Provider newsletter

Spring 2026

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AetnaBetterHealth.com/Virginia

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Aetna Better Health® of Virginia

Our transportation vendor has changed

Aetna Better Health of Virginia is transitioning our transportation benefit vendor from ModivCare to MediDrive, effective ***April 1, 2026***. All rides covered by Aetna Better Health of Virginia will be managed by MediDrive. ModivCare will no longer handle these services.

1. **Will members lose any benefits or services due to this change?**

   No, the transportation benefit and limits are not changing. Members will continue to have access to rides as before. Only the transportation vendor is changing, not the scope or availability of the benefit.

   As a reminder, our value-added benefit offers free rides (15 round trips or 30 one-way trips each year) to places like the grocery store, farmers market, food bank, food pantry, place of worship, library, gym or exercise class, DMV, WIC, and Social Security Office. Benefit limits will not reset. Any used trips from January to March 2026 will be calculated and remaining balances will transfer over to MediDrive.

   Unlimited rides are available for medical appointments and pharmacy.

2. **Do members need to do anything differently to schedule rides?**

   After April 1, 2026, members will schedule rides through MediDrive instead of ModivCare. The transportation phone number will remain the same. However, online, members will be directed to visit member.medidrive.com/login.

3. **What should we tell patients who are concerned about the change?**

   Reassure your patients that their transportation benefit remains the same and that only the vendor managing the benefit is changing. The transition to MediDrive is intended to improve service quality, and support will be available to help with any questions or scheduling needs.

What you need to know about balance billing

Providers are not allowed to bill members for the balance of a bill for any service(s) covered by Aetna Better Health of Virginia.

Aetna Better Health participating providers, by contract, are prohibited from billing any member beyond the member's cost sharing liability, if applicable, as defined on the Aetna Better Health remittance advice.

A provider may seek reimbursement from a member when a service is not a covered benefit and the member has given informed written consent before treatment that they agree to be held responsible for all charges associated with the service.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health Provider Relations Representative to research the complaint.

Aetna Better Health is obligated to notify DMAS when a provider continues the inappropriate practice of balance billing a member.

Providers who balance bill Aetna Better Health members could face the following consequences:

- Termination from the Aetna Better Health network
- Referral to the Virginia Medicaid Fraud Division to open an investigation into the provider's action
- Referral to the Federal Department of Health and Human Services, US Office of Inspector General (HHS-OIG)

Questions about balance billing?

Contact Provider Relations at **1-800-279-1878 (TTY: 711)**, Monday - Friday, 8 AM to 6 PM.

Be more efficient with Availity: Join our Provider Portal

Have you joined our Provider Portal, Availity? With Availity, you can more easily support your patients – our members.

Availity has made it easier for you to:

- Submit appeals and grievances.
- Submit prior authorizations and check their status.
- Submit and check up on claims.
- Plus more!

If you are already registered in Availity, you can simply select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

If you are not registered, we recommend that you do so immediately.

Click here to learn more about Availity Portal Registration.

Go here to register.

Need help?

For registration assistance, call Availity Client Services at **1-800-282-4548** between 8 AM and 8 PM ET, Monday through Friday.

Clinical Practice Guidelines

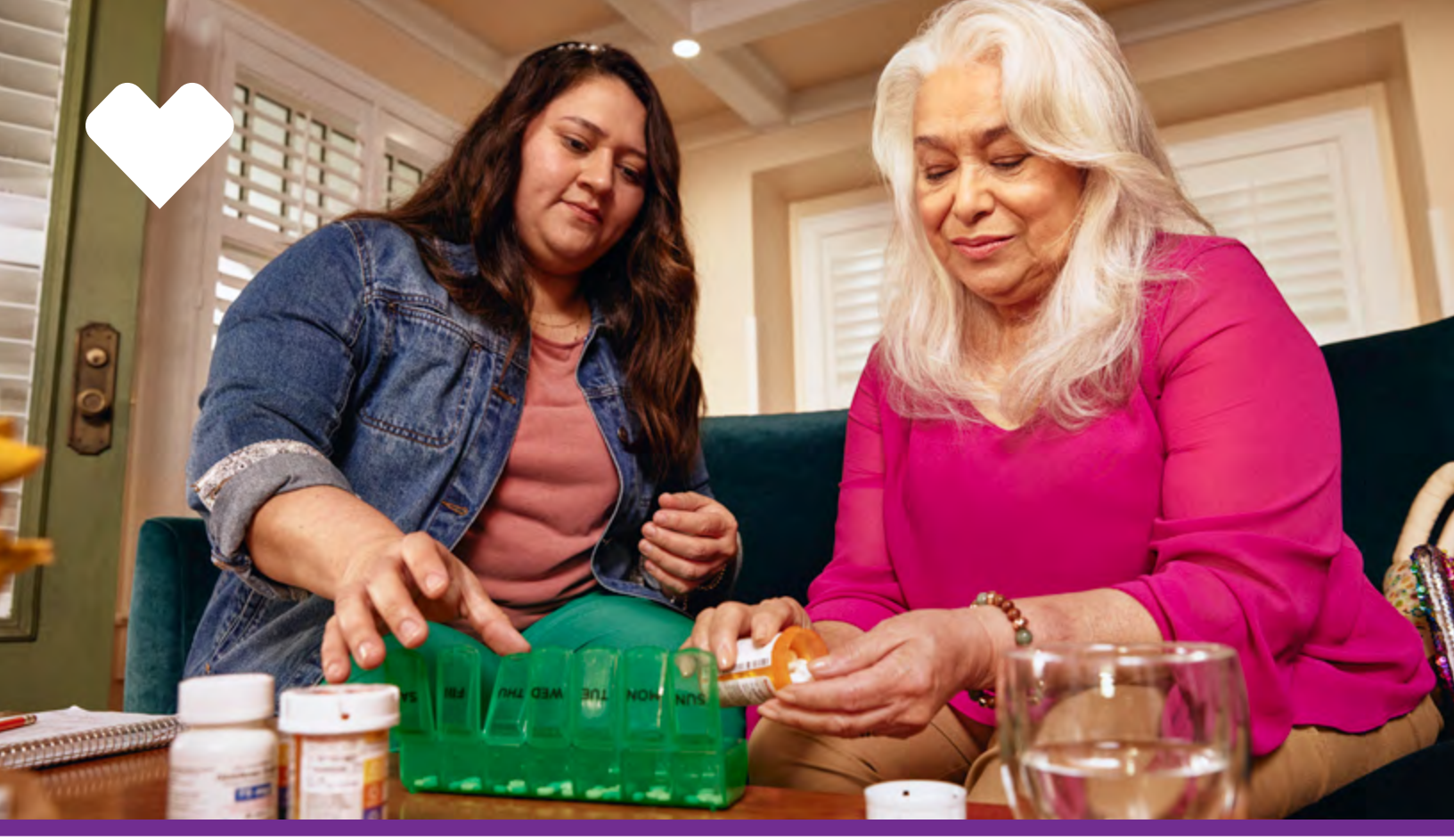
Aetna Better Health of Virginia's Clinical Practice Guidelines and Preventive Services Guidelines are based on nationally recognized recommendations and peer-reviewed medical literature.

The guidelines consider the needs of members, opportunities for improvement identified through our Quality Management program, and feedback from participating providers.

Guidelines are updated as appropriate, but at least every two years.

Learn more

More information about our practice guidelines is on our website at AetnaBetterHealth.com/Virginia/providers. At the bottom of the page, select ***"Clinical practice guidelines."***



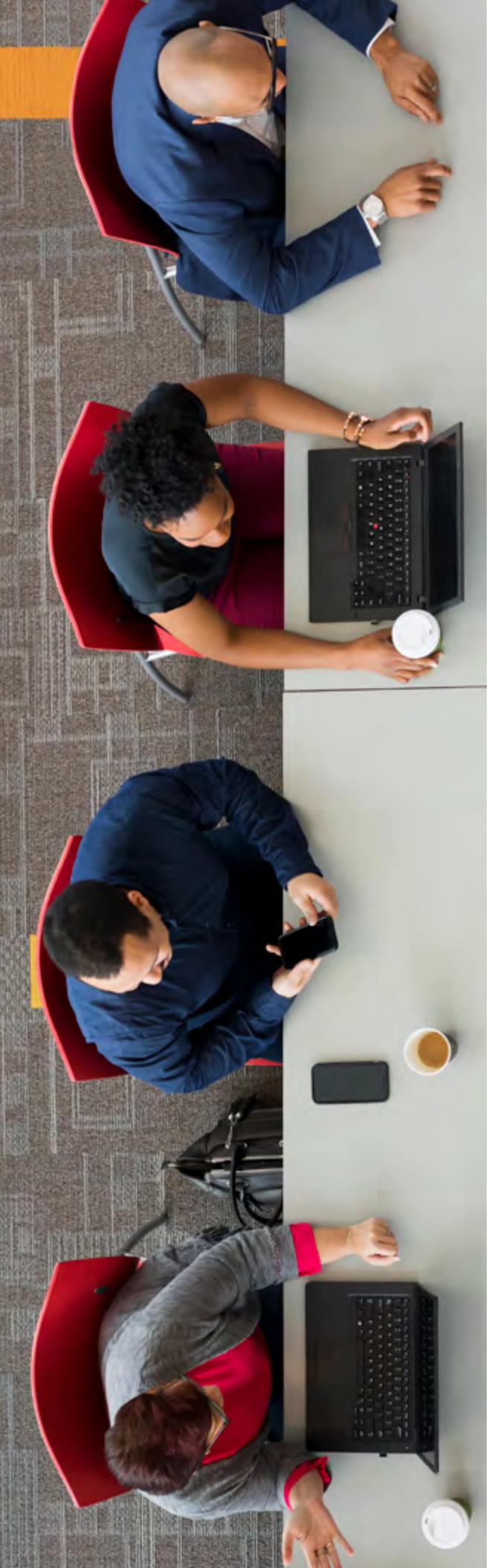
Does your patient need help for a substance use disorder?

The Addiction Recovery and Treatment Services (ARTS) benefit offers many services for members seeking help for opioid or other substance use disorders. ARTS benefits cover a wide range of addiction treatment services which are based on American Society of Addiction Medicine criteria.

ARTS services include the following:

- **Inpatient hospitalization**
- **Residential substance abuse services**
- **Partial hospitalization program**
- **Intensive outpatient program**
- **Medication assisted treatment for opioid use disorders**
- **Care management services**
- **Peer support services**

If you want to learn how our Behavioral Health department can provide support, visit AetnaBetterHealth.com/Virginia.



Help Improve Communication between Treating Providers

A recent survey showed that PCPs are concerned because they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.

This breakdown in communication can pose a risk to quality patient care. We know that coordinating care with many providers, facilities, and behavioral health care professionals can be a challenge.

Important clinical and mental health information to be shared should include:

- Diagnosis.
- Medication.
- Treatment plan.

Providing consistent information about patients to other providers can improve the overall communication between providers through continuity and coordination of care.

Talking with your patients' other treating health care professionals helps you give them the best care. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

Integrated Care Management program

Aetna Better Health of Virginia's Integrated Care Management (ICM) program implements a population-based approach to specific chronic diseases or conditions while engaging the member on an individual basis. All Aetna Better Health of Virginia members with identified conditions are auto-enrolled in the chronic condition program based on claims data.

The chronic conditions managed include:

- Diabetes.
- COPD.
- Asthma.
- Coronary artery disease.
- Depression.
- Congestive heart failure.

The primary goal of our ICM program is to assist our members and their caregivers to better understand their conditions, update them with new information, and provide them with assistance from our staff to help them manage their disease. Members who do not wish to participate can call member services to disenroll from the program at any time.

Services we offer

Services for members with chronic conditions include but are not limited to:

- Coordination of care assistance.
- Disease-specific education and support.
- Assistance in receiving community-based services.

In addition to helping members who have special medical needs, we have care management programs for high-risk pregnancies and opioid management, as well as for pregnant women with substance use disorder and their babies.

Members can be referred to the ICM program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers. We encourage you to refer patients who would benefit from chronic condition management.

Need to refer a patient to Care Management?

Call Member Services at **1-800-279-1878**. We are here to help and look forward to joining you on our members' journey to better health.

Interpreter and translation services is a covered benefit

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the health plan, the provider is financially responsible for associated costs.

For more information, refer to the *"Health Literacy"* section in your Aetna Better Health provider manual. To request interpreter and translation services, call **1-800-279-1878 (TTY: 711)**.

Providers can call interpreters for members

Did you know?

Providers are able to call interpreters for members who need them. There are a few options for requesting interpretation services for both members and providers:

In-person

- The interpreter will meet the member at the location (such as the provider's office).
- Requests should be submitted at least three business days ahead of the appointment.

Over the phone

- Requests can be submitted same day.

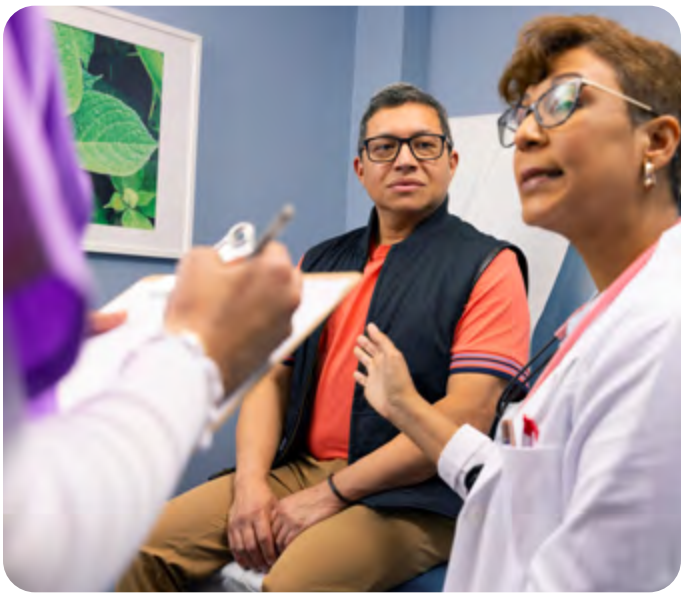
Video (Zoom)

- Requests should be submitted at least three business days ahead of the appointment.
- Emails of each participant are required.

Scheduled video

- The interpreter service provides the link, and the member must have a cellphone.
- Requests should be submitted at least three business days ahead of the appointment.

For more information about having an interpreter available for members, call Provider Services at **1-800-279-1878 (TTY: 711)**.



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.

RN/LPN supervisory visits

The RN/LPN Supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services and to supervise personal care aides. The minimum frequency of these visits is every 90 calendar days.

During the RN/LPN Supervisory visit, the RN/LPN must determine if the Plan of Care continues to meet the individual's needs and document the review of the plan. If it does not, then a new DMAS 97 A/B must be developed and if a change in the amount of hours is needed, the RN/LPN must submit the request to the service authorization contractor for review. Supporting documentation must be included for hours over the Level of Care cap.

A RN/LPN Supervisor must be available to the aides by telephone at all times that an aide is providing services to an individual. A provider may contract with an RN to provide this service. Ongoing assessment of the aide's performance by the RN/LPN Supervisor is also expected to ensure the health, safety, and welfare of the individual.

If the supervising RN/LPN is unable to conduct the regular supervisory visit within required timeframes, it shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver individual's first availability.

Based on continuing evaluations of the aide's performance and the individual's needs, the RN/LPN Supervisor shall identify any gaps in the aide's ability to function competently and shall provide training as necessary. The RN/LPN Supervisor must also perform any subsequent evaluations or changes to the supporting documentation.

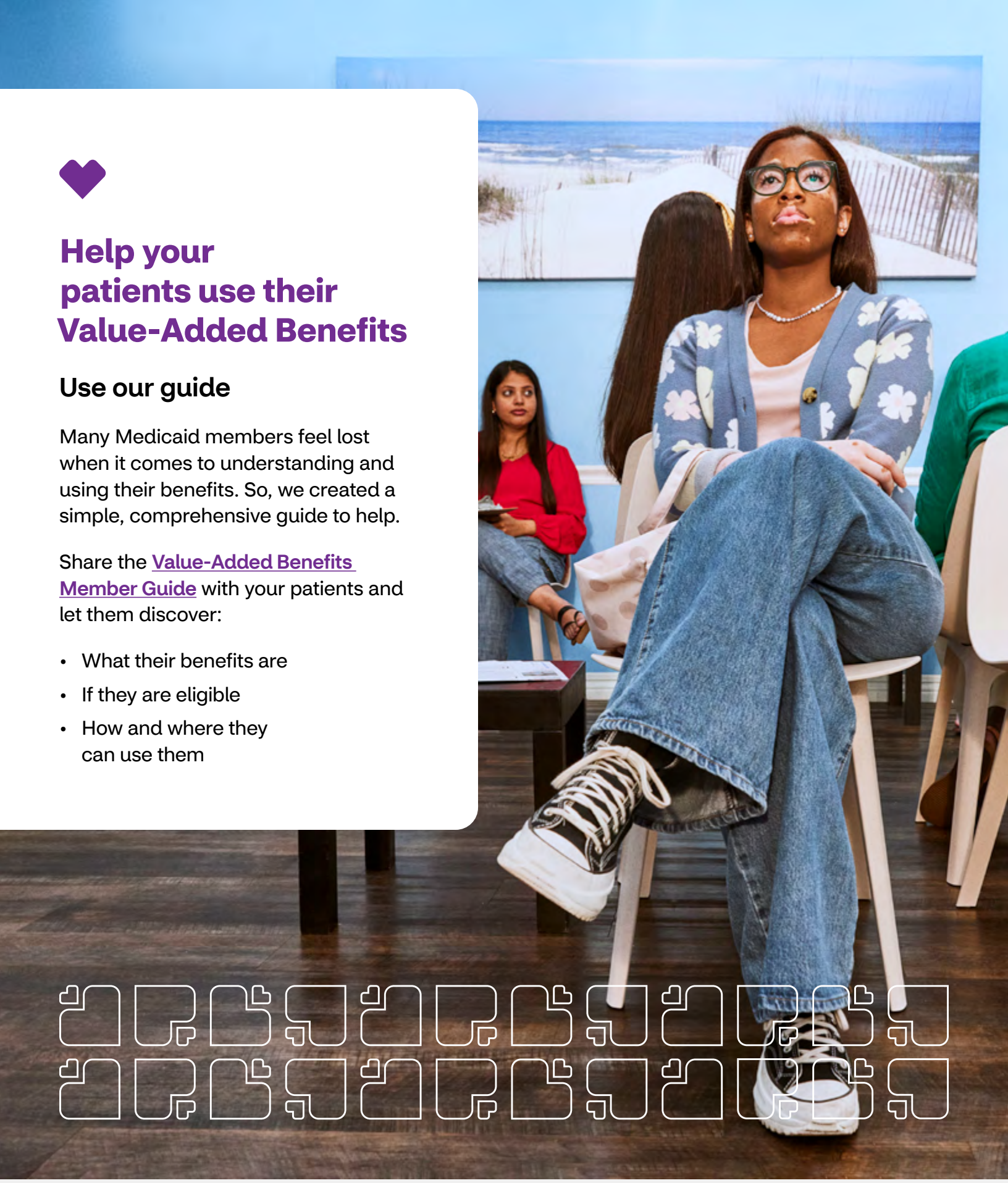
Help your patients use their Value-Added Benefits

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



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