About Aetna Medicare FIDE (HMO D-SNP)

Aetna Medicare FIDE (HMO D-SNP) is a type of Medicare Advantage Plan (Fully Integrated Special Needs Plan) for beneficiaries who are eligible for both Medicare and Medicaid. This plan coordinates all covered Medicare and Medicaid benefits within a single health plan.

Provider Participation and Reimbursement

1) Am I in Aetna Medicare FIDE's Network?

If you are an Aetna Medicare Advantage contracted provider, you participate in Aetna's Medicare FIDE Network and should accept members for the provision of Medicare services.

To check your participation status, please visit the **Availity provider portal** or the provider contact center **1-855-463-0933.**

2) How does Aetna's plan name change from Aetna Medicare Better Health to Aetna Medicare FIDE (HMO D-SNP) impact me as a provider?

There are no changes to business processes or operations. The health plan name change is impactful in name recognition; it's most important for providers to understand that Aetna Medicare Better health is now Aetna Medicare FIDE (HMO DSNP) and to not turn away Aetna's members from the practice/service offered.

3) Will Aetna offer a QMB health plan for 2026?

No, Aetna will no longer offer its Virginia Aetna Medicare Assure Value (HMO D-SNP) in 2026. Aetna will continue to offer the Fully Integrated Dual Eligible Special Needs Plan as Aetna Medicare FIDE (HMO D-SNP).

4) Can I balance bill a member?

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.

5) Should I bill Medicare or Medicaid?

Providers should bill Aetna Medicare FIDE (HMO D-SNP) for amounts due for any services covered under the member's plan. As Medicare Advantage plans, Aetna Medicare FIDE (HMO D-SNP) is

responsible for providing payment for Medicare covered services (up to existing Medicare reimbursement rates).

Participating Medicare providers will be compensated in accordance with their executed contract terms and conditions that you will find in the Medicare service and compensation schedule.

Aetna Medicare FIDE (HMO D-SNP) is also responsible for the management and payment of Virginia Medicaid benefits. Medicaid-only covered services will be reimbursed according to applicable compensation.

For Medicare covered services, Aetna will reimburse providers for Medicare primary payment (up to the existing Medicare Advantage contracted rates) and then adjudicate for Medicaid secondary payment (up to the Medicaid allowable rates) If the claim is eligible for both Medicare and Medicaid reimbursement, payment for the Aetna Medicare FIDE (HMO D-SNP) plan will be made on separate checks: one check from Medicare and one check from Medicaid.

6) What If I'm Not a Medicaid Participating Provider?

Providers who are billing Medicare covered codes will receive both the primary Medicare payment and then secondary Medicaid payment if applicable. If you are billing Medicare covered services as primary, there is nothing to do. You do not need to have a Medicaid contract to receive primary Medicare cost sharing.

If you are billing services that are primary to Medicaid (i.e., services that are not Medicare eligible), the Virginia Department of Medical Assistance Services requires registration to receive payment. If you already have an Active Medicaid ID with Virginia, there is no action needed to receive Medicaid payment. If you need a Medicaid ID, please visit the registration site at **Virginia Department of Medical Assistance Services Online Provider Enrollment System**. Either registering or obtaining an Active Medicaid ID is sufficient to receive a Medicaid payment for Medicaid primary services.

7) How do I submit claims?

Using the member's ID number from the plan ID card, you'll only need to submit one claim. Your claims will automatically process first through Medicare benefits and then through Medicaid benefits. You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to submit a secondary claim to Aetna.

There are three avenues to submitting claims:

- We encourage participating providers to electronically submit claims through ECHO Health, Inc. Use submitter ID **#128VA** when submitting claims to Aetna Medicare FIDE (HMO D-SNP).
- When using Availity, providers must select **Aetna Better Health All Plans NJ-VA MAP D-SNP** as the Payor due to Aetna's claims administration system for this plan.
- For paper claims submissions, please use submitter ID **#128VA** when submitting claims to Aetna Medicare FIDE (HMO D-SNP). Paper claims should be sent to the following address:
  Aetna Medicare FIDE (HMO D-SNP)
  PO Box 982974
  El Paso, TX 79998-2967

8) Am I Required to See Aetna Medicare FIDE (HMO D-SNP) Members?

As a contracted provider to service Aetna Medicare Advantage members, you are required to see these Members. Aetna Medicare FIDE (HMO D-SNP) are Medicare Advantage plans and are included in the Aetna Medicare participation agreement.

Policies and Procedures

1) How Do I Access the Provider Portal?

If you're new to Availity, you can register with Availity for free by clicking **here**. You can utilize all Availity's features and access trainings once you log in.

If you are already using Availity, simply **log in** to your Availity profile and choose "**Aetna Better Health All Plans NJ-VA MAP D-SNP**" from your list of payers for viewing Aetna Medicare FIDE (HMO D-SNP). This allows you to start using the Aetna-specific features. The portal tools inside make all your admin work as easy as possible.

"Aetna Better Health" Availity profile should be used for Aetna Medicare FIDE (HMO D-SNP). "Aetna Medicare" Availity profile should be used for other Medicare Advantage business.

2) What are Availity's Features?

Through the Availity portal, you can:

- Conduct claim inquiries
- Verify member eligibility and benefits
- Update provider rosters and demographic information
- Review authorizations and resubmissions.

3) Do I have to take any Training?

All Special Needs Plans are required to have an approved Model of Care. Providers must take a mandatory Model of Care Training required by CMS each year. A simple Attestation Statement is provided within this training document as well to make it easy for you to get credit for completing the course. You can take the training and record your attestation on the **Provider Training** page.

All providers and office staff who interact with Members are required to complete this training.

4) What other Claims and Patient Information do I have to Submit?

To support Healthcare Effectiveness Data and Information Set (HEDIS) initiatives, be sure to submit encounter data for the Care for Older Adults (COA) measure. Requirements: Advanced Care Planning (CPTII: 1157F, 1158F), Functional Status Assessment (CPTII: 1170F), Medication Review (CPTII: 1159F and 1160F must both be submitted on the same claim, same day), Pain Screening (CPTII: 1125F, 1126F).

5) What are the appointment standards and availability timeframes?

To meet our growing member population, we have to determine if participating offices in our network have sufficient office hours. Please review our **appointment standards**. We may be reaching out to your office about your response to our access and availability questionnaire.

Member Eligibility and Benefits

1) Who is eligible for Aetna Medicare FIDE (HMO D-SNP)?

Enrollees must be:

- Eligible for Medicare; entitled to Medicare Parts A and B
- A United States citizen or lawfully present in the United States
- Eligible for full VA Cardinal Care Benefits (Medicaid)
- Live in the state of Virginia
- Eligible for:
    - QMB+
    - SLMB+
    - FBDE.

2) When and How Can Members Enroll?

Providers may have new enrollees throughout the year. Prospective enrollees can learn more about the plan by visiting the **member website** or speaking to a licensed sales agent. They can call **1-844-934-3324 (TTY: 711)** to enroll.

Initial Enrollment Period
This is the seven-month window for a member to join a Medicare plan. This period begins three months before the month they turn 65. It runs through their birthday month and ends three months after the month they turn 65.

Annual Enrollment Period
Anyone can make changes to their coverage and enroll in a Medicare plan each year, from October 15 to December 7. If the member may choose to make a change during the Annual Enrollment Period, their new coverage won't begin until January 1.

Medicare Advantage Open Enrollment Period
This period takes place from January 1 through March 31 annually. It allows individuals enrolled in a Medicare Advantage plan to make a one-time election to go to either another Medicare Advantage plan or Original Medicare. In either case, their new coverage will start on the first day of the month following the month they make a change.

Special Enrollment Period
In situations like the ones below, the member may be able to join, switch or drop a Medicare Advantage plan outside the basic enrollment periods.

- Moving out of your plan's service area
- Losing your current health care or prescription drug coverage

Aetna Medicare FIDE (HMO D-SNP) members with Medicare and full Medicaid benefits can use the monthly SEP (Special Election Period) to enroll into another Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP).

This SEP can be used once per month. The effective date of the new plan will be the first of the next month.

3) What Care Management Services Do Members Receive?

Members enrolled in the plan have a dedicated care manager who will serve as their main point of contact with the plan. The Care Manager will lead an **Interdisciplinary Care Team (ICT)** that works together to help each Member receive the most appropriate, highest quality of care. Each Member has an **Individualized Care Plan (ICP)** based on the results of their comprehensive **Health Risk Assessment (HRA)**. Care Managers can be reached by phone at **1-855-463-0933** or by email at **ABH_VA_DSNP@aetna.com**

4) What If a Member Loses Eligibility?

If a member loses their Medicaid eligibility, our plan will continue to cover the Member's Medicare benefits for a period of eligibility of six (6) months. The plan will also continue to cover Medicare cost- sharing during this time, however, during this period Medicaid-only benefits will not be covered by our plan. To find out if a benefit is Medicaid only, or to find out if it will be covered, you can call Provider Contact Center at **1-855-463-0933.** This period of eligibility begins the first day of the month after Aetna Medicare FIDE (HMO D-SNP) learns of the loss of Medicaid eligibility. If at the end of the six (6) month period of eligibility, the Member's Medicaid eligibility has not been regained and the member has not enrolled in a different plan, Aetna Medicare FIDE (HMO D-SNP) will disenroll the member from the plan and the member will be enrolled back into Original Medicare. ***Note: During this period, members are NOT liable for cost-share (premiums, copayments, coinsurance, or deductibles) of any kind for Medicare covered services and should not be balance billed. Medicaid services will not be covered during this time.***

5) Will members have Aetna D-SNP AND a Separate Medicaid plan?

No. Aetna Medicare FIDE (HMO D-SNP) is a special kind of Medicare Advantage plan that offers all services covered by original Medicare and a prescription drug plan, along with Aetna Better Health of Virginia (Medicaid) services. Members will receive both their Medicare and Medicaid services from Aetna.

6) What Services and Benefits Are Covered in Our Plan?

Aetna Medicare FIDE (HMO D-SNP) covers all the Member's Medicare, Aetna Better Health of Virginia (Medicaid), Managed Long Term Services and Supports (if applicable), and prescription drug benefits (including Medicare Part D). This includes their medical, behavioral health, medication, and extra benefits all in one health plan, with one identification card, and no deductibles, coinsurance, or copays for plan-covered medical services. Member costs for Part D benefits will be determined by the members Low Income Subsidy (LIS) level.
Supplemental benefits include:

- A fitness program through SilverSneakers
- Home delivered meals following an in-patient or skilled nursing stay. Members can receive 14 meals over 7 days after an inpatient hospital discharge or skilled nursing stay.
- Members get an Extra Benefits Card with a $280 monthly allowance to help you pay for OTC products. If a member is eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI), their Over the Counter (OTC) Wallet will change to the Extra Supports Wallet with additional spending categories such as healthy foods, OTC, transportation, utilities and personal care products.
    - Members must have one of the 26 qualifying chronic conditions to be eligible for SSBCI and the additional spending categories.

- Returning member eligibility will be determined through medical claims review. If there are no claims on file, then a member (new or returning) may contact Member Services to self-attest to determine if they qualify.

- Annual allowance for wigs when members are undergoing chemotherapy (if the chemotherapy is causing hair loss)
- Aetna 24-hour Nurse Line
- 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.** Available for select conditions. Other restrictions apply. To receive these services, you will be connected to a trusted third-party provider.

7) Things to Remember:

- Always verify member eligibility every time prior to rendering services
  - Members should show their member ID each time before completing a visit to a provider
  - You can call the provider contact center at **1-855-463-0933**
  - You can verify member's eligibility in the **provider portal**
- Members must select a primary care physician to coordinate their care.
- Members may only see providers in the Aetna Medicare FIDE (HMO D-SNP) network, except in cases of emergency, urgent care, or out-of-area dialysis services, unless Aetna Medicare FIDE (HMO D-SNP) provides a prior authorization for out-of-network care.
- Members do not need referrals to see in-network providers.

More information

1) Where can I find the provider newsletter and updates on policy information?

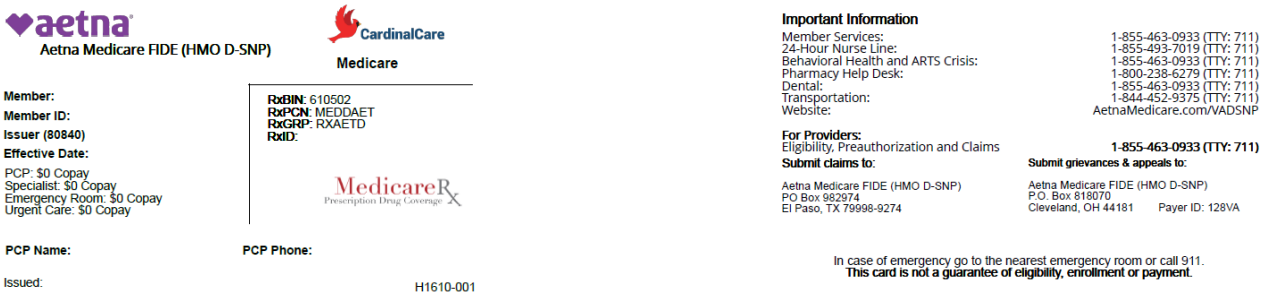
Our provider newsletters and any news and notices can be found **here**.

2) Where can I find the Aetna Medicare FIDE(HMO D-SNP) & provider manual?

The Provider Manual is accessible on our **Provider Website** under the 'Provider Manual' link. While this manual contains basic information about Aetna Better Health and the Department of Medical Assistance Services (DMAS), providers are required to fully understand and apply DMAS requirements when administering covered services. Please refer to **www.dmas.virginia.gov** for further information on DMAS. You can also access the **DMAS Provider Manual here.**

3) What does an Aetna Medicare FIDE (HMO D-SNP) Member ID card look like?

A sample of the Member ID card is presented below:



4) How do I contact Aetna?

For Aetna Medicare FIDE (HMO D-SNP) call **1-855-463-0933** to address:

- Provider needs
- Claim payment statuses
- Discuss prior authorization for services
- Discuss Case Management needs

You may also email the care management department at **ABH_VA_DSNP@aetna.com** if you have any authorization forms to transmit or escalated issues, and you can reach the provider credentialing team at **COEProviderServices@aetna.com** when you have any roster forms or recredentialing/W-9 forms.

You can also address many provider issues such as member eligibility verification, claim submission and disputes and updating rosters at the provider portal found **here**.

Expanded Links:
Availity: **apps.availity.com/**
Availity Registration: **availity.com/provider-portal-registration**
Member Website: **https://www.aetnabetterhealth.com/virginia-hmosnp/members/hmo-snp/**
Virginia's Medicaid Registration Page: **https://virginia.hppcloud.com/ProviderEnrollment/EnrollmentCreate**
Provider Directory: **https://www.aetnabetterhealth.com/virginia-hmosnp/find-provider**
Provider Manual: **https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/snp-manual**

Provider Newsletters: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/news
Provider Portal: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
Provider Training and Orientation: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/training
Provider Website: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/