



## Aetna Medicare FIDE (HMO D-SNP)

2026 Provider Orientation



# Agenda

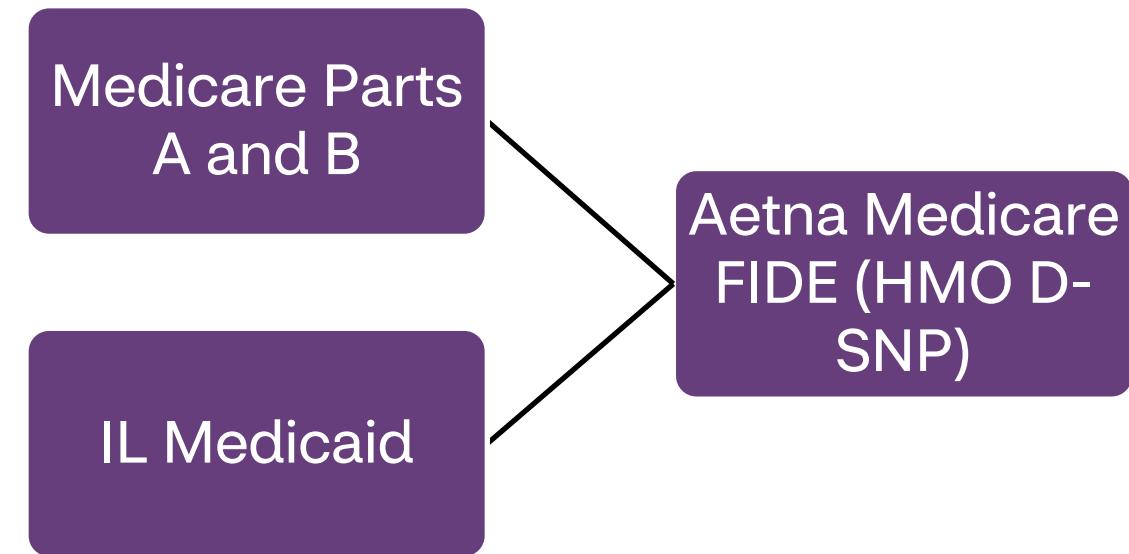
- Overview
- Member Eligibility
- ID Card
- Network
- Care Management Program
- Member Care Team
- Caring for our Members
- Coverage and Benefits
- Verifying Membership
- Claim Submission
- Timely Filing
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# Aetna Medicare FIDE (HMO D-SNP) Overview

**Aetna Medicare FIDE (HMO D-SNP)** is a Fully Integrated Dual Eligible plan. It is a Medicare Advantage plan which serves dual eligible members through Aetna. It covers all Medicare and Medicaid services including prescriptions drugs, behavioral health, Managed Long Term Services and Supports (MLTSS) and additional supplemental benefits at \$0 cost sharing for all members. This plan serves all counties in IL.

## Plan Features

- Coverage of all Medicare and Medicaid benefits including prescription drugs, behavioral health and Managed Long-Term Care Services and Supports (if applicable)
- \$0 cost sharing for all covered services and prescription drugs
- All members have access to a dedicated Aetna care manager
- No referrals for specialists
- In-network primary care provider selection required





# Member Eligibility to join the Aetna Medicare FIDE (HMO D-SNP)

**To join the Aetna Medicare FIDE (HMO D-SNP) plan the member must:**

- Have Medicare Parts A and B
- Have full IL Medicaid benefits
- Be a full-time Illinois resident and live in the plan's service area
- Over the age of 21
- Not be enrolled in a PACE program

**When a member enrolls in the Aetna Medicare FIDE (HMO D-SNP) plan , they will be automatically disenrolled from original Medicare or any Medicare Advantage plan in which they may be enrolled, their Illinois Medicaid plan, their Part D prescription drug plan, and all their Medicare and Medicaid benefits will be covered by the plan.**



# The Member Rights and Responsibilities



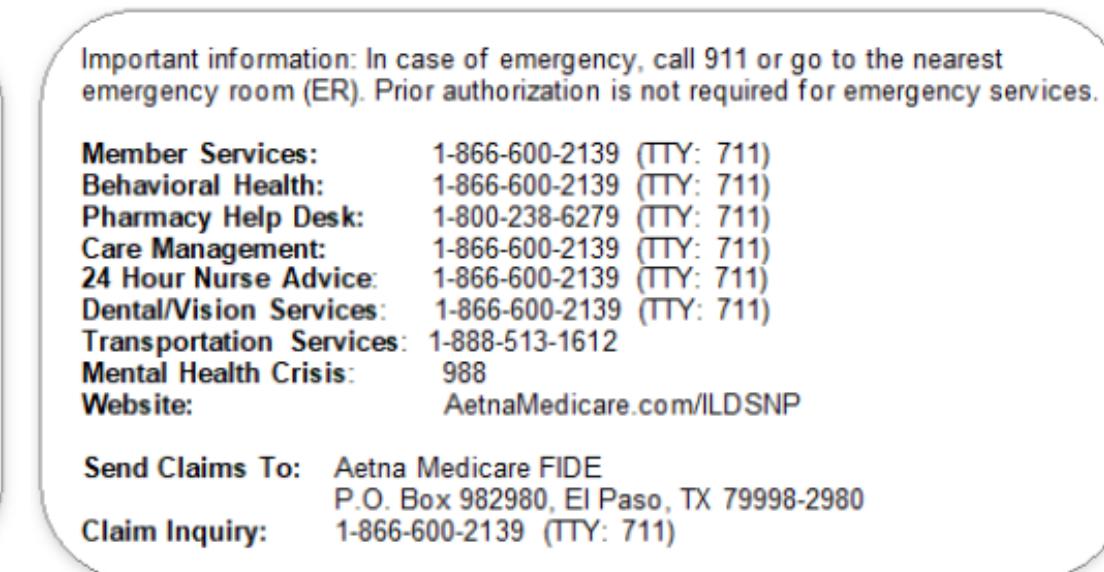
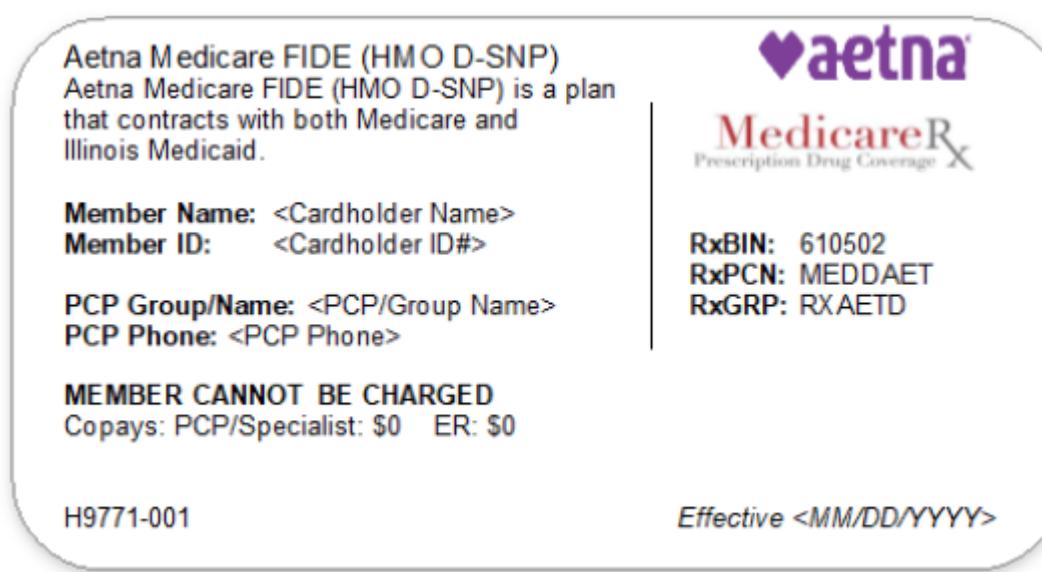
1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides
6. A right to make recommendations regarding the organization's member rights and responsibilities policy
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

**Shared decision-making aids** offer healthcare providers the opportunity to leverage best practice tools tailored to their specific medical specialties. These aids cover a diverse array of medical scenarios, providing specialized information on topics such as diabetes, cardiovascular, wellness screening, flu prevention and more. By incorporating these decision aids into their practice, healthcare providers can enhance the collaborative decision-making process. You can access the aids under [on website](#).

The Member Rights and Responsibilities can be found in the provider manual available [here](#)

# Member ID Card

The Aetna Medicare FIDE (HMO D-SNP) member card represents coverage for both Medicare and IL Medicaid, which may include MLTSS (if applicable)



Use the member ID number on the Aetna Medicare FIDE (HMO D-SNP) when submitting claims for reimbursement. One phone number for member services, care management, provider services and other key plan contacts.

# Large and Trusted Network

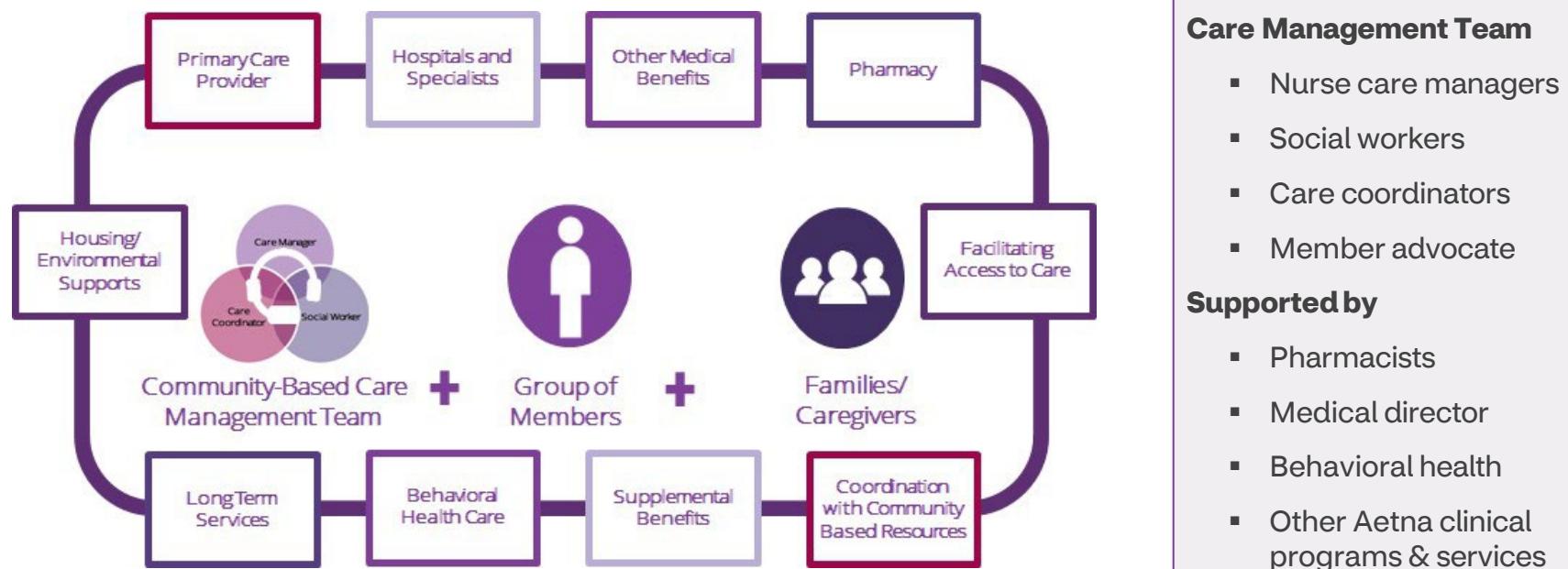
- Aetna Medicare FIDE (HMO D-SNP) Network closely mirrors, but is not the same as, Aetna Medicare Network. Members can utilize the plan-specific [\*\*provider directory\*\*](#).
- Network consists of Aetna Medicare and Medicaid providers statewide.
- Over 66,000 in-network providers across Illinois.
- 68 CVS MinuteClinics® providing general medicine, urgent care and telehealth services in Illinois.
- Dental Network through DentaQuest network available throughout Illinois.
- Vision Network through March Vision with access to 400 providers in Illinois.
- Lab Corp and Quest Labs, as well as other independent labs, are in-network.
- Access to over 67,000 in-network pharmacy locations in our national pharmacy network.



# Care Management Program

Aetna Care Management Program extends beyond traditional case and disease management programs, offering personal, comprehensive support for 100 percent of members.

- Integrated team-based care management model with a personal touch
- Balanced clinical approach that integrates medical, functional, environmental , behavioral health and psycho-social needs through a core care management team



# Member Care Team

## Our personalized, holistic and local care management strategy

### Every member is supported by a dedicated Care Team

- Comprehensive health risk assessment
- Individualized and personalized care plan
- Transitional care if discharged from the hospital
- Assistance with accessing community resources and support
- Help navigating the health care system
- Provide Long Term Services and Supports to members that qualify



### Registered Nurse

Assesses member's needs and risk levels; develops and oversees care plan

### Social Worker

Identifies and addresses social determinants of health

### Care Coordinator

Completes initial outreach, Health Risk Assessment and assists with benefit navigation and appointment scheduling

### Member Advocate

Assists member with Medicaid recertification and accessing benefits



# Provider Role In The Care Management Program

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- Communicate with care managers, ICT members, members and caregivers
- Collaborate with our organization on the ICP
- Review and respond to patient-specific communication
- Maintain ICP in member's medical record
- Participate in the ICT
- Remind member of the importance of the HRA, which is essential in the development of the ICP
- Encourage the member to work with their care management team

# One Plan, One Card, Complete Coverage

Aetna Medicare FIDE (HMO D-SNP) members show one card to receive all services covered by the plan

Medicare Parts A, B, and D	Aetna Medicare FIDE (HMO D-SNP) Supplemental Benefits	Medicaid	Medicaid MLTSS (if applicable)
<ul style="list-style-type: none"><li>• PCP visits</li><li>• Specialist visits</li><li>• Inpatient/outpatient hospital</li><li>• Emergency &amp; urgent care</li><li>• X-rays and diagnostic radiology</li><li>• Lab services</li><li>• Ambulance</li><li>• Therapy (PT/OT/ST)</li><li>• Prescription coverage</li></ul>	<ul style="list-style-type: none"><li>• \$225/month quarterly OTC allowance</li><li>• Virtual medical visits – members have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc or MinuteClinic® video visit.</li><li>• Fitness program</li><li>• Personal emergency response – medical alert system</li><li>• Meals at home following discharge</li><li>• 24-hour nurse line</li><li>• Annual routine physical exam</li><li>• Worldwide emergency and urgent coverage</li></ul>	<ul style="list-style-type: none"><li>• Medicare cost share covered for all members, including Part D copays</li><li>• Additional coverage beyond Medicare limits</li><li>• Preventive and comprehensive dental</li><li>• Hearing services</li><li>• Vision services</li><li>• Podiatry (routine)</li><li>• Chiropractic care</li><li>• Behavioral health services</li><li>• Acupuncture</li><li>• Transportation</li><li>• Medical day care</li><li>• Personal care assistance</li><li>• Additional pharmacy covered items</li></ul>	<ul style="list-style-type: none"><li>• Assisted living services and programs</li><li>• Caregiver/participant training</li><li>• Chore services</li><li>• Community residential services</li><li>• Community transition services</li><li>• Home-based supportive care</li><li>• Home delivered meals</li><li>• Medication dispensing device</li><li>• Residential modifications</li><li>• Respite care</li><li>• Social adult day care</li><li>• Structured day program</li><li>• Supported day services</li><li>• TBI behavioral management</li><li>• Non-medical transportation</li><li>• Vehicle modifications</li></ul>

# Benefits in Illinois

Additional benefits for Aetna Medicare FIDE (HMO D-SNP) enrollees:

## Extra Benefits Card

Members will receive an Extra Benefits Card in the mail that can be used to buy healthy foods and over-the-counter (OTC) items. Separate allowances that the member will receive:

\$225 every month for eligible OTC items

## Virtual medical visits

Members can schedule a Teladoc appointment at [Teladoc.com/Aetna](https://www.teladoc.com/aetna) or by calling **1-855-TELADOC (1-855-835-2362)** (TTY: 711) or MinuteClinic® Video Visit which is available 24/7 via the CVS app or at by visiting the [Minute Clinic Website](#).\*

## Fitness programs

SilverSneakers® gives members access to a large network of fitness centers, community classes, on-demand videos and at-home fitness kits.

## Personal emergency response system (PERS)

Medical alert system that provides users with 24/7 access to help in the event of a fall or other emergency. Includes GPS and fall detection at no additional cost.

## Meals at Home

Members can receive 2 meals after an inpatient hospital discharge or skilled nursing stay.

## Aetna 24-Hour Nurse Line

Member can get guidance and support on your basic health care questions, 24 hours a day, 7 days a week.

## Worldwide urgent and emergency coverage

# Verifying Member Enrollment

To see if the patient is enrolled and to check their eligibility dates you may do one of the following:

## Verify by Phone

Call our Provider Services team at **1-866-600-2139**. Please provide the following information:

- Your National Provider Identifier (NPI) or Tax ID number
- Name of care provider practice or facility
- Member ID number, if you have it
- Member name
- Member date of birth

## Verifying through Availity

Register for our Availity (our secure portal) which features an eligibility lookup tool. Providers will need to fill out and submit the [portal registration form](#).

A link to Availity is also located on our at [Provider Portal Website](#).



# Claims Submission

**Aetna Medicare FIDE (HMO D-SNP) members should NOT be balanced billed for any covered benefit.**



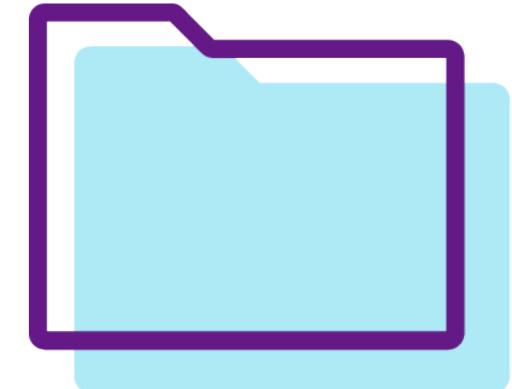
We have an automated system for processing claims for members enrolled in Aetna Medicare FIDE (HMO D-SNP).

- Using the member's ID number from the plan ID card, you'll only need to submit **one claim**. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits.
- You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to resubmit a secondary claim to Aetna.
- We encourage participating providers to electronically submit claims through ECHO. Use submitter ID **#26337** when submitting claims Aetna Medicare FIDE (HMO D-SNP).

# Claim Submission

## Electronic claims can be submitted through three ways:

- Your own claim clearinghouse
  - Ensure that your clearinghouse is compatible with ECHO using the 837 file format.
  - Please use Submitter ID **#26337** when submitting electronic claims
- Availability
  - Information on Availability can be found at the [\*\*Provider Portal Website\*\*](#)
- Paper Claims
  - Please use Submitter ID **#26337** when submitting paper claims



**Aetna Medicare FIDE (HMO D-SNP)**

**PO Box 982970**

**El Paso, TX 79998-2970**

# Tips for Submitting Claims

- Confirm member's eligibility before rendering services.
- To best ensure timely and accurate payment of your claim, submit a "clean claim"
- A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party
  - It does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity
- Clean claims are processed according to the following timeframes:
  - 90% of clean EDI claims adjudicated within 30 days of receipt
  - 90% of clean paper claims adjudicated within 90 days of receipt
- If providers have an approved authorization for a claim, include the authorization number on all claim lines pertaining to the authorization.

# EFT and ERA Setup

Aetna Medicare FIDE (HMO D-SNP) is partnering with ECHO to introduce the new EFT/ERA Registration Services (EERS), a streamlined way for our providers to access payment services.

## What is EERS?

EERS offers providers a standardized method of electronic payment and remittance. Providers will be able to use the ECHO tool to manage EFT and ERA enrollments with multiple payers on a single platform.

## How does it work?

Please complete the ERA/EFT [\*\*enrollment form\*\*](#). Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process.

If you need assistance, contact ECHO Health at [\*\*allpayer@echohealthinc.com\*\*](mailto:allpayer@echohealthinc.com) or **1-888-834-3511**.

To validate your account, please make sure you have an ECHO Health draft number and payment amount so they can validate your enrollment request. A draft number is listed as the EPC draft # on ECHO Health explanation of payments. If you do not have an ECHO draft number available please dial **1-888-834-3511**.

## How do I enroll?

To enroll in EERS, please visit [\*\*ECHO portal guide\*\*](#).

# Provider Disputes

If you are a Contracted Provider, you may use the [\*\*Dispute Form\*\*](#) found online to have your claim reconsidered.

Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

**Aetna Medicare FIDE (HMO D-SNP)**

**PO Box 982970**

**El Paso, TX 79998-2970**

Incomplete or missing information may cause the decision to be upheld or returned to Provider. Common mistakes include:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed

# Timely Filing

In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:

## **New claim submissions –**

Claims must be filed on a valid claim form within your contracted timely filing timeframe. This is from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.

## **Claim Resubmission –**

Claim resubmissions must be filed within your contracted timely filing period. The only exception to this is if a claim is recouped, the provider is given an additional contracted days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

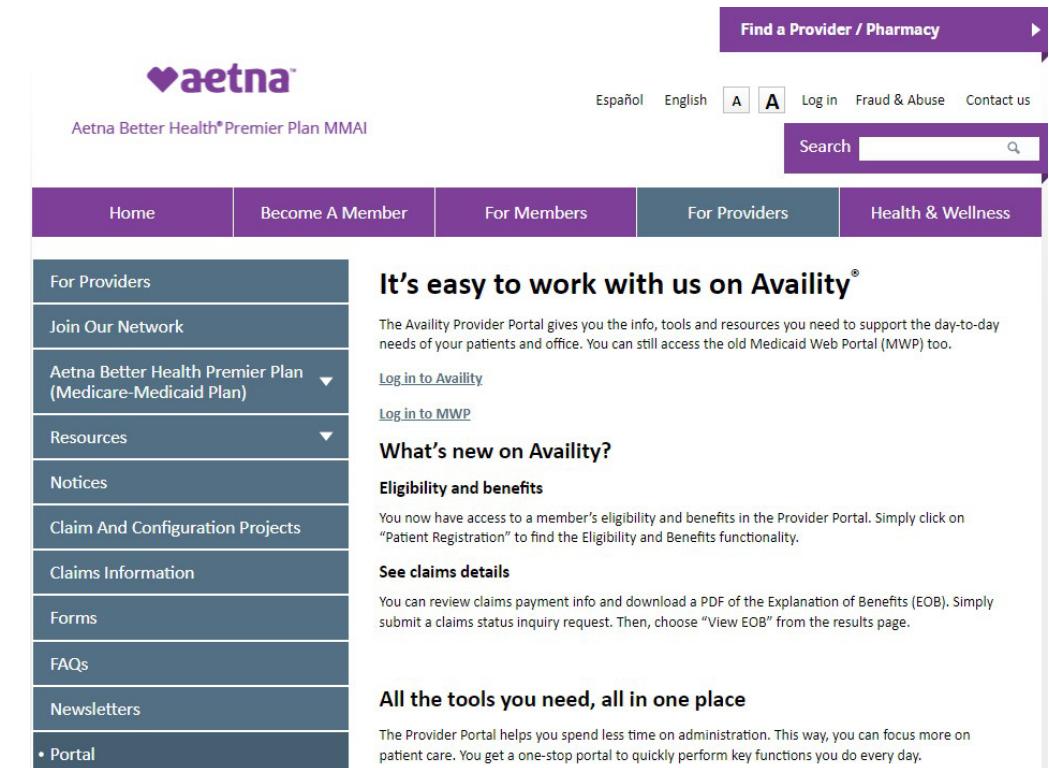


# Provider Portal

If you are already registered in Availity, you will simply select **Aetna Better Health All Plans NJ-VA MAPD-DSNP** for Aetna Medicare FIDE (HMO D-SNP) from your list of payers to begin accessing the portal and all of the features.

**Find out more at the Aetna Medicare FIDE (HMO D-SNP) Provider Portal Website**

If you are not registered, we recommend that you do so immediately by going to the above portal location.



The screenshot shows the Aetna Better Health Premier Plan MMAI Provider Portal. The top navigation bar includes links for 'Find a Provider / Pharmacy', 'Español', 'English', 'Log in', 'Fraud & Abuse', and 'Contact us'. A search bar is also present. The main menu on the left includes 'For Providers', 'Join Our Network', 'Aetna Better Health Premier Plan (Medicare-Medicaid Plan)', 'Resources', 'Notices', 'Claim And Configuration Projects', 'Claims Information', 'Forms', 'FAQs', 'Newsletters', and '• Portal'. The right side features a section titled 'It's easy to work with us on Availity®' with a sub-section for 'Eligibility and benefits' and 'See claims details'. Another section is titled 'What's new on Availity?' and 'All the tools you need, all in one place'.



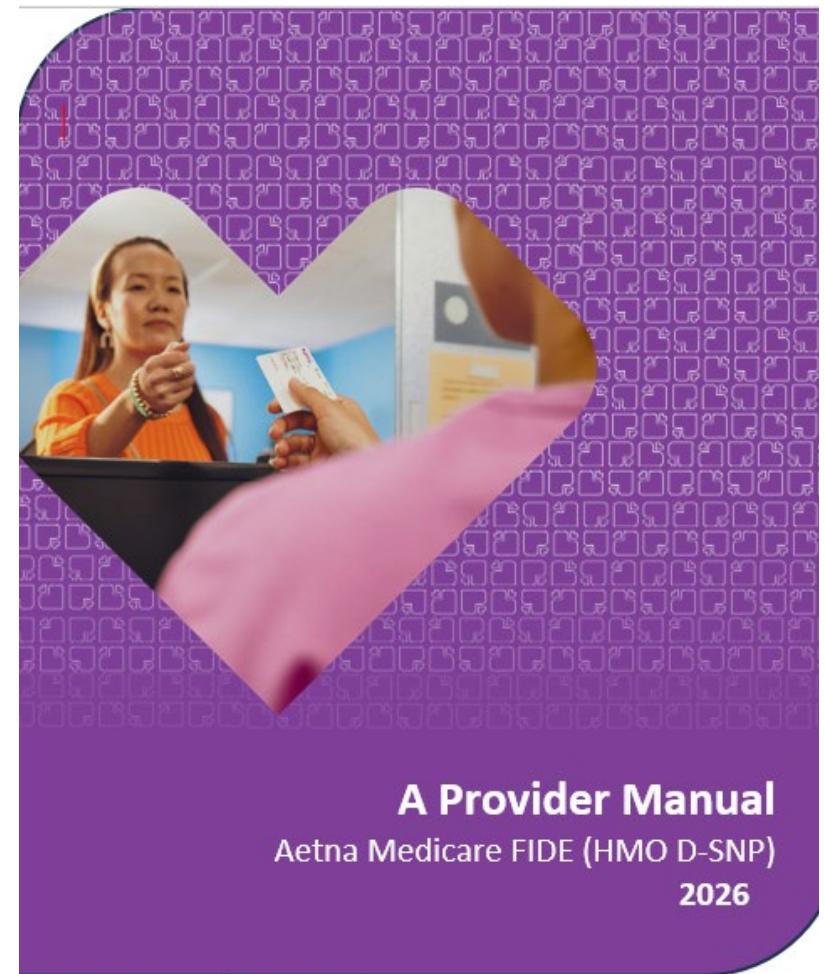
# Provider Manual

**The provider manual contains plan policies, procedures and benefits.**

You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available [here](#) or on our [Handbook Page](#).

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department at **1-866-600-2139** or by email at [coeproviderservices@aetna.com](mailto:coeproviderservices@aetna.com).



# Provider Responsibilities

- Enrollee Privacy Rights
- Enrollee Privacy Requests
- Advanced Directives
- Provider Marketing
- Cultural Competency
- Health Literacy
- Alternative Formats
- Americans with Disabilities Act
- Abuse and Neglect
- Fraud, Waste, and Abuse

# Provider Responsibilities (continued)

## Enrollee Privacy Rights and Requests

- Uphold the privacy requirements of HIPAA when members exercise privacy requests.
- Make information available about Aetna Medicare FIDE (HMO D-SNP) practices regarding their PHI.
- Maintain a process to request access, change, or restrict disclosure of PHI.
- Consistently respond to privacy requests within required time standards.
- Document requests and actions taken.

## Advanced Directives

The advance directive must be prominently displayed in medical records. Must include:

- Providing written information on individual's rights under state law to make medical decisions.
- Written policies about advance directives (including conscientious objections).
- Documenting whether member's advance directive has been executed.
- Members may not be discriminated against due to advance directive decisions and providing unconditional care.

# Provider Responsibilities (continued)

## Provider Marketing

- Aetna may not conduct sales activities in healthcare settings.
- Providers may discuss IL HealthChoice Medicaid plans in response to an inquiry.
- Providers are encouraged to display enrollee materials of participating plans.
- Refer patients to **1-800-MEDICARE**, Enrollment Broker, or CMS's website

## Providers may:

- Educate on plan benefits and policies
- Refer to sources within Aetna
- Discuss participating status

## Providers may not:

- Accept applications
- Induce enrollments
- Accept direct marketing compensation



# Provider Responsibilities (continued)

## Cultural Competency and Health Literacy

- Care without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.
- Treat all enrollees with dignity and respect.
- Participating providers are required to identify language needs and provide translation, oral or sign language interpretation.
- Aetna makes its language interpretation and sign language services available for free. Contact **1-866-600-2139** to access those services.
- Culturally and Linguistically Appropriate Services (CLAS) available at the [\*\*Think Cultural Health\*\*](#) site

## Alternative Formats

- Large print, Braille, and alternative media for plan materials
- Contact Provider Services at **1-866-600-2139** or by email at [\*\*COEProviderServices@AETNA.com\*\*](mailto:COEProviderServices@AETNA.com)

# Provider Responsibilities (continued)

## Americans with Disabilities Act

- Obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities
- Waiting room and exam room furniture meets needs of all enrollees, including those with disabilities.
- Accessibility by public transportation routes
- Clear signage
- Appropriate accommodations such as large print materials
- Additional Resources at the [Americans With Disability](#) website



# Provider Appointment & Access Standards

## Provider Appointment Standards Standards

Aetna Medicare FIDE (HMO D-SNP) monitors provider compliance to appointment availability standards

- Routine, preventive care available within 28 days for most providers from request
  - Dental Care – initial appointment within 21 days
- Urgent care appointments, not deemed an emergency medical condition, triaged, and if deemed necessary, provided within 24 hours
  - Urgent Dental Care – 48 hours
- Appointment not deemed serious (non-urgent complaints) within 72 hours
- Post-hospitalization or emergency department visits within 7 days of discharge

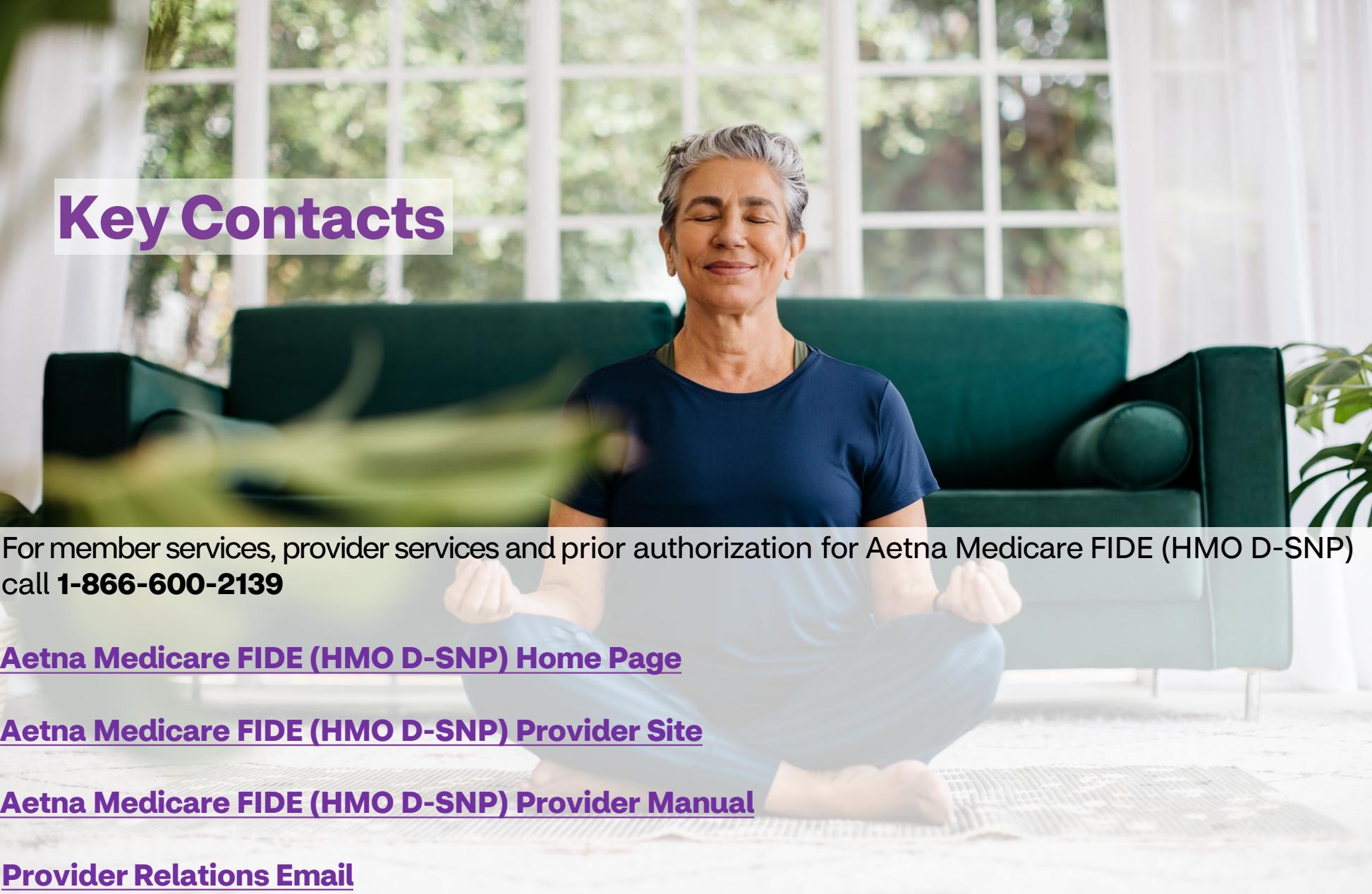
## Provider Access

- Aetna Medicare FIDE (HMO D-SNP) members require access to their medical home/PCP, including after hours and on weekends (“live person” and no answering machines). Provider voicemail messages should direct members to the emergency room in cases of emergency
- Aetna Medicare FIDE (HMO D-SNP) will monitor the availability of 24/7 access and the processes that support after hours availability and response
- Providers are encouraged to use alternative options for communication, such as scheduling appointments via the web, communicating via secure email and expanded office hours or open access scheduling
- This membership necessitates that providers make their practices accessible to accommodate the full range of disabilities that may exist with the population

	Primary Care	Specialist	OB/GYN	Behavioral Health
<b>Emergency</b>	Immediate	Immediate	Immediate	Immediate
<b>Urgent</b>	24 Hours	24 Hours	24 Hours	24 Hours
<b>Non-Urgent (Non-life threatening)</b>	72 Hours	7 Days	7 days	7 days
<b>Routine</b>	Medicare is primary: 30 Days Medicaid is primary: 25 Days	30 Days	30 Days (non-perinatal)	30 Days
<b>Perinatal</b>	N/A	N/A	1 <sup>st</sup> Trimester: 2 Weeks 2 <sup>nd</sup> Trimester: 7 Days 3 <sup>rd</sup> Trimester: 3 Days	N/A
<b>Wait Time</b>	No more than 45 minutes	No more than 45 minutes	No more than 45 minutes	No more than 45 minutes

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

- Follow-up Behavioral Health Medical Management within 3 months of the first appointment
- Follow-up Behavioral Health Therapy within 10 business days of the first appointment
- Next Follow-up Behavioral Health Therapy within 20 business days of the first appointment



## Key Contacts

For member services, provider services and prior authorization for Aetna Medicare FIDE (HMO D-SNP) call **1-866-600-2139**

[\*\*Aetna Medicare FIDE \(HMO D-SNP\) Home Page\*\*](#)

[\*\*Aetna Medicare FIDE \(HMO D-SNP\) Provider Site\*\*](#)

[\*\*Aetna Medicare FIDE \(HMO D-SNP\) Provider Manual\*\*](#)

[\*\*Provider Relations Email\*\*](#)

A photograph of an elderly couple, a man and a woman, standing outdoors. The man, on the left, is wearing a light blue polo shirt and glasses, and has his arm around the woman. The woman, on the right, is wearing a white ribbed sweater and has her hand on the man's arm. They are positioned in front of a white building with a large American flag hanging from a pole to their left. The scene is set during the day with clear skies.

Thank You

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# Aetna Policy Statement

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