Provider newsletter

Fall 2025

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AetnaBetterHealth.com/Virginia

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Aetna Better Health® of Virginia

Help your patients use their Value-Added Benefits

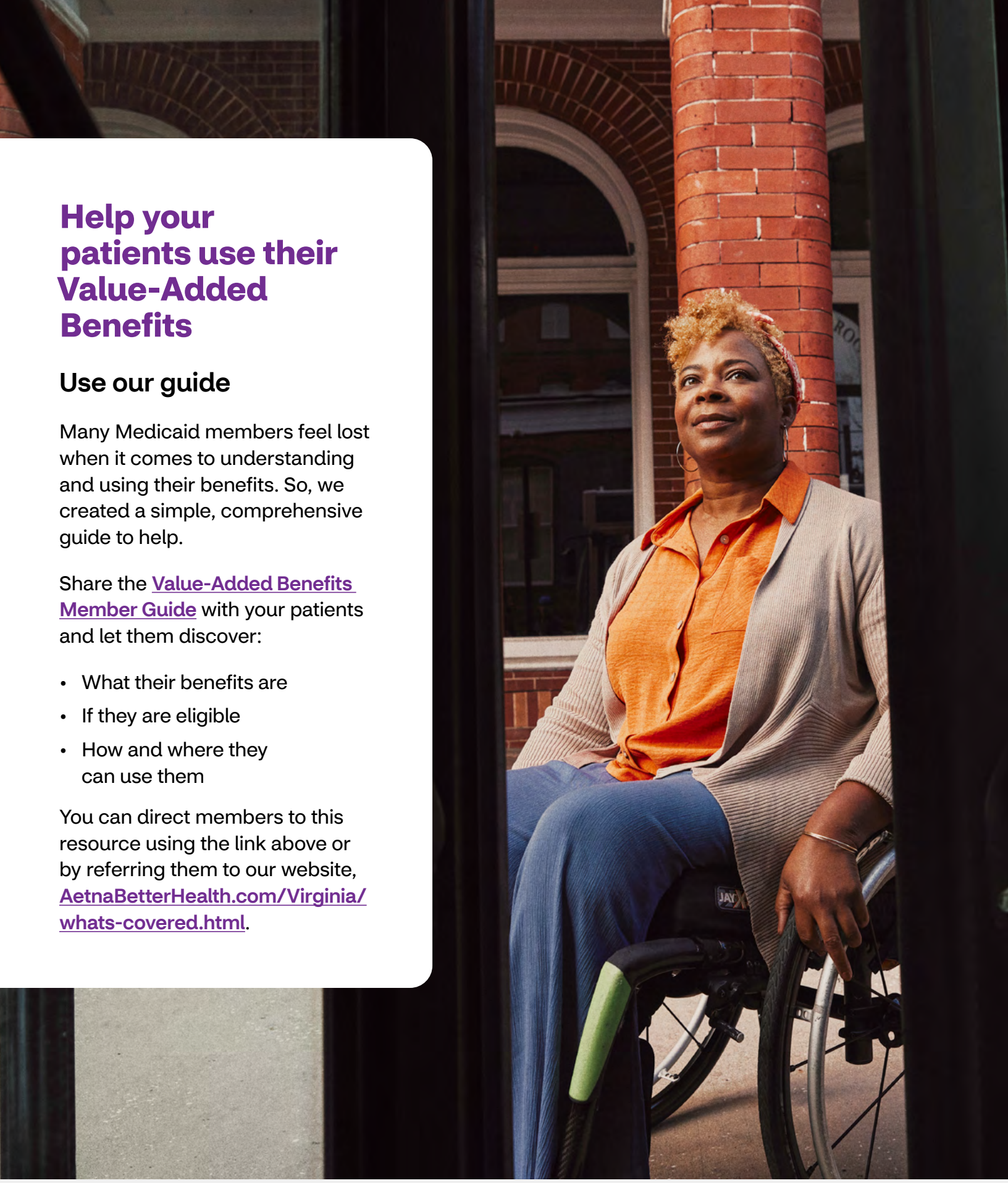
Use our guide

Many Medicaid members feel lost when it comes to understanding and using their benefits. So, we created a simple, comprehensive guide to help.

Share the Value-Added Benefits Member Guide with your patients and let them discover:

- What their benefits are
- If they are eligible
- How and where they can use them

You can direct members to this resource using the link above or by referring them to our website, AetnaBetterHealth.com/Virginia/whats-covered.html.



Our Community Resource Directory (CRD) is on Availity!

You can use Aetna Better Health of Virginia's Provider Portal, Availity, to access the CRD – a tool for finding resources to support members, like food, housing, mental health support, and more.

With access to the CRD in Availity, you can create referrals for members to address many needs related to social determinants of health. This holistic approach ensures that the care team has multiple touch points with members. That's because the CRD interfaces seamlessly with other platforms, such as our Care Management documentation and reporting systems, as well as our members' Medicaid Web Portal.

Data from the CRD highlights the most commonly requested categories by members and the community organizations that have received the most referrals over time.

Access the CRD in Availity Now

First, navigate to Availity. Then, under Payer Spaces, select Aetna Better Health > Applications > Medicaid Community Resource Directory.

New to Availity? Learn how to get started.

The Power of Patient Feedback

Good care is about more than just clinical outcomes. It's also about how patients feel about the care they receive. One of the best ways to understand and improve patient satisfaction is simple: **ask them**.

Collect feedback, continuously

Use tools, like online surveys or feedback forms, to ask patients directly about their experience. Ask them about wait times, communication, or their overall experience. That feedback helps identify what's working and what needs attention.

Why it matters

- Build trust
- Patients feel heard and valued
- Spot trends
- Uncover recurring issues or strengths
- Drive improvement
- Use feedback to improve service delivery, workflows, and staff training

Tip for action

Start small. Add a short satisfaction question to your discharge process or follow-up calls. Over time, build a system that turns feedback into action.

Community resources for our members in need

Aetna Better Health of Virginia's Population Health Management (PMH) program shows that health is more than just optimal delivery of clinical care.

It's also about the well-being of the total population within communities, including social determinants of health, such as socio-cultural background, economic factors, and the reduction of barriers pertaining to access to food, safety, and other resources.

Our PHM programs allow us to meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals.

You can refer a member by directing them to call Member Services at **1-800-279-1878 (TTY: 711)**.

Or, if you would like to offer direct assistance to members in need, feel free to review our list of community resources on our website here.

Important formulary information

Visit our Pharmacy page on our website here for important formulary information, such as the formulary and search tool and formulary updates.

Review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health member.

Quality management spotlight

Provider resources for using the Medicaid Enterprise System

Home and community-based services

Aetna Better Health understands that improving members' health outcomes requires increased collaboration between you, the professional who provides care, and us, the health plan that covers that care. Our goal is to support waiver providers with resources and offer best practice recommendations to ensure our community-based members receive the best quality care.

DMAS released an updated CCC Plus Waiver Provider Manual (Chapter IV) on December 29, 2023. You can access the manual through the Medicaid Enterprise System (MES) portal. The website includes valuable information, such as provider enrollment, training, FAQs, memos, bulletins, user guides, and more.

Personal Care Aides (PCAs)

Providers must evaluate each personal care aide hired to ensure compliance with qualifications, as required by DMAS.

- The aide must complete a minimum 40-hour training program consistent with DMAS requirements that includes special training related to meeting the needs of older adults and those with disabilities.
- The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements.

Providers can meet the DMAS requirements by developing and offering a 40-hour training program for personal care aides. The program should incorporate elements that the aide will need to know to be able to provide safe, quality care to members.

This training must be conducted by an RN who meets the RN staffing requirements for personal care/respite providers. All graduates from the 40-hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion.

Utilization Management (UM)

To support UM/prior authorization decisions, we use nationally recognized, and/or community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

UM/prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Virginia policies and procedures. For prior authorization of elective inpatient and outpatient medical services, we use the following medical review criteria.

Criteria sets are reviewed annually for appropriateness to Aetna Better Health of Virginia population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate practitioners and providers in developing, adopting, or reviewing criteria.

The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting practitioners and providers when appropriate.

These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- MCG guidelines
- Aetna Medicaid Pharmacy Guidelines
- Level of Care Utilization System behavioral health services for adults
- American Society of Addiction Medicine substance use services
- Aetna Clinical Policy Bulletins
- Aetna Clinical Policy Council Review

Medical, behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

A free copy of individual guidelines pertaining to a specific case is available for review upon request by calling **1-800-279-1878**.

Need help? Visit our website.

Then, select each section to learn about:

- Member Rights and Responsibilities.
- UM, including how to reach UM staff by phone and after hours, how we make decisions.
- Our affirmative statement about incentives.
- How to obtain UM criteria.
- Clinical Practice and Preventive Guidelines.
- Medical Record Review Standards.
- Our Care Management programs and referrals.
- Available language services and TTY for referrals.

Access and availability standards

We use accessibility/availability standards based on requirements from NCQA, state, and federal regulations. These standards are communicated to providers and members newsletter, our website, and as part of the provider manual.

Federal law requires that participating providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those offered to Medicaid fee-for-service members.

Providers who do not meet these access standards are provided recommendations for improvements in order to meet the set standard.

The timely access standards for PCPs, behavioral health providers, and prenatal providers can be reviewed in the chart below.

Provider	Appointment	Availability standard
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
Behavioral Health	Non-life-threatening emergency	Within 6 hours
	Urgent care	Within 24 hours
	Initial visit routine care	Within 5 business days
Prenatal	First trimester	7 calendar days
	Initial second trimester	7 calendar days
	Third trimester and high risk	3 working days from date of referral or immediately, if an emergency exists