Aetna Medicare HIDE (HMO D-SNP)

2026 Provider Orientation

Agenda

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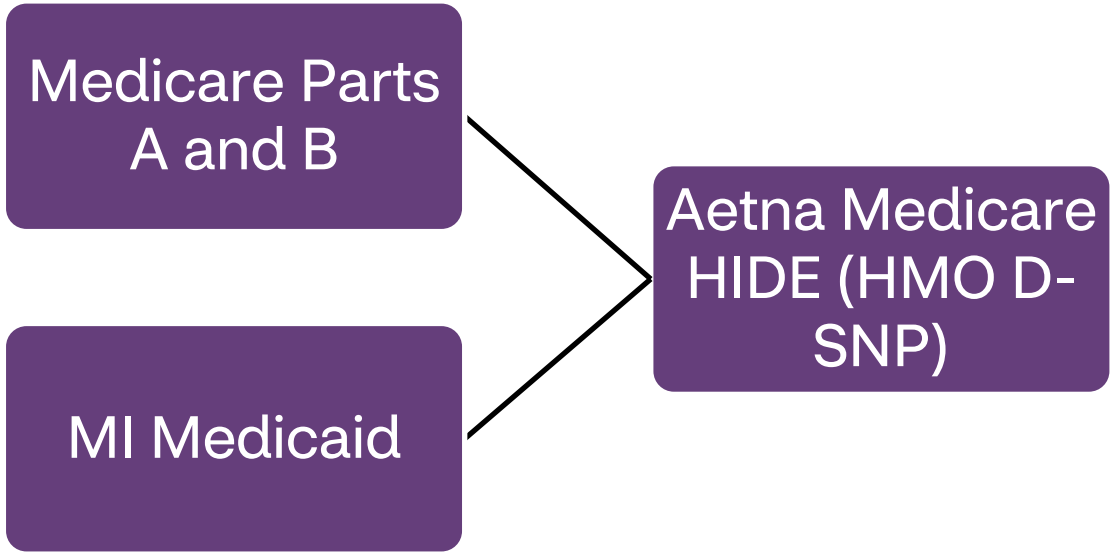
Aetna Medicare HIDE (HMO D-SNP) Plan Overview

Aetna Medicare HIDE (HMO D-SNP) is a Highly Integrated Dual Eligibility product. It is a Medicare Advantage plan which serves dual eligible members through Aetna. It covers all Medicare and Medicaid services including behavioral health, Managed Long Term Services and Supports (MLTSS) and additional supplemental benefits at $0 cost sharing for all members. This plan serves the following counties: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, and Wayne counties.

Plan Features

- Coverage of all Medicare and Medicaid benefits including prescription drugs, behavioral health and Managed Long-Term Care Services and Supports (if applicable)
- 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 Aetna Medicare HIDE (HMO D-SNP)

To join the Aetna Medicare HIDE (HMO D-SNP) the member must:

- Have Medicare Parts A and B
- Have FBDE (Full Benefit Dual Eligible) status
- Have MI Medicaid benefits
- Be a full-time Michigan resident and live in the plan's service area
- Must be 21 years of age or older
- Not be enrolled in a PACE program

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

Member Rights and Responsibilities

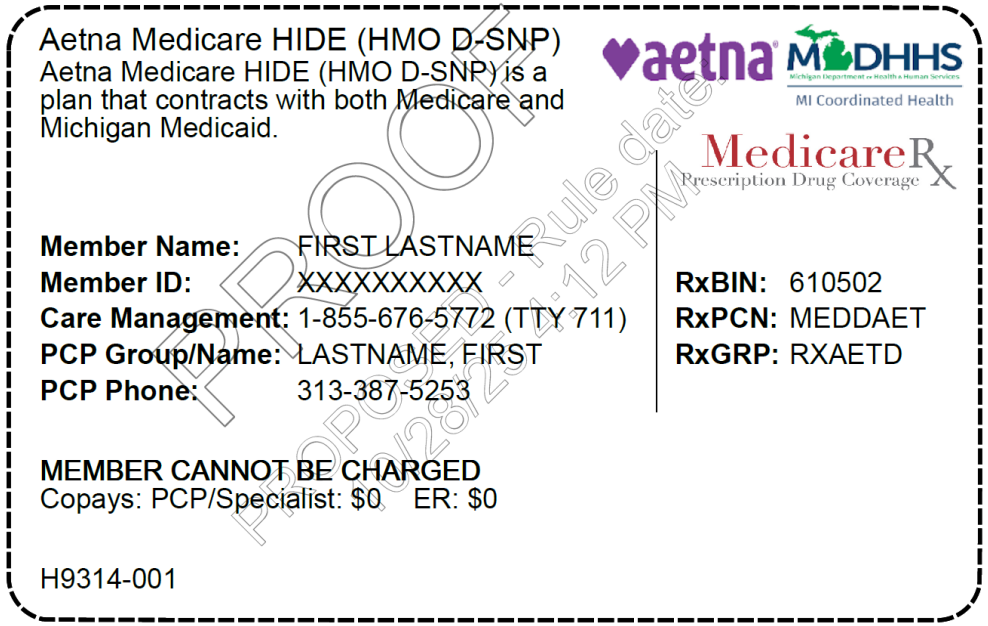
1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions 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 organizations 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.

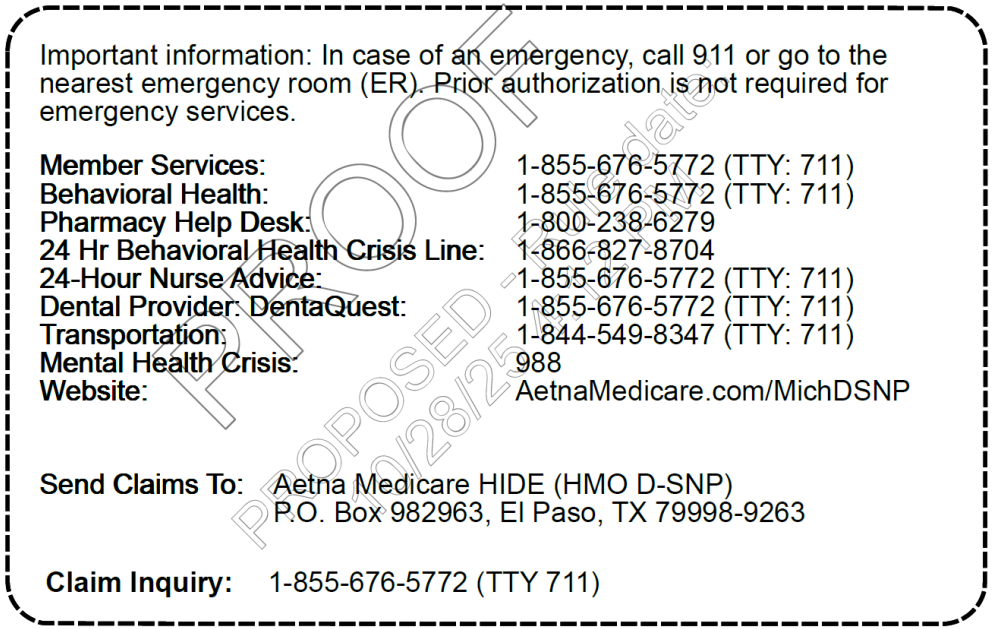
Shared decision-making aids offer healthcare providers the opportunity to leverage best practice tools tailored to their specific medical specialties. These aids cover a diverse array of medical scenarios, providing specialized information on topics such as diabetes, cardiovascular, wellness screening,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

The Member Rights and Responsibilities can be found in the provider manual available here

Member ID Card

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





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

Large and Trusted Network

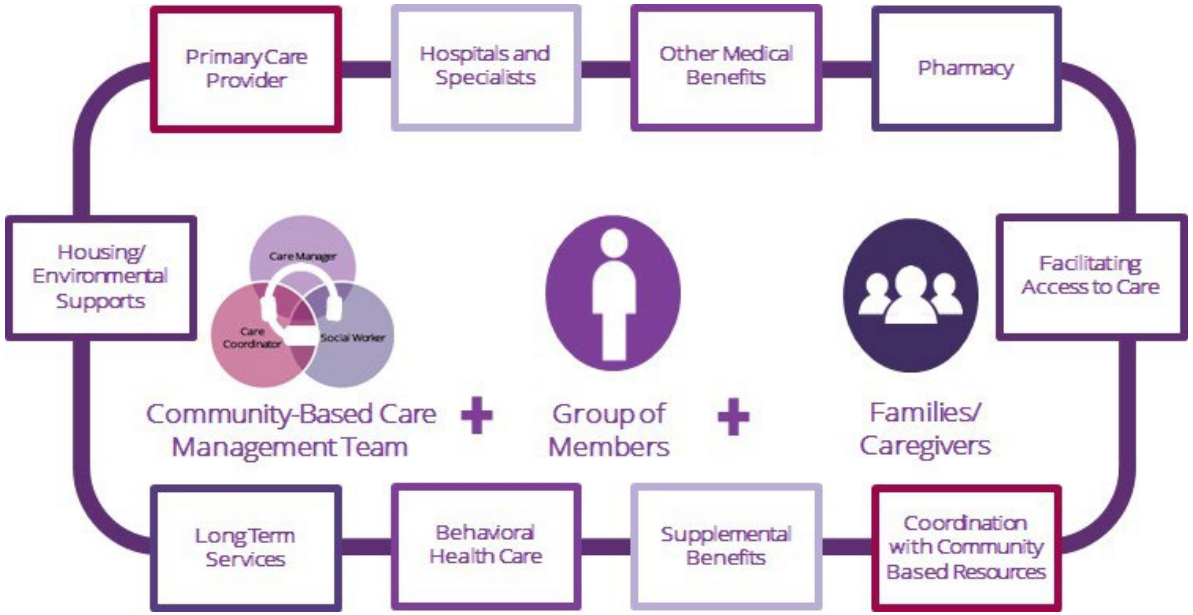
Aetna Medicare HIDE (HMO D-SNP)'s Network closely mirrors, but is not the same as, Aetna Medicare Network. Members can utilize the plan- specific **provider directory**.

- Network consists of Aetna Medicare and Medicaid providers statewide.
- Over 17,000 in-network providers across Michigan service areas.
- CVS MinuteClinics® providing general medicine, urgent care and telehealth services in Michigan.
- Dental Network through DentaQuest network available throughout Michigan.
- Lab Corp and Quest Labs, as well as other independent labs, are in-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



Care Management Team

- Nurse care managers
- Social workers
- Care coordinators
- Member advocate

Supported by

- Pharmacists
- Medical director
- Behavioral health
- Other Aetna clinical programs & services

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

Our care team

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

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

Medicare Parts A, B, and D	Aetna Medicare HIDE (HMO D-SNP) Supplemental Benefits	Medicaid	Medicaid MLTSS (if applicable)
• PCP visits • Specialist visits • Inpatient/outpatient hospital • Emergency & urgent care • X-rays and diagnostic radiology • Lab services • Ambulance • Therapy (PT/OT/ST) • Prescription coverage	• $225/month OTC allowance • 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. • Fitness program • Personal emergency response – medical alert system • Meals at home following discharge • 24-hour nurse line • Annual routine physical exam • Worldwide emergency and urgent coverage	• Medicare cost share covered for all members, including Part D copays • Additional coverage beyond Medicare limits • Preventive and comprehensive dental • Hearing services • Vision services • Podiatry (routine) • Chiropractic care • Behavioral health services • Acupuncture • Transportation • Medical day care • Personal care assistance • Additional pharmacy covered items	• Assisted living services and programs • Caregiver/participant training • Chore services • Community residential services • Community transition services • Home-based supportive care • Home delivered meals • Medication dispensing device • Residential modifications • Respite care • Social adult day care • Structured day program • Supported day services • TBI behavioral management • Non-medical transportation • Vehicle modifications

Benefits in Michigan

Additional benefits for Aetna Medicare HIDE (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** 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 28 meals over 14 days following 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 **1-855-676-5772**. 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 HIDE (HMO D-SNP) members should NOT be balanced billed for any covered benefit.

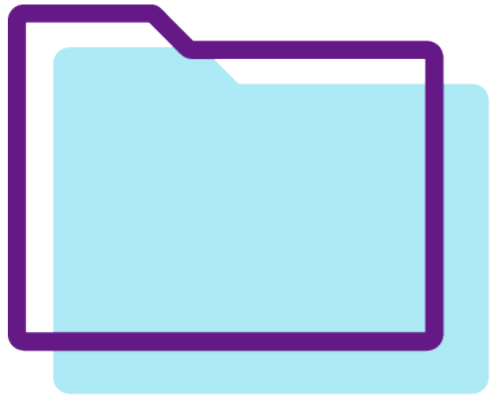
We have an automated system for processing claims for members enrolled in Aetna Medicare HIDE (HMO D-SNP)

- 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 **#128MI** when submitting claims Aetna Medicare HIDE (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 **#128MI** when submitting electronic claims
- Availity
- Information on Availity can be found at the **Provider Portal Website**



Paper Claims

Please use Submitter ID **#128MI** when submitting paper claims

Aetna Medicare HIDE (HMO D-SNP)

PO Box 982963

El Paso, TX 79998-2963

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.

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.

EFT and ERA Setup

Aetna Medicare HIDE (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** or **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 **888-834-3511.**

How do I enroll?

To enroll in EERS, please view the **ECHO Portal Guide.**

Provider Disputes

If you are a Contracted Provider, you may use the **Dispute Form** found online to have your claim reconsidered. You may submit through the portal or by mail.

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

Aetna Medicare HIDE (HMO D-SNP)

PO Box 982963

El Paso, TX 79998-2963

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

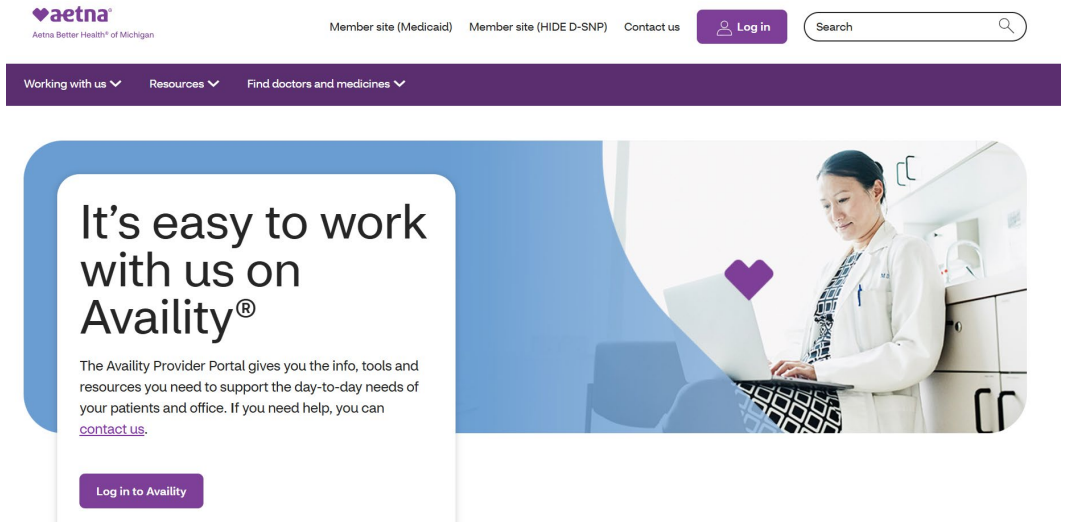
- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

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

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 HIDE (HMO D-SNP) from your list of payers to begin accessing the portal and all of the features. When using Availity services, be sure to select **Aetna Better Health All Plans NJ-VA MAPD-DSNP** in any payer dropdown



Find out more at the Aetna Medicare HIDE (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.

Availity®

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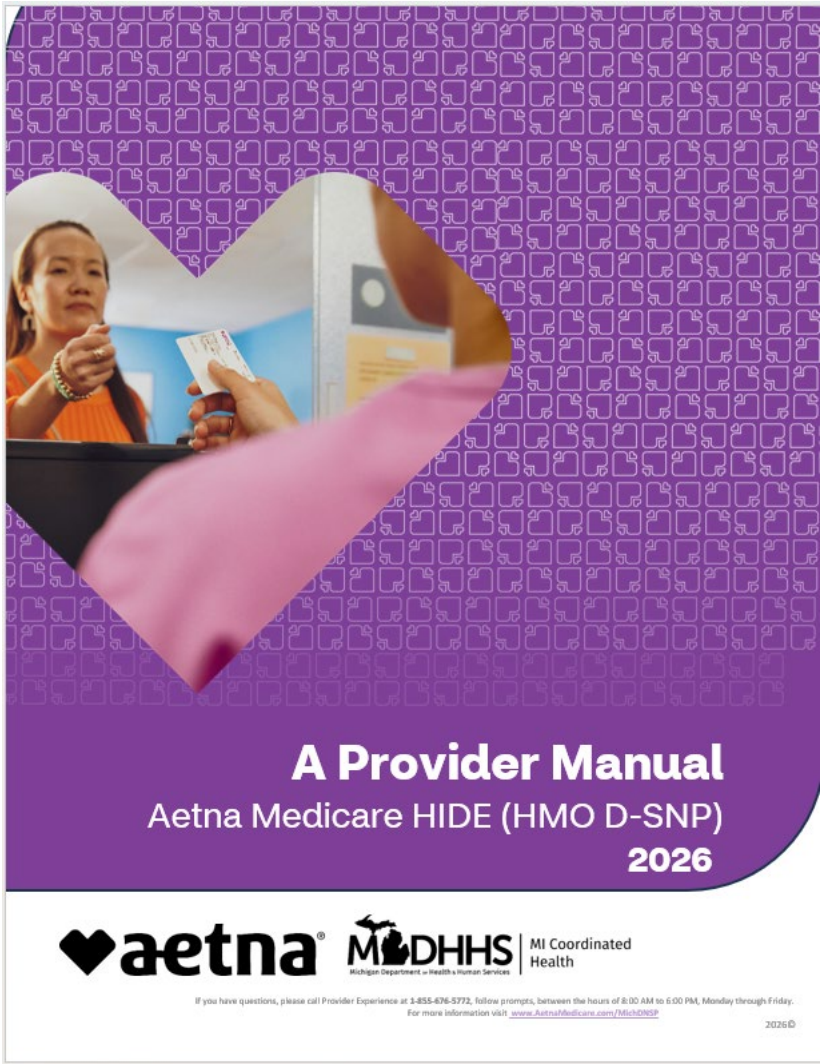
Provider Manual

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 **Provider Manual Page**.

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department at **1-855-676-5772** or by email at **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 HIDE (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 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 **1-855-676-5772** 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 **1-855-676-5772** or by email at **COEProviderServices@AETNA.com**

Provider Responsibilities (continued)

Stay Up-to-Date

Don't miss the quarterly **provider newsletter**—it includes key updates and resources that support compliance and improve member care.

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 HIDE (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 HIDE (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 HIDE (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
Emergency	Immediate	Immediate	Immediate	Immediate
Urgent	24 Hours	Within 5 business days of the request	24 Hours	24 Hours
Non-Urgent (Non-life threatening)	72 Hours	Within 7 business days of the request	72 Hours	6 Hours
Routine	28 Days	Within 28 calendar days	28 Days (non-perinatal)	28 Days
Perinatal	N/A	N/A	1st Trimester: 3 Weeks 2nd Trimester: 7 Days 3rd Trimester: 3 Days High Risk: 3 Days Routine: 3 Weeks Postpartum: 6 weeks	N/A
Wait Time	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 **Medication Management** within 3 months of the first appointment
- Follow-up Behavioral Health **Therapy** within 10 business days of the first appointment
- Next Follow-up Behavioral Health **Therapy** within 30 business days of the first appointment

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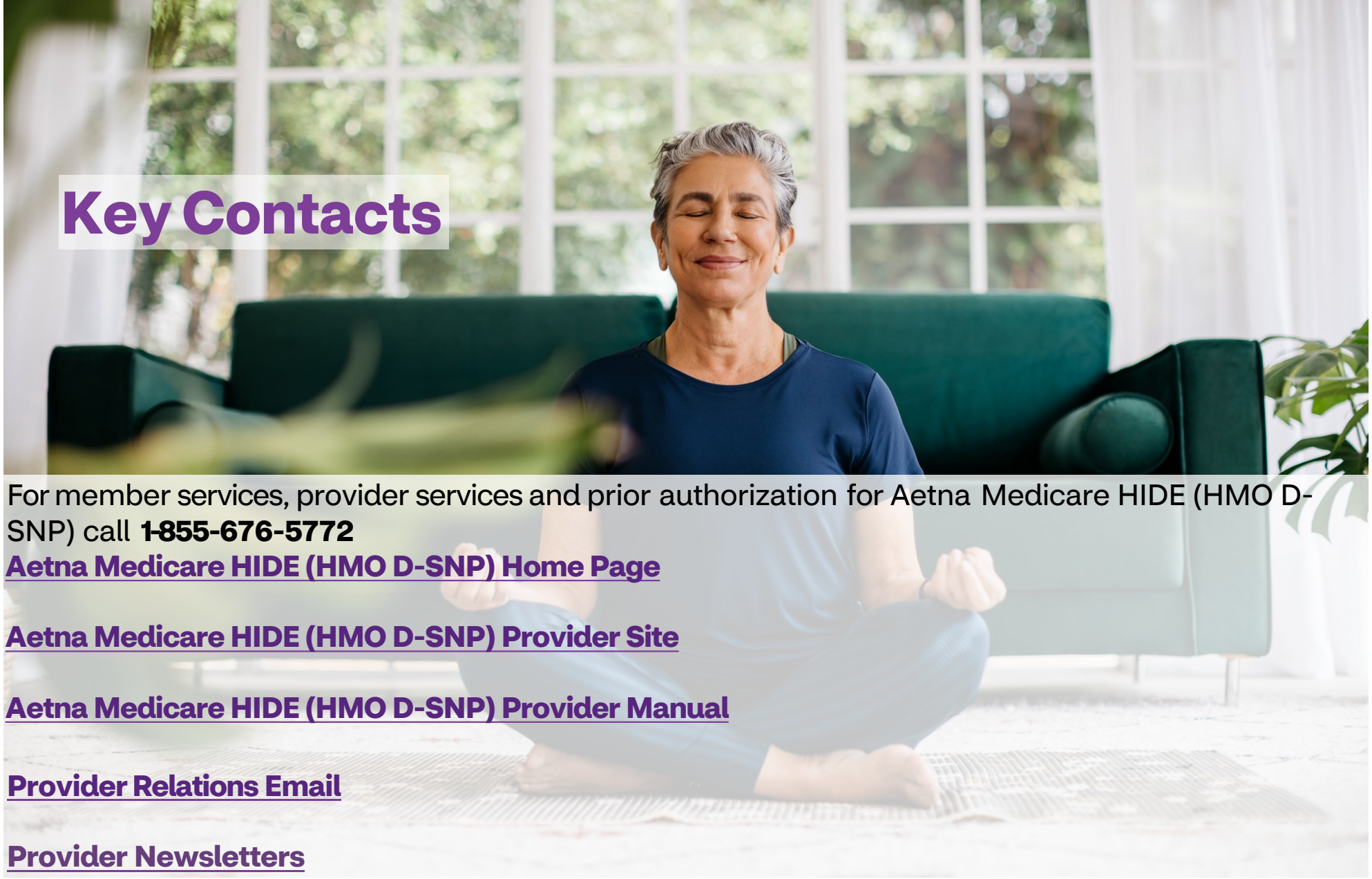

Key Contacts

For member services, provider services and prior authorization for Aetna Medicare HIDE (HMO D-SNP) call **1-855-676-5772**

Aetna Medicare HIDE (HMO D-SNP) Home Page

Aetna Medicare HIDE (HMO D-SNP) Provider Site

Aetna Medicare HIDE (HMO D-SNP) Provider Manual

Provider Relations Email

Provider Newsletters

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