Provider Manual

aetna®

Aetna Better Health® of Virginia

Last reviewed/revised: August 2026
For contract year July 1, 2026 – June 30, 2027

A note to providers:

This provider manual is to be used for Medicaid plans under Aetna Better Health of Virginia.

Our D-SNP product, Aetna Better Health of Virginia HMO-SNP, utilizes a separate manual, which can be found at **AetnaBetterHealth.com/Virginia-hmosnp/providers/hmo-snp-pr/snp-manual.**

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Provider Manual Attachments Section

This section of the Provider Manual contains the most commonly used documents, forms, and flyers providers use. For formulary information, please visit our **pharmacy** section. Simply select one of the below links, print it out, or create a bookmark on your computer for your future reference.

Provider Relations Information

AetnaBetterHealth-VAProviderRelations@Aetna.com

Provider Manual Regulatory Compliance Addendum

Provider Quick Reference Guide

Quality Management Forms and Flyers

You Call the Shots: Teen Vaccine Incentive Form – English | **Spanish**

Diabetes wellness exam flyer – English | **Spanish**

Well Woman Exams Flyer – English | **Spanish**

Men's Health Exams Flyer – English | **Spanish**

Ted E. Bear, M.D., Wellness Club enrollment and incentive form – English | **Spanish**

Claims, Appeals, and Additional Forms

Prior Authorization Request Form

Provider Dispute and Resubmission Form

Behavioral Health/Community Mental Health Rehabilitation Services (CMHRS) Expansion Forms
Critical Incident Report Form

Chapter 1 — Welcome to Aetna Better Health

We are pleased that you are part of our network of providers. At Aetna Better Health, we are committed to providing accessible, high-quality service to our members in Virginia, and we greatly appreciate all our providers' efforts in helping us achieve that goal.

To ensure we communicate effectively with providers, we have developed this Provider Manual. This document will help guide providers through our administrative processes. We will keep you up to date on any changes as they occur. These changes will be communicated to you in our provider newsletter, website, by letter or fax, and through regular contact with Provider Relations Representatives.

Thank you for your participation and interest in caring for our members.

About Aetna Better Health

For 30 years, Aetna Medicaid has honed our approach to serving high-acuity, medically frail, and low-income populations with diverse benefits. In Virginia, we have served the Medicaid population since 1996. Aetna Better Health of Virginia is a statewide Medicaid program offering managed care services and programs to individuals and families who qualify for:

Program	Population
Cardinal Care	Single managed care program that links seamlessly with Virginia's fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that includes Legacy Medallion 4.0, Legacy CCC Plus, and Legacy FAMIS Populations as outlined below:
1. Legacy Medallion	For low-income families and their children, pregnant women, and those in foster care or adoption assistance.
2. Legacy CCC Plus (Commonwealth Coordinated Care Plus)	For individuals with full Medicaid benefits who are 65 and older, children or adults with disabilities, nursing facility residents, or those receiving long-term services and supports.
3. Legacy FAMIS (Family Access to Medical Insurance Security)	For children of working parents who do not otherwise qualify for Medicaid.
Dual Eligible Special Needs Plan (D-SNP)	A Medicare Special Needs Plan for individuals on Medicare and who receive Medicaid assistance.

Our goal is to improve the functional status and quality of life for members while providing budget predictability to our state partners. Our experience in implementing, managing, and caring for high-acuity Medicaid members results in improved access to care, higher quality care in appropriate settings, and a simplified consumer experience in a culturally competent manner. We take seriously our responsibility as a steward of public programs.

Today, Aetna Better Health Medicaid serves nearly three million members through Medicaid managed care plans. In partnership with providers, community resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our most vulnerable members. While our programs and services continue to evolve and expand, our mission remains the same — building a healthier world by improving the lives and wellbeing of every member we are privileged to serve.

Model of care

Our model of care offers an integrated care management approach. The processes, oversight committees, provider collaboration, care management and coordination efforts applied to address member needs result in a comprehensive and integrated plan of care for members. Aetna Better Health works to partner with providers to collaborate on managing member's care needs.

Many components of our integrated care management program influence member health. These include:

- Comprehensive member health assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow members to reside in the least restrictive environment possible.
- Assessments and care plans that identify a member's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Care Management referral and predictive modeling software that identify members at increased risk, functional decline, hospitalization, and emergency department visits.

Our combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improving access to affordable care.
- Improving coordination of care through an identified point of contact.
- Improving seamless transitions of care across health care settings and providers.
- Promoting appropriate utilization of services and cost-effective service delivery.

Our efforts to promote cost-effective health service delivery include:

- Review of network for adequacy and resolve unmet network needs.
- Clinical reviews and proactive discharge planning activities.
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care services.

Service area

Our service area includes the entire Commonwealth of Virginia (all 95 counties and 38 independent cities).

Counties			
Accomack	Cumberland	King George	Prince William
Albemarle	Dickenson	King William	Pulaski
Alleghany	Dinwiddie	Lancaster	Rappahannock
Amelia	Essex	Lee	Richmond
Amherst	Fairfax	Loudoun	Roanoke
Appomattox	Fauquier	Louisa	Rockbridge
Arlington	Floyd	Lunenburg	Rockingham
Augusta	Fluvanna	Madison	Russell
Bath	Franklin	Mathews	Scott
Bedford	Frederick	Mecklenburg	Shenandoah
Bland	Giles	Middlesex	Smyth
Botetourt	Gloucester	Montgomery	Southampton
Brunswick	Goochland	Nelson	Spotsylvania
Buchanan	Grayson	New Kent	Stafford
Buckingham	Greene	Northampton	Surry
Campbell	Greensville	Northumberland	Sussex
Caroline	Halifax	Nottoway	Tazewell
Carroll	Hanover	Orange	Warren
Charles City	Henrico	Page	Washington
Charlotte	Henry	Patrick	Westmoreland
Chesterfield	Highland	Pittsylvania	Wise
Clarke	Isle of Wight	Powhatan	Wythe
Craig	James City	Prince Edward	York
Culpeper	King and Queen	Prince George	

Cities			
Alexandria	Falls Church	Manassas Park	Roanoke
Bristol	Franklin	Martinsville	Salem
Buena Vista	Fredericksburg	Newport News	Staunton
Charlottesville	Galax	Norfolk	Suffolk
Chesapeake	Hampton	Norton	Virginia
Colonial Heights	Harrisonburg	Petersburg	Beach
Covington	Hopewell	Poquoson	Waynesboro
Danville	Lexington	Portsmouth	Williamsburg
Emporia	Lynchburg	Radford	Winchester
Fairfax	Manassas	Richmond	

About this provider manual

This provider manual serves as a resource to providers and outlines operations for Aetna Better Health. Throughout the provider manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. Questions, problems, or concerns that the provider manual does not fully address can be directed to the Provider Relations department. Important contact information can be found in **Chapter 2 — Contacts**. Additional information for providers and members is available online at **AetnaBetterHealth.com/Virginia**.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of Aetna Better Health's provider agreement, including requirements described in this manual, and all federal and state regulations governing the provider. While this manual contains basic information about Aetna Better Health and the Department of Medical Assistance Services (DMAS), providers are required to fully understand and apply DMAS requirements when administering covered services. Please refer to **www.dmas.virginia.gov** for further information on DMAS. You can also access the DMAS Provider Manual **here**.

Chapter 2 — Contacts

Our standard business hours are Monday through Friday from 8 AM to 6 PM EST. Our office is closed on these holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Important phone numbers

Aetna Better Health	Toll-free
Provider Services	**1-800-279-1878 (TTY: 711)**

Important fax numbers

Aetna Better Health	Fax
Member Services	**1-866-207-8901**
Prior Authorizations for Legacy M4	**1-866-669-2454**
Prior Authorizations for Legacy Plus	**1-855-661-1828**
Provider Relations	**1-844-230-8829**
Behavioral Health	**1-833-757-1583**
Addiction and Recovery Treatment Services (ARTS)	**1-833-757-1583**
Appeals	**1-866-669-2459**
Care Management/Disease Management	**1-866-261-0581**
Inpatient Authorizations	**1-877-817-3707**

Important addresses

Department	Address
Claims	You can submit claims or resubmissions through your clearinghouse of choice or use one of Aetna Better Health's clearing house options and use the payer ID 128VA. To register, visit the appropriate clearing house portal and follow the prompts or reach out to your Aetna Better Health of Virginia Provider Relations Liaison for further instructions. Providers may elect to receive their ERA files from the clearinghouse on file with ECHO Health or via the ECHO Health portal. Providers that want to update their payment/ERA distribution preferences with ECHO Health for Medicaid claims payment may do so **here**. Once you've submitted claims, you can visit the Echo Health Portal to review claims payment information. **Paper**: Aetna Better Health of Virginia ATTN: Claims Department PO Box 982974 El Paso, TX 79998-2974
Reconsiderations	Aetna Better Health of Virginia ATTN: Reconsiderations PO Box 982974 El Paso, TX 79998-2974
Appeals	Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181

Websites

In addition to the telephone numbers and addresses above, participating providers may access the Aetna Better Health website 24 hours a day, seven days a week at **AetnaBetterHealth.com/Virginia/providers** for up-to-date information, forms, and other resources. Our provider newsletter can be accessed at **AetnaBetterHealth.com/Virginia/providers/provider-news.**

Within the website, a secure Provider Portal is maintained. The web portal can be accessed directly at **AetnaBetterHealth.com/Virginia/providers/portal.** The secure Provider Portal provides a platform for Aetna Better Health to communicate health care information directly to providers.

The health plan's eligibility and claims information can be accessed via the Provider Portal. Additional information regarding the website and secure web portal is available in the Provider Relations chapter.

Commonwealth of Virginia Medicaid Program

General information regarding the Virginia Medicaid Programs and DMAS can be found online at **www.dmas.virginia.gov**

Topics	For additional information
Provider Information	**www.dmas.virginia.gov** Toll Free: **1-800-772-9996**, **1-800-884-9730** or for Richmond and Surrounding Counties: **804-965-9732** or **804-965-9733**
Provider Bulletins	**vamedicaid.dmas.virginia.gov/provider/library**
Provider Enrollment	**https://virginia.hppcloud.com/** (to access the online enrollment system or to download a paper application) Phone: **1-888-829-5373** or **804-270-5105**
Virginia Medicaid Eligibility	**www.coverva.org** Phone: **1-855-242-8282 (TTY: 1-888-221-1590)**
Adult and Child Abuse & Neglect Hotline	Child Abuse: **www.dss.virginia.gov/family/cps/index.cgi** Phone: **1-800-552-7096** Adult abuse: **www.dss.virginia.gov/family/as/aps.cgi** Phone: **1-888-832-3858**

Reporting suspected fraud, waste, or abuse

Participating providers are required to report to Aetna Better Health and to the state of Virginia all cases of suspected fraud, waste, or abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud waste or abuse to Aetna Better Health in the following ways:

- Write us:
  Aetna Better Health of Virginia
  ATTN: Compliance department
  PO Box 818044
  Cleveland, OH 44180-8044
- Call Aetna Better Health's Fraud, Waste and Abuse toll-free number at: **1-844-317-5825**
- Visit Aetna Better Health's website and complete the requested information: **AetnaBetterHealth.com/Virginia/fraud-abuse**

Chapter 3 — Network Relations Department

The Network Relations department serves as a liaison between Aetna Better Health and the provider community. This department also supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards.

Network Relations

Network Relations assists providers by providing education and assistance regarding a variety of topics. Network Relations will:

- Provide education to provider offices.
- Provide support on Medicaid policies and procedures.
- Clarify provider contract provisions.
- Educate provider on compliance in respond to member's complaint from grievance & appeals.
- Assist with demographic changes, terminations, and initiation of credentialing.
- Conduct member complaint investigation.
- Maintain the provider directory.
- Be a point of contact for provider escalated issues.

Our Network Relations department is responsible for the ongoing education and training of Aetna Better Health's provider community. We maintain a strong commitment to meeting the needs of our providers. To accomplish this, a Network Relations Consultant is assigned to specific groups of participating or contracted providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of our health plan operations and is well versed in the managed care program.

A Network Relations Representative will outreach with participating providers' office/staff periodically to ensure providers' experiences are positive. Consultants are available to meet with office staff and providers for training and education. Provider news, electronic messages, and specialized mailings are sent to providers periodically that include updates to the provider manual, changes in policies or benefits, and general news or information of interest to our provider community. If you need help with determining who your Provider Relations Representative is, please contact our plan by emailing us at AetnaBetterHealth-**VAProviderRelations@Aetna.com**. Providers should always make sure Aetna Better Health of Virginia has their current contact details, so the health plan can contact them when necessary.

Joining the network

Effective July 1, 2022, the provider enrollment process must be initiated through the Virginia Department of Medical Assistance Services (DMAS). Providers must be in compliance with the 21st Century Cures Act by enrolling in the Provider Services Solution (PRSS) portal. Network providers not enrolled by July 1, 2023, may experience payment suppression until fully enrolled.

If you have not received a contract package or communication from an Aetna Better Health liaison two weeks after receiving confirmation of approval as an eligible Virginia Department of Medical Assistance Services Provider, please email **NetworkDevelopment-VAContact@AETNA.com.**

Any provider not yet contracted with Aetna Better Health will first need to enroll with DMAS using their Provider Portal. DMAS will then alert Aetna Better Health of your request to join our network, and we will reach out to you with a contract package.

Start enrollment through the new PRSS enrollment wizard. Type **virginia.hppcloud.com** **in your web browser to get started**. Only one enrollment application is necessary in PRSS. The application process allows for selection of multiple MCO plans. Once approved, your PRSS portal online account will be used to revalidate enrollment, make changes to personal or business information, and check member eligibility.

Find helpful training resources: **vamedicaid.dmas.virginia.gov/training/providers**

Questions?

Contact the PRSS Provider Enrollment Helpline at **804-270-5105** or **1-888-829-5373** or email Provider Enrollment at **vamedicaidproviderenrollment@gainwelltechnologies.com**

Provider orientation

We provide initial orientation for newly contracted providers after joining our network. In follow up to initial orientation, we provide a variety of forums for ongoing provider training and education, such as group or individualized training sessions on select topics (i.e., member benefits, Aetna Better Health website navigation), distribution of provider newsletters and bulletins containing updates and reminders, and online resources through our website at: **AetnaBetterHealth.com/Virginia.**

Chapter 4 — Provider responsibilities and important information

This section outlines general provider responsibilities. Additional responsibilities are included throughout this manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with the terms of the Virginia Medicaid program, provider contract, and requirements in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than the provider contract and this manual.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Advice given to potential or enrolled members should always be given in the best interest of the member.

Commonwealth of Virginia Medicaid (DMAS) provider enrollment

Providers who provide services to Aetna Better Health members must be enrolled as a Medicaid provider at each practice location with the Commonwealth of Virginia and credentialed by Aetna Better Health before they can provide health care to our members. To access online enrollment information or to download a paper application for the Commonwealth of Virginia, please refer to the department's website at **www.dmas.virginia.gov** or phone at **1-888-829-5373** or **804-270-5105**.

National Provider Identifier (NPI) number

The NPI number is a 10-digit number that is provider-specific assigned by the Centers for Medicare and Medicaid (CMS). For additional information, please visit the National Plan/Provider Enumeration System (NPPES) website at **nppes.cms.hhs.gov.** NPI numbers are required for claims submission to Aetna Better Health. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information. On the CMS 1500 form, the rendering provider's (box 31) NPI number is placed in the bottom half of the 24 J fields. The NPI for the billing provider in box 33 is placed in the 33A field.

Access and availability standards

We utilize accessibility/availability standards based on requirements from the National Committee for Quality Assurance (NCQA), state and federal regulations. The Access Standards are communicated to providers and members by newsletter, the Aetna Better Health website, and as part of the Provider Manual. Federal law requires that participating providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid fee-for-service members. Practitioners and providers that do not meet Aetna Better Health of Virginia's access standards are provided recommendations for improvements in order to meet the set standard.

Timely access		
Timely access standards for hours of operation for PCPs: • General appointment availability — 20 hours per week per practice location		
Provider type	**Appointment type**	**Availability standard**
Emergency services	Emergency	Immediately upon request
	Urgent care	Within 24 hours
Primary care services	Routine	Within 30 calendar days of request
Mental health services	Non-life-threatening emergency	Within six hours
	Urgent care	Within 48 hours
	Initial visit routine care	Within 5 working days of request
Maternity care	First trimester	Within seven calendar days of request
	Second trimester	Within seven calendar days of request
	Third trimester and high risk	Three working days from date of referral or immediately, if an emergency exists

Notes:

- A PCP is defined as family practice, internal medicine, pediatric, and general practice providers as well as, nurse practitioners, obstetricians/gynecologists, pediatricians, and specialists who perform primary care functions.
- High volume specialists are determined by the health plan through annual high-volume specialist reports. OB/GYN providers and oncologists-are considered mandatory high volume/high impact specialist providers and will be added to the annual high-volume specialist listing.
- When developing the network, Aetna Better Health considers the linguistic and cultural preferences of health plan membership. Member access to more than one PCP that is multilingual and culturally diverse is required for Medicaid.
- Selection of ancillary provider access as determined by the state.

When the provider is unavailable, arrangements must be made for another PCP to cover services.

Providers must provide covered services to Virginia Medicaid members 24 hour per day, seven day per week and must meet Virginia state standards for timely access to care and services, based on the urgency of need for services.

Cardinal Care access and availability standards

The tables below indicate appointment wait time standards for primary and specialty care; standards for acceptable wait time in the office when a member has arrived for a scheduled appointment, and acceptable after-hour appointment standards.

Provider type	Appointment type	Availability standard
All Provider Types	Emergency	Appointments for emergency services shall be made available **immediately** upon the Member's request.
	Urgent care	All urgent care and symptomatic office visits shall be available within no more than 24 hours of the Member's request; however, as quickly as the symptoms demand. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting.
	Routine	Appointments for routine, primary care services shall be made within **30 calendar days** of the Member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty calendar days, or for routine specialty services like dermatology, allergy care, etc.
Prenatal	First trimester	Seven calendar days of request
	Initial second trimester	Seven calendar days of request
	Third trimester	Within three business days of request.
	High-risk	Within three business days of identification of high risk or immediately if emergency exists.

Behavioral Health (See Chapter 15 for additional information)	
Standard UM Review – outpatient	3 business days if all clinical information is available or up to 5 business days if additional clinical information is required or as expeditiously as the Member's condition requires.
Standard - Mental Health Services (formerly CMHRS) and including Behavioral Health Expansion	14 calendar days
Standard – ARTS SA Case Management and ARTS Peer Support	14 calendar days
Urgent - Mental Health Services (formerly CMHRS) and including Behavioral Health Expansion	72 calendar hours
Urgent ARTS	72 calendar hours
Expedited Urgent — Pre-service Inpatient	3 hours
Expedited Urgent reviews for other urgent services	24 hours

Providers must be available to members 24 hours a day, seven days a week. When the provider is unavailable, arrangements must be made for another PCP to cover services.

Providers must offer hours of operation to members of Aetna's Virginia Medicaid managed care program that are no less (in number or scope) than the hours of operation offered to other non-Medicaid patients, or if a provider serves only Medicaid members, hours of operation comparable to the hours of operation offered to members of the Commonwealth of Virginia's Medicaid Fee-for-Service Program. Providers agree to provide covered services to Virginia Medicaid members on a 24 hour per day, seven day per week basis. Further, providers agree to meet Virginia state standards for timely access to care and services, considering the urgency of need for services.

Monitoring of standards

Monitoring of network provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members for PCPs, specialists, and CCC Plus providers, as needed. To monitor compliance with the access and availability standards, the health plan will:

- Review at least annually results of the Geo-access reports, completed by utilizing industry-standard software, to monitor compliance with the availability standards.
- Review the annual results of the Consumer Assessment of Health Plans Study, a member satisfaction survey, to monitor compliance with the accessibility and availability standards.
- Routinely monitor member complaints.
- Routinely monitor afterhours telephone accessibility and availability through member complaints and member and/or provider surveys or afterhours phone audits to ensure the provider or an associate is available 24 hours a day, seven days a week.
- Conduct announced and ad-hoc site visits to the providers office by Provider Relations representatives for any practices identified as meeting the threshold for member complaints.

Resolution of deficiencies

- In the event a participating network provider fails to meet provider access standards, the Provider Relations Representative will contact the provider to inform them of the deficiency, educate the standards to the provider, and work to correct the barrier to care.
- If there is a serious breach of the participating network providers' commitment to members and noncompliance with access to care, providers may be required to submit a Corrective Action Plan (CAP) and will be monitored until the CAP enables them to be compliant.
- If any network deficiencies are identified through the quarterly Geo-access review, applications or requests for participation will be sent to non-contracted facilities or providers in the affected service area(s).
- The health plan will also monitor and trend any member complaints regarding accessibility and availability of providers by product. If trends are identified, the health plan will promptly begin the recruiting process.

Covering providers

Aetna Better Health must be notified of practitioners who serve as covering providers for any of our network providers. This notification must occur in advance of the provision of any authorized services. Reimbursement to a covering provider is based on Virginia Medicaid fee schedule and dependent on enrollment as a provider with both Aetna Better Health and the state of Virginia Medicaid program. Failure to notify Provider Relations of covering providers may result in claim denials.

Verifying member eligibility

Regardless of contract status, all providers must verify a member's enrollment status prior to the delivery of nonemergent covered services. Providers are not reimbursed for services rendered to members who lost eligibility. Member eligibility can be verified through one of the following ways:

- Aetna Better Health's Secure Web Portal: **AetnaBetterHealth.com/Virginia/providers/portal**
- Aetna Better Health Member Services: **1-800-279-1878**

The Commonwealth of Virginia Medicaid Eligibility Line is **1-855-242-8282**, and it will also have helpful information regarding the member's assigned managed care company and program eligibility.

Secure Provider Portal

The secure Provider Portal is a web-based platform that allows us to communicate member health care information directly with providers and in real time. Providers can perform many functions within this web-based platform. The following information can be attained from the secure Provider Portal:

- Member Eligibility Search — Verify current eligibility of one or more members
- Member ID Card — View a full version of the member ID card (front and back)
- Panel Roster — View the list of members currently assigned to the provider as the PCP
- Provider List — Search for a specific provider by name, specialty, or location
- Claims Status Search — Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
  - **Note to providers:** Claims cannot be billed through the provider portal. Visit **aetnabetterhealth.com/virginia/providers/file-submit-claims.html**
- Remittance Advice Search — Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Lookup Tool — Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
  - Search prior authorization requirements by individual or multiple CPT/HCPCS codes simultaneously.
  - Review prior authorization requirement by specific procedures or service groups.
  - Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information.
  - Export CPT/HCPS code results and information to Microsoft Excel.
  - Ensure staff works from the most up-to-date information on current prior authorization requirements.
- Submit Authorizations — Submit an authorization request online. Three types of authorization types are available:
  1. Medical Inpatient
  2. Outpatient
  3. Durable Medical Equipment (DME) — Rental

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

If you're interested in using this secure online tool, you can register at **AetnaBetterHealth.com/Virginia/providers/portal,** or you can also contact Provider Relations to sign up over the phone. To submit your registration via fax, you can download the form from our website or request a copy from Provider Relations. Please note that internet access and a valid email is required for registration.

Note: Provider groups must first register a principal user known as the "Provider Admin." Once registered, the "Provider Admin" can add authorized users within each entity or practice. For instructions to add authorized users, go to **AetnaBetterHealth.com/Virginia** and select Provider Portal Instructions.

Overview of features for members

Members can register for their own secure member portal accounts at **AetnaBetterHealth.com/Virginia/login.**

We have customized the member portal to meet their needs better. Members will have access to:

- Health and Wellness Appraisal — This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- Educational resources and programs — Members can access self-management tools for specific topics such as smoking cessation and weight management.
- Claim status — Members and their providers can follow a claim from the beginning to the end, including current stage in the process, amount approved, paid, member cost (if applicable) and the date paid.
- Pharmacy benefit services — Members can find out if they have any financial responsibility for a drug, learn how to request an exception for a noncovered drug, request a refill for mail-order medications, and find an in-network pharmacy by zip code. They can also find information on drug interactions, side effects and risk for medications and get the generic substitute for a drug.
- Personalized health plan services information — Members can now view and request a member ID card, change PCPs, and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain referral and information on authorization requirements, and they can find benefit and financial responsibility information for a specific service.
- Innovative services information — Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
- Informed Health Line — The Informed Health Line is available 24 hours a day, seven days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- Wellness and prevention information — We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources, and automated outreach efforts with references to web-based self-management tools.

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online at **AetnaBetterHealth.com/Virginia/login,** or they can call Member Services at **1-800-279-1878**.

Educating members

The federal Patient Self-Determination Act gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Aetna Better Health shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Virginia Medicaid member who is his or her patient:

- For the Virginia Medicaid member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information, the Virginia Medicaid member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the Virginia Medicaid member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Aetna Better Health shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each managed care member is guaranteed the right to request and receive a copy of his medical records, and to request that they be amended or corrected as specified in **45 CFR Part 164**.

PCPs

PCPs are defined as providers who specialize in

- Family practice, general practice, internal medicine, pediatrics, or obstetrics/gynecology.
- Certified nurse practitioners.

The PCP's role is to:

- Manage and coordinate the overall health care of members.
- Make appropriate referrals to participating providers.
- Obtain prior authorization for any referrals to nonparticipating providers.
- Provide or arrange for on-call coverage 24 hours/day, seven days a week.
- Accept new members, unless Aetna Better Health has been provided with written notice of a closed panel.
- Maintain comprehensive and legible medical records.

Specialist providers

The specialist's role is to:

- Agree to discuss treatment of members with the PCP.
- Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment authorized by the PCP.
- Communicate any assessments or recommended treatment plans to the PCP.
- Obtain prior authorization for specified non-emergent inpatient and specified outpatient covered services.
- Maintain comprehensive and legible medical records.

Specialist providers acting as PCP

In limited situations, a member may select a provider specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Specialists who perform primary care functions within certain provider classes, care settings, or facilities include but are not limited to federally qualified health centers, rural health clinics, health departments, and other similar community clinics or other providers.
Specialists that qualify as PCPs include the following:

- Pediatricians
- Family and general practitioners
- Internists
- OB/GYNs
- Specialists who perform primary care functions within certain provider classes, care settings, or facilities. This includes, but is not limited to federally qualified health centers, rural health clinics, health departments, free clinics, and other similar community clinics
- Indian health care providers, including tribal clinic providers
- Other providers approved by the Department

In addition, children and youth with special healthcare needs may request that their PCP be a specialist.

Emergency services

Authorizations are not required for emergency services. In an emergency, please advise the member to call **911** immediately or go to the nearest emergency department. If a provider is not able to provide services to a member who needs emergent care, or if they call after hours, the member should be referred to the closest emergency department and to call **911** if necessary.

Urgent care services

Providers serve the medical needs of our members and are required to adhere to all appointment availability standards. In some cases, it may be necessary to refer members to a network urgent care center (after hours in most cases). Please reference the online directory on the Aetna Better Health website at **AetnaBetterHealth.com/Virginia/find-provider** and type in "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in the network.

Periodically, Aetna Better Health will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Medical home

The National Center for Medical Home Implementation defines a medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management. Performance/care coordination requirements of a medical home include the ability to:

- Provide comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited electronic contacts and ongoing care coordination and health maintenance tracking.
- Provide primary health care services for members and appropriate referral to other health care professionals or behavioral health professionals as needed.
- Focus on the ongoing prevention of illness and disease.

- Encourage active participation by a member and the member's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development.
- Facilitate the partnership between members, their personal provider, and when appropriate, the member's family.
- Encourage the use of specialty care services and supports.

Self-referral/direct access

Aetna Better Health has an open-access network, where members may self-refer, or directly access services without notice from their PCP. Aetna Better Health encourages all members to discuss specialty care with their PCP, who can coordinate needed services.

Services must be obtained from an in-network Aetna Better Health provider. There are exceptions to this, however; emergency, family planning, federally qualified and rural health centers, and tribal clinic services do not require prior authorization for in-network or out-of- network providers. Members may access these services from a qualified provider enrolled with the Commonwealth of Virginia Medicaid program.

Care for Tribal Members

Tribal providers hold a unique position within the Medicaid program, as the Tribes are recognized by the federal government as sovereign nations within the Commonwealth of Virginia. Tribal providers participating in the Virginia Medicaid program are not paid by Aetna Better Health or any other Virginia Medicaid MCOs. They are reimbursed for their services directly by DMAS at a uniform all-inclusive rate for services set by the federal government. Tribal members who are also Virginia Medicaid members have an expanded free choice of providers. In addition to free choice among network providers, Tribal members are guaranteed the right to access services from Tribal providers as well; this ensures that they have access to health care services provided in a setting that is culturally relevant to them. This guarantee in set out in **42 CFR § 438.14(b)(4)**.

Virginia has two Tribes, the Mattaponi and the Nansemond, who established primary care clinics and provide services to Tribal Medicaid members. The Tribal providers listed below have been added to our provider directory with a note that access to services from Tribal providers is limited to members of the Tribal community.

- Aylett Family Wellness (Upper Mattaponi Indian Tribe)
- Fishing Point Healthcare (Nansemond Indian Tribe)

This is to ensure that network providers and care coordinators can identify Tribal providers as being recognized by Aetna Better Health of Virginia. Prescriptions and referrals from Tribal providers must be honored in the same manner as network providers.

Second and third opinions

Aetna Better Health members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion. The member has a right to a third opinion when the recommendation of the second opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion. Aetna Better Health members will incur no expenses other than standard copays for a second and or third opinion provided by a participating provider, as applicable under the member Certificate of Coverage. Out-of-network services must receive prior authorization and are approved only when an in-network provider cannot perform the service.

Procedure for closing a PCP panel

A PCP who no longer wishes to accept new Aetna Better Health members may submit a written notification to Network Relations to close his or her panel. In this situation, any new member who is not an established patient of that PCP cannot select that PCP's office with an approved closed panel.

A PCP may re-open a "closed" panel by submitting a written notification to Provider Relations. This change will be made on the first of the month following submission of the request, no less than thirty days from receipt of the written request. Additional time may be necessary to update printed marketing materials.

When an Aetna Better Health member chooses a PCP who has a "closed" panel, Member Services will notify the subscriber of the provider's panel status. If the provider chooses to make an exception to accept the member, they should contact Member Services for assistance in facilitating an over-ride to assign members to their practice on a case-by-case basis.

Noncompliant members/PCP transfer (termination)

Providers are responsible for delivering appropriate services to facilitate member understanding of their health care needs. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. Aetna Better Health will assist in the resolution of member specific compliance issues by providing comprehensive member education and care management protocols. Please contact Member Services at **1-800-279-1878** for additional assistance in resolving member issues.

If member non-compliance issues persist, additional steps can be taken to address these situations including transfer of the member from a provider practice. The DMAS Managed Care Program has a process in place for the PCP, as well as Aetna Better Health to request transfers of members to another PCP. The PCP or health plan may request that the member be transferred to another PCP based on the following or similar situations:

- The PCP has sufficient documentation to establish that the member/provider relationship is not mutually acceptable, e.g., the member is uncooperative, disruptive, does not follow medical treatment, does not keep appointments.
- Travel distance substantially limits the member's ability to follow through with the PCP services/referrals.
- The PCP has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the service by the member. (Note: fraud and abuse investigation protocols are activated accordingly to investigate all identified potential cases).

The PCP and health plan must not request a transfer due to an adverse change in the member's health or adverse health status. The above reasons do not include a situation where a PCP has terminated a PCP-member relationship prior to managed care enrollment, unless the PCP can establish that the reason(s) for termination still remains an issue. The criteria for terminating a Medicaid member must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid members.

Except in the case of death or illness, the provider agrees to notify the health plan at least 30 days in advance of disenrollment and agrees to continue care for his or her panel members for up to 30 days after such notification, until another PCP is chosen or assigned. It is recommended that your practice have an established policy for dismissing patients from the practice. Aetna Better Health members should be seen and treated in the same manner as other patients you see. Services or appointments cannot be refused in emergency or urgent care situations unless you have provided a member with at least 30 days' notice and

requested that they select another provider. In the event of a member dismissal from your practice, the member should be notified in writing. It is recommended that the practice submit a copy to the health plan of the dismissal notification letter sent to the member. If requested, Aetna Better Health can assist the member in selecting a new provider. This policy is to be used for special situations with specific patients only where just cause exists for dismissing the patient.

Medical records review

All participating PCPs, defined as family practice, general or internal medicine, OB/GYN and pediatrics, who provide medical care in ambulatory settings must comply with the health plan's medical record documentation standards. The following standards are required:

Medical Record Documentation	
1	Past medical history is completed (for members seen three or more times) and is easily identified. It includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
2	Known allergies are documented with reaction type.
3	History and physical documents have subjective/objective information for presenting problem.
4	For members 14 years and older, there is appropriate notation about cigarettes, alcohol, and substance use. (For members seen three or more times, ask about substance abuse history.)
5	Note about follow-up care, calls, and visits. Specific time of return is noted in weeks, months or as needed.
6	An immunization record has been initiated for children and history for adults.
7	Preventive screenings and services are offered according to preventive services guidelines.
8	Any abnormal findings are followed up with and documented in the medical record.
9	Prescribed medications are listed including dosages and dates of fill or refill.
10	Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for under age 18).
11	Treatment plan current problem list is documented.
12	Working diagnoses are consistent with findings.
13	Evidence member is not at inappropriate risk relevant to particular treatment.
14	Blood pressure, weight, BMI percentile, and height measured/recorded at least annually, if member accesses care.
15	Lab and other studies are ordered, as appropriate.
16	Evidence that provider has reviewed lab, x-ray, or biopsy results (signed or initialed reports and the member has been notified of results before filing record).
17	Documentation of communications/contact with referred specialist and discharge summaries from hospitals.

18	Entries in patient records must be signed by the physician rendering the service (name and title) and dated (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature. Care rendered under the supervision of the participating provider must be countersigned by that provider. See DMAS Physician/Practitioner Manual Chapter IV (Covered Services and Limitations). A signature log may be requested in the case of an audit of medical records.
19	The patient's name and ID number must be on each page. All entries are dated and legible.

The Quality Management department will audit PCP practices for compliance with the documentation standards. Written notification of aggregated review results is given to provider offices after the medical record audit has been completed.

The health plan will provide routine education to providers and their respective clinics. This may include, but is not limited to, in-person and virtual trainings, articles in our provider newsletter on the medical record review process, highlights of low compliance, adaptation of any universal forms by Aetna Better Health and updates of any changes within the process and standards. Tools utilized to implement and maintain education may include emails, fax alerts, provider website, Availity, the provider manual, and mailings.

Providers understand and agree that the health plan and its members shall not be required to reimburse them for expenses related to providing copies of patient records or documents to any local, state or federal agency (i) pursuant to a request from any local, state or federal agency (including, without limitation, CMS or such agencies' subcontractors; (ii) pursuant to administration of Quality Management, Utilization Review and Risk Management Programs, including the collection of HEDIS data; or (iii) in order to assist Aetna Better Health in making a determination regarding whether a service is a covered service for which payment is due hereunder.

All records, books, and papers of providers pertaining to members, including without limitation, records, books, and papers relating to professional and ancillary care provided to members and financial, accounting, and administrative records, books, and papers, shall be open for inspection and copying by Aetna Better Health, its designee and/or authorized state or federal authorities during provider's normal business hours. In addition, provider shall allow Aetna Better Health to audit provider's records for payment and claims review purposes. Provider further agrees to maintain all such members' records for services rendered for a period of time in compliance with state and federal laws.

Medical record audits

Aetna Better Health or DMAS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider administrative responsibilities, fraud, waste, or abuse, EPSDT compliance, or quality of care issues. Providers should respond to these requests promptly. Medical records must be made available to Aetna Better Health, DMAS, CMS, and federal or state authorities and their agents for quality review and/or audit upon request. Records must be stored in a secured HIPAA-compliant manner.

Access to facilities and records

Federal and local laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of six years from the end of the contract with Aetna Better Health.
- The date the state of Virginia or their designees completes an audit.
- The period required under applicable laws, rules, and regulations.

Documenting member appointments and eligibility

When scheduling an appointment with a member over the telephone or in person (i.e., when a member appears at an office without an appointment), providers must verify eligibility and document the member's information in the medical record. Please access the Aetna Better Health website to electronically verify eligibility or call the Member Services department at **1-800-279-1878**.

Missed or cancelled appointments

Providers should:

- Document in the member's medical record and follow up on missed or canceled appointments.
- Conduct affirmative outreach to a member who misses an appointment by performing minimum reasonable efforts to contact the member.
- Notify Member Services when a member continually misses appointments.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA has many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities, specifically providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit: **www.hhs.gov/ocr/hipaa.**

In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train office staff on HIPAA.
- Consider the location and handling of the patient sign-in sheet.
- Keep patient records, papers, and computer monitors out of view and in secure locations.
- Have electric shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual's past, present or future physical or mental health, or condition.
  - The provision of health care to the individual.

- The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, social security number).
- Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.
- Release of data to third parties requires advance written approval from the member, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. For additional information, please visit: **www.aspe.hhs.gov/admnsimp/final/pvcguide1.htm.**

Member privacy rights

Aetna Better Health privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 CFR (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of PHI (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health practices regarding their PHI.
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI.
- Providing consistent review, disposition, and response to privacy requests within required time standards.
- Documenting requests and actions taken.

We are required by law to provide members with the **Notice of Privacy Practices**. This notice is included in the member's member packet and in our member newsletter. This notice informs members of their rights about the privacy of their personal information and how we may use and share personal information.

Changes to this notice will apply to the information that we already have about the member as well as any information that we may receive or create in the future. Members may request a copy at any time by calling Member Services at **1-800-279-1878** or by visiting **AetnaBetterHealth.com/Virginia.**

In doctor offices, the member's medical record will be labeled with their identification and stored in a safe location in the office where other people cannot it. If the doctor office uses a computer to store medical information, there should be a special password to safeguard member medical records.

Member medical records cannot be sent to anyone else without their written permission, unless required by law. When a member asks their doctor's office to transfer records, the doctor will give the member a release form to sign. It's the doctor's office responsibility to do this service for our members.

We will assist the member:

- To provide quick transfer of records to other in or out-of-network providers for the medical management of their health
- When the member changes PCPs, to assure that their medical records or copies of medical records are made available to their new PCP.

If a member would like a copy of their medical or personal records, they may send us a written request. The member may also call Member Services at **1-800-279-1878 (TTY: 711)** and ask for a form that they or their representative can fill out and send back to us. Members have a right to review their requested medical records and ask they be changed or corrected.

Member privacy requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Request amendments/correction to records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communication.
- Receive a **Notice of Privacy Practices**

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health in writing.

Cultural competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, cultural, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, sexual preference, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health expects providers to treat all members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement proven methods for responding to those challenges. Additionally, as part of our cultural competency program, we encourage our providers to access information on the Office of Minority Health's web-based **A Physician's Guide to Culturally Competent**

Care. The American Medical Association, American Academy of Family Physicians and the American College of Physicians endorse this program, which provides up to 9.0 hours of category 1 AMA credits at no cost. To access Aetna Better Health's Provider Cultural Competency training document, please visit **AetnaBetterHealth.com/Virginia/providers/provider-education/cultural**.

Health literacy — limited English proficiency (LEP) or reading skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and state requirements, Aetna Better Health is required to ensure members with LEP have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons identified with LEP are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, sexual preference, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with LEP or reading skills.
- Those with diverse cultural and ethnic backgrounds.
- The homeless.
- Individuals with physical and mental disabilities.

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the health plan, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health Member Services.
- Representatives will assist the provider via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services dials the language interpretation service and uses an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health staff (e.g., Care Managers or Member Services) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health Member Services to link with an interpreter.

Aetna Better Health provides alternative methods of communication for members who are visually impaired, including large print and/or other formats. Alternative methods of communication are also available for hearing impaired members, which include accessing the state relay line (711). Contact our Member Services for more information on how to access alternative formats/services for visually or hearing impaired.

Aetna Better Health requires the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver

information in a manner that is understood by the member. If interpreter services are declined, please document this in the members' medical record. This documentation could be important if a member decides that the interpreter, he or she has chosen has not provided him/her with full knowledge regarding his/her medical history, treatment, or health education.

During the credentialing process for Aetna Better Health, we ask what other languages are spoken in the office so we may refer our members with special language needs.

Individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a provider's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Site visits will be conducted by our Provider Relations staff to ensure that network providers are compliant.

Receipt of federal funds, compliance with federal laws and prohibition on discrimination

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84.
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91.
- The Rehabilitation Act of 1973.
- The Americans With Disabilities Act of 1990.
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law.
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.).
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act).
- HIPAA Administrative Simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network providers must comply with all applicable CMS laws, rules, and regulations, and network providers are prohibited from discriminating against any member on the basis of health status.

Providers shall provide covered services to members that are generally provided by a provider and for which the provider has been credentialed by Aetna Better Health. Such covered services shall be delivered in a prompt manner, consistent with professional, clinical, and ethical standards and in the same manner as to the provider's other patients. Provider shall accept members as new patients on the same basis as the provider accepts non-members as new patients. The provider shall not discriminate against a member on the basis of age, race, color, creed, religion, gender, gender identity, sexual preference, national origin, health status, use of covered services, income level, or on the basis, that member is enrolled in a managed care organization or is a Medicare or Medicaid member.

Out-of-network services

If Aetna Better Health is unable to provide necessary medical services covered under the contract within the network of contracted providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network providers for as long as the organization is unable to provide the services. Aetna Better Health will provide any necessary information for the member to be able to arrange

the service. The member will not incur any additional cost for seeking these services from an out-of network provider.

Clinical practice guidelines

Aetna Better Health adopts evidence-based clinical practice guidelines (CPGs) for medical and behavioral health conditions from nationally recognized sources. Clinical practice guidelines and treatment protocols promote consistent application of evidence-based methodologies. We make the CPGs available to our network providers to help improve health care. We review CPGs at least every two years. We may review them more frequently if national guidelines change within the two-year period. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member.
- Constitute procedures for or the practice of medicine by the party distributing the guidelines.
- Guarantee coverage or payment for the type or level of care proposed or provided.

CPGs are available on our website at: **AetnaBetterHealth.com/Virginia/providers/guidelines.** For assistance in obtaining hard copies from the nationally recognized sources, contact your Provider Relations Representative. For Behavioral Health practice guidelines, Virginia adopted the American Psychiatric Association guidelines.

Financial liability for payment for services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a network provider may collect deductibles, coinsurance, or copayments from members in accordance with the terms of the member's certificate of coverage or their member handbook. As of July 1, 2022, copays for FAMIS members have been eliminated. Providers must make certain they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved member certificate of coverage and/or their member handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a noncovered service, of the member's responsibility to pay the full cost of the services.
- Agreeing that, when referring a member to another provider for a noncovered service, the provider must ensure the member is aware of his or her obligation to pay in full for noncovered services.

Health care acquired conditions (HCAC)

Procedures performed on the wrong site, wrong body part, wrong person, or wrong procedure are referred to in this policy as "wrong site/person/procedures," or WSPPs. CMS has adopted a national payment policy that all WSPP procedures are never reimbursed to facilities. CMS prohibits providers from passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse providers for WSPPs or for any WSPP-associated medical services. In addition, Aetna Better Health prohibits passing these charges on to patients.

HCACs are preventable conditions that are not present when patients are admitted to a hospital but become present during the course of the patient's stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria:

1. The conditions are high-cost, high-volume, or both.
2. Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; could reasonably have been prevented through the application of evidence-based guidelines.

Effective **October 1, 2008**, CMS no longer issues payment for the extra care resulting from HCACs. CMS also prohibits passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse hospitals for the extra care resulting from HCACs. In addition, Aetna Better Health prohibits passing these charges on to patients.

General reminders to all providers

- Obtain prior authorization from Aetna Better Health for all services requiring prior authorization before rendering the service.
- Referrals to nonparticipating providers, regardless of level of care must be preauthorized, unless specifically exempted from authorization, such as family planning and emergency services.
- Authorization approval does not guarantee authorized services are covered benefits.
- Benefits are always contingent upon member eligibility at the time of service.
- Understand that prior authorization is approved by Aetna Better Health based upon the present information that has been made available to the health plan. Payment for prior authorized covered services is subject to the compliance with Aetna Better Health's Utilization Management program, contractual limitations and exclusions, and coordination of benefits.
- Accept medical necessity and utilization review decisions; refer to the Grievance and Appeal Section of this provider manual if a provider disagrees with a review decision or claim that has been processed.
- Agree to collect only applicable copayments, coinsurance, and/or deductibles, if any, from members. Except for the collection of copayments, coinsurance, and/or deductibles, providers shall look only to Aetna Better Health for compensation for medically necessary covered services.
- Agree to meet credentialing and recredentialing requirements of Aetna Better Health.
- Agree to provide medical records for Quality Management review at no cost to health plan or members.
- Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner.
- Providers shall provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services.
- Providers must obtain authorizations for all hospitalizations and confinements, as well as services specified in this manual and other provider communications as requiring prior authorization.
- Providers must comply fully with the terms of their agreement and maintain an acceptable professional image in the community.
- Providers must keep their licenses and certifications current and in good standing and cooperate with Aetna Better Health's recredentialing program. Aetna Better Health must be notified of any material change in the provider's qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health.

- Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/recredentialing process. Providers must furnish Aetna Better Health with evidence of coverage upon request and must provide the plan with at least thirty days' notice prior to the cancellation, loss, termination, or transfer of coverage.
- Providers shall ensure the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna Better Health including medical records data required and ensure the information is submitted on the applicable claim form.
- In the event the provider or Aetna Better Health seeks to terminate the agreement, it must be done in accordance with the contract.
- Providers must submit demographic or payment data changes at least sixty days prior to the effective date of change.
- Providers shall be available to Aetna Better Health members as outlined in the Access and Availability Standards section of this manual. Providers will also arrange 24-hour, on-call coverage for their patients by providers that participate with Aetna Better Health, as outlined within this manual.
- Providers must become familiar and to the extent necessary, comply with Aetna Better Health members' rights as outlined in the "Members Rights and Responsibilities" section of this manual.
- Participating providers agree to comply with Aetna Better Health's Provider Manual, quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures and any other policies Aetna Better Health may implement, including amendments made to the mentioned policies, procedures, and programs from time to time.
- Providers will ensure they honor all Aetna Better Health members' rights, including, but not limited to treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care, and to actively participate in decisions regarding health and treatment options.
- Providers of all types may be held responsible for the cost of service(s) where prior authorization is required, but not obtained, or when place of service does not match authorization. The member shall not be billed for applicable service(s).
- Aetna Better Health encourages providers to contact Provider Relations at any time if they require further details on requirements for participation. They can be reached by email at **AetnaBetterHealth-VAProviderRelations@Aetna.com.**

Provider responsibilities to Aetna Better Health

Federal law and statutes (as outlined in the contract) are detailed below.

Civil rights, equal opportunity employment, and other laws

Provider shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Provider recognizes that the Virginia Fair Employment Practice Act prohibits provider, in connection with its provision of services under this Amendment, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, or privileges of employment because of race, color, religion, sex, disability, or national origin. Provider guarantees its compliance with the Virginia Fair Employment Practice Act. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and prohibited relationships

Provider acknowledges that Aetna Better Health is prohibited from contracting with parties listed on the non-procurements portion of the Commonwealth of Virginia's General Services Administration's "Lists of parties Excluded for Federal Procurement or Non-procurement Program." This list contains the names of parties debarred, suspended, or otherwise excluded by state agencies, and contractors declared ineligible under state statutory authority. Provider warrants that it is not on this list at the time of entering into this Amendment. Should provider's status with respect to this list change, provider agrees to notify Aetna Better Health immediately.

Provider acknowledges that Aetna Better Health may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Provider warrants that it is not so excluded. Should provider's exclusion status change, Provider agrees to notify Aetna Better Health immediately. Further, provider shall not employ or contract for the provision of health care, utilization review, medical social work, or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Provider acknowledges that Aetna Better Health is prohibited from maintaining a relationship with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, and that Aetna Better Health is prohibited from having relationships with "affiliates" as the term is defined under the Federal Acquisition Regulation. Provider warrants that Aetna Better Health is not prohibited from maintaining a relationship with provider on these grounds, and provider agrees to notify Aetna Better Health immediately should its status change.

Federal sanctions

In order to comply with federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106), health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. CMS requires Aetna Better Health and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. The Controlling Interest Worksheet will be included with the credentialing application, as well as the recredentialing application. This Form must be completed, signed, and dated when returned from the provider.

Medically necessary services

The term "medically necessary" refers to health care services that a physician provides to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.

These services adhere to the following generally accepted standards of medical practice. All services provided to Medicaid members must be medically necessary and reflect:

- Health care services and supplies which are medically appropriate.
- Necessary to meet the basic health needs of the member.
- Rendering delivery of the covered service in the most cost-efficient manner and setting appropriate.

- Consistent in type, frequency, and duration of treatment with evidence-based guidelines of national medical, research, or health care coverage organizations or government agencies.
- Consistent with the diagnosis of the condition.
- Provision of services required for means other than convenience of the member and/or his/her provider.
- Provision that is no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Provision of services of demonstrated value.
- Provision of services that is no more intense level of service than can be safely provided.

New technology

Emerging technologies are a daily occurrence in health care. Aetna Better Health has a Clinical Policy Research and Development team review new and emerging technology. We review new medical technologies and new technology applications regularly. We determine whether and how such technologies will be considered medically necessary and/or not experimental/investigational under our benefits plans. The committee uses evidence-based clinical research to make determinations regarding the efficacy of the new technologies. Providers are advised of new technologies approved for coverage by Aetna's Clinical Policy Research and Development team via routine communications including the provider newsletter, bulletins, and ongoing Provider Relations contact.

Notice of provider termination

Aetna Better Health will make a good faith effort to give written notice of termination of a contracted provider, within thirty days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. It is the provider's responsibility to provide timely notification as indicated in the provider contract if they are requesting a termination from the network.

Health care reform update payments outside the United States

Effective **January 1, 2011**, Section 6505 of the Patient Protection and Affordable Care Act prohibits Medicaid health plans from making payments to financial institutions or entities located outside of the United States. This includes payments to providers, hospitals, and ancillary health care providers for items or services provided to Medicaid members through the Aetna Better Health contract with the state of Virginia. If you or your organization are located outside of the United States, or utilize a financial institution located outside of the United States, your payments will not be sent until you are located in the United States, or in the latter instance, establish a relationship with an entity located in the United States.

Provider responsibilities to members

This section outlines the provider responsibilities to Aetna Better Health members. This information is provided to providers to assist in understanding the requirements in place for the Medicaid program. Establishing an early PCP relationship is the key to ensuring that every Aetna Better Health member has access to necessary health care and to providing continuity and coordination of care. The member will already have chosen a PCP on the date their enrollment is effective. If necessary, Aetna Better Health will assign a PCP in the event that no selection is made.

PCP qualifications and responsibilities

To participate as a Virginia Managed Care Medicaid provider, the PCP must:

1. Be a Medicaid-enrolled provider and agree to comply with all pertinent Medicaid regulations. Effective April 1, 2022, provider enrollment in Virginia Medicaid and with Virginia Medicaid managed care plans requires enrollment in the DMAS Medicaid Enterprise System (MES) in order to comply with the requirements of the 21st Century Cures Act. Failure to enroll in MES may result in denial of payment for services. Additional information about MES and enrollment requirements can be found on the MES website at **https://vamedicaid.dmas.virginia.gov/provider.**

2. Sign a contract with Aetna Better Health as a PCP which explains the PCP's responsibilities and compliance with the following Managed Care Medicaid requirements:

    a. Treat Managed Medicaid members in the same manner as other patients.

    b. Provide the Managed Medicaid member with a medical home including, when medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community-based agency services.

    c. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.

    d. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours a day, seven days a week access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours.

    e. Not refuse an assignment or transfer a member or otherwise discriminate against a member solely based on age, sex, race, physical or mental handicap, national origin, type of illness or condition, except, for refusal of an assignment or transfer of a member, when that illness or condition can be better treated by another provider type.

    f. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the provider's office, e.g., TTD/TDD and language services, to accommodate the member's special needs.

    g. Maintain a medical record for each member and comply with the requirement to coordinate the transfer of medical record information if the member selects another PCP.

    h. Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the member's needs. Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services include but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans.

i. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.

j. Comply with all disease notification laws in the Commonwealth.

k. Provide information to the department as required.

l. Inform members about all treatment options, regardless of cost or whether such services are covered by the Virginia Medical Assistance Program

3. Provide accurate information to the health plan in a timely manner so that PCP information can be exchanged with DMAS and Aetna Better Health Provider Relations via the Provider Network File.

Advanced directives

Aetna Better Health maintains written policies and procedures related to advance directives that describe the provision of health care when the member is incapacitated. These policies ensure the member's ability to make known his/her preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health's policy defines advance directives as a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (statutory or as recognized by the courts of the state) relating to the provisions of health care when the individual is incapacitated. The advance directive policy details our obligation for advance directives with respect to all adult individuals receiving medical care by or through the health plan. These obligations include, but are not limited to:

- Providing written information to all adult individuals concerning their rights under state law to make decisions concerning their medical care, accept or refuse medical or surgical treatment and formulate advance directives for health care.
- Documenting in a prominent part of the individual's medical record whether the individual has executed an advance directive.
- Not conditioning the provision of care or otherwise discriminating against an individual based on whether that individual has executed an advance directive.
- Ensuring compliance with requirements of state law concerning advance directives.
- Educating health plan staff and providers on advance directives.

Aetna Better Health's policies provide guidance on Aetna's obligations for ensuring the documentation of any advance directive decisions in the provider's member records, and monitoring provider compliance with advance directives including the right of the member to note any moral or religious beliefs that prohibit the member from making an advance directive.

Aetna Better Health will ensure that our providers are informed of their responsibilities in regard to advance directives. Our Provider Relations staff educates network providers on information related to advance directives through the Provider Contract, Provider Manual, Provider newsletters and during Provider Relations' onsite office visits. Aetna Better Health Network Management is responsible for:

- Ensuring provider contracts contain requirements that support members' opportunity to formulate advance directives.
- Ensuring the provider manual contains guidance on advance directives for Aetna Better Health members.

Aetna Better Health's Quality Management staff distributes medical record documentation standards annually to the providers. One of the medical record documentation standards requires that if a member has an executed advance directive, a copy must be placed in the member's medical record. If the member does not have an executed advance directive, the medical record would provide documentation that a discussion regarding advance directives has occurred between the provider and the member.

Aetna Better Health is committed to ensuring that adult members understand their rights to make informed decisions regarding their health care. Aetna Better Health's advance directives Medicaid Policy and Procedure provides guidance on our obligations for educating members and providers. Aetna Better Health educates providers on advance directives processes to ensure our members have the opportunity to designate advance directives.

At the time of enrollment, the health plan distributes written information to members on advance directives (including Virginia state law) through the member handbook. The information in the materials includes:

- Member's rights under state law, including a description of the applicable state law.
- Aetna Better Health's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- The member's right to file complaints regarding non-compliance with the state.

Aetna Better Health is responsible for educating members and providers about advance directives rights. The Compliance Officer is responsible for ensuring advance directives information appears, no less than annually, in our materials. Advance directives information is available in the:

- Member handbook
- Member newsletter
- Website
- Provider manual
- Provider newsletters

Our Care Managers educate and offer advance directives information when appropriate. Additionally, providers are audited during on-site reviews to ensure policy and procedure compliance.

Chapter 5 — Credentialing and provider changes

Aetna Better Health's credentialing policy

Aetna's credentialing policy has adopted the highest industry standards, which are a combination of URAC/NCQA/CMS, plus applicable state and federal requirements. Exceptions to these standards are reviewed and approved based on local access issues determined by the local health plan. Aetna Better Health must follow and apply the provisions of state statutes, federal requirements, and accreditation standards that apply to credentialing activities.

Statement of confidentiality

Provider information obtained from any source during the credentialing/recredentialing process is considered confidential and used only for the purpose of determining the provider's eligibility to participate with in the Aetna Better Health network and to carry out the duties and obligations of Aetna Better Health operations, except as otherwise required by law.

Provider information is shared only with those persons or organizations who have authority to receive such information or who have a need to know in order to perform credentialing related functions. All credentialing records are stored in secured/locked cabinets and access to credentialing records is limited to authorized personnel only. Individual computer workstations are locked when employees leave their workstation. Access to electronic provider information is restricted to authorized personnel via sign-on security. All employees are trained and acknowledge training in accordance with federal HIPAA regulations. Disposal of all confidential documents must be via the locked confidential shred receptacles placed throughout the work area.

Credentialing/recredentialing

Aetna Better Health of Virginia uses current NCQA standards and guidelines for the review, credentialing and recredentialing of providers, with additional standards as required by the state of Virginia. The majority of the process uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Professional providers and most other types of providers can use CAQH, whereas MLTSS non-traditional providers are credentialed and recredentialed through Aetna Medicaid's dedicated unit.

The Universal Credentialing Data Source was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing Data Source is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

All new providers (with the exception of hospital-based providers), including providers joining an existing participating practice with Aetna Better Health of Virginia, must complete the credentialing process and be approved by the Credentialing Committee.

Providers are recredentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Failure to complete the reappointment application and submit all of the required documents can cause providers to be terminated from the Aetna Better Health network. **Please note that while you are being credentialed, you will be listed as nonparticipating with Aetna Better Health of Virginia until your credentialing has been approved.**

Provider credentialing

Aetna Better Health is committed to providing quality health care services to our members, and our

credentialing processes help us achieve that goal.

To be eligible to join the Aetna Better Health of Virginia network, providers must have completed all required state licensure, and certification registration. The Letter of Interest (LOI) should be on the provider's letterhead or in writing.

Upon completion of the credentialing process, the provider will receive a copy of the executed contract along with a welcome packet from the Aetna Better Health of Virginia Network Contract Specialist with the effective date of participation.

What to submit to Aetna Better Health Intake Team

- LOI
- Credentialing document
- Demographic changes
- Change of ownership or mergers
- Terminations (locations/providers)

The LOI/must include the following:

- Provider name
- Medicaid ID number
- License number (if applicable)
- Medicare ID number (if applicable)
- NPI
- Geographic location(s)
- Information outlining facility, specialty, and service offerings

The following are the general requests for a complete credentialing application submission and required documents:

- Complete facility application nontraditional provider application (if applicable)
  - Copy of State of Virginia License
  - Facility Credentialing Questionnaire
  - Accreditation (if applicable)
  - Current copy of professional liability insurance certificate
  - W9
  - Employment Qualification Attestation Form (if atypical and/or providing HCBS services)
- Complete Practitioner Credentialing Form
  - CAQH ID number
  - Authorize Aetna Better Health to access CAQH profile
  - Group roster (if applicable)
  - CAQH attestation updated within the last three months
- Upload required supporting documents to CAQH
  - Current Virginia medical license
  - Current Curriculum Vitae or resume
  - Proof of highest level of education
  - DEA license

- Board certificate(s) (if applicable)
- Current copy of professional liability insurance certificate
- W9

CREDENTIALING APPROVAL DATE

Aetna Better Health of Virginia determines the credentialing approval date as the date the plan's medical director approves the credentialing documents received from the provider.

NETWORK PARTICIPATION DATE

Aetna Better Health of Virginia uses the first day of the month following the credentialing approval date as the network participation date. Providers will receive notification of this date from the plan.

RECREDENTIALING REQUIREMENTS

Aetna Better Health of Virginia uses current NCQA standards and guidelines for the review, credentialing and recredentialing of providers and uses CAQH ProView. CAQH ProView allows providers to submit one application to meet the needs of all the health plans and hospitals participating in the CAQH effort. To maintain the accuracy of the data, CAQH sends providers a reminder every 90 days to re-attest to their information.

Facility: Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated. **Facility application (if applicable)**

- Copy of state of Virginia license
- Facility Credentialing Questionnaire
- Accreditation (if applicable)
- Current copy of professional liability insurance certificate
- W9
- Employment Qualification Attestation Form (if typical and/or providing HCBS services)

Provider: Aetna Better Health of Virginia recredentials providers on a regular basis (every 36 months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA) requirements. Termination of the provider contract can occur if a provider misses the 36-month timeframe for recredentialing.

- CAQH must have been re attested within the last 90 days
- All required documents must be uploaded into CAQH
  - Current Virginia Medical license
  - Current Curriculum Vitae or resume
  - Proof of highest level of education
  - DEA license
  - Board certificate(s) (if applicable)
  - Current copy of professional liability insurance certificate
  - W9

WHAT PROVIDERS ARE NOT CREDENTIALED?

- Pathology
- Emergency Medicine

- Anesthesia
- Radiology
- Laboratory
- Physician assistants
- Assistants or technicians
- Locum tenens
- Provisionally licensed providers or providers without a fully unencumbered Virginia license

WHAT PROVIDERS DO NOT REQUIRE CREDENTIALING?

- Nurse practitioners employed by provider groups or by a medical facility
- Hospitalists
- Nurse anesthetists

Nurse practitioner recredentialing

- Nurse practitioners who have a solo practice

List of specialties credentialed

Facility

- Acute rehabilitation facility
- Acute short-term hospital
- Addiction facility, inpatient
- Addiction facility, intensive outpatient
- Addiction facility, outpatient
- Addiction facility, partial hospitalization
- Addiction facility, residential
- Behavioral health rehabilitation services
- Children's hospital
- Community mental health center
- Convalescent care facility
- Crisis stabilization program
- Diabetic treatment center
- Diagnostic laboratory
- Dialysis center
- Federally qualified health center
- Federally qualified health center - mental health
- Home health care agency
- Hospital
- Independent lab
- Inpatient psychiatric facility services
- Intensive outpatient program
- Internal medicine
- Internal medicine, hospice, and palliative care
- Interventional cardiology
- Long term acute care hospital
- Mental health facility, inpatient
- Mental health facility, intensive outpatient

- Mental health facility, outpatient
- Mental health facility, partial hospitalization
- Mental health facility, residential
- Nursing care agency
- Outpatient diabetics self-management training
- Outpatient physical therapy facility
- Outpatient speech pathology facility
- Partial day/hospitalization program
- Portable X-ray supplier
- Psychiatric hospital, acute and long term
- Residential treatment facility
- Rural health clinic
- Skilled nursing facility
- Substance abuse facility
- Voluntary interruption of pregnancy center

Atypical

- Adult day care
- Assisted living
- Case management
- Early intervention education
- Freestanding hospice
- Home delivered meals
- Home health care agency (non-skilled services only)
- Home infusion
- Home modification
- Homemaking
- Independent durable med equipment
- Infusion center
- Personal care
- Personal emergency response system
- Respite care
- Service facilitator

Provider

- Addiction medicine
- Addiction psychiatry
- Addictionology
- Adolescent and young adult medicine
- Adolescent medicine
- Adolescent medicine and pediatric
- Aerospace medicine
- Allergy/immunology
- Applied behavioral analysis
- Audiologist
- Cardiology
- Cardiovascular disease

- Child abuse
- Child psychiatry
- Clinical psychologist
- Clinical social worker
- Counselor
- Counselor, addiction
- Counselor, autism spectrum
- Counselor, child & adolescent
- Counselor, child & adolescent, addiction
- Counselor, child & adolescent, autism spectrum
- Counselor, child & adolescent, dialectical behavior therapy
- Counselor, child & adolescent, expressive therapy services
- Counselor, child & adolescent, family therapy
- Counselor, child & adolescent, home based services
- Counselor, child & adolescent, religious based services
- Counselor, child & adolescent, trauma/crisis
- Counselor, dialectical behavior therapy
- Counselor, expressive therapy services
- Counselor, family therapy
- Counselor, home based services
- Counselor, religious based services
- Counselor, trauma/crisis
- Critical care medicine
- Critical care medicine/anesthesiology
- Critical care medicine/neurological surgery
- Critical care medicine/obstetrics & gynecology
- Cytopathology
- Dermatology
- Dermatopathology/dermatology
- Dermatopathology/pathology
- Developmental behavioral pediatrics
- Drug and alcohol counselor
- Endocrinology
- Endocrinology, diabetes & metabolism
- Endocrinology, reproductive
- Endodontics
- Facial plastic surgery
- Family medicine, hospice, and palliative care
- Family practice
- Forensic psychiatry
- Gastroenterology
- General practice
- Geriatric medicine/internal medicine
- Gynecology
- Hematology
- Hematology/oncology
- Hematology/pathology

- Immunopathology
- In vivo and in vitro nuclear medicine
- Infectious disease
- Lactation consultant non-RN
- Licensed professional counselor
- Marriage/family therapist
- Massage therapist
- Maternal & fetal medicine
- Medical genetics
- Medical microbiology
- Medical toxicology
- Medical toxicology/preventive medicine
- Midwife
- Neonatal-perinatal medicine
- Neonatology
- Nephrology
- Neurodevelopmental disabilities
- Neurology
- Neurology & psychiatry
- Neurology, child
- Neurology/psychiatry, hospice, and palliative care
- Neuromuscular medicine physical medicine & rehab
- Neuromuscular medicine psychiatry & neurology
- Neuromusculoskeletal medicine
- Neuropathology
- Neuropsychologist
- Neuroradiology
- Neurotology
- Nuclear cardiology
- Nuclear medicine
- Obstetrics & gynecology
- Obstetrics/gynecology, hospice, and palliative care
- Occupational medicine
- Occupational therapist
- Occupational therapy
- Oncology
- Oncology, gynecologic
- Oncology, medical
- Oncology, orthopedic
- Ophthalmology
- Optometrist
- Oral surgeon
- Otolaryngology
- Otolaryngology (pediatrics)
- Otolaryngology/facial plastic surgery
- Otology
- Otology/neurotology

- Otorhinolaryngology
- Otorhinolaryngology/plastic surgery
- Pain management
- Pediatric allergy & immunology
- Pediatric ambulatory
- Pediatric anesthesiology
- Pediatric cardiology
- Pediatric critical care
- Pediatric dentistry
- Pediatric dermatology
- Pediatric emergency medicine
- Pediatric endocrinology
- Pediatric gastroenterology
- Pediatric hematology-oncology
- Pediatric infectious disease
- Pediatric intensive care
- Pediatric internal medicine
- Pediatric medical genetics
- Pediatric nephrology
- Pediatric neurology
- Pediatric ophthalmology
- Pediatric orthopedic
- Pediatric otolaryngology
- Pediatric pathology
- Pediatric physical medicine and rehabilitation
- Pediatric plastic surgery
- Pediatric pulmonology
- Pediatric radiology
- Pediatric rehabilitation medicine
- Pediatric rheumatology
- Pediatric sports medicine
- Pediatric surgery
- Pediatric thoracic & cardiovascular surgery
- Pediatric thoracic surgery
- Pediatric urology
- Pediatrics
- Pediatrics, hospice, and palliative care
- Perinatology
- Periodontics
- Physical medicine & rehabilitation
- Physical medicine, hospice, and palliative care
- Physical therapist
- Podiatrist
- Preventive medicine
- Preventive medicine/aerospace medicine
- Preventive medicine/occupational
- Preventive medicine/occupational therapy

- Preventive medicine/public health
- Proctology
- Psychiatric nurse
- Psychiatry
- Psychiatry, addiction
- Psychiatry, autism spectrum
- Psychiatry, child & adolescent
- Psychiatry, child & adolescent, addiction
- Psychiatry, child & adolescent, autism spectrum
- Psychiatry, child & adolescent, home based services
- Psychiatry, child & adolescent, religious based services
- Psychiatry, child & adolescent, trauma/crisis
- Psychiatry, geriatric
- Psychiatry, home based services
- Psychiatry, religious based services
- Psychiatry, trauma/crisis
- Psychological examiner
- Psychologist
- Psychologist, addiction
- Psychologist, autism spectrum
- Psychologist, child & adolescent
- Psychologist, child & adolescent, addiction
- Psychologist, child & adolescent, autism spectrum
- Psychologist, child & adolescent, expressive therapy services
- Psychologist, child & adolescent, family therapy
- Psychologist, child & adolescent, home based services
- Psychologist, child & adolescent, psychological testing
- Psychologist, child & adolescent, religious based services
- Psychologist, child & adolescent, trauma/crisis
- Psychologist, child & adolescent, dialectical behavior therapy
- Psychologist, dialectical behavior therapy
- Psychologist, expressive therapy services
- Psychologist, family therapy
- Psychologist, home based services
- Psychologist, psychological testing
- Psychologist, religious based services
- Psychologist, trauma/crisis
- Psychosomatic medicine
- Pulmonary disease
- Radiation oncology
- Registered dietician
- Registered nurse anesthetist
- Rehabilitation medicine
- Respiratory therapist
- Retinal ophthalmology
- Rheumatology
- Roentgenology

- Sleep medicine
- Sleep medicine - family practice
- Sleep medicine - neurology
- Sleep medicine - pediatric
- Sleep medicine-internal medicine
- Sleep medicine-ophthalmology/otolaryngology
- Spinal cord injury medicine
- Sports medicine
- Sports medicine/internal medicine
- Sports medicine/pediatrics
- Sports medicine/rehabilitation
- Surgery
- Surgery, colon & rectal
- Surgery, congenital cardiac/thoracic
- Surgery, general vascular
- Surgery, hand
- Surgery, hand/orthopedic
- Surgery, hand/plastic
- Surgery, head & neck
- Surgery, hospice, and palliative care
- Surgery, knee
- Surgery, neurological
- Surgery, obstetrics & gynecology
- Surgery, oncology
- Surgery, oral & maxillofacial
- Surgery, orthopedic
- Surgery, plastic
- Surgery, plastic and reconstructive
- Surgery, thoracic
- Surgery, thoracic cardiovascular
- Surgery, urological
- Surgical critical care
- Underseas medicine
- Urology
- Vascular neurology

If you have questions about the credentialing process or to check the status, please email Provider Relations at **Aetnabetterhealth-VAProviderRelations@aetna.com.**

Facility licensure and accreditation

Health care delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Ongoing monitoring

Ongoing monitoring consists of monitoring provider and or provider sanctions, or loss of license to help manage potential risk of substandard care to our members.

Additions or provider terminations

In order to meet contractual obligations and state and federal regulations, providers who are in good standing are required to report any terminations or additions to their agreement at least 90 days prior to the change in order for Aetna Better Health to comply with CMS and/or accreditation requirements.

Providers are required to continue providing services to members throughout the termination period.

Providers are responsible to notify Provider Relations of any changes in professional staff at their offices (providers, provider assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact Provider Relations to discuss staff training, if needed.

State and accreditation guidelines require Aetna Better Health to make a good faith effort to provide written notice of a termination of a network provider at least thirty days before the termination effective date to all members who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all members who are patients of that PCP must be notified when a provider termination occurs.

Continuity of care

Providers terminating their contracts without cause are required to provide 60 days' notice (or otherwise determined by their contract) before terminating with Aetna Better Health. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Providers may also contact our Care Management department for assistance with continuity of care.

Non-discrimination

Aetna does not discriminate against any qualified applicant based on race, color, creed, ancestry, religion, age, disability, sex, national origin, citizenship, sexual orientation, disabled veteran, or types of procedures performed or types of patients the provider specializes, or Vietnam veteran status, in accordance with federal, state, and local laws.

All employees of Aetna Better Health are required to attend online training within 60 days of hire and annually thereafter, which requires passing a comprehensive quiz at the end of each training module. This training includes our Code of Business Conduct and Ethics, and Unlawful Harassment, both of which address our non-discrimination policies and practices.

Aetna maintains a compliance line **1-844-317-5825**, which is available 24 hours per day, seven days for all employees, as well as members and providers to call to report compliance matters. All Aetna Better Health employees have been educated on the compliance line and are encouraged to call if they suspect discrimination.

For any questions regarding the credentialing or recredentialing status of a provider, please contact Provider Relations.

Chapter 6 — Member benefits

Aetna Better Health believes that the essence of a successful Medicaid program is the extent that members understand their benefits and how to access them. We also go beyond simply educating members about covered services and put incentive programs in place to encourage benefit utilization.

Benefits for All Members

Physical Health Services

Aetna Better Health and DMAS cover physical health services (including dental and vision) for Cardinal Care members:

- Adult day health care
- Cancer screenings and services (colorectal cancer screening, mammograms, pap smears, prostate specific antigen and digital rectal exams, reconstructive breast surgery)
- Care management and care coordination services
- Clinic services
- Clinical trials (routine patient costs related to participation in a qualifying trial)
- Court-ordered services, emergency custody orders (ECO), and temporary detention orders (TDO)
- Dental services (more on this below)
- Durable Medical Equipment (DME) (respiratory, oxygen, and ventilator equipment and supplies; wheelchairs and accessories; hospital beds; diabetic equipment and supplies; incontinence products; assistive technology; communication devices; rehabilitative equipment and devices)
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) (more on this below)
- Early Intervention (EI) services (more on this below)
- Emergency and post-stabilization services
- Gender dysphoria treatment services
- Glucose test strips
- Hearing services
- Home and community-based waiver services (more on this below)
- Home health
- Hospice
- Hospital care (inpatient and outpatient)
- Human Immunodeficiency Virus (HIV) services (testing and treatment counseling)
- Immunizations (adult and child)
- Laboratory, radiology, and anesthesia services
- Lead Investigations
- Oral services (hospitalizations, surgeries, services billed by a medical provider)
- Organ transplants (for all children and for adults who are in intensive rehabilitation)
- Orthotics (children under age 21)
- Nutritional counseling for chronic disease
- Podiatry services (foot care)
- Prenatal and maternal services (pregnancy/postpartum care) (more on this below)
- Prescription drugs
- Preventive care (regular check-ups, screenings, well-baby/child visits)
- Prosthetics (arms/legs and supportive attachments, breasts, and eye prostheses)
- Regular medical care (PCP office visits, referrals to specialists, exams)
- Radiology services

- Rehabilitation services (inpatient and outpatient, including physical/ occupational therapy and speech pathology/audiology services)
- Renal services (dialysis, End Stage Renal Disease services)
- School health services (more on this below)
- Surgery services
- Telehealth services (more on this below)
- Tobacco cessation services
- Transportation services
- Tribal clinical provider type services
- Vision services (eye exams/treatment/ glasses to replace those lost, damaged, or stolen for children under age 21 (under EPSDT))
- Well visits

DMAS contracts with a Dental Benefits Administrator, DentaQuest, to provide dental services to all Medicaid/FAMIS members. See the table below for dental services available to members. Members are not responsible for the cost of dental services received from a participating dental provider. Some dental services will require prior approval. Aetna Better Health will work with the Department's Dental Administrator to authorize some services, including anesthesia when medically necessary. For questions about members' benefits, call DentaQuest Member Services at **1-888-912-3456 (TTY: 1-800-466-7566)** or visit **dmas.virginia.gov/dental**.

Dental Service	Children/Youth Under Age 21	Pregnant/ Postpartum People	Adults Age 21 and Older
Braces	Covered	Not covered	Not covered
Cleanings	Covered (including fluoride)	Covered	Covered
Crowns	Covered	Covered	Limited coverage
Dentures	Covered (including partials)	Covered (including partials)	Covered
Exams	Covered (including regular check-ups)	Covered	Covered
Extractions and Oral Surgeries	Covered	Covered	Covered
Fillings	Covered	Covered	Covered
Gum Treatment	Covered	Covered	Covered
Root Canals	Covered (including treatment)	Covered	Covered
Sealants	Covered	Not covered	Not covered
Space Maintainers	Covered	Not covered	Not covered
X-Rays	Covered	Covered	Covered

Behavioral Health Services

Aetna Better Health, DMAS, or its contractor covers the behavioral health treatment services in the table below for Aetna Better Health members. Behavioral health refers to mental health and addiction services. In Virginia Medicaid, the continuum of services for addiction treatment is called "Addiction and Recovery Treatment Services" (ARTS).

Mental Health Services
• 23-hour crisis stabilization • Applied behavior analysis • Assertive community treatment • Community stabilization • Functional family therapy • Intensive in-home • Mental health case management • Mental health intensive outpatient • Mental health partial hospitalization program • Mental health peer recovery supports services • Mental health skill-building services • Mobile crisis • Multisystemic therapy • Psychiatric residential treatment facility □ • Psychosocial rehabilitation • Residential crisis stabilization • Therapeutic day treatment • Therapeutic group home □ • Inpatient psychiatric services • Outpatient psychiatric services • Outpatient behavioral health therapy
□ Services that are managed by the DMAS' behavioral health administrator contractor.

Addiction and Recovery Treatment Services (ARTS)

• Screening, Brief Intervention and Referral to Treatment
• Substance Use Case Management Services
• Outpatient Services
• Intensive Outpatient Services
• Partial Hospitalization Services
• Substance Use Residential Treatment
  – ASAM 3.1
  – ASAM 3.3
  – ASAM 3.5
  – ASAM 4.0
• Medication Assisted Treatment
• Peer Recovery Support Services
• Opioid Treatment Services
• Office Based Addiction Treatment

Long-Term Services and Supports (LTSS)

Aetna Better Health and DMAS cover LTSS such as private duty nursing, personal care, and adult-day health care services. Before receiving LTSS, a community-based or hospital team will conduct a screening to see if members meet "level of care" criteria.

Members can get LTSS in their home, the community, or a nursing facility. Members who are interested in moving from the nursing facility into their home or the community should talk with their care manager.

Receiving certain types of care will end their enrollment with managed care and Aetna Better Health, but they will still have Medicaid. These types of care include:

- Intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- Care from one of the following nursing facilities:
  - Bedford County Nursing Home
  - Birmingham Green
  - Dogwood Village of Orange County Health
  - Lake Taylor Transitional Care Hospital
  - Lucy Corr Nursing Home
  - The Virginia Home Nursing Facility
  - Virginia Veterans Care Center
  - Sitter and Barfoot Veterans Care Center
  - Braintree Manor Nursing Facility and Rehabilitation Center
- Care from Piedmont, Hiram Davis, or Hancock state operated long term care facility.
- Program of All Inclusive Care for the Elderly (PACE) care.

If a member gets LTSS, they may need to pay for part of their care. If a member has Medicare, Aetna Better Health will cover nursing facility care after they have used all of the skilled nursing care that was available to them.

Benefits for Home and Community Based Services (HCBS) Waiver Enrollees

Some members may qualify for HCBS waiver services (see table below). Developmental Disability waiver services are managed through the Department of Behavioral Health and Developmental Services (DBHDS). You can also find more information about Developmental Disability waiver services on the DBHDS website at **mylifemycommunityvirginia.org** or by calling **1-844-603-9248**.

Waiver	Description	Examples of Covered Benefits
Commonwealth Coordinated Care (CCC) Plus Waiver	Provides care in your home and community instead of a nursing facility. You can choose to receive agency-directed or consumer directed services, or both.	• Adult Day Health Care • Assistive technology • Environmental modifications • Personal care • Personal Emergency Response System • Private duty nursing • Respite • Transition services

Waiver	Description	Examples of Covered Benefits
Developmental Disability Waivers: **Building Independence (BI)** **Community Living (CL)** **Family and Individual Supports (FIS)**	Provides supports and services to members with developmental disabilities to help with successful living, learning, physical and behavioral health, employment, recreation, and community inclusion. Waivers may have a waiting list. You should put your name on the waiting list if you need to so that when space opens up you can start receiving these services.	• Assistive technology • Benefits planning services • Electronic home-based services • Employment and day supports • Environmental modifications • Personal emergency response system • Crisis supports • Residential options

Benefits for Children/Youth Under Age 21

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

Benefits are not the same for all Cardinal Care members. Medicaid children and youth under age 21 are entitled to EPSDT, a federally-required benefit. EPSDT provides comprehensive services to identify a child's condition, treat it, and make it better or prevent it from getting worse. Covered services include any medically necessary health care, even if the service is not normally available to adults or other Medicaid members. EPSDT services are available at no cost. Examples of EPSDT services include:

- Screenings/well-child visits and immunizations
- Periodic screening services (vision, hearing and dental)
- COVID-19 counseling visits
- Developmental services
- Eyeglasses (including a replacement for glasses that are lost, broken, or stolen) and other vision services
- Orthotics (braces, splits, supports)
- Personal care or personal assistance services (for example, help with bathing, dressing and feeding)
- Private duty nursing
- Treatment foster care case management
- Clinical trials may be considered on a case-by-case basis

FAMIS children are eligible for well-child visits and immunizations, but not all EPSDT services.

Early Intervention (EI) Services

If a member has a baby under the age of three who is not learning or developing like other babies, that child may qualify for EI services. EI services include, for example:

- Speech therapy.
- Physical therapy.
- Occupational therapy.
- Service coordination.
- Developmental services to support the child's learning and development.

EI services do not require service authorization from Aetna Better Health. There is no cost to the member for EI services.

School Health Services

The Department covers the cost of some health care or health-related services provided to Cardinal Care-enrolled children at their school. School health services can include certain medical, behavioral health, hearing, personal care, or rehabilitation therapy services, such as occupational therapy, speech therapy, and physical therapy services and are based on the child's individualized education plan (IEP), as determined by the school. A member's child's school will arrange for these services and children can get them for free. Children may also receive covered EPSDT services while they are at school.

Benefits for Family Planning and Pregnant/Postpartum People

Members can get free health care services to help them have a healthy pregnancy and a healthy baby. This includes health care services for up to 12 months after they give birth. Aetna Better Health and DMAS cover the following services:

- Labor and delivery services
- Doula services
- Family planning (services, devices, drugs – including long-acting reversible contraception – and supplies for the delay or prevention of pregnancy)
- Lactation consultation and breast pumps
- Nurse midwife/provider services
- Pregnancy-related services
- Prenatal/infant services and programs
- Postpartum services (including postpartum depression screening)
- Services to treat any medical condition that could complicate pregnancy
- Smoking cessation services
- Substance use treatment services
- Abortion services (only if a doctor certifies in writing that there is a substantial danger to the mother's life)

Members do not need a service authorization or a referral for family planning services. Members can get family planning services from any provider, even if they are not in Aetna Better Health's network.

Newborn Coverage

If a member has a baby, the member needs to report the birth to DMAS as quickly as possible so that the child can get health insurance. The member can do this by calling **Cover Virginia** at **1-833-5CALLVA** or by contacting their **local DSS.**

Added Benefits for Aetna Better Health Members

For all members (some eligibility requirements)

Adult Vision

One eye exam and $125 for glasses or contacts per year

- Benefit details: Member can call Vision Service Plan (VSP) at **1-800-877-7195**
- Eligibility: Age 21+, no prior authorization

Adult Hearing

One hearing exam and $1,500 for hearing aids plus 60 batteries per year. Unlimited visits for hearing aid fittings are included.

- Benefit details: Member must receive prior authorization, then call Member Services at **1-800-279-1878 (TTY: 711)** and ask to be transferred to a Care Coordinator.
- Eligibility: Age 21+, requires prior authorization

Non-Emergent Transportation

Unlimited rides to medical appointments and pharmacy. Plus, free rides (15 round trips or 30 one-way trips each year) to grocery store, farmers market, food bank, food pantry, place of worship, library, gym, or exercise class, DSS, DMV, WIC, and Social Security Office

- Benefit details: Members can call MediDrive at **1-800-734-0430**
- Eligibility: All members aged 18+, no prior authorization required

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Home Delivered Meals

Meals delivered to a member's home after hospital discharge (two meals each day for seven days for a total of 14 meals through Mom's Meals)

- Benefit details: Members can call Member Services at **1-800-279-1878 (TTY: 711)** and ask to be transferred to a Care Coordinator.
- Eligibility: Age 21+ discharged from the hospital; requires prior authorization

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Native Medicine Reimbursement

Some members, including those who are part of the federally recognized Tribal Nation in the Commonwealth wish to participate in Native healing practices. This benefit supports Native practices, and it requires no prior authorization. Member can receive reimbursement up to $200.

- Benefit details: Members associated with a federally recognized Tribe go to forms section and follow directions on the **Member Reimbursement Request Form for Native Medicine form.**
- Eligibility: Member must be affiliated with a federally recognized Tribal Nation

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MyActiveHealth Management

Personalized secure member website. Access to personalized health information and online support. A personalized and interactive mobile program that sends text messages regarding diabetes education and support; personal care management; appointment and medication reminders; and exercise/weight goal setting and tracking.

- Benefit details: To access the MyActiveHealth services, the member must register (if new) or log into the member portal on the member website. There is no referral needed. Members can visit their Member Portal. Or members can visit MyActiveHealth with their smartphone. Members can call **1-855-231-3716** to ask for a printed copy of the health survey. Members can also ask for info on health conditions and wellness topics in print.
- Eligibility: Age 18+, no prior authorization

Over-the Counter Period Products Stipend

A monthly stipend of $20 for members with periods to spend on their choice of period products through CVS Pharmacy®

- Benefit details: Visit the CVS Health® OTC Health Solutions website at **cvs.com/otchs/abhva**. Or, call OTC Health Solutions at **1-888-628-2770 (TTY: 711)**. You can speak with a live agent Monday through Friday, 9 AM to 8 PM ET. You can also order at any time via our automated interactive voice response (IVR) system. Members need to have their member ID ready when placing your order.
- Eligibility: All members who are women aged 10 to 55

GED

Eligible members have access to CampusEd, which has more benefits and offerings for the member to not only help them earn their GED, but also start a new career. Aetna Better Health will pay for the GED testing voucher which can be taken at the nearest GED testing site, once the course has been completed. The test costs $30 per test ($120 total). To receive the test vouchers, the course must be completed first.

- Benefit details: Members can call Member Services at **1-800-279-1878 (TTY: 711)** and ask to be transferred to a Care Coordinator.
- Eligibility: Age 16+ (Ages 16 and 17 must be in juvenile detention and had not go to school)

Weight Management

Personalized weight management with a registered dietitian, which includes a 12-week certified nutritionist program and six counseling visits

- Benefit details: Members can call Member Services at 1-800-279-1878 (TTY: 711) and ask to be transferred to a Care Coordinator.
- Eligibility: All members with Care Manager referral, no prior authorization required

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For children and members who are pregnant or recently gave birth

Baby Diapers

Newborn baby diapers for the first month of the baby's life (300 diapers)

- Benefit details: Members can receive 300 size 1 diapers after the birth of their baby.
- Eligibility: Members who recently delivered a baby

New Mom's Stipend

$25 per month for OTC products

- Benefit details: Members who are pregnant or recently gave birth who are also connected with a care manager can receive $25 per month for certain over-the-counter (OTC) products through CVS Pharmacy®. Members can use this OTC benefit to buy items to care for themselves and their baby's needs.
- Eligibility: Members who are pregnant/are new moms and are connected with a care manager

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New Moms Box

Members who have recently given birth can receive a New Moms Box that contains items filled with things mom and baby need. The box is delivered for free and is automatically delivered to eligible members.

- Benefit details: This box is reserved for members who are involved with case management. It is automatically sent to members. Members do not have to contact anyone to receive this box.
- Eligibility: Moms who have recently given birth who are actively involved in case management

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Pacify

Pacify is an evidence-based telehealth mobile app and perinatal solution that provides 24/7 access to a national network of International Board-Certified Lactation Consultants (IBCLC's) and Doulas via live video consultation. Pacify improves health outcomes for health plan members, and produces cost-savings our health plan clients.

- Benefit details: Members can download the app following **these instructions.**
- Eligibility: All members

Healthy Food Card

Monthly, $50 will be added to a refillable debit card that members with specific conditions (high risk pregnancy, childhood obesity, and/or aging out of foster care aged 17 to 26) can use to purchase healthy foods at specific retailers or online for home delivery. Healthy foods for purchase include fresh fruit and vegetables, canned fruits and vegetables, frozen produce and meals, fresh salad kits, dairy products, meat and seafood, beans and legumes, pantry staples (flour, sugar, spices, etc.), healthy grains (bread, cereals, pastas, etc.), nutritional shakes and bars, soups, and water/vitamin water.

- Benefit details: Members can contact InComm at **https://www.aetnabetterhealth.com/virginia/healthy-food-card.html**, to order the card.
- Eligibility: Member must have one or more of the following conditions: high risk pregnancy, childhood obesity, and/or aging out of foster care between ages 17 to 26

Ted E. Bear, M.D., Wellness Club

Promotes parents to have their child's well child checkup, which includes physical exam, immunizations, and growth and development. Each child receives a gift card upon completion of well child checkup.

- Benefit details: Members can email **QualityManagementPrograms@Aetna.com**
- Eligibility: Members ages newborn to age 17

Swim Lessons

Water safety and swimming lessons for members six and younger

- Benefit details: Members can go to their local YMCA with their Aetna Better Health of Virginia membership cards. They then can sign up and attend classes.
- Eligibility: Members under the age of 6

Youth Sport Physicals

Annual sports participation physical offered to members 7 to 18 years of age maximum annual benefit of $25.

- Benefit details: Diagnosis code must be billed with Z02.5. CPT code must be 99429. Once per year on an annual basis, NOT calendar year. Can be billed by PAR and non-PAR providers
- Eligibility: Members aged 7-18; no prior authorization required

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For members with certain health conditions

Therapeutic Shoes or Shoe Inserts for Diabetic Members

One pair of therapeutic shoes or shoe inserts per year is limited to $200 annually

- Benefit details: Members can call Member Services at **1-800-279-1878 (TTY: 711)** and ask to be transferred to a Care Coordinator.
- Eligibility: All members with diabetes, requires prescription from podiatrist or orthopedic doctor

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Asthma Home Care

Members with an asthma diagnosis can receive one set of hypoallergenic bedding and $150 - $400 to use towards one deep carpet cleaning annually, depending on service location.

- Benefit details: Members can call Member Services at **1-800-279-1878 (TTY: 711)** and ask to be transferred to a Care Coordinator.
- Eligibility: Members with an asthma diagnosis

New Added Benefits for 2024

Medication lockbox: Eligible members who are aged 18 or older, are prescribed opioids, and have children in the home can receive a lockbox to secure their medications.

Calming Comfort Collection: Eligible members with anxiety or depression or elderly members in nursing facilities can receive a curated box with therapeutic resources.

Go Get Active: Eligible members aged 5 to 18 who receive a well-child visit can receive up to $200 to engage in healthy programs and activities (e.g., after-school programs, sports programs, and zoo or state park admissions).

Electronic companion pets: Eligible members with memory care issues or an intellectual disability can receive one electronic companion pet for comfort and emotional support.

ESL classes: Members aged 18 and older can receive $250 toward English as a Second Language (ESL) classes.

Tattoo removal: Members aged 16 and older can receive $150 to use for the removal of human trafficking or gang-related tattoos.

Post-graduate support: Members aged 18 years and older who have a high school diploma or GED can receive $500 to go toward higher education, military, or trade school.

Legal services and support: Members aged 18 and older who are tenants can receive $300 for legal services and education for housing support.

Wellness Rewards:

Members can get rewards for focusing on their health.

Wellness visits

Diabetes well visit: $25

Members can complete your annual diabetes wellness exam, as recommended by their doctor. These include:

- HbA1c labs.
- Blood pressure check.
- Diabetic eye exam.
- Kidney evaluation.

Well woman exam: $25

Members can complete their annual well woman exam, as recommended by their doctor. These include:

- Pap smear.
- Mammogram.
- Chlamydia screening.
- Colorectal cancer screening.
- Flu vaccine.
- Pneumonia vaccine.
- Tdap vaccine.
- Shingles vaccine.

Men's health: $25

Members can complete important preventive care services, as recommended by their doctor. These include:

- Colorectal cancer screening.
- Prostate exam.
- Flu vaccine.
- Pneumonia vaccine.
- Tdap vaccine.
- Shingles vaccine.

Pregnancy and birth care: $50

Members can earn rewards for going to their pre- and postnatal visits

Children's health
With the Ted E. Bear, M.D. Wellness Club®, members can earn rewards for getting childhood care, such as:

- Wellness exams
- Shots (as needed)
- Weight and nutrition counseling
- Growth and development checks

The member's provider must complete the **incentive form (PDF)** at their visit.

The member will get rewards for each well-child visit:

- $10: Ages 0 through 4
- $15: Ages 5 through 10
- $20: Ages 11 through 13
- $25: Ages 14 through 17

Young adult health

"You Call the Shots" for Teens: $50
Members aged 9 to 13 can earn up to $50 by getting these shots:

- $10 Tdap
- $10 Meningococcal
- $10 HPV (first dose)
- $10 HPV (second dose)

For completing all four shots, the member becomes eligible for an extra $10

Members are eligible for one incentive per calendar year per reward type.

Chapter 7 — Member eligibility and enrollment Member Services

Member Services provides information for members on eligibility, benefits, grievances, education, and available programs. Member advocates can provide services for members having trouble with their health care needs, finding providers, and filing grievances or appeals, as well as assist providers with noncompliant members and/or discharges.

Member Services can be reached 24 hours a day/7 day a week at **1-800-279-1878 (TTY: 711)**.

Eligibility for Cardinal Care members

Managed Care Covered Populations

The Medicaid and FAMIS populations listed below will be enrolled in managed care unless they meet an exclusion to managed care participation, as described in the below section, **Populations Excluded from Managed Care**, and the state's Managed Care Waiver.

1. Former Medallion 4.0 populations, including low-income families and children covered populations, including:
    a. Pregnant individuals, and postpartum individuals through the end of the postpartum period, including Medicaid, FAMIS MOMS, and FAMIS PC
    b. Infants born to a Medicaid-eligible individual or an individual-eligible for FAMIS MOMS
    c. Medicaid and FAMIS Children under age 19
    d. Children under age 21 who are in foster care or subsidized adoptions
    e. Adults, including individuals:
        i. Under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older
        ii. Ages 19 to 64 who are parents or caretaker adult relatives with a child under age 19 (MAGI adults)
        iii. Ages 19 to 64 who are childless (MAGI adults)

2. Former Commonwealth Coordinated Care Plus Populations, including Aged, Blind and Disabled (ABD), Medically Complex MAGI Adults, and LTSS Covered Populations including:
    a. ABD individuals, including disabled children and adults
    b. Medicaid Works individuals
    c. Individuals who are in long-term care institutions or some long-stay hospitals
    d. Individuals who receive services under the 1915(c) Commonwealth Coordinated Care. (CCC) Plus home- and community-based care (HCBS) Waiver.
    e. Individuals who receive services under one (1) of the three (3) 1915(c) Developmental Disability (DD) HCBS Waivers, including the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) Waivers. Individuals enrolled in any of the Developmental Disability (DD) Waivers will be enrolled in managed care for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services).
    f. Managed care enrolled individuals who elect to receive hospice care.
    g. Managed care eligible populations who have Medicare (dual-eligible).
    h. Individuals in a MAGI Adult Aid Category (100,101, 102, 103) with a medically complex indicator of XA, XG, XP, or X, as described below.

i. A MAGI adult who has a LTSS indicator, as shown in the table below, will have an auto-generated medically complex benefit indicator of "XA."

LTSS Service	LTSS Indicator
Nursing Facility	1 (custodial) or 2 (skilled)
Long-Stay Hospital	L
CCC Plus Waiver without private duty nursing	9
CCC Plus Waiver with private duty nursing	A
Developmental Disability Waivers	R (FIS), S (BI), Y (CL)
Hospice	D or D1

ii. A MAGI adult who participated in the former Governor's Access Plan for seriously mentally ill (SMI) individuals, will have a "FG" benefit indicator and an auto-generated medically complex indicator of "XG."

iii. A MAGI adult who attests that they are medically complex by responding "yes" to the "yes/no" question shown below on their Medicaid application, will have an auto-generated medically complex benefit indicator of "XP."

Do you need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in your home? Or has a doctor or nurse told you that you have a physical disability or long-term disease, mental or emotional illness, or addiction problem?

For individuals with an "XP" benefit indicator, A MCO Member Health Screening (MMHS) is required to verify the member's attested medically complex status, must be completed within three (3) months, and must be submitted prior to the end of the Member's initial four (4) months of enrollment with the Contractor.

iv. A MAGI adult who receives a MMHS that demonstrates that the member has, 1) a complex medical or behavioral health condition and a functional impairment, or 2) an intellectual or developmental disability, will have a medically complex benefit indicator of "X."

3. Managed care eligible populations listed above who have other third-party liability insurance (TPL), except coverage purchased through HIPP and FAMIS Select
4. Managed Care eligible populations listed above who are in the hospital at the time of initial MCO enrollment

Populations Excluded from Managed Care

In accordance with state regulations, the following populations are excluded from managed care program participation:

1. Individuals enrolled in a Program of All-inclusive Care for the Elderly (PACE) program
2. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program or the FAMIS Select program
3. Individuals with temporary eligibility coverage (less than 3 months), retroactive eligibility coverage (other than newborns), enrolled in presumptive eligibility groups, or who are Medicaid-eligible in limited coverage groups, including:
    a. Individuals enrolled in Plan First (the Department's family planning program for coverage of limited benefits surrounding pregnancy prevention)
    b. Individuals in Medicare-Related Covered Groups (Medicare Savings Plans or MSPs) for whom Medicaid pays the Medicare costs on behalf of these beneficiaries. These individuals do not have full Medicaid benefits, and include, Qualified Medicare Beneficiaries (QMBs), Special Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or, Qualifying Individuals (QIs)
4. Medically Needy (spenddown) individuals who have a limited period of full coverage; (Medically Needy LTSS participants who meet their spenddown and maintain ongoing eligibility will be managed care enrolled)
5. Other individuals with temporary or limited Medicaid eligibility coverage
6. Individuals who elect hospice benefits while enrolled in fee-for-service will not be enrolled into Managed Care. However, a Managed Care enrolled individual who subsequently enters a hospice program will remain Managed Care enrolled
7. Individuals who live in areas where less than two MCOs participate, such as Tangier Island
8. Individuals under age 21 years of age who are approved for admission to a VA Medicaid Psychiatric Residential Treatment Facility (PRTF) programs)
9. Individuals in fee-for-service with end stage renal disease (ESRD) will be enrolled into Managed Care unless the individual requests to be excluded from Managed Care participation within the individual's first 90 days of Managed Care enrollment. Individuals who do not request exclusion within the first 90 days of Managed Care enrollment or who develop ESRD while enrolled in Managed Care, will remain Managed Care enrolled
10. Individuals of any age who are institutionalized in State or private ICF/ID and State ICF/MH facilities (a State acute care facility is not excluded)
11. Individuals receiving care in a Christian Science Sanatoria Facility. Individuals will be excluded from Managed Care when admitted to a Christian Science Sanatoria and services will be covered under the fee-for-service program within Department- established criteria and guidelines, per 12 VAC 30 50-300 (Christian Science Nursing Services are not covered)
12. Individuals aged 21 to 64 who are hospitalized in a State or private institution for mental disease (IMD), other than individuals admitted to an IMD as part of a Contractor approved admission, in lieu of an acute care hospital (psychiatric unit)
13. Individuals who reside at Piedmont, Hiram Davis, and Hancock State facilities operated by DBHDS
14. Individuals who reside in nursing facilities operated by the United States Department of Veterans Affairs, the Virginia Home Nursing Facility, local government-owned nursing homes, and individuals authorized by the Department to receive care/treatment in facilities located outside of Virginia, including but not limited to Braintree Manor Nursing and Rehabilitation Center located in Braintree, Massachusetts. These include the following nursing facilities:

a. Bedford County Nursing Home
b. Birmingham Green
c. Dogwood Village of Orange County Health
d. Lake Taylor Transitional Care Hospital (Different from Lake Taylor Long-Stay Hospital)
e. Lucy Corr Nursing Home
f. The Virginia Home Nursing Facility
g. Virginia Veterans Care Center
h. Sitter and Barfoot Veterans Care Center
i. Braintree Manor Nursing Facility and Rehabilitation Center

15. Individuals who are incarcerated (individuals on house arrest are not considered incarcerated)
16. Individuals enrolled in the Birth Injury Fund

Enrollment for Cardinal Care members

Upon initial eligibility determination and during the annual enrollment period for Medicaid, members who want to be enrolled into managed care plan can contact the enrollment broker for the Commonwealth of Virginia.

Eligible individuals must enroll in the program. To participate, the member must be eligible for Medicaid. Reasons a member would not be eligible to participate in the program:

- Lost Medicaid eligibility
- Does not meet one of the eligible categories listed above
- Enrolled in hospice under the regular fee-for-service Medicaid program prior to any benefit assignment.
- Enrolled in the Medicaid Health Insurance Premium Payment program
- Enrolled in Program of All-Inclusive Care for the Elderly
- Enrolled in the Medicaid Money Follows the Person Program
- Lives in an intermediate care facility for individuals with intellectual and developmental disabilities
- Receiving care in a psychiatric residential treatment level C facility (children under 21)
- Lives in a veteran's nursing facility
- Lives in one of these state long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock Verification of eligibility Member eligibility and enrollment can and should be confirmed by utilizing one of several methods:
  - Virginia Medicaid Eligibility System at **1-800-772-9996** or **1-800-884-9730** (outside of Richmond), or **804-965-9732** or **804-965-9733** for Richmond and the surrounding counties
  - Provider web portal eligibility search at **www.virginiamedicaid.dmas.virginia.gov**
  - Aetna Better Health Member Services at **1-800-279-1878**

Providers may obtain Medicaid eligibility and plan assignment information for members by calling Virginia's MediCall Automated Voice Response System (toll-free numbers are available 24 hours per day, seven days a week) at **1-800-772-9996** or **1-800-884-9730** or via the online Automated Response System accessed through the Virginia Medicaid Web portal at **www.virginiamedicaid.dmas.virginia.gov**.

How to Access Long-Term Services and Supports (LTSS)

Aetna Better Health provides coverage for LTSS, including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can help the member live in their own home or other setting of their choice and improve their quality of life. Examples of services covered include personal assistance services (assistance

with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community-based waiver), but also in nursing facilities.

Commonwealth Coordinated Care (CCC) Plus Waiver

Some members may qualify for home and community-based care waiver services through the Commonwealth Coordinated Care (CCC) Plus waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers). The waiver is meant to allow a member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, the member may choose how to receive personal assistance services. Members have the option to receive services through an agency (known as agency directed) or may choose to serve as the employer for a personal assistance attendant (known as consumer directed.) CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or consumer-directed)
- Respite care (agency or consumer-directed)
- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for Members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology
- Environmental modifications

Consumer-Directed Care

Consumer-directed care refers to personal care and respite care services provided under the Cardinal Care Waiver. These are services in which the member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. The member will receive financial management support in the role as the employer to assist with enrolling the providers, conducting provider background checks, and paying providers. The member's Care Coordinator will also monitor the member's care if they are receiving Cardinal Care Waiver services to make sure the care provided is meeting the member's daily needs.

Nursing Facility Services

If a member is determined to meet the coverage criteria for nursing facility care and choose to receive long-term services and supports in a nursing facility, Aetna Better Health will provide coverage for nursing facility care. If the member has Medicare, Aetna Better Health will provide coverage for nursing facility care after the member has exhausted their Medicare covered days in the nursing facility, typically referred to as skilled nursing care. If a member is interested in moving out of the nursing facility into the community, please have them contact their Care Coordinator.

Screening for Long Term Services and Supports

Before a member can receive long-term services and supports (LTSS), the member must be screened by a community based or hospital screening team. A screening is used to determine if a member meets the level of care criteria for LTSS.

Freedom of Choice

If a member has been approved to receive long-term services and supports, they member has the right to receive care in the setting of their choice, including:

- In the member's home
- In another place in the community
- In a nursing facility

Members can choose the doctors and health professionals of their choice from the Aetna Better Health network. If they prefer to receive services in their home under the Cardinal Care Waiver, for example, the member can choose to directly hire their own personal care attendant(s), known as consumer-directed care. Another option the member has is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal assistance workers on the member's behalf This is known as agency direction. The member will also have the option to receive services in a nursing facility from our network of nursing facility providers.

Developmental Disability Waiver

If a member is enrolled in one of the DD waivers, the member will be enrolled in Cardinal Care for their nonwaiver services. The DD waivers include:

- The Building Independence (BI) Waiver,
- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

DD Waiver services, DD and ID targeted care coordination services, and transportation to/from DD waiver services will be paid through Medicaid fee-for-service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21. If a member has a developmental disability and needs DD waiver services, the member will need to have a diagnostic and functional eligibility assessment completed by their local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in the member's person-centered individualized service plan. The DD waivers have a wait list.

Individuals who are on the DD waiver waiting list may qualify to be enrolled in the Cardinal Care Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in the member's community. For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the department of Behavioral Health and Developmental Services (DBHDS) website at: **www.mylifemycommunityvirginia.org** or call **1-844-603-9248**.

A Care Coordinator will work closely with the member and the member's DD or ID case manager to help them get all their covered services.

Non-Emergency Transportation Services

Non-Emergency transportation services are covered by Aetna Better Health for covered services, carved out services, and enhanced benefits. FAMIS children are covered only for medically necessary professional ambulance services when used locally to or from a covered facility or provider office.

Exception: If the member is enrolled in a DD Waiver, Aetna Better Health provides coverage for their transportation to/from the member's non-waiver services. Transportation may be provided if the member

has no other means of transportation and needs to go to a provider or a health care facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at **1-800-735-0430, Option 1**. If the member is having problems getting transportation to their appointments, call our Member Services at **1-800-279-1878**. In case of a life-threatening emergency, call **911**.

Transportation to medical appointments is a covered benefit and members must call three working days before their visit or we will not be able to guarantee a ride. We must preauthorize the service. Members may ask for medical transportation for eye, dental, behavioral health, and medical visits. Transportation is not covered for picking up prescriptions and refills at a pharmacy when drugs can be delivered or mailed. Transportation is covered if the pharmacy does not have delivery, will not mail the prescription, or the prescription cannot be filled at the medical facility. Normally, the prescription should be filled initially on the return trip from the medical appointment. Transportation may be in the form of a public or private vehicle. This transportation must be used only when the member visit is for care that is covered, and the member does not have their own transportation.

Transportation to and From DD Waiver Services

Transportation to a member's DD Waiver services is covered by MediDrive, the DMAS Fee-for-Service (FFS) Transportation Broker. Members can find out more about how to access DD transportation services through MediDrive on the **DMAS website** or by calling MediDrive at **1-800-734-0430**.

ID/D Members needing transportation services for their acute care should check the back of their Medicaid ID card for the Aetna Better Health transportation telephone number, as acute care or medical care transportation may be a different transportation broker.

Transportation for DD Waiver-covered trips must be scheduled with the member's day support or supported employment provider. Aetna Better Health acute care trips must be scheduled at least five business days in advance Monday through Friday by calling **1-800-279-1878**. Urgent acute care trips can be scheduled with less than five days' notice. If a member has problems getting transportation to their DD waiver services, the member may call their DD or ID Waiver case manager or the DMAS Transportation Contractor at **1-800-734-0430**. Members may also call their Care Coordinator. Care Coordinators will work closely with the member and the member's DD or ID Waiver case manager to help get the services that they need.

Member Patient Pay

LTSS Members may have a patient pay responsibility towards the cost of nursing facility care and home and community-based waiver services. A patient pay is required to be calculated for all members who get nursing facility or home and community-based waiver services. When a member's income exceeds a certain amount, the member must contribute toward the cost of their long-term services and supports. If a member has a patient pay amount, they will receive notice from their local Department of Social Services with their patient pay responsibility. DMAS also shares patient pay amounts with Aetna Better Health if the member is required to pay towards the cost of their long-term services and supports.

Medicare members and Part D drugs

If a member has Medicare, members will receive prescription medicines from Medicare Part D, not from the Medicaid program. Medicaid does not pay the copayment for the medicines that Medicare Part D covers.

Coverage for newborns born to moms covered under Cardinal Care

Members who have a baby while covered under Cardinal Care will need to report the birth as quickly as possible in order for the baby to be enrolled in Medicaid. Members can do this by:

- Calling the Cover Virginia Call Center at **1-855-242-8282** to report the birth over the phone.
- Reporting the **baby's birth and name** on the State's MES system by following the **instructions located on our portal**.
- Contacting their local department of Social Services to report the birth.

Identification cards for Cardinal Care members

Members are provided a Medicaid ID card from the Commonwealth of Virginia. Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in the Aetna Better Health plan. The ID card will be mailed to each new member when a PCP is selected or assigned.

Members are encouraged to always keep the identification card with them. If the card is lost or stolen, the member should call Member Services immediately to request a new card. Should a member present without a card or present with a Virginia Medicaid ID card, services should not be denied. To confirm the Aetna Better Health member's PCP selection, call Member Services at **1-800-279-1878**.

The Aetna Better Health identification card will include the following information:

- Aetna Better Health's name
- Member name
- Member/state Medicaid ID number
- PCP name and telephone number
- Member Services telephone number
- Claim submission information
- 24-hour Informed Health Line telephone number
- Behavioral Health/Crisis telephone number

There are four different member ID cards with product identifiers in the lower right-hand corner of each card:

1. MEVAFAMIS1 — Copay No / $0
2. MEVAFAMIS2 — Copay Yes / $0
3. MEVAFAMIS5 — Copay Yes / $0
4. MEVATANF1 — (Medallion) Copay Nonapplicable

Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled. The ID card will be mailed to each new member when a PCP is selected or assigned. We encourage members to always keep their identification card with them.

Member rights and responsibilities

Cardinal Care members have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability.
- Be treated with respect and consideration for their privacy and dignity.
- Get information (including through their handbook) about their health plan, provider, coverage, and benefits.

- Get information in a way they can easily understand; interpretation, written translation, and auxiliary aids are available free of charge.
- Access health care and services in a timely, coordinated, and culturally competent way.
- Get information from their provider and health plan about treatment choices.
- Participate in all decisions about their health care, including the right to say “no” to any treatment offered.
- Ask their health plan for help if their provider does not offer a service because of moral or religious reasons.
- Get a copy of their medical records and ask that they be changed or corrected in accordance with State and Federal Law.
- Have their medical records and treatment be confidential and private. Aetna Better Health will only release a member’s information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse.
- Make recommendations regarding the organization’s member rights and responsibilities policy
- Live safely in the setting of their choice. If you or someone you know is being abused, neglected, or financially taken advantage of, call your local DSS or Virginia DSS at **1-888-832-3858**. This call is free.)
- Receive information on their rights and responsibilities and exercise those rights without being treated poorly by your providers, Aetna Better Health, or DMAS.
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- File appeals and complaints and ask for a State Fair Hearing
- Change their Medicaid managed care health plan at any time for cause.
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).

Right to be safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If a member is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, a member should call their local department of social services or the Virginia Department of Social Services' 24-hour toll-free hotline at: **1-888-832-3858**. Members can make this call anonymously; they do not have to provide their name and the call is free. Trained social workers may be provided to assist and help the member receive the types of services they need to assure that they are safe.

Right to confidentiality

Aetna Better Health will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse. Aetna Better Health staff will ask questions to confirm the member’s identity before we discuss or provide any information regarding their health information. We understand the importance of keeping personal and health information secure and private. Both Aetna Better Health and the member’s doctors make sure that all member records are kept safe and private. We limit access to personal information to those who need it. We maintain safeguards to protect it. For example, we protect access to our buildings and computer systems. Our privacy office also assures the training of our staff on our privacy and security policies. If needed, we may use and share personal information for treatment, payment, and health care operations. We limit the amount of information that we share about members as required by law. For

example, HIV/AIDS, substance abuse and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

Member responsibilities

Cardinal Care members also have some responsibilities. This includes the responsibility to:

- Follow this handbook, understand their rights, and ask questions when they do not understand or want to learn more.
- Treat providers, Aetna Better Health staff, and other members with respect and dignity.
- Choose their PCP and, if needed, change their PCP.
- Be on time for appointments and call their provider's office as soon as possible if they need to cancel or if they are going to be late.
- Show their Member ID Card whenever they get care and services.
- Provide complete and accurate information about their medical history and their symptoms.
- Understand their health problems and talk to their providers about treatment goals, when possible.
- Work with their care manager and care team to create and follow a care plan that is best for them.
- Invite people to their care team who will be helpful and supportive to be included in their treatment.
- Tell Aetna Better Health when they need to change their care plan.
- Get covered services from Aetna Better Health's network when possible.
- Get approval from Aetna Better Health for services that require a service authorization.
- Use the emergency room for emergencies only.
- Pay for services they get that are not covered by Aetna Better Health or DMAS.
- Report suspected fraud, waste, and abuse (see below).

Call Aetna Better Health's Member Services at 1-800-279-1878 (TTY: 711) to let them know if:

- Their name, address, phone number, or email have changed.
- Their health insurance changes in any way (from their employer or workers' compensation, for example) or they have liability claims, like from a car accident.
- Their Member ID Card is damaged, lost, or stolen.
- They have problems with health care providers or staff.
- They are admitted to a nursing facility or the hospital.
- Their caregiver or anyone responsible for them changes.
- They join a clinical trial or research study.

Reporting Fraud, Waste, and Abuse

As a Cardinal Care member, members are responsible for reporting suspected fraud, waste, and abuse concerns and making sure they do not participate in or create fraud, waste, and abuse. Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is the practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain health care standards.

Examples of member fraud, waste, and abuse include:

- Falsely reporting income and/or assets to qualify for Medicaid.
- Permanently living in a state other than Virginia while receiving Cardinal Care benefits.
- Using another person's Member ID Card to get services.

Examples of provider fraud, waste, and abuse include:

- Providing services that are not medically necessary.
- Billing for services that were not provided.
- Changing medical records to cover up illegal activity.

Information on how to report suspected fraud, waste, or abuse is included in the table below:

The Department's Fraud and Abuse Hotline

Phone	**1-804-786-1066** Toll free: **1-866-486-1971** **TTY: 711**
Email	**RecipientFraud@DMAS.virginia.gov**
Mail	Department of Medical Assistance Services Recipient Audit Unit 600 East Broad St Suite 1300 Richmond, VA 23219

Virginia Medicaid Fraud Control Unit (Office of the Attorney General)

Phone	**1-804-371-0779** Toll free: **1-800-371-0824** **TTY: 711**
Fax	**804-786-3509**
Email	**MFCU_mail@oag.state.va.us**
Mail	Office of the Attorney General Medicaid Fraud Control Unit 202 North Ninth Street Richmond, VA 23219

Virginia Office of the State Inspector General Fraud, Waste, and Abuse Hotline

Phone	**1-800-723-1615** **TTY: 711**
Email	**covhotline@osig.virginia.gov**
Mail	State Fraud, Waste, and Abuse Hotline 101 N. 14th Street The James Monroe Building 7th Floor Richmond, VA 23219

Persons with special health care needs

The health plan is required to do the following for members identified as persons with special health care needs:

- Conduct an assessment to identify any special conditions of the member that require ongoing care management services.
- Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
- For individuals determined to require care management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the member .

PCP assignment

Each Aetna Better Health member is assigned a PCP. Members are allowed to select a PCP at the time of enrollment and may change their PCP voluntarily at any time by contacting Member Services. For involuntary termination of a PCP, please see Noncompliant members/PCP Transfer in Provider Responsibilities and Important Information chapter.

PCP selection PCPs include providers in the following specialties:

- Family practice
- General practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology
- Certified nurse practitioners

Every family member enrolled in the plan must choose a PCP, although it does not have to be the same provider. All members have the option of changing their PCP. Members may request to change their PCP following the initial visit without cause. PCP change requests made before the 15th of the month are made effective the first of the same month. PCP change requests made after the 15th of the month are made effective the first of the next month (i.e., request received October 15 effective November 1).

- Aetna Better Health members are given the opportunity to select a PCP.
- If a member has NOT selected a PCP upon enrollment, Aetna Better Health shall assign one for them.
- Aetna Better Health shall consider factors such as age, gender, language(s) spoken, location, and special needs. • Upon notice of the current automatically assigned PCP by Aetna Better Health, the member can request a PCP change if not satisfied with the assigned PCP.
- A list of PCPs is made available to all Aetna Better Health members. Member Service representatives are available to assist members with selecting a PCP.
- Members have the freedom to select participating PCPs based on age/gender limit restrictions.
- Members are encouraged to choose a PCP that is geographically convenient to them; however, members are not restricted by any geographic location. Aetna Better Health members may change their PCP at any time, by contacting Member Services at **1-800-279-1878**.
- Members with a disabling condition and/or chronic illness may request that their PCP be a specialist. These requests will be reviewed by the Aetna Better Health Medical Director to ensure that the specialist requested agrees to accept the role of PCP and assume all the responsibilities associated with this role. Members need to contact Member Services directly for such requests. Member Services will route the request directly to the Medical Director for review.

Aetna Better Health may initiate a change in a member's PCP under the following circumstances:

- The member's PCP ceases to participate in Aetna Better Health's network.
- The provider/patient relationship will not work to the satisfaction of either the provider or the patient.
- The provider requests the patient select another PCP and sends written notification to the member and to Aetna Better Health, giving a minimum of 30-days' notice.

Members are advised to get to know and maintain a relationship with their PCP. They are instructed to always contact their PCP before obtaining specialty services or going to the emergency room. It is the responsibility of all PCPs to manage the care of each patient, directing the patient to specialty care services as necessary. It is the responsibility of the specialist provider to work closely with the PCP in the process.

Newborn enrollment

Newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health by the Medical Service Administration. Unless the mother selects a different Medicaid Managed Care Plan, newborns born during the mother's Aetna Better Health enrollment are eligible to receive services from Aetna Better Health. Hospital social service coordinators or local caseworkers usually initiate the process of educating and facilitating the Medicaid enrollment process with mother of an Aetna Better Health newborn. To notify Virginia Medicaid of the child's birth, a Newborn Eligibility Notification form (DMAS E-213) will be submitted to Virginia Medicaid or FAMIS by Aetna Better Health's Enrollment department.

Participating Providers and Hospitals are encouraged to submit newborns via the streamlined online enrollment process through the Medicaid provider web portal at **www.virginiamedicaid.dmas.virginia.gov**. Newborns are retrospectively enrolled with Aetna Better Health back to the date of birth by the state. Delayed newborn enrollment may cause a delay in claim reimbursement for Providers. Once the file is received from the state with the newborn enrolled, your claim will be processed.

If the mother has not selected a PCP for her newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member. Member removal from PCP panel The PCP may request removal of a member from their panel upon submission of supporting documentation verifying circumstances that warrant removal. Circumstances that may warrant a disenrollment request include, but are not limited to:

- Failure to follow a recommended health care treatment plan. (This can occur after one verbal or one written warning of the implication and possible effect of noncompliance.)
- Documented chronic missed appointments.
- Documented behavior, which is consistently disruptive, unruly, abusive, or uncooperative.
- Documented behavior which constitutes a threat or danger to the office staff or other patients.

To remove a member from their panel, PCPs should:

- Notify the member in writing to choose another PCP and of the reason for termination with 30 days' notice and by certified mail.
- Manage care for emergent services during this time.
- Fax termination notification with supporting documentation to the Provider Relations department. The fax number is **1-844-230-8829**.

Provider Relations department will review the notification to determine whether the termination needs to be addressed for care management intervention or be forwarded to the Compliance department for direct action with DMAS.

Member disenrollment from Aetna Better Health

DMAS has sole authority for disenrolling members. DMAS may disenroll members for any of the following reasons:

- Loss of eligibility
- Placement of the member in a long-term nursing facility, state institution or intermediate care facility for individuals with intellectual disabilities for more than thirty days
- Member selection of a different Medicaid Managed Care Plan
- Member change of residence outside of the Aetna Better Health service area
- Profound noncompliance of a member to follow prescribed treatments or requirements that are consistent with state and federal laws and regulations when agreed upon by the DMAS
- Abuse of the system, threatening or abusive conduct/behavior that is disruptive and unruly which seriously impairs Aetna Better Health ability to provide service to either the member or others
- Commitment of intentional acts to defraud Aetna Better Health and/or DMAS for covered services

Violent or life-threatening behavior

The provider must provide written notification that a member has demonstrated one or more of the above behaviors, in addition to the following supportive documentation as appropriate:

- Police report and or incident report from staff involved or threatened
- Copy of member's chart documenting member was previously counseled on the behavior by the PCP (if applicable)
- Any other documentation to support request for disenrollment Fraud or misrepresentation Medicaid fraud carried out by members may include the following:
  - Lying or holding back information when signing up to be a member of Virginia Medicaid or FAMIS
  - Letting someone else use the member's Aetna Better Health Member ID card
  - Not telling the Social Security Administration or DMAS for Community Based Services about changes in income and family status
  - Not telling Virginia Medicaid that the member has other insurance

For cases of fraud or misrepresentation:

- Police report, or if no police report:
  - Documentation as to why it was not reported
  - Documentation that indicates the case was referred to the Commonwealth of Virginia's Office of the State Inspector General, phone: **804-625-3255**, fax: **804-786-2341**, email: **osig@osig.virginia.gov**
- Incident report on the fraudulent activity
- Copies of altered prescription and/or copies of original prescription
- Copy of patient signature log from the pharmacy, along with the pharmacy profile
- Copies of any member correspondence (i.e., PCP dismissal letter to the member, letter from Aetna Better Health to the member, explaining our policies, etc.)
- Additional documentation to support request for disenrollment, especially if there is no police report to show patterns of past questionable behaviors involving drugs, changing doctors, etc.

Member education

New member information educational and informational materials are frequently sent to our members. Aetna Better Health members are sent a welcome packet upon enrollment. The welcome packet contains the following:

- Welcome newsletter
- List of covered drugs (formulary)
- Instructions to access the online Provider Directory
- Addiction and Recovery Treatment Services (ARTS) informational letter
- Notice of privacy practices that contains Aetna Better Health protocols relative to ensuring member privacy of records
- Care manager/coordinator name and contact information

Member identification cards are sent separately via first class mail service prior to the mailing of a new member welcome packet. Aetna Better Health identification cards indicate the PCP's name and telephone number. Medicaid members must sign a Medical Release of Information Form when they enroll with the Virginia Medicaid Program. This release authorizes the release of medical records to Aetna Better Health and any representative of Aetna Better Health to promote:

- Continuity of care
- Assist in the coordination of care
- Clinical review
- State and federal sponsored audit
- Accreditation

Member outreach activities

The Aetna Better Health Member Outreach department and Quality Management department are responsible for contacting members to assist with coordinating gaps in care. The Member Outreach department frequently coordinates activities within the community to provide member education and information regarding Aetna Better Health member initiatives.

Advanced directives

Please see the Provider Responsibilities and Important Information chapter for additional information.

Member grievance and appeal process

Members have the right to file a complaint (grievance) or dispute an adverse determination (appeal). The health plan asks that all providers cooperate and comply with all Aetna, Medicaid, and/or CMS requirements regarding the processing of member complaints and appeals, including the obligation to provide information within the timeframe reasonably requested for such purpose. For further guidance on the member grievance and appeal process, please contact Member Services. Member appeals mailing address: Aetna Better Health of Virginia PO Box 81139 5801 Postal Road Cleveland, OH 44181

Member handbook

A member handbook is available upon request. Changes to any program or any service site changes are provided to members in a timely manner. The member handbook includes information about covered and noncovered services and covers key topics such as how to choose and change a PCP, copays, and guidance to emergency care. The member handbook is available electronically on the Aetna Better Health website.

Chapter 8 - Care Management

The purpose of Care Management is to identify, assess, and provide intervention in cases that due to their chronicity, severity, complexity, and/or cost, require close management to affect an optimal member outcome in a cost-effective manner. The care manager will review medical management/Utilization Management data such as, but not limited to, specific high-risk diagnosis, multiple admissions, or ER visits length of stay admissions greater than seven days, and/or multiple disciplines/therapies required for a treatment.

Providers, nurses, and plan staff work together to identify those who may benefit from care management. Aetna Better Health identifies members by several means, including health risk assessments and data screening. We may receive a referral from a health information line nurse, chronic condition management program staff, discharge planner or other UM staff. Referrals can also be made by members and their families or caregivers. All members have access to a care manager. Care managers typically are registered nurses or social workers. The care manager works with you, the member, caregiver and/or family to come up with a plan of care that meets the member's needs. The amount help that a member receives depends on the individual.

If you have a member who has a chronic condition, you or your staff can make a referral to Aetna Better Health's chronic condition management program at any time. To make a referral or to find out more information call Member Services and ask for the Integrated Care Management department. Additional information and instructions regarding how to use chronic condition management services are available on our website under **For Members** then clicking **Special Programs** then **Disease Management** tabs.

The care manager requests information to assess the member's current medical status, treatment plan, and potential medical treatment requirements and identify those non-medical issues that may impact the member's medical outcome. The care manager will collaborate with specialty consultants, attending provider, the PCP, the member, the member's "family," and other members of the health care team in order to facilitate the highest quality of service, at the most cost-effective level, that support the goals established to achieve the member's best long-term outcome.

The care manager will attempt to identify and direct the use of alternative resources within the community that serve to support achieving established goals in the event a benefit is not available.

The care manager serves as a liaison for Providers, members, family, and/or alternate payers to insure compliance to the treatment plan, facilitate the appropriate use of cost effective alternative services, as well as assess effectiveness of the treatment plan based on goals achieved.

Cases will be considered closed upon the termination of the member, refusal of the member or family to participate with the care coordination process; and/or if the provider and/or member agree that the reassessment, current treatment plan and/or progress of the member is such that care coordination intervention is no longer required to maintain the member at his/her optimum level of wellness. To request an evaluation for complex care management support, providers may contact Aetna Better Health at **1-800-279-1878** or by emailing **AetnaBetterHealthVA-CaseManagement@AETNA.com**.

Aetna Better Health implements a population-based approach to specific chronic diseases or conditions. All Aetna Better Health members with identified conditions are auto enrolled in the program based on claims date. Members that do not wish to participate can call member services and notify the Plan of their desire not to participate and they will be disenrolled from the program. All members are sent educational material to promote better member understanding of the disease or condition affecting them. Information

also addresses self-care, appropriate medical care, and testing which are supported by evidence-based practices and tools. Additionally, auto alert flags to the care manager's desktop identifying members with significant "gaps" in their care and/or disease/condition education. Care managers reach out to those members in an effort to educate and assist the members in obtaining needed services including lifestyle modifications and health resource access.

Our goal is to assist our members/your patients, to better understand their chronic conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Providers can contact the plan at **1-800-279-1878** and follow the prompts to enroll a member in our Care Management program.

The following services are offered by the program:

- Support from health plan nurses and other health care staff to ensure that patients understand how to best manage their condition and periodically evaluate their health status.
- Assist foster care members, their foster care parents and legal guardians to ensure they receive the services needed and provide support to best manage any issues.
- Support high risk maternity members to assist in preventing complications or pre-term births. Periodic newsletters to keep them informed of the latest information on conditions and their management.
- Educational and informational materials that assist patients in understanding and managing medications prescribed by providers, how to effectively plan for visits to see providers and reminders as to when those visits should occur.

What is a Health Risk Assessment?

A Health Risk Assessment (HRA) is completed for all members. Within the first few weeks after the member is enroll with Aetna Better Health, their care coordinator will meet with them to ask questions about their health, needs, and choices. The care coordinator will talk with the member about any medical, behavioral, physical, and social service needs that they may have. This meeting may be in-person or by phone and is known as a health risk assessment. An HRA is a complete assessment of the member's medical, behavioral, social, emotional, and functional status. The HRA is generally completed by the member's care coordinator within the first 30 to 60 days of their enrollment with us depending upon the type of services that they require. This health risk assessment will enable the member's care coordinator to understand their needs and help them receive the care they need.

What is a care plan?

Members who are engaged and/or enrolled in case management will have a care plan. A care plan includes the types of health services that are needed for a member and how to obtain them. The care plan is developed based on the member's health risk assessment. After health risk assessment is complete, the care team will meet with the member to discuss health and/or long-term services and supports they may need and want as well as their goals and preferences. Together, the member and their care team will make a personalized care plan, specific to their needs.

How do I refer a member to care management?

- Providers can contact the Plan at **1-800-279-1878** and follow the prompts to enroll a member in our care management program **or**
- Send an Email: **AetnaBetterHealthVA-CaseManagement@Aetna.com** with the members information and the reason for referral
- For early intervention, the provider may send an email to: **EarlyInterventionServices@Aetna.com**

Population Health Management

Population Health Management programs are available to help support members in their health care journey. We have special programs available for members who are managing conditions or just trying to stay healthy.

You can learn about these programs online at **www.aetnabetterhealth.com/virginia/population-health-programs.html**

Coordinated Care Delivery

To support collaborative care management with provider partners and reduce care fragmentation, the health plan and participating providers will share responsibility for delivering coordinated, patient-centered care. Each party will work collaboratively to ensure timely communication, clear accountability, and seamless transitions across care settings in support of patient outcomes and experience. Roles and responsibilities are outlined below and will be reviewed at least annually or when processes change. This collaborative approach is intended to help reduce patient frustration, improve accountability, and support improved health outcomes.

Role / Function	Health Plan Responsibilities	Provider Partner Responsibilities
Designated Point of Contact	Assign care management contact(s) and provide contact information.	Assign practice contact(s) and ensure availability for coordination activities and timely response.
Identification & Outreach	Identifying populations and stratifying members based on risk, clinical needs, and social drivers of health.	Support outreach by validating member status, encouraging engagement, and coordinating with the member's care team as needed.
Referrals to Care Management	Maintain a defined referral intake process and confirm receipt, triage, and assignment. Communicate enrollment status and next steps to the provider partner.	Refer eligible members using the defined process and provide relevant clinical context.
Care Plan Development & Updates	Develop an individualized care plan with the member / caregiver and share relevant care plan components and goals with the provider partner.	Engaging patients in recommended care plans and reinforcing care management interventions.

Role / Function	Health Plan Responsibilities	Provider Partner Responsibilities
Documentation & Sharing Information	Maintain documentation of care management activities and communicate relevant updates to provider partners consistent with privacy, consent, and data-sharing requirements.	Accurately document care coordination and follow up activities in the medical record and provide requested clinical information to support coordinated, patient-centered care.
Social Determinants of Health (SDOH) Coordination	Provide SDOH resource navigation and community referrals.	Screen for social risks when appropriate; coordinate referrals and document outcomes.
Gaps in Care Coordination	Communicating care gaps and care management engagement status to provider partners.	Review care gap reports shared by the health plan and take appropriate clinical action within the scope of practice.
Transitions of Care	Coordinate post-discharge outreach, medication reconciliation support, and share discharge-related information with provider partners when available.	Schedule timely follow-up visits, review discharge instructions and reconcile medications as clinically appropriate.

Chapter 9 — Pharmacy

The Aetna Better Health pharmacy benefit covers medically necessary prescription products for self-administration in an outpatient setting. The pharmacy benefit provides FDA approved outpatient prescription medications that are clinically proven to be safe and effective. Providers are encouraged to refer to the formulary when selecting prescription drug therapy for eligible members.

Aetna Better Health requires that prescribers have a valid and active NPI. Prescriptions from prescribers who do not have both of these numbers will reject at the point of sale.

Aetna Better Health covers prescription medications and certain over-the-counter medicines when you write a prescription for members enrolled in Virginia Medicaid managed care. We partner with CVS Health, our Pharmacy Benefit Manager, in the administration of the pharmacy benefits.

Aetna Better Health members must have their prescriptions filled at an in-network pharmacy.

Prescriptions, drug formulary and specialty injectables

Aetna Better Health has a preferred drug list located at **AetnaBetterHealth.com/Virginia**. This preferred drug list is also available by calling the member services phone number listed on the back of the member's card or by contacting your Provider Relations representative.

When possible, it is requested that a drug from the preferred list be selected for the member's use. The adoption of using a preferred drug or generic medications will provide the prescriber a smooth process to allow the member to receive medications without call backs and delays at the pharmacy.

This list of preferred medications is updated at least annually. It may be updated more often. To view the most update list of covered drugs, check the formulary using the online search tool, located at **AetnaBetterHealth.com/Virginia**. You can also download the preferred drug list from our website.

Nonpreferred medications are also available through our prior authorization process. Nonpreferred medications may require step therapy as well as supportive documentation showing the benefit of the drug to the member. To request coverage of a nonpreferred drug, you need to provide information to support an exception request by submitting a Pharmacy Prior Authorization Request Form. Some drugs or drug classes may have specific prior authorization request forms, so please visit our site to determine if a specific prior authorization form is needed. Please also include any supporting medical records that will assist with the review of the prior authorization request. Pharmacy Prior Authorization Request Forms are available on our website and requests may be made telephonically: **1-800-279-1878** or fax: **1-855-799-2553**.

Electronic prior authorization (ePA) is also readily available. Requests may be submitted free of charge through CoverMyMeds® (**www.covermymeds.com/main**) or SureScripts (**www.surescripts.com/enhance-prescribing/prior authorization**).

A selection of OTC medications is available to the members. Members must have a prescription from their prescriber for their drug benefit to apply. OTC medications may be limited to a 34-day supply.

How can you find a drug on the Formulary?

There are three ways to find a drug at **AetnaBetterHealth.com/Virginia**:

- You can search alphabetically.
- You can search by brand and generic name.
- You can search by therapeutic class.

Prior authorization process

Aetna Better Health's pharmacy prior authorization processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy prior authorization process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain prior authorization prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs
- Prescriptions that do not conform to Aetna Better Health's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)

Aetna Better Health's Pharmacy team and medical directors are responsible for adverse decisions, including a complete denial or approval of a different medication. Using specific, evidence-based prior authorization pharmacy review guidelines, Aetna Better Health may require additional information prior to deciding on the medical necessity of the drug requested, such as when:

- Formulary alternatives that have been tried and failed or cannot be tolerated (i.e., step therapy).
- There are no therapeutic alternatives listed on the formulary.
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the FDA or as accepted by established drug compendia).

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Pharmacy team or Medical Director may contact the prescriber to discuss the case or consult with a board-certified provider from an appropriate specialty area, such as a psychiatrist.

Aetna Better Health will offer a 72-hour supply if the member's prescription has not been filled due to a pending prior authorization decision and the pharmacist believes that the Member's health would be compromised without the drug.

Step therapy

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. Drugs having step therapy are identified on the formulary with "ST." Certain drugs on the Aetna Better Health formulary have quantity limits and are identified on the formulary with "QL."

Quantity level limits

Aetna Better Health applies quantity limits on medications to ensure safety, promote cost-effective dosing and deter waste and abuse. Quantity limits are reviewed and set based on the FDA-approved dosing and medically accepted uses. For example, medications FDA-approved for once daily administration are typically limited to one dose per day. Some medications may also be limited at a specified quantity per fill.

If you have any additional questions or comments about this or other pharmacy benefits, please feel free to contact the Pharmacy department at **1-800-279-1878**.

To obtain prior authorization, please call our Pharmacy Prior Authorization department at **1-800-279-1878** or fax the request to 855-799-2553. ePA can also be used by submitting prior authorization requests through CoverMyMeds® (**www.covermymeds.com/main)** or SureScripts (**www.surescripts.com/enhance-prescribing/prior authorization).**

Noncovered drugs

The following is a listing of noncovered drugs:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents whose primary purpose is cosmetic, including but not limited to hair growth. Agents used in the treatment of covered Gender Dysphoria services are not primarily cosmetic
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug are not covered
- Recalled drugs
- Experimental drugs or non-FDA approved drugs, except for children and youth covered under EPSDT
- Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis, and rheumatoid arthritis, which may not be available at local pharmacies. Specialty medications may require prior authorization before they can be filled and delivered. Providers can call **1-800-279-1878** to request prior authorization or complete the applicable prior authorization form and fax to **1-855-799-2553**. Specialty medications can be delivered to the provider's office, member's home, or other location as requested. Other specialty pharmacies are included in our network, visit our website to determine what other pharmacies are in our network.

CVS Caremark Specialty can be reached at **1-800-237-2767** if needed.

Mail order prescriptions

Aetna Better Health offers mail order prescription services through CVS Caremark. All members can access this service in one of three ways.

- By calling CVS Caremark toll-free at **1-855-271-6603**/TDD **1-800-231-4403**, Monday through Friday from 8 AM to 8 PM ET. They will help the member sign up for mail order service. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By going to: **www.caremark.com,** members can log in and sign up for Mail Service online. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.

- By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then, the member calls CVS Caremark and asks CVS Caremark to mail them a mail service order form. When the member receives the form, the member fills it out and mails CVS Caremark the prescription and the order form. Forms should be mailed to:

  CVS Caremark
  PO Box 2110
  Pittsburgh, PA 15230-2110

Chapter 10 — Concurrent Review

Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities, rehabilitation facilities, long term acute care facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. Providers must notify Aetna Better Health within 24 hours of an elective/emergent/urgent admission. All planned admissions must be prior authorized. Clinical information must be provided within 24 hours after notification of admission. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Hearst Corporation's MCG evidence-based care guidelines (formerly Milliman Care Guidelines). Admission certifications are conducted within three calendars day of notification with or without clinical information. This is based upon decision timeline regulations. It is imperative that clinical information is submitted timely (24 hours after notification of admission).

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of additional days. Providers should continue to provide clinical information timely, to prevent delay in approval or unnecessary denied days. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

Medical criteria

To support inpatient concurrent review decisions, Aetna Better Health uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Concurrent review staff that make medical necessity determinations are trained on the criteria. These criteria are established and reviewed according to Aetna Better Health policies and procedures.

Criteria sets are reviewed annually for appropriateness to the Aetna Better Health's population needs and updated as applicable when national guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The Aetna Clinical Policy Council reviews clinical policy bulletins. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting providers when appropriate. These are to be consulted in the order listed. For inpatient medical care reviews, Aetna Better Health uses the following medical review criteria:

- MCG for physical and behavioral health criteria
- Aetna Clinical Policy Bulletins
- Criteria required by applicable state or federal regulatory agency

The guidelines span the continuum of member care and describe best practices for treating common conditions.

These guidelines are updated regularly as each new version is published. A free copy of individual guidelines pertaining to a specific case is available for review upon request by phone **1-800-279-1878**.

Inpatient clinical information must be faxed to **1-877-817-3707** for concurrent review.

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending provider are responsible for developing a discharge plan for the member and for involving the member and family in

implementing the plan.

Our Concurrent Review Nurse works with the hospital discharge team and attending providers to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating of discharge planning for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending provider with names of network providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending provider of covered benefits as indicated.

Chapter 11 — Prior Authorization

The requesting provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict provider, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

How to request prior authorizations

A prior authorization request may be submitted by:

- 24/7 secure Provider Portal.
- Faxing the request form to **1-833-280-5224**
- Call the Prior Authorization department directly at **1-800-279-1878**

Please use a cover sheet with the practice's correct phone and fax numbers to safeguard PHI and facilitate processing.

Prior authorization request must include the following information:

1. **Member Information**: Name, date of birth, sex, and identification number of the member.
2. **Provider Information**:
    a. **Referring/Requesting Provider**: Provider name, address, phone number, fax number, specialty, NPI, and contact person
    b. **Service Provider/Facility**: Provider name, address, phone number, fax number, specialty, NPI, and contact person
3. **Request Information**:
    a. Problem/diagnosis with applicable CPT code(s), ICD -10 Code(s) CMS HCPCS codes. National Drug Code (NDC).
    b. Procedure/test required with applicable CPT code(s), ICD -10 Code(s) CMS HCPCS codes. National Drug Code (NDC).
    c. Dates(s) of service
    d. Number of visits being requested
    e. Place of Service: Outpatient, inpatient, office
4. **Other Clinical Information**: Include clinical notes, laboratory, and X-ray reports, etc. (For procedures, please attach additional pages as necessary.)

All clinical information should be submitted with request.

Urgent Services are requests for medical care or treatment that could result in the following circumstances:

1. Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

For inpatient requests

2. All planned hospital admissions require prior authorization.
3. Inpatient admission notification should be submitted with 24 hours. (Fax: **1-877-807-3707**)

Timeliness of decisions and notifications to providers and/or members

Aetna Better Health makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by DMAS, Aetna Better Health adheres to the following decision/notification time standards.

Decision	Decision Timeframe	Notification to	Notification Method
Urgent preservice approval	Based on members need but no more than 72 hours/3 calendar days from receipt of request	Provider	Oral or electronic/written
Urgent preservice denial	Based on members need but no more than 72 hours/3 calendar days from receipt of request	Provider and member	Oral and electronic/written
Non-urgent preservice approval	Based on members need but no more than 14 calendar days from receipt of the request	Provider	Oral or electronic/written
Nonurgent preservice denial	Based on members need but no more than 14 calendar days from receipt of the request	Provider and member	Oral and/ electronic/written
Urgent concurrent approval	72 hours/3 calendar days of receipt of request	Provider	Oral or electronic/written
Urgent concurrent denial	72 hours/3 calendar days of receipt of request	Provider	Oral and electronic/written
Post-service approval	30 calendar days of receipt of request	Provider	Oral or electronic/written
Post-service denial	30 calendar days from receipt of the request.	Provider and member	Electronic/written
Termination, suspension reduction of a previously authorized service	At least 10 calendar days before the date of the action.	Provider and member	Electronic/written

Decision	Decision Timeframe	Notification to	Notification Method
Pharmacy Review Medical Drugs	24 hours of receipt of request	Provider	Oral and electronic/written
Oncology Treatment Plans (Eviti Vendor)	24 hours of receipt of request if injectable, Non-injectables 72 hours/3 calendar days	Provider	Oral and electronic/written
High-Cost Drug Reviews	24 hours of receipt of request	Provider	Oral and electronic/written

If Aetna Better Health approves a request for expedited determination, a notification will be sent to the member and the provider involved, as appropriate, of its determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

If Aetna Better Health denies a request for an expedited determination, the request will automatically be transferred to the standard time frame. Aetna Better Health will promptly provide the member oral notice of the denial of an expedited review and of their rights. Aetna Better Health will send to the member within 72 hours, a written letter of the members' rights.

In accordance with **SMD # 21-005,** for a member participating in a qualifying clinical trial as defined in Section 22, service authorization reviews must be expedited and completed related to the qualifying clinical trial within 72 hours, including when the qualifying clinical trial is performed by out of network or out of state providers.

Out-of-network providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the decision. Aetna Better Health sends documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by case basis in consultation with Aetna Better Health's Medical Director(s).

Prior authorization list

Treating providers must request authorization for certain medically necessary services. (See attachments.)

A complete and current list of services that require prior authorization can be found online at **AetnaBetterHealth.com/Virginia.** Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Prior authorization and coordination of benefits

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is required. If the service is not covered by the primary payer, the provider must follow Aetna Better Health's prior authorization rules.

Chapter 12 – Quality Management

Program description

Aetna Better Health maintains a quality management (QM) program that promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated throughout Aetna Better Health and the provider network. We promote the integration of our quality management activities with other systems, processes, and programs throughout Aetna Better Health.

Scope

Quality management is a company-wide endeavor that uses an integrated and collaborative approach involving each functional area to monitor processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, grievances and appeals), business application systems, and databases that are accessible to all areas. It is designed to include all members and stakeholders. Our quality program also includes a structure of oversight committees with representation that includes network providers and individual members.

The program addresses members with special needs in the monitoring, assessment, and evaluation of care and services provided. Emphasis is placed on, but not limited to, clinical areas relating to women, infants and children, adolescents, and young adults. Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), HEDIS and non-clinical areas, such as member satisfaction and provider satisfaction, are also included in the comprehensive effort to improve outcomes of care and service.

The Aetna Better Health Quality Improvement Program includes components to monitor, evaluate, and implement the Commonwealth contractual standards and processes to improve the following:

- Quality management
- Utilization management
- Records management
- Information management
- Care management
- Member services/enrollee satisfaction survey
- Customer Assessment of Healthcare and Providers Systems (CAHPS) Surveys
- Provider services
- Organizational structure
- Credentialing/Re-credentialing
- Network performance
- Fraud and abuse detection and prevention
- Access and availability to care and services
- Data collection, analysis, and reporting
- Compliance with NCQA and state standards
- HEDIS reporting requirements
- Medicaid Managed Care Performance Measures
- Preventive care
- Review of translation line utilization to identify specific cultural/linguistic needs
- Peer review
- Performance Improvement Projects (PIPs)

- Oversight of sub-contractors and delegated activities
- Continuity and coordination of care
- Annual QI work plan
- QI program effectiveness annual evaluation
- Delegation vendor/entity oversight

Program purpose

Aetna Better Health's QM Program allows the health plan the flexibility to target activities that focus on patterns identified at the local market level, providing a structure for promoting and achieving excellence in all areas through continuous improvement.

The program's key purpose is to facilitate improvement in members' biological, psychological, and social well-being with an emphasis on quality of care as well as non-clinical aspects of all services, including social determinants of health. Where the member's condition is not amenable to improvement, our goal is to maintain the member's current health and functional status.

Affirmative statement

Employees must avoid situations where their personal interest could conflict or appear to conflict with their responsibilities, obligations, or duties to the Health plan's interest or present an opportunity for personal gain apart from the normal compensation provided through employment. Aetna Better Health does not use incentives to reward restrictions of care. Utilization management decision making is based only on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. No reviewing provider may perform a review on one of his/her patients, or cases in which the reviewing provider has a proprietary financial interest in the site providing care.

Member privacy

It is Aetna Better Health's policy to conduct business in a manner that protects the privacy of our members. Confidentiality is maintained in accordance with federal and state laws. Confidential information requested, used and disclosed in the course of an investigation, is limited to the minimum amount necessary to accomplish the intended purpose; and controlled to maintain confidentiality and to minimize health plan access to a "need to know" basis. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Provider responsibilities

Network practitioners and providers are required by contract to:

- Cooperate with QI activities
- Maintain the confidentiality of member information and records
- Allow the Plan to use practitioner performance data

Goals and objectives

The goal of the Quality Improvement program is to facilitate consistent delivery of high-quality coordinated member care and service throughout Aetna Better Health by assessing and improving care/service processes and outcomes.

The objectives of the Aetna Better Health Quality Improvement program are as follows:

- Design and maintain structures and processes that support continuous quality improvement, including systematic measurement, analysis, intervention, and re-measurement. This includes

mechanisms to evaluate and improve member care outcomes.

- Comply, coordinate, and monitor for compliance with state and federal regulations and NCQA standards. This includes attending and participating in the Virginia DMAS quality and Advisory Group meetings.
- Coordinate, integrate, and communicate quality improvement activities with other departments including Member Services, Case Management, Behavioral Health, Pharmacy, Network Relations, Financial Services, Claims, Utilization Management, and Information Services.
- Monitor and evaluate medical care provided to Aetna Better Health members to ensure quality and medical appropriateness, identify over and underutilization, and ensure safety of services through prospective, concurrent, and retrospective review.
- Monitor and evaluate the behavioral health care provided to Aetna Better Health members to ensure accessibility, quality, and safety of services as well as continuity and coordination of behavioral and medical care.
- Conduct and oversee clinical and non-clinical performance improvement projects (PIPs) that demonstrate an ongoing measurement and intervention improvement in member care, service, safety, and satisfaction.
- Monitor credentialing and re-credentialing activities.
- Educate enrollees, health plan staff, and providers on the importance of Quality and Utilization Management programs and the results of non-confidential studies or reports (i.e., HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) via newsletters and the Aetna Better Health website.
- Measure availability and accessibility to care and services at least annually.
- Measure member satisfaction and identify sources of dissatisfaction through:
  - Review and analysis of member complaint data
  - Annual member satisfaction surveys
- Measure provider satisfaction and identify sources of dissatisfaction through:
  - Review and analysis of provider complaint data
  - Annual provider satisfaction surveys
- Provide members a mechanism to offer suggestions for improving internal operations and services through participation on the Member Access Committee and through the health plan's review of enrollee complaints and appeals.
- Address specific concerns identified by the Plan's clinical or administrative staff.
- Establish and maintain clinical practice guidelines, including preventive health, pertinent for the population and annually measure compliance via HEDIS measures and other applicable measures and standards.
- Measure compliance to medical record standards on a random number of physicians. Typically, this is done concurrently with the HEDIS medical record review.
- Monitor standards for oversight of sub-contracted vendors and for delegated entities for quality improvement, credentialing/ re-credentialing, utilization management and claims processing.
- Develop methods to evaluate continuity and coordination of care.
- To support objectives aimed at the development, monitoring, and servicing members with complex health needs in conjunction with Care management.
- Monitor cultural and linguistic needs to ensure processes are in place to serve a diverse membership.
- Accurately record documentation of QI investigations and activities, including documentation of quality improvement committee meetings, qualitative and quantitative reports of trends/patterns, and analysis of the trends/patterns.

- Evaluate at least annually and modify as necessary:
  - The effectiveness of quality improvement interventions for the previous year (demonstrated improvements in care and service) and trending of clinical and service indicator data.
  - The appropriateness of the program structure, processes, and objectives.
- The work plan for the upcoming year that includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues.
- Promote performance-based reimbursement models that connect provider reimbursement to performance against a defined set of quality and utilization metrics. Reimbursement models include but are not limited to shared savings/risk programs, care coordination fees, pay for quality, and episode bundled payment arrangements.

Patient safety

Aetna Better Health has a patient safety program in place which is intended to support practitioners and providers (e.g., hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, behavioral health facilities), in their efforts to monitor for and reduce the incidence of medical errors. The program may include one or more of the following; prescription drug utilization review and tracking and trending of adverse events; prior authorization of pharmacy claims to ensure medical appropriateness and prevent unsafe prescribing; analysis of procedure and/or diagnosis codes to identify opportunities for improvement in medical practices and communicate any findings directly to the practitioner and/or provider involved; and education of providers and members about prevention and detection of unsafe practices.

Governing body

The Aetna Better Health Board of Directors has delegated ultimate accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO). The CMO is responsible for providing national strategic direction and oversight of the QM Program for Aetna Better Health members. The Board of Directors delegates responsibility of the health plan quality improvement process to the Quality Management Oversight Committee (QMOC), which oversees the quality program.

Program accountability – Board of Directors

Aetna Better Health Board of Directors has ultimate accountability for the QAPI and related processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network. The chief executive officer on behalf of the Quality Management Oversight Committee submits the QAPI and any subsequent revisions to the board of directors for approval. In addition, the chief executive officer annually submits to the board of directors an evaluation of the previous year's QAPI activities, summary reports, data, outcomes of studies and credentialing activities (i.e., annual evaluation). The proposed annual QAPI work plan is also submitted to the board of directors for approval. After evaluating the information, the board of directors may provide further direction and recommendations to the Chief Executive Officer for enhancements to the QAPI and work plan.

Committee structure

Quality management and performance improvement activities are reported to the board of directors through the following committees:

- Quality Management Oversight Committee (QMOC)
- Quality Management Utilization Management Committee (QMUM)
- Delegation Oversight Committee (DOC)

- Aetna Credentialing and Performance Committee (CPC)
- Aetna Practitioner Appeal Committee (PAC)
- Aetna National Quality Oversight Committee (NQOC)
- Drug Utilization Review (DUR) Board
- Service Improvement Committee (SIC)
- Grievance and Appeals Committee
- Member Advisory Committee

Quality Management Oversight Committee (QMOC)

The Quality Management Oversight Committee's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee is designated to provide executive oversight of the QAPI and make recommendations to the board of directors about Aetna Better Health's quality management and performance improvement activities, including the annual QAPI, work plan and evaluation and work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers.

Quality Management Utilization Management Committee (QMUM Committee)

The Quality Management Utilization Management (QMUM) Committee's primary purpose is to advise and make recommendations to the Chief Medical Officer on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management program. Summary reports are submitted to the Quality Management Oversight Committee for review/approval and board of directors.

Aetna Credentialing and Performance Committee (CPC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated decision-making authority to the Aetna Credentialing and Performance Committee's (CPC). This committee is responsible for credentialing and recredentialing individual providers (i.e., practitioners) who deliver services to members. This committee is also responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect the health or welfare of members.

Aetna Practitioner Appeals Committee (PAC) - subcommittee to CPC

The purpose of the Aetna Practitioner Appeals Committee (PAC) is to conduct professional review hearings of providers who appeal decisions made by the Aetna Credentialing and Performance Committee involving professional competence or conduct of the provider. The committee, which is, facilitated by an Aetna medical director, consists of providers who are appointed on an ad hoc basis by the Aetna Credentialing and Performance Committee. The committee reports through CPC and to the Aetna Better Health QMOC.

Aetna Quality Oversight Committee (NQOC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated authority to the Aetna Quality Oversight Committee (QOC) to conduct the credentialing/recredentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.

Service Improvement Committee (SIC)

The Service Improvement Committee advises and makes recommendations to the Quality Management Oversight Committee and/or Aetna Better Health management about customer (member and provider) issues.

Grievance & Appeals Committee

The Grievance & Appeals Committee reviews expression of dissatisfaction by members, including complaints. The committee also reviews issues decisions on appeals that are filed by members or providers on behalf of members.

Member Advisory Committee (MAC)

The Member Advisory Committee (MAC) solicits enrolled member feedback and opinion regarding issues related to access and the quality of care and services provided to members as well as potential programs, activities and educational materials. Members provide feedback to Aetna Better Health aimed at improving member care and services.

Drug Utilization Review (DUR) Board

The DUR is designed to analyze member and practitioner/provider drug utilization patterns to identify educational and/or intervention opportunities that promote patient safety and appropriate utilization, monitor quality outcomes, and to drive cost-effective drug therapy.

Member profiles

Member profiles play a pivotal role in the management of member care both by Aetna Better Health's integrated care management team, as well as by the member's medical home/PCP. Member profiles are used to:

- Identify members who have under-or-over utilized health services, including emergency department services, hospital admissions and prescribed medications, and could benefit from integrated care management services
- Identify members who may lack appropriate access to needed services or could benefit from education about how to best utilize the health care system (e.g., persons with high emergency room utilization, or lack of preventive service utilization)
- Identify medical homes/PCPs that do not appear to be following recommended clinical practice guidelines or need to reach out to their assigned members more effectively and facilitate better management of the member's care
- Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection

Provider profiles

Aetna Better Health uses the provider profile to monitor a provider's utilization practices along with members' health outcomes to identify opportunities for improvement. The objectives of the provider profiles are to identify provider utilization patterns that vary significantly from peer network provider groups; identify trends that can be addressed through provider outreach; provide information to network providers about their practice patterns; safeguard confidentiality by maintaining secure access to the profile interface; provide information to be used as a component of quality management oversight; and provide information to be used as a component of provider incentive compensation.

Member and provider satisfaction surveys

Member and provider satisfaction with health care services is assessed to discover areas that are working well and identify opportunities for improvement. Member surveys are conducted by an Aetna Better Health approved vendor using nationally standardized survey items. The results are distributed to members, providers, and DMAS. Additional focused surveys of specific populations or users of identified services may be conducted at the discretion of the Chief Executive Officer. Member surveys include but are not limited to questions related to availability and accessibility of healthcare, practitioners, utilization, quality of care and service, quality of member services, requests to change practitioners and/or sites, and cultural competency. Provider surveys address satisfaction with Aetna Better Health's utilization management procedures (prior authorization, concurrent review), claims processing, and Aetna Better Health's response to inquiries.

When areas for potential improvement are identified from member or provider surveys or other sources (such as member complaints, grievances/appeals or PIPs), Aetna Better Health uses a formal process to evaluate the areas identified. The identified issues are prioritized, and concerns addressed; interventions are implemented, and the issue is reassessed to determine change and satisfaction.

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of members, opportunities for improvement identified through our QM Program, and feedback from participating providers. Guidelines are updated as appropriate, but at least every two years. Aetna Better Health adopts and distributes clinical practice guidelines. The link is available on our website at **AetnaBetterHealth.com/Virginia/providers/guidelines.** Aetna Better Health also adopts behavioral health guidelines from the American Psychiatric Association. We provide information about updated guidelines in the Provider Newsletters and on our website.

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to compare performance of managed health care plans reliably. Aetna Better Health collects this data annually.

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by the Center for Medicare and Medicaid Services (CMS) and DMAS. Accrediting bodies such as the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS data, The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes, and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:

1. Administrative (uses claims and encounter data)
2. Hybrid (uses medical record review on sample of members along with claims and encounter data)
3. Survey

Why does the health plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings, and results of test that may not be available in claims/encounter data. Typically, a health plan employee will call the provider's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the Plan may ask the provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the health plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the health plan will ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the health plan?

The HIPAA Privacy Rule permits a provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 § CFR 164.506 (c) (4). Thus, a provider may disclose protected health information to a health plan for the Plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the provider bill the health plan for providing copies of records for HEDIS?

Providers may not bill either the Plan or the member for copies of medical records related to HEDIS. Aetna Better Health of Virginia does not contract with third party healthcare information management companies and does not reimburse medical record vendors, nor the fees associated with practitioners delegating medical record copying services to an outside vendor.

How can providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the provider and the Plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the Plan remote access to provider electronic medical records (EMRs) and setting up electronic data exchange from the provider EMR to the Plan. Please contact the QM department for more information.

How can providers obtain the results of medical record reviews?

The Plan's QM department can share the results of the medical record reviews performed at provider offices and show how results compare to that of the Plan overall. Please contact the QM department for more information.

Additional information about the QM program goals and outcomes as they relate to member care and services can be found on our website at **AetnaBetterHealth.com/Virginia/providers/provider-quality.** An annual QM summary highlights our accomplishments and can be obtained by contacting Provider Services. We also communicate outcomes in the provider newsletters.

Chapter 13 — Billing and Claims

Aetna Better Health processes claims for services provided to eligible members in accordance with applicable policies and procedures. Aetna Better Health will comply with all applicable state and federal laws, rules, and regulations related to claim adjudication.

Important note: Aetna Better Health requires providers and their vendors to submit claims for medically necessary services covered under the Aetna Better Health agreement, provided that the member has provided the provider with the information that is necessary to verify that the member is enrolled in the Virginia Medicaid programs within not fewer than 21 days before the deadline for the provider to submit its claim to the Aetna Better Health established by the provider agreement. A provider who does not comply with this requirement agrees not to bill the member for those medically necessary services covered under the Aetna Better Health contract or assert any contractual assignments or benefits or rights to reimbursement or statutory liens against the member.

When to file a claim/timely filing of a claim

All claims, even those services where a per member, per month is paid, must be submitted to Aetna Better Health. All claims should be submitted timely. Our timely filing guidelines are as follows:

- New claim submissions — Claims must be filed on a valid claim form within 365 days from the date of services (unless there is a contractual exception). For hospital inpatient claims, date of service means the date of discharge of the member.
- In the event that another payer is prime, providers have 365 days from the date of the remittance advice to submit a coordination of benefits claim. The timeframe for submission begins on the date of payment from the primary payer.
- Adjustments of claims must be identified and submitted within 365 days from the date of the adjudication decision (either an incorrect payment or an incorrect denial). Please refer to Chapter 14 for reconsideration/appeal guidelines.
- This can be found on our website in the **Quick Reference Guide.**

Failure to submit accurate and complete claims within the prescribed time period may result in payment delay and/or denial.

Clean claims

A “clean” claim means a claim that:

- Has been completed properly according to Medicaid billing guidelines.
- Is accompanied by all necessary documentation required by federal law, state law. or state administrative rule for payment.
- Can be processed and adjudicated without obtaining additional information from the provider or from a third party.

How to file a claim

Aetna Better Health’s claim processing system is QNXT. Both electronic and paper claims submissions are accepted. To assist Aetna Better Health in processing and paying claims efficiently, accurately, and timely, the health plan highly encourages providers to submit claims electronically, when possible. To facilitate electronic claims submissions, Aetna Better Health has established Availity as our Provider Portal vendor. Aetna Better Health receives EDI claims directly from our clearinghouse, which is accessible via Availity, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, member enrollment, and then uploads them into QNXT each business day. Within 24 hours of file receipt, Aetna

Better Health provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Virginia DMAS Provider Registration

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 prior to rendering services to Medicaid members using the State's Provider Services Solution module, PRSS.

In accordance with State of Virginia DMAS rules and edits, the Aetna Better Health will reject claim submissions 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 must not balance bill the Medicaid subscriber.

Providers of Aetna Better Health patients must be registered with the State of Virginia's MES, using their NPI, taxonomy code (according to registers specialty type), practice address and billing address.

Registration must occur prior to rendering services to the plan's membership. Atypical providers are not required to have an NPI. Aetna Better Health will perform edits based on the Medicaid ID submitted using the G2 qualifier in the rendering and/or billing loops.

Taxonomy Code Submission

Providers are required to submit claims with the billing and/or rendering, provider taxonomy codes that are consistent with the provider's registered specialty and services being rendered. Aetna Better Health

will reject the claim if the taxonomy code does not match what is entered on the MES file for NPI submitted on the claim or if the taxonomy code was omitted. Aetna Better Health strongly encourages sending the taxonomy codes associated to the Referring and Attending Provider types when they are sent 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

The following page provides some **general taxonomy** billing guidance based on the sources cited above. Please note that DMAS publishes billing guides with specific requirements related to taxonomy and code alignment that should be referenced in addition to this manual.

Claim forms (CMS-1500 and UB-04)

All claims must be submitted on a standard claim form and contain the basic data elements necessary for processing. For additional information on the standard CMS form visit **www.nucc.org**, and for the UB form visit **www.nubc.org**.

- When filing a claim, select the appropriate claim form.
  - Medical and professional services should use current version of the CMS-1500 Health Insurance Claim Form, if submitting paper. If submitting electronically, use the ANSI 837P.
  - Hospital inpatient, outpatient, skilled nursing, and emergency room services should use UB-04, if submitting paper. If submitting electronically, us the ANSI 837I.
  - Rural health clinics and federally qualified health centers should use UB-04 or CMS 1500, as appropriate for the services rendered, if submitting paper claims. For electronic claims, use the 837I or 837P, as appropriate.
- Please contact our Provider Relations Department with additional questions.
- Complete the claim form.
  - Paper claims must be legible and suitable for imaging for record retention. This includes attachments. Complete all required fields and include additional documentation when necessary.
  - For both electronic and paper, if the claim fails data entry requirements, is illegible, has poor-quality copies and/or required documentation is missing, the claim will be voided (unaccepted). If these are not corrected timely, this could result in the claim being denied for untimely filing.
- Submit your claims electronically or mail the original claim to the address provided below. Faxed claims are not routinely accepted.
  - To submit a paper claim and/or include supporting documentation, such as members' medical records, clearly label and send to:

    Aetna Better Health
    PO Box 982974
    El Paso, TX 79998-2974

Electronic submissions/EDI Information

- Electronic Clearing House - Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Availity's Provider Portal enables access to our EDI vendor. If you are not currently enrolled with Availity and would like to be able to submit claims electronically, please select this **link** to enroll. Payer ID: 128VA
- Electronic fund transfers (EFT) can be established with Aetna Better Health. You can enroll in EFT/ERA Registration Services (EERS). To enroll in EERS, visit **PayerEnrollServices.com**.

Claim filing tips

- Dates of service on the claim should fall within the prior authorized service date range. Including dates of services outside the authorized range may result in denials.
- Claims must have current, valid, and appropriate ICD-10 diagnosis codes.
- The diagnosis codes must be coded to the highest degree of specificity (seventh digit) to be considered valid.
- Claims must be submitted with valid CPT, HCPCS, and/or revenue codes.
- Claims submitted with nonstandard CPT, HCPCS, revenue codes, or modifiers will NOT be processed and will be returned to the provider. These claims should be reworked and submitted timely to the initial claims address.
- Each CPT or HCPCS code line must have a valid place of service (block 24B) code when billing on a CMS-1500 form.
- Accident details should be provided when applicable (Block 10A-C of CMS-1500 Form).
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500 Form).
- Providers must submit the appropriate NPI numbers in Block 33A of the CMS-1500 and Block 56 of the UB-04.
- Billing provider taxonomy information should be submitted (Block 33B of the CMS-1500 form)
- All providers, including federally qualified health centers and rural health clinics, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.

Balance billing

Aetna Better Health participating Providers are prohibited, by contract, from billing any member beyond the member's cost sharing liability, if applicable, as defined on the Aetna Better Health remittance advice.

A provider may seek reimbursement from a member when a service is not a covered benefit and the member has given informed written consent before treatment that they agree to be held responsible for all charges associated with the service.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health Provider Relations Representative to research the complaint. Aetna Better Health is obligated to notify DMAS when a provider continues the inappropriate practice of balance billing a member.

Coordination of benefits

By law, Medicaid is the payor of last resort. Aetna Better Health, as an agency of the Commonwealth of Virginia is considered the payor of last resort when other coverage for a member is identified. Aetna Better

Health shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

These claims must be received by Aetna Better Health within 365 days from the member's primary carrier remittance advice date. The timeframe for submission begins on the date of payment from the primary payer. A copy of the primary carrier RA and disposition detail must accompany the claim.

Aetna Better Health pursues Third Party Liability claims based on requirements and/or limitations under Aetna Better Health's contract with the Commonwealth of Virginia.

Participating and/or non-participating Providers are required to follow Aetna Better Health's policies on authorization requirements when Aetna is deemed the primary payer. If the claim is processed as secondary by Aetna Better Health, then that payer's authorization rules are applied.

Correct coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect coding

Examples of incorrect coding include:

- "Unbundling," or fragmenting one service into components and coding each as if it were a separate service or billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when a higher level, more comprehensive code is appropriate.

Correct coding initiative

Aetna Better Health utilizes claims editing systems designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Our edit guidelines are based on, but not limited to NCCI, CPT-4, HCPCS, and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy, and literature research input from academic affiliations.

The major areas of reviews are:

- Procedure Unbundling - Billing two or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure.
- Incidental Procedures - A procedure that is performed at the same time as a more complex procedure; however, the procedure requires little additional provider resources and/or is clinically integral to the performance of the primary procedure.
- Mutually Exclusive Procedures - Two or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service.
- Multiple Surgical Procedures - Surgical procedures are ranked according to clinical intensity and paid following percentage guidelines.
- Duplicate Procedures - Procedures that are billed more than once on a date of service.

- Assistant Surgeon Utilization - Determination of reimbursement and coverage.
- Evaluation and Management Service Billing - Review the billing for services in conjunction with procedures performed.

When reviewing a remittance advice, any CPT code that has been changed or denied by the editing system will be noted by the appropriate disposition code.

Itemized billings

Aetna Better Health may require that providers submit an itemized billing statement along with their original claims. Claims billed in excess of $50,000.00 will require an itemized billing statement. If an itemized billing statement is not received, then the claim will be denied for an itemized billing statement.

Interim claims

Aetna Better Health follows DMAS guidelines for Interim Claims:

- Interim claims should be billed with a patient status of 30 with at least 60 days billed.
- Pending submission of the final bill & itemization, Aetna Better Health will process the interim claims submitted in accordance with the applicable coverage. When the final bill & itemization are received, the previous associated interim claims will be retracted, and the final bill will be processed accordingly.
- The final bill (bill type 114) must include the entire stay (all dates of services) for the inpatient stay.

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Certain modifiers may affect payment amounts as defined by the State of Virginia Medicaid Fee Schedule or contract with Aetna Better Health. Below are examples of a few commonly used modifiers:

- **Modifier 59 — Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499).

- **Modifier 25 — Significant, Separately Identifiable Evaluation and Management Service by the Same Provider on the Same Day of the Procedure or Other Service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

- **Modifier 50 — Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, a provider may bill the component code with modifier 50. Services should each be billed on one line reporting one unit with a 50 modifier.

- **Modifier 57 — Decision for Surgery** — must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period.

Note: Refer to the CPT Manual for further detail on proper modifier usage.

Multiple procedures

Multiple procedures performed on the same day and/or at the same session are processed at 100% of the contracted rate for the primary procedure, 50% of the contracted amount for the secondary procedure, and 50% of the contracted amount for any subsequent procedures; or as defined by a provider's current contract with Aetna Better Health or Medicaid guideline changes.

Durable medical equipment (DME)

Providers submitting claims for DME rental should use CMS-1500 form. DME rental claims are only paid up to the purchase price of the DME.

- DME rental claims are only paid up to the purchase price of the durable medical equipment. Under Medicaid Regulations a DME rental is considered a purchase after 10 months.
- In cases where there is no rate available, the MCO is required to utilize the reimbursement methodology set forth in 12VAC30-80-30.A(6) to determine the Fee-For-Service benchmark rate. If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, plus 30%. A copy of the invoice must be included when the claim is submitted to Aetna Better Health.

Electronic Visit Verification (EVV)

EVV phase 1 launched in Virginia on Sept 1, 2020. EVV Phase 2 is for FACILITY Virginia Medicaid providers.

This continues to support Cures compliance for the Commonwealth of Virginia and is implemented in a provider choice model. The provider must select and implement the EVV application that suits its business requirements. Neither DMAS nor Aetna Better Health will endorse, approve, or recommend any specific EVV vendor to a provider. The six required data elements to be considered a valid EVV submission. If any of these EVV data elements are missing, the claim will be denied. If the EVV claim submission passes the intake rules, the standard claim processing rules will apply. The six required data elements required on the 837i include:

1. Member ID
2. Rev Code of the service provided
3. Date the service (Single date)
4. Start and End time for the service (do not cross over days)
5. Physical location for the service (ie: 123 Any St, Town, VA 23000)
6. Attendant's name and unique ID that you created by the facility

There are unique codes and processes for submitting EVV claims. Make sure correct codes are used and appropriate units are entered correctly. Otherwise, your claim might be denied. Rev Codes for EVV for Facility Providers providing service with facility types 32 or 34:

0550 Skilled Nursing Assessment

0551 Skilled Nursing Care, Follow-Up Care
0559 Skilled Nursing Care, Comprehensive Visit
0571 Home Health Aide Visit (no PA required)

0424 Physical Therapy, Home Health Assessment
0421 Physical Therapy, Home Health Follow-Up Visit
0434 Occupational Therapy, Home Health Assessment

0431 Occupational Therapy, Home Health Follow-Up Visit
0444 Speech-Language Services, Home Health Assessment
0441 Speech-Language Services, Home Health Follow-Up Visit

Individual receiving the service

Date of service,

Type of Service,

Location of service delivery - must be physical address, CANNOT be Geo address, Individuals providing the service - Last Name, First Name and Unique Attendants ID, and Time the service begins and ends.

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0441 Speech-Language Services, Home Health Follow-Up Visit

The codes that must follow EVV requirements for Agency Directed providers are T1019 and T1005. There are exceptions when EVV will not be required. These include when the service is provided by a live-in caregiver, in a group home setting, or in a school setting. If that is the case, then the claims must include

the UB modifier and correct place of service must be noted. Live-in was added the first of January 2021, and the school and group home option began the first of September 2020. If a member has a second visit during the day, then that visit should have the 76 modifiers noting as such. The first visit should NOT have the 76 modifier, only the second visit of the day.

S5126, Personal Care, and S5150, Respite Care, are both Consumer Directed CPT codes and cannot be billed by agency providers. S5135 are "Companion" Care Consumer directed and are carved out and will not be paid by Aetna Better Health.

Home health care

Phase 2 begins Jan 1, 2024. EVV Phase 2 is for FACILITY Virginia Medicaid providers. This continues to support Cures compliance for the Commonwealth of Virginia and is implemented in a provider choice model. The provider must select and implement the EVV application that suits its business requirements. Neither DMAS nor Aetna Better Health will endorse, approve, or recommend any specific EVV vendor to a provider.

The six required data elements to be considered a valid EVV submission. If any of these EVV data elements are missing, the claim will be denied. If the EVV claim submission passes the intake rules, the standard claim processing rules will apply. The six required data elements required on the 837i include:

1. Member ID
2. Rev Code of the service provided
3. Date the service (Single date)
4. Start and End time for the service (do not cross over days)
5. Physical location for the service (ie: 123 Any St, Town, VA 23000)
6. Attendant's name and unique ID that you created by the facility

There are unique codes and processes for submitting EVV claims. Make sure correct codes are used and appropriate units are entered correctly. Otherwise, your claim might be denied.

Rev Codes for EVV for Facility Providers providing service with facility types 32 or 34 0550 Skilled Nursing Assessment

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0421 Physical Therapy, Home Health Follow-Up Visit
0434 Occupational Therapy, Home Health Assessment

0431 Occupational Therapy, Home Health Follow-Up Visit
0444 Speech-Language Services, Home Health Assessment
0441 Speech-Language Services, Home

Providers submitting claims for Home Health should use a UB-04 form. Providers must bill in accordance with their contract and/or Commonwealth of Virginia Medicaid guidelines.

- Home Health providers billing for Personal Care and Respite services should bill on a CMS-1500 with the appropriate CPT revenue codes.

Hospice

Hospice is a covered contracted benefit under Aetna Better Health. Contact the member's care coordinator once Hospice care is under consideration to ensure appropriate services are arranged for the members continued care and comfort. As with all programs, Enhanced Benefits (see Chapter 6) will continue to be available for the member. All claims need to be resubmitted to original Medicare for processing, regardless of whether they are related to Hospice services or not.

Hospice services should be billed on a UB-04 form. There are five levels of hospice care and two service intensity add on codes:

Revenue Code	Description
0651	Routine home care • Unit, per day • Less than 8 hours per day • Not continuous
0652	Continuous home care which is furnished during a period of crisis and primarily consists of nursing care • Unit, hourly • Minimum of 8 hours a day
0655	Inpatient respite care which is short-term care and intended to relieve family members or others caring for the individual • Unit, per day • Free standing facility • 5 day maximum
0656	General inpatient care which is short term and intended for pain control or acute or chronic symptom management which cannot be provided in other settings. • Unit, per day • Free standing facility
0658	Hospice room & board, nursing facility resident • Unit, per day • Must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831 • Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay • The room & board revenue code 0022 should be billed as zero with the RUG code. The charges should be listed on the 0658 revenue code.
0551	• Skilled Nursing Visit, RN, last 7 days of life • Service intensity add on code • Procedure code G0299 • Must be billed in conjunction with revenue code 0651 (routine home care)

0561	• Medical Social Service Visit, Clinical Social Worker, last 7 days of life • Service intensity add on code • Procedure code G0155 • Must be billed in conjunction with revenue code 0651 (routine home care)

National Drug Code (NDC)

The NDC is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

Federal regulations require states and managed care organizations to collect NDC numbers from providers on claims for the purposes of billing manufacturers for drug rebates. As a result, providers will not be reimbursed for drugs unless a valid 11-digit NDC number, unit of measure, and quantity administered are reported on the UB-04 or CMS-1500 claims.

A complete NDC data set consists of:

- An 11-digit National Drug Code number
- Unit of measure code
  - F2: International unit
  - GR: Gram
  - ML: Milliliter
  - UN: Unit
- NDC units are based on the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered, and the unit of measurement is required for billing.
- Provider must submit Revenue Codes, HCPCS Codes and related service units in addition to the required NDC information. This is required because claims are priced based on revenue, HCPCS or CPT codes and the units of service. If the NDC number on the claim doesn't have a specific revenue, HCPCS or CPT code assigned to it, assign the appropriate miscellaneous code.
- If the NDC data set is missing, incomplete, or invalid, Aetna Better Health will deny the affected claim line. The claim will need to be resubmitted with the required NDC information and/or correct number of units within the time allowed for potential payment.
- If the medication comes in a box with multiple vials, using the NDC on the box (outer packaging) is recommended.

It should be noted that many NDC numbers are displayed on drug packing in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting an NDC from a 10-digit to an 11-digit format requires a strategically placed zero, dependent upon the 10-digit format. The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted, additional "0" is in a bold font and underlined in the following example. **Note**: that hyphens indicated below are used solely to illustrate the various formatting examples for an NDC. Spaces or hyphens should not be used when entering the actual data in your claim.

Converting NDCs from 10-digits to 11-digits					
10-Digit Format on Package	10-Digit Format on Example	11-Digit Format	11-Digit Format Example	Actual 10-digit NDC Example	11-Digit Conversion of Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99	0002-7597-01	00002-7597-01
5-3-2	99999-999-99	5-4-2	99999-0999-99	50242-040-62	50242-0040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-09	60575-4112-1	60575-4112-01

NDC Billing Instructions

All institutional and professional claims must include the following information:

- NDC and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- The actual metric decimal quantity administered

Note: Virginia Medicaid requires the use of the Unit of Measurement Qualifiers following the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity.

Examples of NDC quantities for various dosage forms as follows:

- Tablets/Capsules – bill per UN
- Oral Liquids – bill per ML
- Reconstituted (or liquids) injections – bill per ML
- Non-reconstituted injections (i.e., vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
- Creams, ointments, topical powders – bill per GR
- Inhalers – bill per GR

UB-04 Claim Form

To report the NDC on the **UB-04** claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above).
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

CMS-1500 Claim Form

To report the NDC on the **CMS-1500** claim form, enter the following information:

- In Field 24A of the CMS-1500 form, in the shaded area, enter the NDC Qualifier of 4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

837I/837P Claims Submission for NDC

ANSI Page	Loop	Segment	Data Element	Comments
352	2400-Service Line	SV1	SV101 Product or Service ID Qualifier	Use "HC" for HCPCS Codes NDCs will not be processed in this segment; however, an NDC must be sent in the LIN segment to supplement a drug HCPCS code. For Agency Directed (AD) services, this is the type of service (procedure) code performed for EVV requirements.
427	2410-Drug Identification	LIN	LIN02 Product or Service ID Qualifier	Use "N4" for NDC
427	2410-Drug Identification	LIN	LIN03 National Drug Code	An NDC is required when a drug is dispensed. Aetna Better Health will capture only the first occurrence of the LIN segment for each service line. If billing for a compound medication with more than one NDC, then each applicable NDC must be sent as a separate service line.
429	2410-Drug Identification	CTP	CTP04 Quantity	Input the actual NDC quantity dispensed
430	2410-Drug Identification	CTP	CTP05 Composite Unit of Measure	Input the unit/basis of measure

What if an NDC is no longer active?

When billing with NDCs on claims, it is important to ensure that the NDC used is valid for the date of service. This is because NDCs can expire or change. An NDC's inactive status is determined based on a drug's market availability in nationally recognized drug information databases.

Additionally, an NDC is considered to be obsolete two years after its inactive date. It is a good idea to conduct a periodic check of records or automated systems where NDCs may be stored in your office for billing purposes. To help ensure that correct reimbursement is applied, the 11-digit NDC on your claim should correspond to the active NDC on the medication's outer packaging. Inactive products will continue to be reimbursed until they become obsolete.

Special billing instructions for NDC

Tuberculosis Oral Drugs

- Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499. Modifier U2 must be used in Block 24-D of the CMS-1500 (02-12) claim form. Clinics bill Medicaid with their actual cost for the drugs. If no modifier is billed, the claim may be denied. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family Planning Drugs and Devices

- Birth control pills must be billed using code J8499 along with modifiers FP and U2 in
- Block 24-D of the CMS-1500 (02-12) claim form. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

You can find more information about NDC online

- The U.S. Food and Drug Administration (FDA) package insert includes the NDC information. Online, the FDA publishes an online searchable **National Drug Code Directory** and has other public resources
- The Centers for Medicare & Medicaid Services (CMS) publishes a **CMS HCPCS/NDC Crosswalk**
- **RC Claim Assist,** powered by RJ Health, is a free tool accessible to the Aetna Better Health network to provide an easy-to-use resource for correct billing units for medical drug codes.

Additional benefits of RC Claim Assist

- Provides a comprehensive crosswalk of HCPCS/CPT drug codes, product names and NDCs
- Reduces number of resubmissions for claims payment
- Complete drug information on package size billable units
- Aligns providers and payers on managing medically covered pharmaceuticals

Skilled nursing facilities

Providers submitting claims for skilled nursing facilities should use a UB-04 form. Providers should bill Aetna Better Health using level of care HCPCS coding (e.g. level of care 101 is billed under HCPCS code LC101). Bill with the corresponding HCPCS code for services rendered. Contact the Claims Inquiry Claims Research (CICR) department with additional questions or concerns.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and

information across distance. Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth.
- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code, as defined by the American Medical Association (AMA);
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information; and
- Services delivered via telehealth meet all applicable state laws, regulations, and licensure requirements on the practice of telehealth.

Telehealth billing requirements

Providers shall submit claims for telehealth services using the appropriate CPT/HCPCS, modifier & place of service code for the professional service delivered.

- Place of Service (POS) should indicate where the service would have been provided had the client been served face-to-face (not where the client is located, or necessarily where the provider is located, when the service is received). For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. POS 02 ("telehealth") should not be used.
- GT is used as a modifier to telemedicine services delivered synchronously.

Vaccines for Children (not applicable to FAMIS)

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under the Vaccines for Children (VFC) program. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Centers for Medicare and Medicaid Services (CMS) require. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check "YES" in Block 11-D (Is there another health benefit plan?) on the CMS-1500 claim form.

Reimbursement for Children Ages 19 and 20

Since Medicaid policy provides coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code and Medicaid will reimburse the acquisition cost for these vaccines. Medicaid will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

Status of claims

Providers may check the status of a claim by login into our secure **provider portal** or by calling the Claims Inquiry Claims Research (CICR) department.

Provider Portal

Aetna Better Health encourages providers to take advantage of using our online **Provider Secure Web Portal**. It is quick, convenient, and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic.

Claims Inquiry Claims Research (CICR) Department

1-800-279-1878, listen for desired menu option. The CICR Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing.
  - Excludes corrections to prior authorization numbers (providers must call the prior Authorization Department directly)
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections)
- Be prepared to give the service representative the following information:
  - Provider name or NPI number
  - Member name, member identification number, and date of birth
  - Date of service
  - Claim number from the remittance advice on which you have received payment or denial of the claim

Resubmissions and corrected claims

Providers have 365 days from the last paid or denied date to resubmit a corrected version of a processed claim. The review and reprocessing of a corrected claim does not necessarily constitute reconsideration or claim dispute. Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Ways to submit

Submit the Resubmission Form, along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriate on initial submission. Resubmitted claims without all of the original claim lines may result in the adjustment and possible recoupment of the wrong claim line.
- Altered claims must be clearly initialed at the correction site. Initialing corrections ensures the integrity of a corrected claim.
- Corrected claims must be clearly identified as a resubmission by stamping/writing “corrected claim” or “resubmission” on the paper claim form. If submitting electronically, the frequency code in the CLM05-3 segment in the 2300 Claim Loop must show a “7” for a replacement/adjustment claim or an “8” if the claim is to be voided.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction. Remember corrections must be made on the claim form.

Failure to mail and accurately label the resubmission to the correct address may cause the claim to deny as a duplicate.

Provider Portal

Log into the Provider Portal and follow the resubmission process located in the help feature. **Note**: Upload any and all supporting documentation as needed.

Claim reconsiderations

Providers have 365 days from the last paid or denied date to correct and resubmit claims.

- Resubmission: A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information
- Reconsideration: A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors

A resubmission or reconsideration should be submitted with the **Provider Claims Resubmission/ Reconsideration Form** to the following address:

Aetna Better Health of Virginia
Attn: Reconsiderations
PO Box 982974
El Paso, TX 79998-2974

Note: Resubmissions may also be submitted through the Provider Portal. Examples of reconsideration requests:

- Contract interpretation issues
- Timely filing (submit acceptance report if billed electronic)
- Entire claim denied due to the member providing the incorrect insurance information
- Rejected as cosmetic and submitting medical records/documentation
- Coding edit reconsideration

Timely filing denials

It is the responsibility of the provider to maintain their account receivables records, and Aetna Better Health recommends that providers perform reviews and follow-up of their account receivables on at least a monthly basis to determine outstanding Aetna Better Health claims. Aetna Better Health will not be responsible for claims that were received outside timely filing limits.

Recognizing that providers may encounter timely filing claims denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by providers. If a claim is denied for timely filing, complete the **Provider Claim Resubmission/ Reconsideration Form** available on the Aetna Better Health's website and attach proof of timely filing.

Electronic submission

Electronic claim submission (EDI) reports are available from each provider's claims clearinghouse after each EDI submission. These reports detail the claims that were sent to and received by Aetna Better Health. Providers must submit a copy of the acceptance report from the provider's respective clearinghouse that indicates the claim was accepted by Aetna Better Health within timely filing limits to override timely filing denial and pay the claim.

Confirm that the claim did not appear on a rejection report. If Aetna determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the provider.

Paper submission

Providers must submit a screen print from the provider's respective billing system or database with documentation that shows the claim was generated and submitted to Aetna Better Health within the timely filing limits.

Documentation should include:

- The system printout that indicates:
  - That the claim was submitted to Aetna Better Health.
  - The name and ID number of the member.
  - The date of service.
  - The date the claim was filed to Aetna Better Health.
- A copy of the original CMS-1500 or UB-04 claim form that shows the original date of submission.

Remittance advices

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Aetna Better Health generates checks three times a week. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and to make corrections for any claims requiring resubmission.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), a provider must currently submit claims through EDI and receive payment for claims by EFT. Providers must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for providers to receive payment and reconcile outstanding accounts. Contact our Provider Relations Department if you are interested in receiving ERAs.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the processed amount and the discount/penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the processed amount above. Claims that have refunds applied are noted with a Claim status of REVERSED in the claim detail header with a non-zero refund amount listed.
- The Amount Paid is the total of the net amount, plus the refund amount, minus the Amount Recouped.

- The Ending Balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative amount paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes the:
  - Member name
  - Member ID number
  - Date of birth
  - Account number
  - Authorization ID, if obtained
  - Provider name
  - Claim status
  - Claim number
  - Refund amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

Refer to **Attachments** to view a sample remittance advice and check.

Overpayment

Network providers may voluntarily disclose overpayments or improper payments of funds directly to Aetna Better Health. We ask that the provider return the overpayment within sixty calendar days after the date on which the overpayment was identified. Send the refund check along with an explanation to Aetna Better Health, at the address below.

Aetna Better Health of Virginia
Attn: Finance Provider Refund Check Dept.
PO Box 842635
Dallas, TX 75284-2635

Other general claims instructions

Aetna Better Health claims are paid in accordance with the terms outlined in the provider contract for this product.

Chapter 14 — Inquiry, Grievance and Appeals

Aetna Better Health has an inquiry, grievance, and appeals process for members and providers to dispute a claim authorization or an Aetna Better Health decision. This includes both administrative and clinical decisions of Aetna Better Health, including grievances and appeals regarding reasonable accommodations and access to services under the Americans with Disabilities Act. A provider has sixty days (which must be done in writing) and a member has sixty days from the Notice of Action to file an Appeal. A provider has sixty days to file a grievance and a member can file a grievance at any time. A grievance may be filed in writing or by calling Provider Services. Members have a one-level internal appeal process through Aetna Better Health.

There are no punitive actions to members or providers for filing a complaint. Members and providers have the right to submit written comments with all levels of the process.

Provider inquiries and grievances

In order to ensure a high level of satisfaction, Aetna Better Health shall provide a mechanism for providers to express dissatisfaction with Plan decisions. Providers may express questions or dissatisfactions through our provider inquiry and grievances process.

If a provider has questions regarding member benefits/eligibility, claim status/payment, remittance advices, authorization inquires, etc., please access the Provider Portal, or contact the CICR department. Inquiries are handled on a daily basis and are normally resolved on the initial contact.

To submit a dissatisfaction regarding an issue in the health plan, you may contact Provider Relations at **1-800-279-1878**. Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be documented within our internal system and conveyed to the complainant.

After following these steps, if you are still dissatisfied you may have the right to file an appeal. Please refer to the Appeals section for instructions on filing an appeal.

Members and providers also have the right to request and receive a written copy of Aetna Better Health Utilization Management criteria, along with the entire appeal file used when making our determination, in cases where the appeals are related to a clinical decision/denial. Aetna Better Health members will receive assistance, if required, to file either a grievance or an appeal. Aetna Better Health also provides a toll-free number for members at **1-800-279-1878**. Interpretive services are also available to members by calling the telephone numbers above.

The member may request continuation of benefits during the health plan appeal review or a state fair hearing. The request must be filed within ten days of the mail date of the Notice of Action. If Aetna Better Health's action is upheld in a hearing, the member may be liable for the cost of any disputed services furnished while the Appeal was pending determination.

Claim reconsideration vs. claim appeal

Aetna Better Health has two separate and distinct processes designed to assist providers with issue resolution. There is a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as program integrity audit recoveries. This process must assure that appropriate decisions are made as promptly as possible. The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal. If the

provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing an appeal. However, before filing an appeal, the provider should verify the claim does not qualify to be submitted as a claims resubmission or reconsideration.

	Reconsideration	Appeal
Form	Resubmission/reconsideration form	Appeal form
Address	Aetna Better Health of Virginia Attention: Reconsiderations PO Box 982974 El Paso, TX 79998-2974	Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181
Appropriate Categories	1) Claim resubmissions 2) Corrected claims (including missing/ incomplete/ invalid diagnosis, procedure, or modifier denials) 3) Timely filing 4) COB (missing/ illegible primary explanation of benefits)	1) Denied days for inpatient stays 2) Authorization denials for late notification 3) Claim denial for no authorization/ preauthorization /medical necessity not met/noncovered charges/benefit exhausted 4) Services denied per finding of a review organization
Timeframe	365 days from the date of the adjudication decision (either an incorrect payment or an incorrect denial)	Claim denial appeals must be submitted within 60 calendar days of the date of denial.

Provider appeal of claim action

Providers may appeal any adverse claim action. Prior to appealing a claim action, providers may contact the CICR department for claims information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections as well as the steps below, in order to minimize claims issues:

- Contact the CICR department at **1-800-279-1878** as the first step is to clarify any denials or other actions relevant to the claim. A representative will be able to assist a provider with a possible resubmission of a claim with modifications.
- If an issue is not resolved after speaking with Aetna representatives or by submitting a claims resubmission/reconsideration, providers may challenge actions of a claim denial or adjudication by filing a formal appeal with the Aetna Better Health Appeals department.
- The appeal must be filed in writing and must specifically state the factual and legal basis for the appeal, including a chronology of pertinent events and a statement as to why the provider believes the action by Aetna Better Health was incorrect.
- Providers must attach copies of any supporting documents, such as claims, remittance advices, medical records, correspondence, etc. If additional copies of medical records are requested for appeal consideration, such copies are created at the provider's expense.

- Appeals should state “formal provider appeal” on the document(s) and should be mailed to:
  Aetna Better Health of Virginia
  PO Box 81040
  5801 Postal Road
  Cleveland, OH 44181

Examples of appeals:

- Denied as not medically necessary
- If a cosmetic denial is upheld and would like it reviewed a second time

Tips to writing an effective appeal

In the event that a provider does not agree with Aetna Health Care of Virginia’s decision regarding requested services or benefit coverage, we have provided tips to writing an effective grievance or appeal letter:

- Include the name, address, and phone number where the appealer can be reached in case there are any questions.
- Include the patients name, date of birth, and insurance ID number.
- Describe the service or item being requested.
- Address issues raised in our denial letter.
- Address the medical necessity of the requested service.
- Include information about the patient’s medical history:
  - Prior treatments
  - Surgery date
  - Complications
  - Medical condition and diagnosis

If applicable to an appeal situation, please also provide:

- Any unique patient factors that may influence our decision.
- Why alternate methods or treatments are not effective or available.
- The expected outcome and/or functional improvement.
- An explanation of the referral to an out-of-network provider.

When submitting an appeal, be sure to provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

Expedited appeal requests

Expedited requests are available for circumstances when application of the standard Appeal time frames would seriously jeopardize the life or health of the member or the member’s ability to attain, maintain, or regain maximum function. A verbal request indicating the need for an expedited review should be made directly to the Appeal & Grievance department at 1-800-279-1878. Those requests for an expedited review that meet the above criteria will have determinations made within 72 hours or earlier as the member’s physical or mental health requires.

Process definitions and determination timeframes

Process	Definition	Determination
Grievance	A complaint/grievance is any expression of dissatisfaction expressed by a provider regarding an issue in the health plan. If a provider is dissatisfied with any issue regarding the health plan, the provider may contact the respective customer service departments at the number(s) listed above. Complaints/ grievances must be received within 60 calendar days of the date of the incident that gave rise to the complaint.	Within 90 calendar days of receipt of the complaint/ grievance
Appeal	An appeal is a request by the provider when the resolution of a complaint or reconsideration is not resolved to the provider's satisfaction and the provider appeals the health plan's decision within the prescribed time frames. Examples: a denial or a limited authorization of a requested service, including the type or level of service, that the service is determined to be experimental, investigational, cosmetic, not medically necessary, or inappropriate. The Appeal must be received within sixty calendar days after the date of the health plan's Notice of Action.	72 hours from receipt of the expedited appeal; within 30 calendar days from receipt of the standard appeal request

Mail written inquires and grievances to:	Mail written appeals to:
Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181	Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181

Fraud, Waste and Abuse

Aetna Better Health will not tolerate health care fraud, waste, or abuse in any of its relationships with either internal or external stakeholders. Aetna Better Health will identify, report, monitor, and, when appropriate, refer for prosecution situations in which suspected fraud, waste, or abuse occurs.

Medicaid managed care fraud is defined as the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some payment or unauthorized benefit to himself and some other person. This includes any act that constitutes fraud under applicable federal or state law.

Medicaid managed care waste is defined as the rendering of unnecessary, redundant, or inappropriate services and medical errors and incorrect claim submissions. Generally not considered criminally negligent actions, Medicaid managed care waste is rather the misuse of resources and involves taxpayers not receiving reasonable value for their money in connection with any government-funded activities due to inappropriate act or omission by players with control over or access to government resources. Waste goes beyond fraud and abuse and most waste does not involve a violation of law; it relates primarily to mismanagement, inappropriate action, and inadequate oversight.

Medicaid managed care abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary costs to the Medicaid Plan, Federal, or State programs.

To report fraud, waste, and abuse, contact the Compliance, Fraud, Waste, and Abuse line at **1-844-317-5825** or submit concerns for fraud, waste, and abuse at **AetnaBetterHealth.com/Virginia/fraud-abuse.**

Aetna Better Health follows a mandatory corporate compliance plan that incorporates annual employee training, system controls, data mining tools, internal auditing, and a designated Special Investigations Unit (SIU) to monitor, detect, investigate, and report potential fraud, waste, and abuse. All Aetna Better Health staff complete required training in identifying potential fraud, waste and abuse and are provided the tools for reporting questionable situations upon hire and annually thereafter. Training includes how to detect and prevent member, provider, and employee fraud, waste, and abuse. Additionally, all customer service staff receives thorough training for fraud, waste, and abuse. Our goal is to operate at the highest level of ethical standards.

The SIU detects and investigates cases of potential health care fraud, waste, and abuse. Examples of fraud and abuse include but are not limited to the following:

- Submitting a claim for services not furnished either by using genuine patient information to fabricate entire claims or by padding claims with charges for procedures or services that did not take place.
- Submitting a claim with inaccurate diagnosis or procedure codes with the intent of maximizing payments or obtaining coverage that the member is not entitled to.
- Submitting a claim knowing reimbursement has previously been remitted.
- Misrepresenting dates of services, description of service, or identity of member or Provider in order to obtain reimbursement to which the provider or member is not entitled.
- Submitting a claim for noncovered services in a manner that categorizes them as covered services.
- Submitting a claim for a more costly service than the one actually performed, commonly known as “upcoding” — i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code).
- Submitting unbundled claim(s) for the purpose of avoiding these claim policies and procedures.

The SIU utilizes state-of-the-art data analysis tools to detect irregularities, which could be indicators of possible fraud, waste, and abuse. Clinical investigators and experienced fraud, waste, and abuse investigators work collaboratively to conduct investigations identified through various sources.

Statistical sampling and extrapolation methodology may be used in the computation of overpayments.

The SIU reviews medical claims on a prospective and retrospective basis using sophisticated data mining technology tools to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU also may request supporting documentation or schedule an onsite audit to investigate previously paid claims. The investigation does not mean that a provider is practicing fraud. In many cases, the SIU finds the provider billing practice was in error. In all cases, the SIU will work with the appropriate Provider Relations Representative to communicate what is believed an inappropriate billing practice.

If a provider or member is suspected of fraud, waste or abuse, an investigation begins, an audit is performed, and the member or provider is referred to our Fraud, Waste and Abuse meeting. When appropriate and an investigation and audit is warranted, those cases are reported to external entities, i.e., including DMAS, CMS and the Virginia Department of Health and Human Services Office of Inspector General. Reports include the name and ID number of the party involved; the source of the suspected fraud, waste, or abuse; the provider type; nature of the fraud, waste, or abuse; the approximate dollar amount involved; and the legal and administrative status of the case.

If a prepayment or post-payment audit of medical records is indicated to support the paid or submitted claims, Aetna Better Health will utilize our edit guidelines based on but not limited to NCCI, CPT-4, HCPCS, and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy, and literature research input from academic affiliations. If a prepayment or post-payment audit is indicated, the medical record documentation must support the claim.

The HHS-OIG compliance criteria suggest voluntarily conducting an initial, or baseline, audit. Claims self-audits can decrease the risk of enforcement action.

Our credentialing process for contracted providers includes a verification that the provider is eligible to participate. We specifically check the Excluded Provider Database on the HHS OIG website to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid, or SCHIP. This information is also requested on the credentialing and recredentialing application.

Aetna Better Health contract provisions with participating providers specifically state, that they shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. The provider hereby certifies that no such excluded person currently is employed by or under contract with them or with any “downstream” entity with which they contract relating to the furnishing of these services to Medicaid members.

Our Credentialing Verification Center conducts ongoing monitoring of the HHS OIG and state professional registration boards internet sites. Any information found pertaining to participating Aetna Better Health providers are referred for review by the credentialing committee to ensure compliance.

Our delegated credentialing entities are required to verify that the providers with whom they contract are eligible to participate, including checking the HHS OIG website to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid, or CHIP. Part of our ongoing evaluation of the delegated entities is confirmation of ongoing monitoring of state and federal websites to identify current sanctions or complaints.

As required by the Deficit Reduction Act of 2005, it is Aetna Better Health’s policy to provide detailed information to Aetna Better Health employees, vendors or other subcontractors, and other persons acting on behalf of Aetna Better Health, about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, “False Claims Acts”). The False Claims Acts assist the federal and state government in preventing and detecting fraud, waste, and abuse in Federal health care programs, such as Medicare and Medicaid.

Chapter 15 — Behavioral Health Services

Aetna Better Health offers a wide range of treatment options for individuals with a mental health or substance use disorder. These services include specialized behavioral health services provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, and mental health rehabilitation service providers (public or private). We also cover inpatient hospital services for acute medical detoxification. Services range from outpatient to hospital care, including crisis services. These services may be provided in the member's home or in the community, for a short or long timeframe, and aim to help individuals live in the community and maintain the most independent and satisfying life possible.

Aetna Better Health members can reach out to their Care Manager or Member Services if they need help scheduling an appointment to speak with a behavioral healthcare professional.

Aetna Better Health will engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person-centered treatment approaches, to lower morbidity among members with SMI and SED, including members with co-occurring developmental disabilities, substance use disorders and smoking cessation.

Aetna Better Health is committed to having an integrated care model that looks at all aspects of a person – physical, emotional, lifestyle, beliefs, and values. We treat behavioral and physical health together.

Behavioral Health Access Standards

Behavioral Health and Substance Use Services	
Appointment Type	**Access/Appointment Standard**
Emergent	Within 6 hours for non-life-threatening emergency services/immediately for life-threatening emergencies
Urgent care	Within 24 hours of request
New member appointments/ Routine follow-up appointments	3 business days if all clinical information is available or up to 5 business days if additional clinical information is required or as expeditiously as the Member's condition requires
Aftercare appointments	Within 5 business days after hospital discharge
After-Hours Care	24/7 coverage

Behavioral Health Decision Turnaround Times

Standard – Mental Health Services (formerly CMHRS) and including Behavioral Health Expansion	14 calendar days
Standard – ARTS SA Case Management and ARTS Peer Support	14 calendar days
Urgent – Mental Health Services (formerly CMHRS) and including Behavioral Health Expansion	72 hours
Urgent ARTS	72 hours
Expedited Urgent — Pre-service Inpatient	3 hours
Expedited Urgent reviews for other urgent services	24 hours
Urgent Concurrent	72 hours

Behavioral Health Care Providers

Communication between behavioral health care providers and the member's PCP helps to ensure members receive coordination of care. The sharing of clinical information promotes quality health care and a comprehensive treatment plan to assess for coexisting medical conditions, medication interactions or other medical concerns. Behavioral health care providers shall refer members with known or suspected and untreated physical health problems or disorders to such member's PCP for examination and treatment, with the member's or the member's legal guardian's written consent. Behavioral health care providers shall send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the member's PCP, with the member's or the member's legal guardian's consent.

Behavioral health providers may only provide physical health care services within the scope of their licenses.

Behavioral health providers should use the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) when assessing members for behavioral health services and document the DSM diagnosis and assessment/outcome information in the member's Medical Record.

Behavioral Health Care Services

Behavioral health and substance use services are covered services for Aetna Better Health members. Providers, members, or other responsible parties should contact Aetna Better Health directly at **1-800-279-1878 (TTY: 711)** to verify available behavioral health and substance use benefits and to seek an appointment or direction for obtaining behavioral health and substance use services.

Aetna Better Health members have access to integrated care managers for assistance in obtaining both routine and higher complexity health care services. PCPs can also contact Aetna Better Health for assistance in facilitating specialty behavioral health services for our members.

Aetna Better Health provides a comprehensive range of behavioral health care services for our members. Services include:

- Outpatient routine office visits for therapy and medication management.
- Hospital based services for both behavioral health and substance use disorders.

- Home-based therapy services.
- Access to many helpful community-based resources.

Aetna Better Health will assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatry services.

Aetna Better Health requires, through Provider contract provision, that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within five days from the date of discharge. Behavioral Health Service providers will contact members who have missed an appointment within 24 hours to reschedule the appointment.

Some behavioral health services are covered through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). The member's care manager will work closely with the BHSA to coordinate the services, including those that are provided through the BHSA.

For members to access certain behavioral health services, certain services require preauthorization. For preauthorization, call **1-800-279-1878 (TTY: 711).** These include but are not limited to:

1. Outpatient services in a psychiatrist's or licensed clinical psychologist's private office, certified hospital outpatient departments, and in the community mental health clinics approved and/or operated by the Virginia Department of Behavioral Health and Developmental Services.
2. Medically necessary outpatient individual, family and group mental health and substance abuse treatment services.
3. Short-term inpatient hospital services are covered for members under the age of 21 in participating hospitals when preauthorized by the Aetna Better Health behavioral health provider. Hospital stays for the treatment of medical conditions that relate to substance abuse (like acute gastritis, seizures, pancreatitis, and cirrhosis) need to be preauthorized by us.
4. Psychological tests, when related to an apparent or diagnosed psychiatric illness and as part of your doctor's plan for deciding what the mental illness or disease is and how to treat it.
5. Children who have special needs for medically necessary assessment and treatment services, including children who have been victims of child abuse and neglect, can get this care if: (1) the services are delivered by a doctor or provider whose specialty is in the diagnosis and treatment of child abuse and neglect; (2) the services are provided by a doctor or provider who has similar expertise. A provider who meets these standards will be verified by DMAS.
6. Services required by a Temporary Detention Order are covered for members up to 96 hours.
7. All care given in a free-standing psychiatric hospital is covered for members up to the age of 21 and over the age of 64. When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by federal and state law

Mental Health Services, including Behavioral Health Expansion

Aetna Better Health offers a variety of services that help youth and adults who are struggling with mental health disorders and serious emotional disturbance. Individuals can benefit from treatment to achieve improved mental health, recovery, and improved standard of living. These services include settings in outpatient, residential, and community-based treatment. Other options that are helpful include case management and peer services (someone who has experienced similar issues and in recovery), as well as care coordination services.

As a provider, you will need to submit the DMAS Mental Health Services Authorization Review Form or the ARTS and MHS Registration Form for the following services that require prior authorization by Aetna Better Health:

- Mobile Crisis
- Community Stabilization
- 23-Hour Crisis Stabilization
- Residential Crisis Stabilization Unit
- Multisystemic Therapy
- Functional Family Therapy
- Applied Behavior Analysis
- Mental Health Partial Hospitalization
- Mental Health Intensive Outpatient
- Assertive Community Treatment
- Therapeutic Day Treatment
- Mental Health Skill Building Services
- Intensive In-Home
- Psychosocial Rehabilitation
- Mental Health Peer Support – Individual and Group

Addiction and Recovery Treatment Services (ARTS)

Aetna Better Health offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment to achieve recovery and improved standard of living. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication-assisted treatment options, counseling services, and behavioral therapy options are also available. Other options that are helpful include peer services (someone who has experienced similar issues and in recovery), as well as care coordination services.

As a provider, you will need to submit the ARTS Service Authorization Review Form or the ARTS and MHS Service Registration form for the following services that require prior authorization by Aetna Better Health:

- Intensive Outpatient Services
- Partial Hospitalization Services
- Clinically Managed Low Intensity Residential Services
- Clinically Managed Population Specific High Intensity Residential Services
- Clinical Managed High Intensity Residential Services
- Medically Monitored Intensive Inpatient Services
- Medically Managed Intensive Inpatient Services
- Substance Use Case Management
- ARTS Peer Support – Individual and Group

Behavioral Health Provider Resources

- **Virginia Department of Medical Assistance – Behavioral Health**
- **Project BRAVO FAQs**
- **Behavioral Health Provider Training and Resources**
- **ARTS and MHS Doing Business with the MCOs Spreadsheet**
- **Appendix D of the Mental Health Manual**
  - Download this manual for guidance on behavioral health requirements and billing.

Chapter 16 — Provider Specialties Resources

Applied Behavior Analysis (ABA)

Board-certified Applied Behavior Analysis (ABA) professionals provide intervention that is based upon the principles of respondent and operant conditioning to change behavior of social significance. The primary goal of ABA therapy is to teach skills that promote independence and reduce harmful behaviors. Aetna Better Health of Virginia has a developed an **ABA-specific guide** that assists these professionals navigate as a network provider.

Brain Injury

Brain injury Services Targeted Case Management is for members 18 years or older, and providers are required to be accredited by the Commission on Accreditation of Rehabilitation Services. Aetna Better Health has published a **specific guide** to assist providers with documentation to accurately credential, request authorization, and submit claims.

Doulas

Doulas play an important role in supporting maternal health. Aetna Better Health is committed to support this program. Our **doula guide** includes useful tips and guidance that will help navigate the process of being a Doula provider in the Aetna Better Health of Virginia network.

Birthing Centers, Midwives, OB/GYN, Pediatricians – Registering Baby's Name

It's important that babies receiving Medicaid have a name. Babies need a name before they can get a permanent Medicaid ID and Social Security number. Once a baby is born, providers can register them on the E-213 form in the Medicaid Enrollment System (MES) portal. It is important to enter the first, middle (if provided) and last name exactly as spelled by the parent. **This guide** can help providers effectively complete the E-213 form.