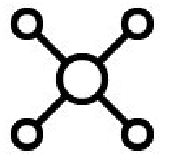
Aetna Assure Premier Plus (HMO D-SNP)

Fall 2021 Provider Newsletter



Aetna Assure Premier Plus (HMO D-SNP) Statewide Expansion

Effective January 1, 2022, Aetna Assure Premier Plus (HMO D-SNP), a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) will operate statewide in all 21 counties of New Jersey. Aetna Assure Premier Plus (HMO D-SNP) is a Medicare Advantage managed care plan option for individuals with Medicare and full NJ FamilyCare/Medicaid coverage. This plan 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.

As a participating provider in this plan, you should be aware of the following:

- Key plan features
  - $0 cost sharing for all plan covered services and prescription drugs
  - One member ID card to access all covered services
  - All members have a dedicated Aetna care manager
  - No referrals for specialists
  - In-network primary care provider selection is required
- Using the member's ID number from the plan ID card, you will need to submit **one claim**. Your claims will automatically be processed first under the Medicare benefits and then under the Medicaid benefits. Use submitter ID #46320 when submitting claims. Members should not be balanced billed for any covered benefit.
- You can use the provider portal to access, eligibility, panel rosters, claims status, and much more. Simply select Aetna Better Health in Availity to see all the ways that we support you.

Below are additional resources for you and your office staff

- Aetna Assure Premier Plus (HMO D-SNP) plan website
- Aetna Assure Premier Pus (HMO D-SNP) provider website
- Aetna Assure Premier Plus (HMO D-SNP) Provider FAQ
- Aetna Assure Premier Plus (HMO D-SNP) Provider Orientation
- You can reach the designated care manager for an Aetna Assure Premier Plus (HMO D-SNP) member by calling **844-362-0934 (711)** Monday to Friday, 8:00 AM to 5:00 PM.

2022 Member ID Card

Aetna Assure Premier Plus (HMO D-SNP)

aetna

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Effective Date: <Effective Date>
Issue Date: <Issue Date>

PCP:	$0 Copay
Specialist:	$0 Copay
Emergency Room:	$0 Copay
Urgent Care:	$0 Copay
Dental:	$0 Copay

Issuer: 80840
RxBIN: 610502
RxPCN: MEDDAET
RxGrp: RXAETD
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
Dental Provider: LIBERTY Dental

MedicareRx
Prescription Drug Coverage

H6399-001

Important Information: In case of an emergency, call 911 or go to the nearest emergency room (ER). Prior authorization is not required for emergency services.

For Members

Member Services:	1-844-362-0934 (TTY: 711)
Behavioral Health Crisis:	1-844-362-0934 (TTY: 711)
Care Management:	1-844-362-0934 (TTY: 711)
24-Hour Nurse Advice:	1-844-362-0934 (TTY: 711)
Dental Services:	1-844-362-0934 (TTY: 711)
Website:	AetnaBetterHealth.com/New-Jersey-hmosnp

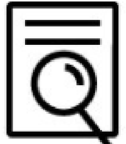
For Providers

Medical
Eligibility Verification: **1-844-362-0934 (TTY: 711)**
Prior Authorization: **1-844-362-0934 (TTY: 711)**

Pharmacy
Pharmacy Help Desk: **1-800-238-6279 (TTY: 711)**
Claim Inquiry: **1-844-362-0934 (TTY: 711)**

Submit claims to:
Aetna Assure Premier Plus (HMO D-SNP)
P.O. Box 61925
Phoenix, AZ 85082-1925

If you have any questions, please call Aetna Assure Premier Plus (HMO D-SNP) at **844-362-0934 (711)** Monday to Friday, 8:00 AM to 5:00 PM.



Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

- We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don't reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at 1-844-362-0934, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-844-362-0934.

Population Health Management

Aetna Assure Premier Plus maintains Population Health Management (PHM) programs and activities selected to meet the needs of the member population and target their individual risks. These programs are designed to support delivery of care. Each PHM program includes measurable goals that are used to determine program effectiveness. Aetna Assure Premier Plus continues to work collaboratively with provider networks to ensure that the recommended screenings and services are completed for the served membership.

Below are some of the programs we offer to members:

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/or 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 Assure Premier Plus care managers will work with members and providers to ensure that members receive the right care and services that meet members' needs.

Model of Care

2021 Medicare compliance training and DSNP MOC attestation requirements for participating providers.

Participating providers in our Medicare Advantage (MA) plans, Medicare-Medicaid Plans (MMPs) and/or Dual Eligible Special Needs Plans (DSNP) must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities identified in the Medicare compliance FDR program guide (PDF) and/or DSNP Model of Care (MOC) (PDF) training guide.

New for 2021

- MA/MMP: Providers who participate only in our MA/MMP plans no longer need to complete an annual FDR attestation.
- DSNP/FIDE: Providers who also participate in our DSNP/FIDE plans must still complete the annual DSNP Model of Care (MOC) training (PDF) and attestation requirements.
- Delegated Entities: Provider attestation collection for the FDR compliance requirements continue to be required for Delegated Entities. Delegated Entities will receive their attestation directly through Adobe Sign. Completion of both the DSNP Model of Care (MOC) training (PDF) (if applicable) and attestation is still required. Notification regarding requirements will be sent directly to providers via Adobe Sign email or postcard notification.

Take a moment to review our training resources on the Aetna Medicare page to ensure you're in compliance. These include the Medicare compliance FDR program guide (PDF), the DSNP Model of Care (MOC) training guide (PDF) – required only if you are in our DSNP network – and the frequently asked questions document (PDF).

Note: Our compliance department completes random audits on an annual basis to ensure compliance.

Where to get more information

Have questions on the Medicare FDR compliance or DSNP/FIDE programs? Review the frequently asked questions document (PDF) for more information and contacts.

Please review our Model of Care scope, goals, efforts, and components, which are listed in the Provider Manual, located at https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/PROVIDER_MANUAL.pdf.

To keep up with compliance news, you can also view our quarterly FDR Compliance Newsletters.

Clinical Criteria for Utilization Management Decisions

How to Request Criteria

Aetna Assure Premier Plus medical necessity decisions for requested medical and behavioral services are based upon CMS National Coverage and Local Coverage Determinations, and nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

Aetna Assure Premier Plus uses the following medical review criteria for physical and behavioral health medical necessity decisions which are consulted in the following order:

- National Coverage Determination (NCD) or other Medicare guidance (e.g., Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, Medicare Learning Network (MLN) Matters Articles)
  - https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx
- Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC)
  - https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx
- Aetna Clinical Policy Bulletins (CPB) available on Aetna.com
  - http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html
- Medical Coverage Guidelines (MCG): For inpatient stays, Aetna Medicare uses MCGs as a resource for determining medical necessity for inpatient hospital and long-term acute care hospital (LTACH) stays in conjunction with Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A. Medicare guidelines are very general so MCGs provide condition specific guidance
  - https://mcg.aetna.com/
- Pharmacy clinical guidelines
  - https://www.aetnabetterhealth.com/new-jersey-hmosnp/pharmacy-prescription-drug-benefits.html

The criteria and guidelines are disseminated to all affected practitioners, and/or providers, upon request.

To request criteria, call Provider Experience at 1-844-362-0934 or visit our website at https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/index.html

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Complex Care Management Referral Options

Empowerment through care management

Aetna Assure Premier Plus offers an evidence-based care management program to help our members improve their health and access the services they need. Care managers typically are nurses or social workers. These professionals create comprehensive care plans that help members meet specific health goals.

All members are assigned their own care manager. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a care manager contact the member are:

- Does the member frequently use the emergency room instead of visiting your office for ongoing issues?
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), hypertension, or End Stage Renal Disease (ESRD), yet does not comply with the recommended treatment regimen and would benefit from telemonitoring of these conditions?
- Does the member need help to apply for a state-based long-term care program?
- Does the member live with 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)?

What happens to your referral?
After you make a referral, the member's care manager contacts the member. The care manager might also contact the member's caregivers or others as needed.

What will a care manager do?
To help the member learn how to manage their illness and meet their health and other needs, a care manager contacts the member to schedule a time to complete an assessment. The care manager asks the member questions about his or her health and the resources currently being used. Answers to these questions help the care manager determine what kind of assistance the member needs most.

Next, the member and the care manager work together to develop a care plan. The care manager also educates the member on how to obtain what they need. The care manager also may work with the member's health care providers to coordinate these needs. The amount of care management and frequency of contact with the member and others will vary based upon the individual needs of the member.
To make referrals for care management consideration, please call Provider Experience at 1-844-362-0934. A care manager will review and respond to your request within 3-5 business days.

Collaborative Care

COVID has affected many things. It had a huge impact on healthcare and how it is delivered. It even had an impact on how often people were able to see their providers. The inability to see providers lead to negative outcomes for many groups of people, particularly those with chronic conditions.

The impact that COVID has had on individuals with Diabetes is especially concerning. According to the American Diabetes Association, although people with Diabetes are not more likely to get COVID, they are more likely to have worse complications from the virus. Knowing this, how can providers and managed care organizations work together to get better outcomes for members with Diabetes?

1) Educating the member on the importance of scheduling and keeping doctor's appointments. As a team, we can work to remove any barriers that may prevent the patient from attending a scheduled appointment.
2) Collaboratively, we can let the members know about the benefits that Aetna Assure Premier Plus (HMO D-SNP) offers. Aetna Assure Premier Plus (HMO D-SNP) offers glucose monitors, test strips, DSME/nutrition education and SilverSneakers benefits to the member at no cost. These offerings can help the member monitor and manage their condition.

3) Lastly, we can educate the member on the benefits of vaccination. Aetna Assure Premier Plus (HMO D-SNP) offers the vaccination at no cost to the member. Getting vaccinated will help the member protect themselves and their families.

Helping the member manage their condition during this difficult time, isn't easy but through collaborative efforts, we can make sure our members have the best outcomes possible. If you have any questions, please contact Provider Experience.

Financial Liability for Payment for Services

Balance billing enrollees is prohibited under the Aetna Assure Premier Plus (HMO D-SNP). In no event should a provider bill an enrollee (or a person acting on behalf of an enrollee) for payment of fees that are the legal obligation of Aetna Assure Premier Plus (HMO D-SNP). This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Providers must make certain that they are:

- Agreeing not to hold enrollees liable for payment of any fees that are the legal obligation of Aetna Assure Premier Plus (HMO D-SNP), and must indemnify the enrollee for payment of any fees that are the legal obligation of Aetna for services furnished by providers that have been authorized by Aetna Assure Premier Plus (HMO D-SNP) to service such enrollees, as long as the enrollee follows Aetna Assure Premier Plus (HMO D-SNP) rules for accessing services described in the approved enrollee Evidence of Coverage (EOC).
- Agreeing not to bill an enrollee for medically necessary services covered under the plan and to always notify enrollees prior to rendering services.
- Agreeing to clearly advise an enrollee, prior to furnishing a non-covered service, of the enrollee's responsibility to pay the full cost of the services.
- Agreeing that when referring an enrollee to another provider for a non-covered service, provider must make certain that the enrollee is aware of his or her obligation to pay in full for such non-covered services.

Provider Portal

Our enhanced, secure, and user-friendly web portal is available at https://apps.availity.com/availity/web/public.elegant.login
This HIPAA-compliant portal is available 24 hours a day. It supports the functions and access to information that you need to take care of your patients. Popular features include:

- **Single sign-on.** One login and password allow you to move smoothly through various systems.
- **Personalized content and services.** After login, you will find a landing page customized to you.
- **Real-time data access.** View updates as soon as they are posted.
- **Better tracking.** Know immediately the status of each claim submission and medical prior authorization (PA) request.
- **eReferrals.** Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- **AutoAuths.** Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- **Detailed summaries.** Find easy access to details about denied PA requests or claims.
- **Enhanced information.** Analyze, track, and improve services and processes.
- **Provider notices/communications.** Review the provider manual and other documents related to members' benefits.

To access the provider portal, please go to https://apps.availity.com/availity/web/public.elegant.login
Select Aetna Better Health (Aetna Medicaid) from your list of payers to begin accessing the portal and its features.

For more information, contact Provider Experience at 1-844-362-0934.

Cultural Competency Training

Providers and their office staff are responsible for ensuring all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all patients.

This includes those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Providers should ensure that patients are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages from all staff members. Providers should also honor members' beliefs, be sensitive to cultural diversity, and foster respect for members' cultural backgrounds.

Aetna Assure Premier Plus (HMO D-SNP) conducts initial cultural competency training during Provider orientation meetings. If you have not previously completed Cultural Competency training or annual re-training, please take a moment to watch the video below and visit: https://thinkculturalhealth.hhs.gov/

https://youtu.be/dOZLf-RYvHk

Additionally, our Quality Interactions© course series is available to Provider who with to learn more about cultural competency. This course is designed to help you:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with your patients to help obtain better health outcomes

To access the online cultural competency course, please visit: www.hrsa.gov/culturalcompetence.

Pharmacy Benefits

Aetna Assure Premier Plus's List of Covered Drugs ("the Drug List" or the formulary) is a comprehensive list of covered prescription drugs, over-the-counter drugs, and items at participating network pharmacies. The Drug List and network pharmacies are posted on the plan's website at https://www.aetnabetterhealth.com/new-jersey-hmosnp/index.html. 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 is also posted on the plan's website.

Visit https://www.aetnabetterhealth.com/new-jersey-hmosnp/index.html for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at 1-844-362-0934.

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, call Member Services toll-free at 1-844-362-0934. 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)

Aetna Assure Premier Plus does not charge member copays for covered prescription and OTC drugs as long as Aetna Assure Premier Plus's rules are followed, and drugs are filled at a network pharmacy.

Covered drugs are designated the following coverage tiers.

- Tier 1 Preferred Generic drugs have a $0 copay
- Tier 2 Generic drugs have a $0 copay
- Tier 3 Preferred Brand name drugs have a $0 copay
- Tier 4 Non-Preferred drugs have a $0 copay
- Tier 5 Specialty drugs have a $0 copay

Member's Rights and Responsibilities

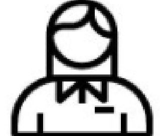
As a practitioner who ensures high quality care for Aetna Assure Premier Plus members, you should be aware of the members' rights and responsibilities. Some of the rights members are afforded are as follows:

- A right to receive information about Aetna Assure Premier Plus, our services, our practitioners and providers, and member rights and responsibilities
- A right to be treated with respect and recognition of the member's dignity and right to privacy
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Aetna Assure Premier Plus or the care we provide
- A right to make recommendations regarding Aetna Assure Premier Plus's member rights and responsibilities policy

In addition, our members have the following responsibilities:

- A responsibility to supply information, to the extent possible, that Aetna Assure Premier Plus and our practitioners and providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

For a complete list of member rights and responsibilities visit our website at https://www.aetnabetterhealth.com/new-jersey-hmosnp/index.html to see our Member Handbook.



Appointment Availability Standards

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 State of New Jersey Division of Medical Assistance & Health Services (DMAHS) and 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.

The table below indicates 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.

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Primary Care	Immediate	Within 24 hours	Within 28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
Specialist Care	Immediate	Within 24 hours of referral	Within 28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
OB/GYN	Immediate	Within 24 hours	Initial Prenatal Care • 1st Trimester: Within 3 weeks • 2nd Trimester: Within 7 calendar days • 3rd Trimester: Within 3 calendar days • High Risk: Within 3 days • Routine Care: Within 3 weeks • Postpartum Care: Within 6 weeks	No more than 45 minutes, except when the provider is unavailable due to an emergency
Behavioral Health	Immediate	Within 24 hours	Within 10 days of the request	No more than 45 minutes, except when the provider is unavailable due to an emergency

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 30 business days of the first appointment