Provider Newsletter

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Improve Patient Outcomes with Our Free Provider Texting Communication Platform

To help providers reach their patients, we have developed a new service to help address our members' health care needs that align with HEDIS® measures.

Aetna Better Health of Virginia has partnered with mPulse to provide a digital solution for conducting outreach to members for care/service reminders and education via text message.

Aetna Better Health provides all funding for this program. Therefore, there is **no risk nor cost to you**.

Does it work?

Based on past campaign activities, our research indicates more than 95% of our members read text messages within the first three minutes of receipt.

By participating in this program, you can provide care and service reminders using the most effective mode of outreach (text) – and we're here to help every step of the way.

If you are interested in learning more and participating in the program, contact Tiffany Woods at woodst9@aetna.com.

Learn more about HEDIS.

Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

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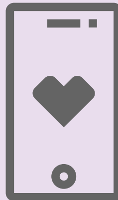
12-Months Extended Postpartum Coverage for New Moms

Virginia recently expanded postpartum coverage for new mothers receiving Medicaid services from 60 days to 12 months. Virginia's postpartum Medicaid expansion includes continuous eligibility, regardless of change in income, during the postpartum coverage period.

Additionally, after pregnancy, in addition to typical postpartum care services, Medicaid members are also able to continue to receive other health care services under Medicaid for 12 months.

Invite Your Patients to Our Health Education Series



Aetna Better Health of Virginia offers members various health education sessions. During these sessions, members can engage with professional health experts and learn about health conditions and how to manage them, as well as how to live a healthier life. **Members may be eligible to receive a $50 gift card for attending these sessions.** For more information and to register, email QualityManagementPrograms@Aetna.com.

Availity: Better for Your Faxing Needs

Did you know? You can submit prior authorizations (PA), medical records, or additional information forms for your requests online through Availity.

Register for Availity here.

On Availity, submit a PA or PA inquiry transaction and upload your documentation. Or, view the status to retrieve the event, then upload the documentation. If you did not use Availity for the initial request, you can still use Availity to upload your documentation. Perform a PA inquiry, then follow the status in your Availity PA/referral dashboard to upload your document.

Always include a current form with your initial request. View them here under "Forms."

New Wellness Rewards for Members

Did you know? Aetna Better Health members can earn rewards for getting important preventive care services.* Below are the available rewards a member may be eligible.

Diabetes Well Visit

Members may receive a $25 incentive for having completed a hemoglobin A1c test, blood pressure check and/or a diabetic eye exam. All services are also based on the provider's recommendation.

Well Woman Exam

Members who complete eligible screenings and exams, which includes: Pap smear, mammogram, chlamydia screening, colorectal cancer screening, and flu vaccine, may receive a $25 incentive. The age requirements for each screening/exam are outlined, however all are also based on the provider's recommendation.

Men's Health (NEW!)

Members who complete eligible screenings deemed medically and age appropriate by the provider may receive a $25 incentive.

Screenings include preventative care services, colorectal cancer screening, prostate exam, and flu vaccine.

Moving On: Transitioning from Pediatrics to Primary Care (NEW!)

This is a new incentive specific to members transitioning from pediatrics to adult primary care. The age requirements are 18 to 20, as this is a transitional time for many young adults who are managing their healthcare independently without the assistance of a parent/ guardian.

Members may receive a $50 incentive for having completed various services, which include preventative care services, adult medical screenings, weight management, and recommended vaccinations.

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

Interpreter and Translation Services Is a Covered Benefit

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.

For more information, refer to the "Health Literacy" section in your Aetna Better Health provider manual. To request interpreter and translation services, please call **1-800-279-1878**.

Does Your Patient Need Help for a Substance Use Disorder?

Drug and alcohol use disorders have reached epidemic levels in the United States. On a national level, the focus is on opioid prescriptions and opioid street drugs. The global pandemic has exacerbated substance use disorders due to isolation, loneliness and problems accessing outpatient services and supports.

Statewide use patterns include opioids, alcohol, marijuana, cocaine, and methamphetamine. Substance use disorders occur across all demographics, including age, gender, ethnicity, educational level, and income. Willingness to seek and engage in treatment may be a challenge for many people.

The Addiction Recovery and Treatment Services (ARTS) benefit offers an array of services for persons seeking help for opioid or other substance use disorders. ARTS benefits cover a wide range of addiction treatment services which are based on American Society of Addiction Medicine criteria.

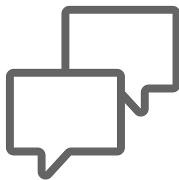
ARTS services include the following:

- Inpatient hospitalization
- Residential substance abuse services
- Partial hospitalization program
- Intensive outpatient program
- Medication assisted treatment for opioid use disorders
- Care management services
- Peer support services

If you want to learn how our Behavioral Health department can provide support, you can call Member Services at **1-800-279-1878**, Monday through Friday, 8 AM to 6 PM.

Help Improve Communication Between Treating Providers

A recent survey showed that PCPs are concerned because they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.



This breakdown in communication can pose a risk to quality patient care. We know that coordinating care with many providers, facilities, and behavioral health care professionals can be a challenge.

Important clinical and mental health information to be shared should include diagnosis, medication, and treatment plan.

Providing consistent information about patients to other providers can improve the overall communication between providers through continuity and coordination of care.

Talking with your patients' other treating health care professionals helps you give them the best care. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

Providers Can Call Interpreters for Members

Did you know? Providers are able to call interpreters for members who need them. There are a few options for requesting interpretation services for both members and providers:

- **In-person**
  - The interpreter will meet the member at the location (such as the provider's office).
  - Requests should be submitted at least three business days ahead of the appointment.
- **Over the phone**
  - Requests can be submitted same day.
- **Video (Zoom)**
  - Requests should be submitted at least three business days ahead of the appointment.
  - Emails of each participant are required.

- **Scheduled video**
  - The interpreter service provides the link, and the member must have a cellphone.
  - Requests should be submitted at least three business days ahead of the appointment.

Questions?

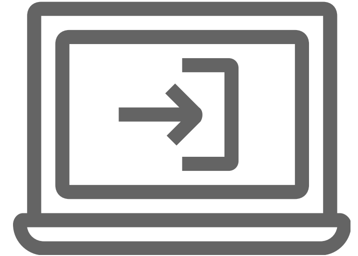
For more information about having an interpreter available for members, call Provider Services at **1-800-279-1878 (TTY: 711)**.

Quality Management Spotlight

Provider Resources for Using the Medicaid Enterprise System

Home and Community-Based Services

We know that improving our members' health outcomes requires increased collaboration between you, the professional who provides care, and us, the health plan that covers that care.



Our goal is to provide waiver providers with supportive resources and to offer best practice recommendations as a way to ensure our community-based members receive the best quality of care.

DMAS released an updated *CCC Plus Waiver Provider Manual* on August 1, 2022. You can access the manual through the Medicaid Enterprise System (MES) Portal on the MES website. The MES website includes valuable information, such as details about provider enrollment, training, FAQs, and more.

[MES Provider Resources]

DMAS CCC Plus Waiver Provider Manual Spotlight

List of Excluded Individuals and Entities

DMAS requires providers to validate federal program eligibility for all employees, contractors, and other entities on a monthly basis using the Health and Human Services Office of the Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) website and to immediately report any exclusion information to DMAS. Refer to the *CCC Plus Waiver Provider Manual*, Chapter II, pages 6 and 7 for more information.

Agency Personal Care Aide Training

All Personal Care Aides must complete a minimum of 12 hours of training annually in addition to initial training requirements. The provider agency is required to provide this training and ensure that it is related to the performance of personal care services.

Documentation of this training must be kept in the employee's personnel files. Refer to the *CCC Plus Waiver Provider Manual*, Chapter II, page 20 for more information. Additional personnel requirements can be found in Chapters II and IV of the *CCC Plus Waiver Provider Manual*.

Behavioral Health Program Spotlight

Our members have let us know that they want to hear more about behavioral health programs and supports that are available to them. As a member of our valued provider network, we appreciate your help in sharing this information with the patients you serve. Here are some of our current behavioral health initiatives that may benefit your patients:

Transition-Age Youth (Central Virginia): Provides enhanced care coordination for those aged 16-29 to reduce acute behavioral health admissions and use of community-based crisis services and to improve independent living skills

Flourish Health (statewide): Provides evidence-based enhanced multisystemic therapy statewide to youth with no other behavioral health services; offers 24-hour initial response

Juvenile Justice Integrated Program (Central Virginia): Community reintegration and supports utilizing Behavioral Health, Peer Support Services, Community Health Workers, Case Management support, and coordination of care with juvenile probation and parole, guardian ad latems, and community-based providers

For more information about these programs, contact Member Services or the member's Care Manager.

Integrated Care Management Program

Aetna Better Health of Virginia's Integrated Care Management (ICM) program implements a population-based approach to specific chronic diseases or conditions while engaging the member on an individual basis. All Aetna Better Health of Virginia members with identified conditions are auto-enrolled in the chronic condition program based on claims data. The chronic conditions managed include:

- Diabetes.
- COPD.
- Asthma.
- Coronary artery disease.
- Depression.
- Congestive heart failure.

The primary goal of our ICM program is to assist our members and their caregivers to better understand their conditions, update them with new information, and provide them with assistance from our staff to help them manage their disease. Members who do not wish to participate can call member services to disenroll from the program at any time.

Services we offer:

Services for members with chronic conditions include but are not limited to:

- Coordination of care assistance.
- Disease-specific education and support.
- Assistance in receiving community-based services.

In addition to helping members who have special medical needs, we have care management programs for high-risk pregnancies and opioid management, as well as for pregnant women with substance use disorder and their babies.

Members can be referred to the ICM program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers. We encourage you to refer patients who would benefit from chronic condition management.

Need to refer a patient to Care Management?

Please call Member Services at **1-800-279-1878**. We are here to help and look forward to joining you on our members' journey to better health.

Clinical Practice Guidelines

Aetna Better Health of Virginia's Clinical Practice Guidelines and Preventive Services Guidelines are based on nationally recognized recommendations and peer-reviewed medical literature.

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.

Where to learn more:

More information about our practice guidelines, are on our website at **AetnaBetterHealth.com/Virginia**.

Simply scroll down and select Practice Guidelines on the left-hand menu.

Community Resources for Our Members in Need

Aetna Better Health of Virginia's Population Health Management (PMH) program shows that health is more than the just optimal delivery of clinical care.

It's also about the well-being of the total population within communities, including social determinants of health, such as socio-cultural background, economic factors, and the reduction of barriers pertaining to access to food, safety, and other resources.

Our PHM programs allow us to meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals.

You can refer a member by directing them to call our Member Services department at **1-800-279-1878**.

Or, if you would like to offer direct assistance to members in need, feel free to review our list of community resources on our website here.

Help Stop Fraud!

Fraud, waste, and abuse are widespread in the health care industry and generally result in the increase of health care costs. Aetna Better Health is dedicated to fighting fraud, waste, and abuse through its Fraud Prevention Program. This program is designed to detect and eliminate health care fraud, waste, and abuse.

The most common types of health care fraud, waste, and abuse are:

- Billing for services never provided
- Billing for more expensive services than were actually provided
- Incorrectly stating a diagnosis to get higher payments
- Performing unnecessary services to get higher payments
- Misrepresenting non-covered procedures as medically necessary
- Selling or sharing a member's identification number for the purpose of filing false claims

If you believe you have information relating to health care fraud, waste, and abuse, please contact our Fraud Prevention Department. Our Fraud Prevention Department will review the information and will maintain the highest level of confidentiality as permitted by law.

To report suspected fraud or abuse, contact us:

- Toll-free FWA Hotline is **1-844-317-5825**
- Email **reportfraudabuseVA@aetna.com**

You can help support our mission to reduce and eliminate fraud in the health care industry by following a few simple guidelines:

- Be careful when providing health care information, including a member's identification number.
- Inform your patients to be cautious of "free" medical treatments in which the patient is required to provide them with health care information.
- Aetna Better Health receives bills from providers to pay. This includes doctor visits, inpatient and outpatient services, and equipment and supplies, etc. There will be times when a member receives a letter telling them how we paid for these services. If a member receives a letter, it's important they know to fill it out and return it as soon as possible in the postage paid envelope provided.
- Understand the benefit plan and what types of treatments, drugs, services, etc. are covered.

How to Request Prior Authorization

If a service you are providing our member needs prior authorization, please call:

Program	Phone number	Fax
Prior Authorizations for Legacy M4	**1-800-279-1878**	**866-669-2454**
Prior Authorizations for Legacy Plus	**1-800-279-1878**	**855-661-1828**

For weekend, after-hours admissions, and urgent/emergent issues after hours, call **1-800-279 1878** (TTY: **711**) and follow the prompts for afterhours preauthorization. You will be directed to an on-call nurse that can assist you. You may also request a prior authorization on the Provider Portal. When requesting a prior authorization, please include:

- Member's name and date of birth
- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service

Emergency services do not require prior authorization; however, notification is required the same day. For post stabilization services, hospitals may request prior authorization by calling our Prior Authorization department. All out-of-network services must be authorized. Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

Cultural Competency and Health Equity Training

Culture is a major factor in how people respond to health services. If affects their approach to:

- Coping with illness
- Accessing care
- Taking steps to get well

We ask that all of our providers complete cultural competency training. Patient satisfaction and positive health outcomes are directly related to good communication, in a culturally competent manner, between a member and his or her provider. By completing the attestation form on our website, your records in the Aetna Better Health provider directory will be updated to reflect you have completed this required training.

Learn more about health equity and cultural competency here. Training resources are also available.

As part of our cultural competency program, we also 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.

Learn More about Our Medicare Advantage Dual Eligible Special Needs plans (HMO DSNP)

Our Medicare Advantage Dual Eligible Special Needs plans are for people who have both Medicare and Medicaid.

Our plans are designed for people with special health care needs. We offer additional benefits and services not covered under Medicare, such as dental, hearing aids, and eyewear.

To learn more about our HMO DSNP plans, call **1-855-463-0933** or visit us at **AetnaBetterHealth.com/Virginia-hmosnp**.

Provider Appointment Standards

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**
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
	Non-life-threatening emergency	Within six hours
Behavioral Health	Urgent care	Within 48 hours
	Initial visit routine care	Within 10 working days
	First trimester	7 calendar days
	Initial second trimester	7 calendar days
Prenatal	Third trimester and high risk	3 working days from date of referral or immediately, if emergency

Member Rights and Responsibilities

As a provider to our members, it is important that you know our members' rights and responsibilities. To view our members' rights and responsibilities, visit our website here.

Thank you for providing our members with the highest quality of care!

Aetna Better Health of Virginia was rated 3 out of 5 in NCQA's Medicaid Health Plan Ratings 2022. The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes clinicians in key clinical areas. NCQA's HEDIS® is the most widely used performance measurement tool in health care. NCQA's website (www.ncqa.org) contains information to help consumers, employers and others make informed health care choices.