. They ensure that your medical preferences are properly carried out by your health care provider. Advance directives include a living will and durable power of attorney for healthcare (DPA).

You should know that the AMA has developed training materials and ethical guidelines that provide understanding as to what patients want and physicians are able to provide. You can find those guidelines at **ama-assn.org**.

Additionally, Medicare offers payment for a voluntary advance-care planning (ACP) consultation offered by the physician or other qualified health professional when done face- to-face with the patient, family member(s) and/or surrogate.

*For additional information on the medical records audit components refer to your provider manual*

*Sources: AMA. "Advance directives: How to talk with patients about them." Retrieved from* ***https://www.ama-assn.org/delivering-care/patient-support-advocacy/advance-directives-how-talk-patients-about-them***
*"Advance Directives: Having the Talk." Retrieved from* ***https://www.webmd.com/palliative-care/features/advance-directives-having-the-talK***
*"Billing and coding: Advance Care Planning"* ***https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58664***

## Cultural Competency Training

Providers and their office staff are responsible for ensuring all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all patients. This includes those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Providers should ensure to address and document that patients are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages from all staff members. Providers should also honor members' beliefs, be sensitive to cultural diversity, and foster respect for members' cultural backgrounds.

Aetna conducts initial cultural competency training during Provider orientation meetings. If you have not previously completed Cultural Competency training or annual retraining, please take a moment to watch the video below:

**How Effective Healthcare Communication Contributes to Health Equity** and visit:
**thinkculturalhealth.hhs.gov/**

Additionally, Aetna's Quality Interactions© course series is available to Provider who wish to learn more about cultural competency. This course is designed to help you:
· Bridge cultures
· Build stronger patient relationships
· Provide more effective care to ethnic and minority patients
· Work with your patients to help obtain better health outcomes

To access the online cultural competency course, please visit:
**hrsa.gov/culturalcompetence**

## Clinical Criteria for Utilization Management Decisions

**How to request criteria**

Aetna 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:

1. 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)
2. Medicare Coverage Database (**link**)
3. Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC) (**link**)
4. Aetna Clinical Policy Bulletins (CPB) available on Aetna.com (**link**)
5. 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 (**link**)

6. Pharmacy clinical guidelines
7. Aetna Medicaid Pharmacy Guidelines

To request criteria, call Provider Experience at **1-855-463-0933** or visit our website at **http://www.aetnabetterhealth.com/virginia-hmosnp/providers**

## 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 **1-855-463-0933**, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling **1-855-463-0933**. Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.

## Provider Update

**Kidney Health Evaluation for Patients with Diabetes (KED) HEDIS Measure**

**Measure Definition**

Members 18 - 85 with diabetes (type 1 or type 2) who received a kidney health evaluation including both of the following during measurement year (MY):

- Estimated glomerular filtration rate (eGFR) and
- Urine albumin-creatinine ratio (uACR)

The uACR can be obtained through both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart.

**Commonly used Claim CPT Codes**

- eGFR: 80047
- Quantitative urine albumin test: 82043
- Urine creatinine test: 82570

**Insights and Recommendations**

- To be identified as diabetic for the HEDIS measure, member must have 1 of the following during the measurement year or year prior to the measurement year:
  - At least 2 diagnoses of diabetes on different dates of service or
  - A dispensed insulin or hypoglycemics/antihyperglycemic and at least 1 diagnosis of diabetes
- Order both the blood and urine components and apply appropriate coding
- Bill/code labs performed in-house
- Remind members to take medication as prescribed
- Educate members how diabetes affects kidneys and how to prevent kidney damage
- Coordinate diabetic care as needed with specialists, such as endocrinologists, nephrologists, cardiologists and ophthalmologists

# MA Plan Provider Responsibilities Following Quality Improvement Organization (QIO) Notification of Appeal

The Centers for Medicare and Medicaid Services (CMS) requires that all Medicare Advantage members be given the right to request an expedited review with the discontinuation or denial of previously approved services in a Hospital, Skilled Facility, HHA (Home Health Agency), or CORF (Comprehensive Outpatient Rehabilitation Facility), also defined as a Fast Track Appeal. Members are eligible for a Fast Track Appeal if they disagree with the discontinuation or denial of previously approved services in a Hospital, Skilled Facility, HHA, or CORF. If the member disagrees with the discharge and contacts the QIO, this policy will apply.

**Provider Responsibilities (Skilled Facility, HHA, or CORF) DENC:**

- Provide the Detailed Explanation of Non-coverage (DENC): When a QIO notifies the provider that a beneficiary has requested an expedited review, the provider must deliver a DENC to the beneficiary as soon as possible, but not later than noon of the day after the QIO's notification.
- Regulatory Requirements specify that the provider is required to hand deliver the DENC to the member.
- Additionally, CMS requires that the Medicare Advantage Plan documents the date the DENC was provided to enrollee. Therefore, the Plan requires that the provider provides that date of delivery by faxing a completed Fax Back Form (FBF) to the Aetna Fast Track Appeals Team at 860-754-2579.
- The Plan will make 3 diligent attempts to obtain the completed FBF from the provider.

See for more detail:
100.2.1: MA Plan Responsibilities Following BFCC-QIO Notification of Appeal
**Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance**

**Provider Responsibilities (Hospital) DND:**

- The hospital must deliver a completed copy of the Detailed Notice of Discharge (DND) notice to the member upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed a discharge from an inpatient hospital stay. The DND must be provided no later than noon of the day after the QIO's notification.
- Regulatory Requirements specify that the provider is required to hand deliver the DND to the member.
- Additionally, CMS requires that the Medicare Advantage Plan documents the date the DND was provided to enrollee. Therefore, the Plan requires that the provider provides that date of delivery by faxing a completed Fax Back Form (FBF) to the Aetna Fast Track Appeals Team at 860-754-2579.
- The Plan will make 3 diligent attempts to obtain the completed FBF from the provider.

See for more detail:
**100.2.1: MA Plan Responsibilities Following BFCC-QIO Notification of Appeal Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance**