Provider Newsletter

Spring 2026

Aetna Medicare HIDE (HMO D-SNP)

Contents

Quarterly News

Fast, Secure Clinical Data Exchange Between Hospitals and SNFs

Sharing complete clinical information between the hospital and the skilled nursing facility is essential for safe, coordinated care and to reduce the risk of readmissions. When a skilled nursing facility has details as medications, diagnoses, therapy notes, and discharge instructions, they can continue treatment without delays or errors. The easiest way to send this information is electronically through the Availity® provider portal. It allows providers to upload clinical documents quickly and securely. If you're not registered, you can sign up at www.Availity.com.

Splitting Claims

To ensure accurate processing of services that span calendar years, we are communicating the process for splitting claims and encounters that include dates of service in both 2025 and 2026.

Effective January 1, 2026, MMP services, any dates of service (DOS) occurring in 2025 must be submitted on a separate claim from those occurring in 2026. Claims should not combine dates that cross calendar years 2025 and 2026. This requirement ensures accurate processing and compliance with billing guidelines.

This rule does not apply to inpatient claims where a member is admitted in 2025 and discharged in 2026. These claims should continue to be submitted as a single claim for the entire stay.

Second Opinions

An enrollee may request a second opinion from a provider within the Aetna Medicare HIDE (HMO D-SNP) network. Providers should refer the enrollee to another network provider within an applicable specialty for the second opinion.

Transition From Sepsis 2 to Sepsis 3 Criteria for Pre-Pay DRG Review

Effective 07-01-2026

Aetna Medicare HIDE (HMO D-SNP) is implementing an update to our clinical review process for inpatient claims involving Sepsis. Beginning on the effective date above, the Clinical Claim Review (CCR) unit will transition from Sepsis-2 criteria to Sepsis-3 clinical criteria for pre-pay Diagnosis-Related Group (DRG) validation.

This change aligns with current evidence-based definitions and will be applied to all applicable

inpatient hospital claims.

Member Resources

Balance Billing

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

Understanding Our Members' Communication Needs

Communication and language barriers are associated with inadequate quality of care and poor clinical outcomes, such as higher hospital readmission rates and reduced medication adherence. People with limited English proficiency or those who experience limited vision or hearing may need an interpreter, and those with vision impairment may need materials presented in alternative formats while receiving care in order to ensure equitable care. While most our members are primarily English- speaking, approximately 5% of our members primarily speak a language other than English. The largest group among these members are those who primarily speak Arabic—about 1.72% of our member population. To assist with translation services needs for multiple languages (including ASL) on various formats, including in-person, telephonic, and by video (Zoom), you or the member can call our Interpreter Services line at 855-676-5772 (TTY: 711). This number is also included on each member's ID card.

Language	Active Members	% of Active Members
ENGLISH	13178	72.43%
No Language	3865	21.24%
UNKNOWN	673	3.70%
ARABIC	313	1.72%
SPANISH	76	0.42%
BENGALI	27	0.15%
ALBANIAN	21	0.12%
KOREAN	6	0.03%
TAGALOG	6	0.03%
VIETNAMESE	5	0.03%
CHINESE	4	0.02%
BOSNIAN	3	0.02%
URDU	3	0.02%
HINDI	2	0.01%
LAO	2	0.01%
POLISH	2	0.01%
PUNJABI	2	0.01%
Total	**18193**	**100.00%**

Understanding Our Members' Communication: *Top languages of the enrolled members as of February 1st, 2026.*

Telephonic interpretation can be requested on the same day. All others may need to be requested three business days in advance, and the member will need a cell phone for interpreter service requests via video/Zoom.

For more information, or if you have a request for any other alternative translation assistance needed for one of our members, call Member Services at 1-855-676-5772.

Member Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna DSNP members, you should be aware of the members' rights and responsibilities. For a complete list of member rights and responsibilities visit our **provider manual.**

Shared Decision-Making Aids

Shared decision-making aids are communication tools used as a way for providers and patients to make informed health care decisions based on what is important to the patient. They do not replace physician guidance but are intended to help complement the discussions between patients and physicians on treatment decisions.

Here are evidence-based aids that provide information about treatment options, lifestyle changes, and outcomes:

American Heart Association | Health Topics

Diabetes | American Heart Association

Flu Prevention | American Heart Association

Heart Facts | American Heart Association

Mayo Clinic | Care that fits

Statin Choice | Mayo Clinic

Depression Medication Choice | Mayo Clinic

Krames Online

We believe our patients' well-being comes first—always. We understand that during clinical encounters, not every question can be addressed in the moment. To support you and your patients beyond the visit, Krames Online provides 24/7 access to trusted health education resources.

With more than 4,000 topics covering health

conditions and medications, Krames Online empowers you to confidently guide patients and their families to reliable answers for both common and complex questions. Providers can easily encourage patients to use the search function to continue learning at their own pace.

This resource reflects our commitment to supporting your care delivery—ensuring patients receive the information they need, the answers they deserve, and the tools that reinforce informed, high-quality care.

June is Alzheimer's & Dementia awareness month.

Alzheimer's disease is a brain illness that usually occurs in older adults, though it can appear as early as age 40. It is the most common cause of dementia and is a progressive condition, meaning it worsens over time. Alzheimer's causes a series of changes to the brain's nerve cells, including the development of clumps and tangles, and leads to the loss of connections between nerves.

Please review these tips with your patients' caregivers or with any patient who has expressed concern for a loved one living with dementia. You may also direct them to: https://aetna.kramesonline.com/Search/3,S,88905

Provider Resources

The organization requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members.

Keep your information current

Keeping your details up to date in our directories helps members find the right information about you and your practice. This also helps ensure that you receive timely payment, communications, reminders and more.

Updating your provider data info

Need to update your provider information? The best way to do so is to get in touch with us. You can request to make updates to your provider information, including:

- New service locations for an existing contracted TIN
- Change of name, address, phone number, fax and office hours
- Specialty, hospital affiliations, board certifications and other details

Just complete these steps:

1. Email us at COEProviderServices@Aetna.com. In your email, be sure to:
   - Include a copy of your W-9, if applicable. If you're contracted as a group, send a group W-9. Otherwise, just send an individual W-9
   - Ask us for us a Provider Change Request (PCR) form

2. Complete the PCR form. After you receive your PCR form, be sure to:
   - Complete all required fields within the PCR form
   - Email the form back to us

After you send us your materials and information, we'll process the change or contact you for more details.

Need to update your participation in our network?

Call us at 1-855-676-5772. Or just email us to learn more.

Timely Filing of Claim Submissions

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 and Resubmissions – Claims must be filed on a valid claim form and submitted based on the contracts timely filing limit. For hospital inpatient claims, date of service means the date of discharge of the enrollee. Non-network providers rendering prior authorized services within 365 days from the date services were performed and follow the same timely filing guidelines as Original Medicare guidelines.

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

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum

appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

Visit our website to review the appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/ SA) providers.

Operational Resources

We want to support our health care providers as we work together to reach health care goals. We offer a variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. This section includes just some of the resources. Additional tools and resources can be found on your provider manual.

For more information, contact our provider service department at 855-676-5772 or our provider website at www.aetnabetterhealth.com/michigan/providers/index.html

Pharmacy Benefits

Aetna Medicare HIDE (HMO D-SNP) List of Covered Drugs ("the Drug List" or the formulary) is a comprehensive list of covered prescription drugs, over-the counter drugs and items covered at participating network pharmacies. The Drug List is posted on the plan's website at website. The Drug List is **updated monthly** throughout the year, and the date of **last change is noted on the front cover of the Drug List**. Changes to the plan's Drug List are also posted on the plan's website.

Visit website for the updated Drug List and formulary search tool. For a printed copy of anything on our website, call Member Services toll-free at 1-855-676-5772.

The Drug List has detailed information about prior authorization, quantity limitation, step therapy, or formulary exceptions under "Necessary actions, restrictions, or limits on use." To request prior authorization or formulary exception reviews, you can submit electronically through your electronic health record (EHR), fax to 1-844-242-0914 or call Member Services toll- free a 1-855-676-5772. A Member Services representative will work with you to submit a request for prior authorization or formulary exception.

Types of rules or limits:

- Prior approval (or prior authorization)
- Quantity limits
- Step therapy

If a medication is not on the Drug List (called Formulary Exception)

The Aetna Medicare HIDE (HMO D-SNP) formulary covers most drugs identified by Medicare as Part D drugs and some over-the-counter drugs and items under Medicaid. Our members have no copays for covered Part D and Medicaid drugs.

Plan members have a copay or coinsurance for prescription drugs as long as the member follows the plan's rules.

Tiers are groups of drugs on our Drug List.

• Tier 1 - Preferred Generic - $0.

• Tier 2 - Generic - $0.

• Tier 3 - Preferred Brand - 22% OR For generic or brand drugs treated like generics: $0, $1.60, or $5.10. For brand drugs: $0, $4.90, or $12.65.

• Tier 4 - Non-Preferred Drug - 25% OR For generic or brand drugs treated like generics: $0, $1.60, or $5.10. For brand drugs: $0, $4.90, or $12.65.

• Tier 5 - Specialty - 25% OR For generic or brand drugs treated like generics: $0, $1.60, or $5.10. For brand drugs: $0, $4.90, or $12.65.

OTCs have a $0 copay

Complex Care Management Referral Options

Empowering members through coordinated care

Aetna DNSP offers an evidence-based care management program to help members improve their health and access needed services. Care managers—typically nurses or social workers—develop individualized care plans and support members in meeting their health goals. All members are assigned a care manager, with support levels based on clinical and social needs. Some of the reasons you may want to ask the health plan to have a case manager contact the member are:

- Does the member frequently use the emergency room instead of visiting their providers office for ongoing issues?
- Has the member recently had multiple hospitalizations?

- Is the member having difficulty obtaining authorizations for medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), yet does not comply with the recommended treatment regimen?
- Does the member need help applying for a state-based long-term care program?
- Does the member have HIV?
- Is the member pregnant with high-risk conditions?
- Is the member pregnant and over 35 years of age?
- Has the member received a referral to a specialist, but is unsure of the next steps?
- Does the member need information on available community services and resources not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)?

A care manager will contact the member—and caregivers when appropriate—to complete an assessment. This helps determine the level of support needed.

The care manager will then work with the member to develop a care plan, provide education, and coordinate services with the member's healthcare providers. Frequency of outreach varies based on the member's individual needs.

How to refer

To request care management support, call Provider Services at 1-855-676-5772. A care manager will review and respond within 3–5 business days.

Reminder: Required Prior Authorization Form

To help us process requests efficiently and ensure members receive timely access to care, please remember to use the Prior Authorization Form available on our website when submitting requests. The form must be fully completed, including the urgency designation (Standard or Expedited). Providing complete and accurate information allows our team to correctly prioritize incoming requests and avoid delays in review. Thank you for your partnership and commitment to supporting high quality, timely care for our shared members.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through Availity
- Fax the Prior Authorization Request Form to 1-844-241-2495. Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.
- Through our toll-free number at 1-855-676-5772

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit Availity, or call us at 1-855-676-5772.

If response for non-emergency prior authorization is not received within 15 days, please contact us at 1-855-676-5772.

When requesting prior authorization, please provide the following:

- 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
- DOS

Important Note:

- Emergency services do not require prior authorization; however, notification is required the same day.
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed, and authorizations are not a guarantee of payment.
- If providers do not receive outreach or response to non-emergency authorizations, please reach out to provider services at 1-855-676-5772
    - For post stabilization services, hospitals may request prior authorization by calling 1-855-676-5772

Decision	Decision/notification timeframe
Urgent pre-service approval/denial	Within seventy-two (72) hours of receipt of request
Non-urgent pre-service	Within five (5) calendar

approval/denial	days of receipt of request
Post-service approval/denial	Within thirty (30) calendar days of receipt of request

Due to the federal and state guidelines, the turnaround time (TAT) for non-urgent pre-service decisions (5 days). It is critical that you submit complete and accurate information upfront to support your authorization request. This includes the designated point of contact, all required medical documentation, and relevant medical history. Missing or incomplete details can delay the review process and impact timely access to care for enrollees. Ensuring thorough submissions helps us meet regulatory requirements and deliver prompt decisions within the timeframe.

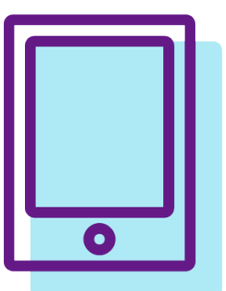
Availability of Criteria

We use the MCG criteria to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCGs are updated regularly as each new version is published. UM Criteria is electronically available to practitioners and copies of individual guidelines are available for review upon request.

You can request a copy of the Medical Necessity Criteria. Call us at 1-855-676-5772 or our provider website at www.aetnabetterhealth.com/michigan/providers/index.html

Cultural Competency Training

When we think of culture, we might first think of race or ethnicity. But culture means much more than that. It's a major factor in how people respond to health services. And it affects their approach to coping with illness, getting care and working toward recovery.



Patient satisfaction and positive health outcomes are linked to good communication between members and providers. Each segment of our population requires special sensitivities and strategies to embrace cultural differences.

Culturally competent providers:

- Effectively communicate with patients
- Understand their individual concerns
- Ensure patients understand their care plans

Complete the training

You'll want to complete a short training about cultural competency. Take these quick steps:

1. Complete this 7-minute video training about How Effective Healthcare Communication Contributes to Health Equity .
2. Then, email us to confirm you've completed the training. Once we receive your email, we can give you credit for completing the training on this topic.

Population Health Management (PHM) Strategy

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. (Provide a description of how they are identified for inclusion and available programs).

Keeping Members Healthy

Programs are targeted to align with low-risk populations. With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy. The PHM program for members is a Flu Vaccination Program that includes educational activities to promote annual flu vaccination.

Managing Members with Emerging Risk

Programs are targeted to align with medium risk populations. Engagement with practitioners focuses on supporting Patient Care Medical Home models to centralize care and patient- driven decision-making. The PHM program for members is a Hepatitis C Program that supports members in completing a prescribed treatment regimen.

Patient Safety and Outcomes Across Settings

Programs are targeted to align with members that experience health services across settings. Engagement with practitioners focuses on communication and collaboration with their patients to share information to prevent duplication and potential for harm. The PHM program for members is Appropriate Use of Acute Care Settings that includes early notification through in-patient alerts.

Managing Multiple Chronic Conditions

Programs are targeted to align with high and intensive risk populations. Engagement with practitioners focuses on maintaining engagement outside of clinic and office visits. The PHM program for members is Life Planning/Advance Directives/Palliative Care that includes providing life planning/advance directive information to members

upon enrollment.

Cognitive Impairment Program

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

You can learn about these programs online at www.aetnabetterhealth.com/michigan/providers/index.html or in your provider handbook. You can also call 1-855-676-5772 (TTY: 711).