Provider newsletter

Winter 2025

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AetnaBetterHealth.com/Virginia

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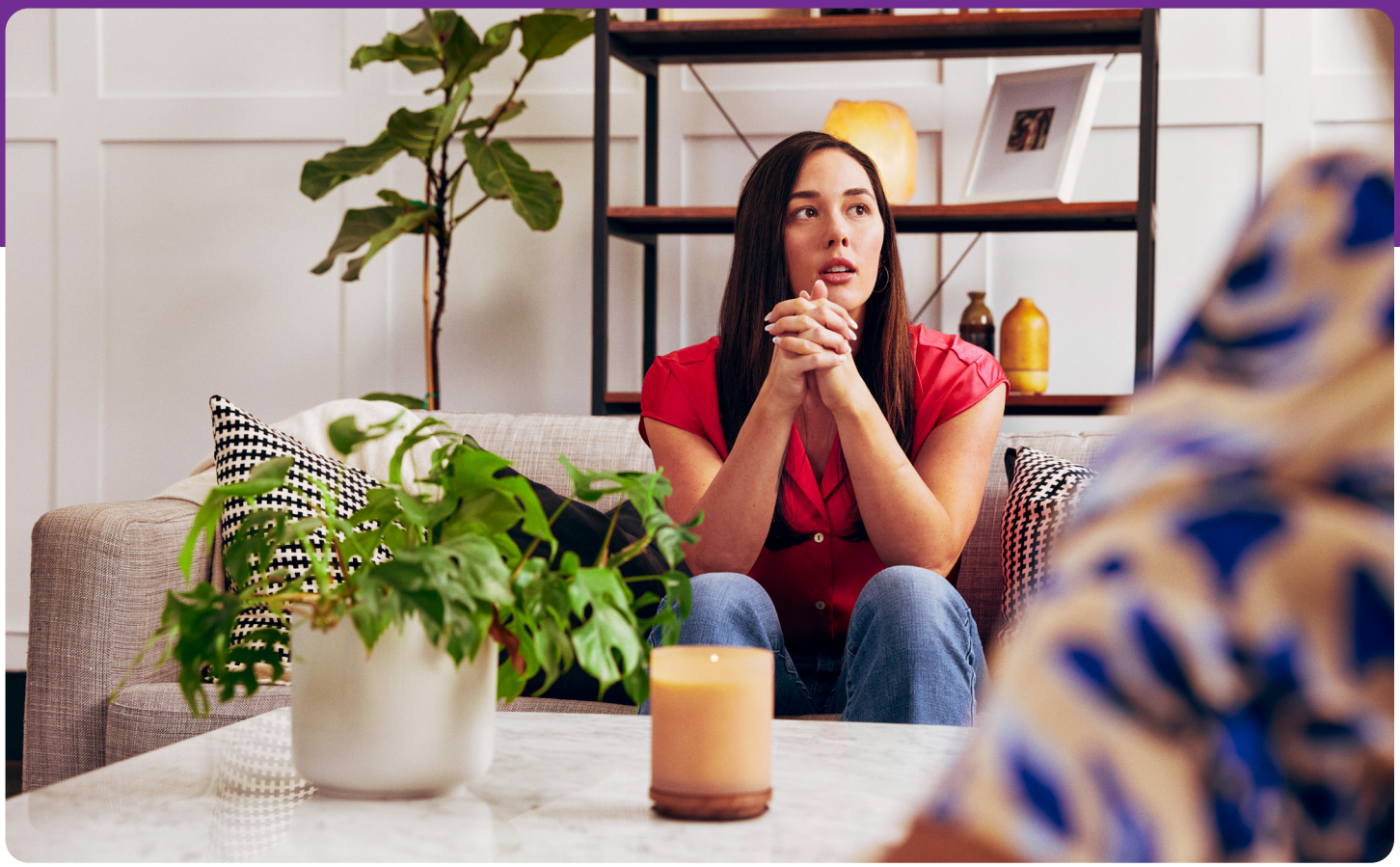
Aetna Better Health® of Virginia

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.

Understanding CAHPS: Why it matters for providers

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** is a nationally standardized survey developed by the **Agency for Healthcare Research and Quality (AHRQ)**. Its purpose is to measure patients' experiences with their health plans and health care providers, like how often patients receive timely care, clarity of communication, and coordination of services.

Why is CAHPS important?

CAHPS results directly influence **quality ratings**, such as Medicaid Star Ratings, and can impact reimbursement and member retention. These surveys ask about critical aspects of care, including:

- Getting needed care and appointments quickly.
- Coordination among providers.
- How well doctors and staff communicate and show respect.

What can providers do?

Every interaction matters. Providers can improve CAHPS scores by:

- Ensuring timely access to care.
- Explaining treatments in clear, easy-to-understand language.
- Listening attentively and addressing patient concerns.
- Coordinating care across specialists and services.

Survey Timeline

CAHPS surveys are typically mailed between **February and May**, with follow-up reminders and phone outreach for non-respondents. Responses are anonymous and help identify opportunities for improvement.

Your Role

Encourage patients to complete the survey if they receive one. Their feedback helps us enhance care quality and improve outcomes for all members.

Best practices for verifying coverage and prior authorization requirements for services

Recently, we've noticed an increase in the number of provider appeals as it relates to prior authorization and non-covered services.

To prevent unnecessary claim denials for these reasons, Aetna Better Health recommends following these guidelines:

1. Verify the member's eligibility and benefit coverage for the services
2. Utilize ProPat to verify whether prior authorization is required
3. Verify the service is a covered service per DMAS via the DMAS Fee Schedule

Learn more

For more information on claim submissions, visit our website or download the DMAS Practitioner Manual.

Important Resources

- Member Eligibility: Call **1-800-279-1878** or use our Availity Provider Portal
- ProPat
- DMAS Fee Schedule*

*Be advised that flag code 999 means non-covered, and rates marked as IC are reimbursed at the individual consideration of the health plan. Once you determine if the code is covered, you may use our prior authorization lookup tool to determine if prior authorization, medical records, etc., are required.

Did You Know? We Cover Doula Services

What can a doula do for your patients?

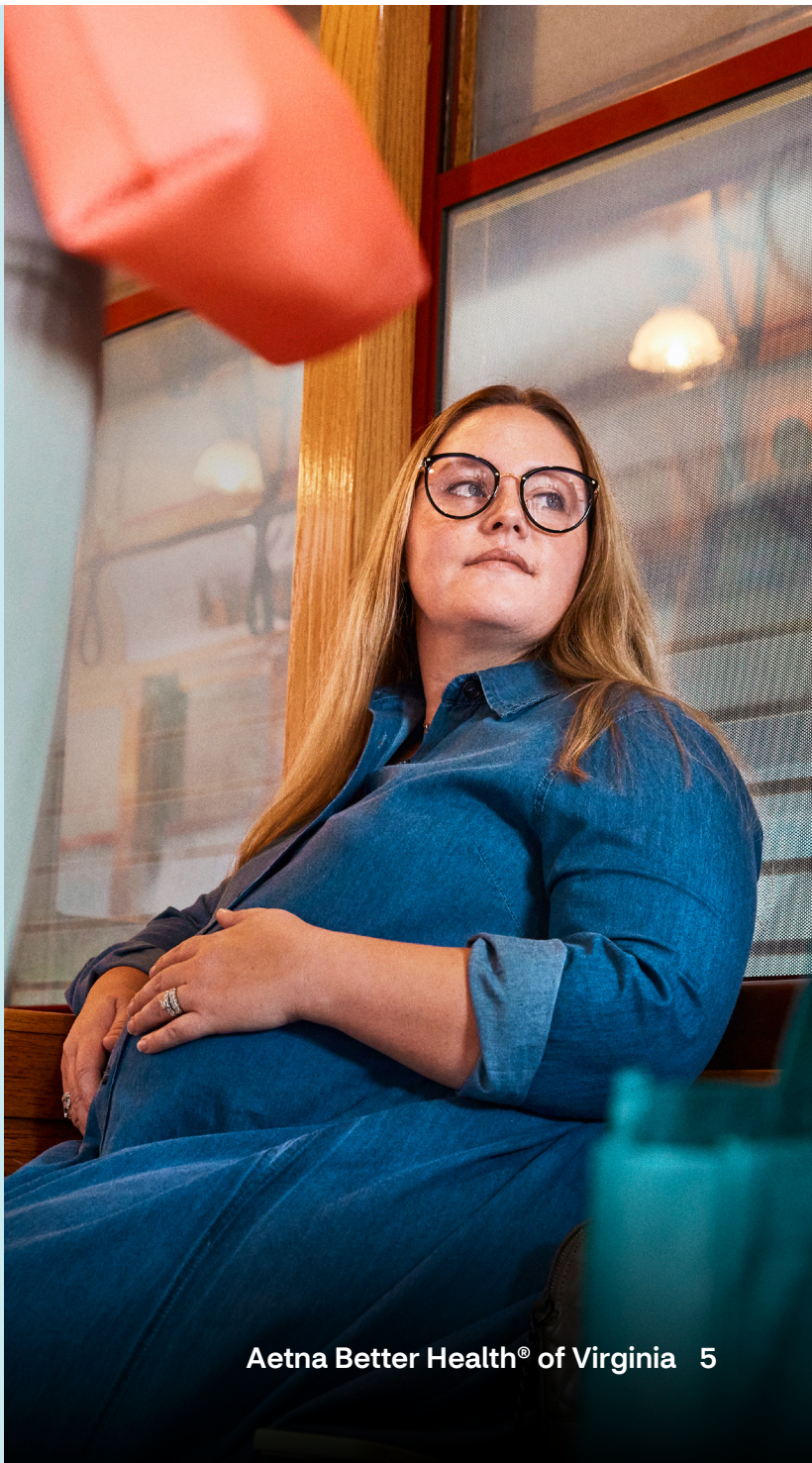
A doula is not a nurse, doctor, or midwife, but, instead, a professional who supports moms, their partner, and their babies by providing both physical and emotional support to expecting mothers during pregnancy, childbirth, and during the postpartum period.

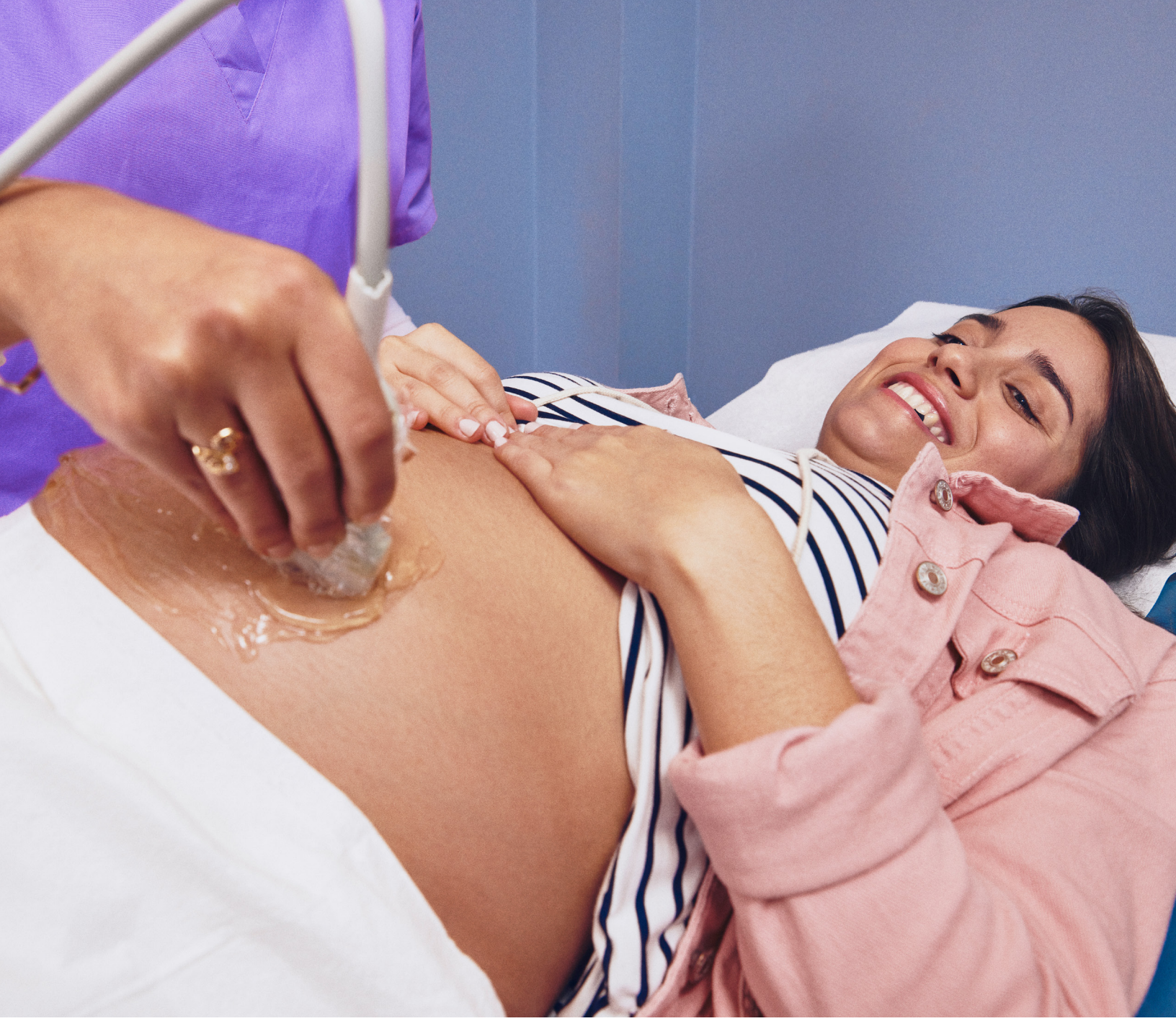
Doulas offer guidance and support to not only expecting mothers, but to their partners and family members as well. They also play a role in facilitating communication between the patient and other health care staff. Some additional services a doula may offer include:

- Physical comfort, such as through breathing techniques or massages during labor and delivery.
- Emotional support and encouragement.
- Information and resources and pregnancy, labor and delivery, and the postpartum period.
- Communication of health care wishes from patient and family to health care providers.
- Non-medical help with breastfeeding.
- Help with caring for newborns, such as bathing and feeding.

Doulas may improve health outcomes and improve patient satisfaction, such as:

- Decreased need for pain relief during labor and delivery.
- Reduced incidence of C-sections.
- Decreased length of labor.
- Increased positive childbirth experiences.





Qualifications to be recognized as a doula vary by state. In Virginia, doulas have to complete specific training requirements and become recognized by the state's certification process. Once this has been completed, doulas can begin providing services to Medicaid members.

For members to receive doula services, they must get a recommendation from their PCP, OB/GYN, therapist, or other identified professional. The Doula Care Recommendation Form must be shared with the doula, and the doula needs this form before services can begin. The completed form can be emailed to AetnaBetterHealthVA-CaseManagement@Aetna.com or faxed to **860-807-4933**.

Better Communication Means Better Patient Care

Treating behavioral health and medical problems together can improve outcomes for both.

How you can help make the connection

Understand

Understand how important it is to communicate regularly with your patients' medical and behavioral health providers.

Your contact helps share clinical information for thorough treatment and continuity of care. It's especially important:

- When patients have coexisting health problems.
- When medications are prescribed.
- If you have medical concerns.

Talk

Talk with your patients about how coordinated care can lead to better results. Ask for their okay for you to communicate with their other treating providers. Working together can mean reduced costs and better results, including:

- Lower mortality.
- Higher satisfaction.
- Lower readmission rates.

Ask your patients to sign a release form

Ask your patients to sign an authorization to release information. Other treating providers need to know diagnoses, treatment plan summaries, medications, referrals, and consultation availability.

Learn more about HIPAA rules for sharing information

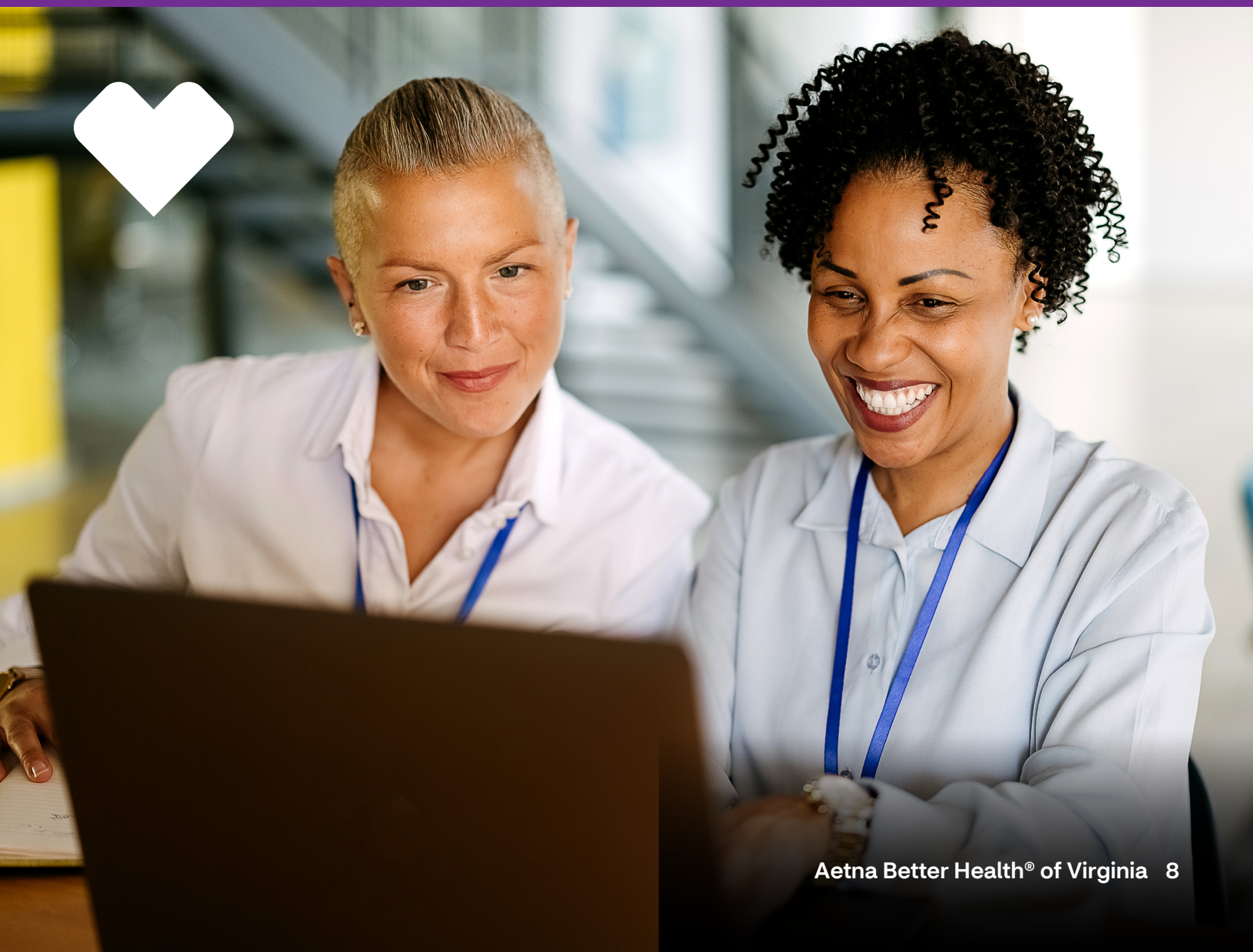
Quality Management Spotlight

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.



Notable formulary changes for select specialty medications effective January 1, 2026

These changes are being made in accordance with the decisions made by the Department of Medical Assistance Service's Pharmacy and Therapeutics Committee in October 2025.

View the memo **here**.

Drug Name	Status	New PDL Status	Notes
Adalimumab-adbm (unbranded Cyltezo)	Added	Preferred	Max dose available 40mg. Multiple units needed for higher doses.
Adalimumab-bwwd (Hadlima)	Added	Preferred	Max dose available 40mg. Multiple units needed for higher doses.
Adalimumab (Humira)	Status Change	Non-Preferred	Branded Reference Product

The preferred biosimilar products are interchangeable with the branded reference product in alignment with the commitment to both optimal clinical outcomes and fiscally responsible health care.

Additionally, **Pyzchiva** (an interchangeable biosimilar for Stelara) is being added as Preferred on **January 1, 2026**.

Existing utilizers with active authorizations will be lettered, including the respective prescriber. Current authorizations will be transitioned to the preferred products.

Additional utilization management may exist.

For more information, visit: aetnabetterhealth.com/virginia/providers/pharmacy.html

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 via 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 for 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.

Measure	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	Seven calendar days
	Initial second trimester	Seven calendar days
	Third trimester and high risk	Three working days from date of referral or immediately, if an emergency exists