Aetna Medicare Dual Core (HMO SNP)

Provider training

January 2018

Training outline

- **Aetna Medicare Dual Core (HMO SNP) plan overview**
- **Supplemental benefits**
- **Prior authorization (PA) requirements**
- **Claims submission**
- **Participating provider disputes**
- **Provider responsibilities**
- **Cultural competency**
- **Secure provider portal**
- **Contacts and resources**

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Overview

Aetna Medicare Dual Core (HMO SNP)

What is it?

Aetna Medicare Dual Core (HMO SNP) is a Medicare plan offered to dual-eligible individuals in select counties in Texas.

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What is a DSNP?

SNPs (Special Needs Plan) are benefit plans customer designed to meet the needs of specific groups of members with special healthcare needs.

The DSNP is available to eligible members:

- Residing within the program's service area.
- Meeting dual-eligibility status requirements.

In many states, we'll enroll partial-benefit duals as well as full-benefit duals.

For this plan, we are accepting one partial-dual population: Qualified Medicare Beneficiaries (QMB) and three full-dual populations: Qualified Medicare Beneficiary Plus Medicaid (QMB+), Specified Low-income Medicare Beneficiary Plus Medicaid (SLMB+) and Full Benefit Dual Eligible (FBDE).

Dual Eligibility qualifications is determined by the member's enrollment in:

- A federally administered Medicare program based on age and/or disability status.
- The state-administered Medicaid program based on low income and assets.

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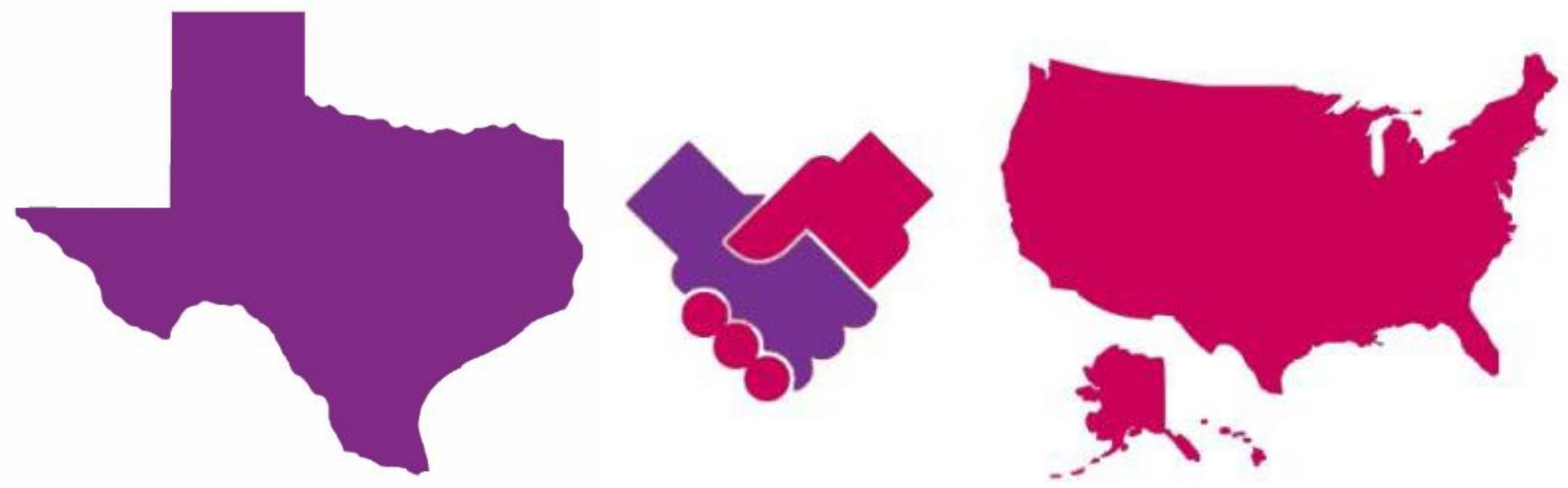
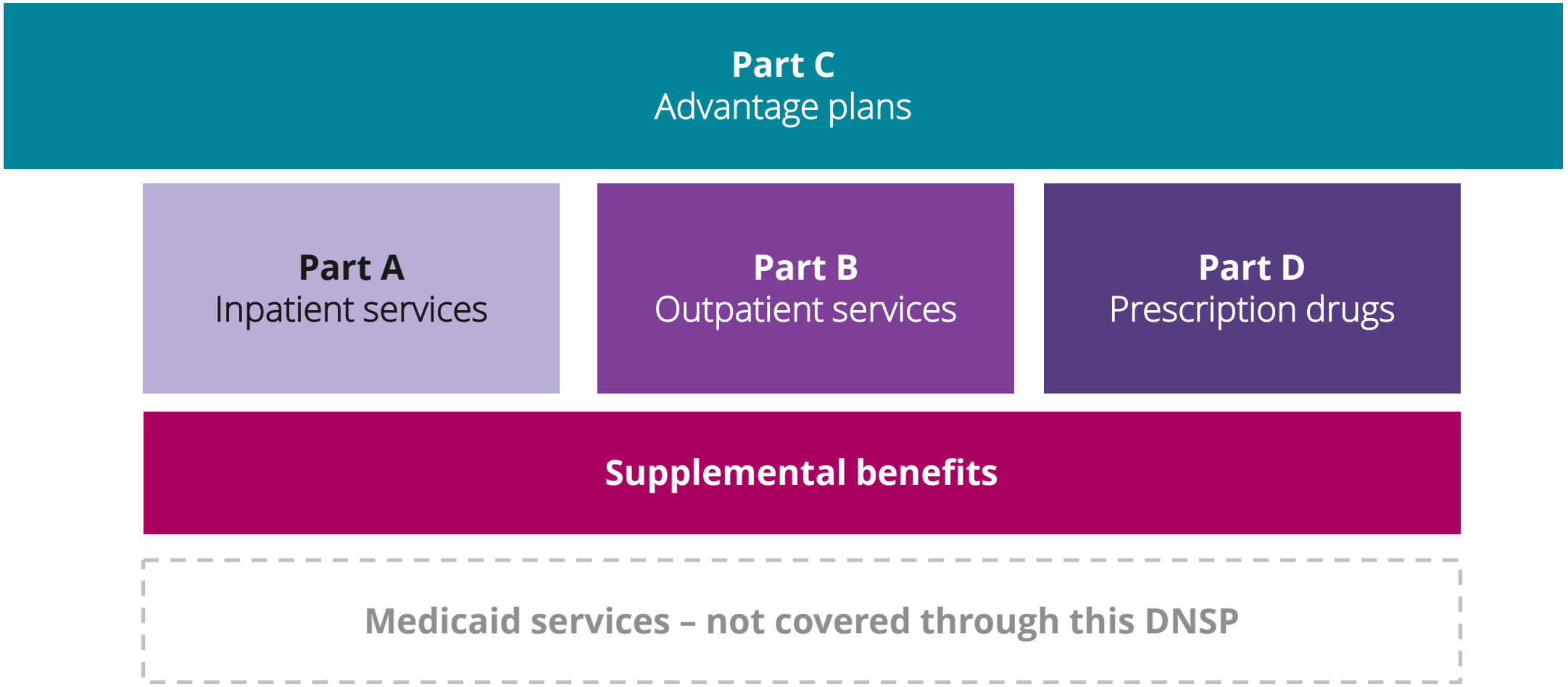
Aetna Medicare Dual Core (HMO SNP)

A Duals Special Needs Plan (DSNP) is a type of Medicare Advantage plan for dual-eligible individuals.



Medicare Advantage (MA) plans

This particular Medicare Advantage plan is a Medicare Advantage Prescription Drug (MAPD) plan.



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Part A covered services: “Hospital insurance”

Inpatient care in a hospital

Inpatient care in a skilled nursing facility (SNF)

Hospice care

Home health

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Part B covered services: “Medical insurance”

There are numerous Part B covered services. The complete list may be found in the Medicare and You handbook.

Preventative Services

(cancer screenings, flu shots)

Diabetes supplies

(testing strips, lancets)

Durable medical Equipment (DME)

(wheelchairs, walkers)

Lab services

(blood tests, tissue specimen)

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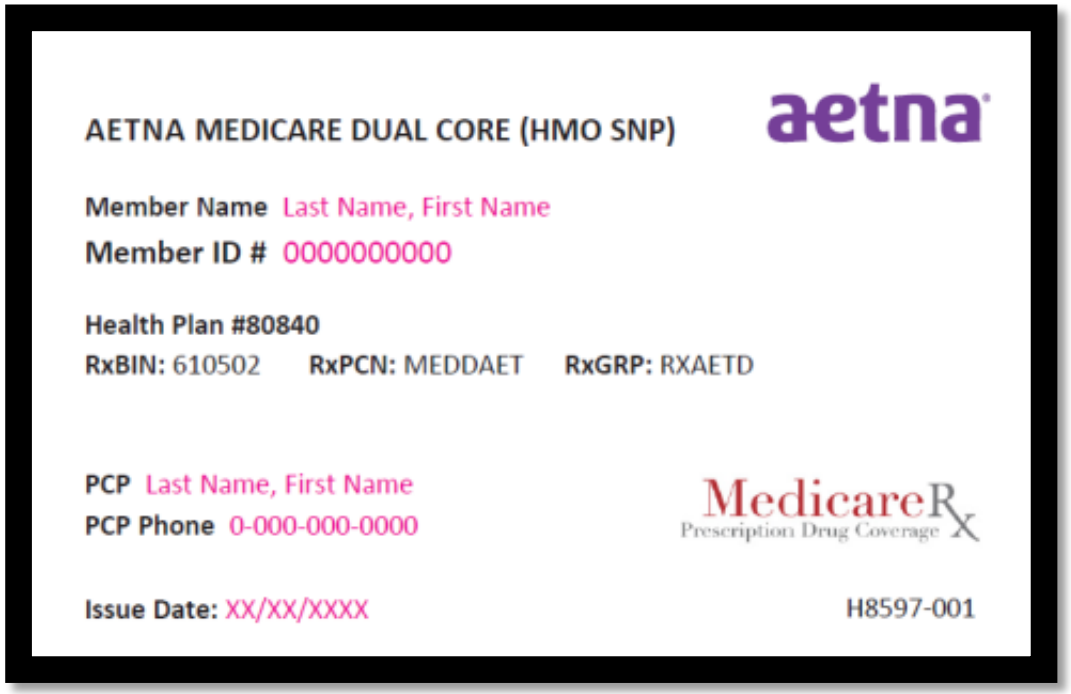
Member ID Card

Information on the Dual Core member ID card can help you file claims more efficiently and accurately.

Be sure to obtain a copy of the member ID card, as well as their Medicaid ID card for your files.

The member ID card also contains information pharmacies will need to fill prescriptions.

Providers should remind patients to bring both their Dual Core ID card and their Medicaid ID to the pharmacy when they have a prescription filled.



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Member Eligibility

Dual-eligibility

Based on age, financial resources and disability status.

Medicare

- Must maintain Medicare eligibility based off age or disability.

Medicaid

Must maintain Medicaid eligibility in their state of primary residence.

Member Eligibility (cont'd)

Dual eligibility

As a reminder, there are different types of dual-eligibility.

Aetna Medicare Dual Core (HMO SNP) accepts three styles of full-benefit dual eligibility and one style of partial-benefit dual eligibility.

Full benefit dual eligible

Medicare cost-share protection and full Medicaid benefits

QMB Plus: Qualified Medicare beneficiaries with full Medicaid

FBDE : Full benefit dual with Medicaid

SLMB Plus: Specified low-income Medicare beneficiaries with full Medicaid

Partial benefit dual eligible

Medicare cost-share protection only (no Medicaid benefits)

QMB-only: Qualified Medicare beneficiary

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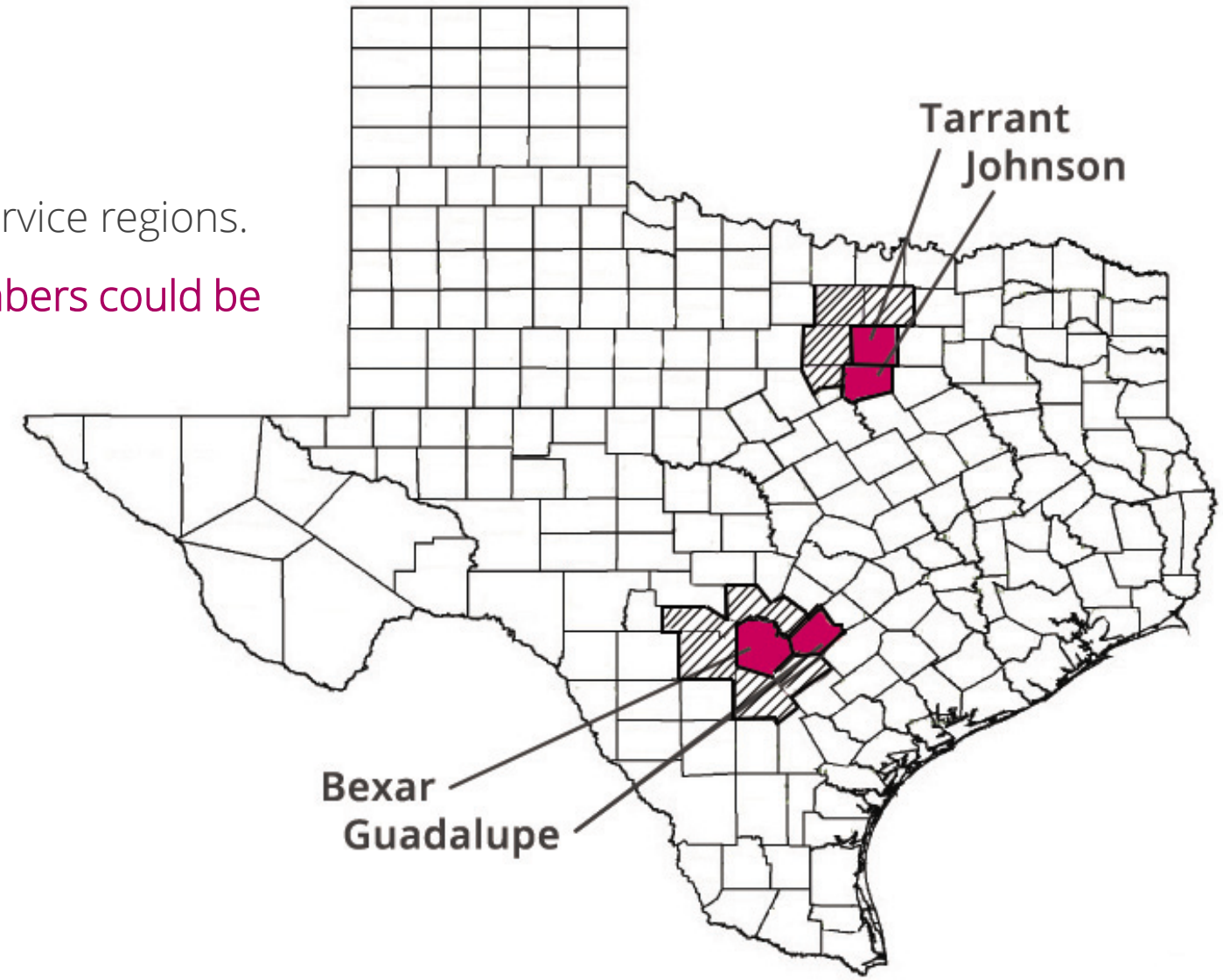
Member Eligibility (cont'd)

Service area-based eligibility

- 4 counties in total.
- Situated inside of current Medicaid service regions.
- If Medicare eligible, your current members could be eligible.



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Enrollment Timeline

When is it happening?

October 15, 2018

Open enrollment began.

Eligible beneficiaries allowed to sign up for the plan.

January 1, 2019

Coverage year (CY) 2019 benefits became effective for all active enrollees.

Important Plan Details

- This is a health maintenance organization (HMO) plan.
- Providers who are already contracted with Aetna Medicare HMO will also be a provider for this DSNP.
- There are 10 supplemental benefits offered by this plan.

Supplemental Benefits

Supplemental Benefits

	Fitness Membership	OTC Assistance	Smoking Cessation	Health Education	Remote Access Technologies	Outpatient Blood Services	Vision
Vendor	Silver Sneakers	CVS	Aetna	Aetna	Aetna	Aetna	VSP Vision Care
Coverage	Free access to approved gyms and fitness classes	$25 per month toward approved OTC medications	Smoking cessation products and services	Information for resources to members for a healthier lifestyle.	Nurse Hotline available 24 hours a day, 7 days a week	Waives deductible associated with the first 3 pints of blood received.	1 routine exam, $100 to use towards contacts, glasses and frames.
Important Notes		The $25 is a “use it lose it” benefit each month	Nicotine Replacement Therapy (NRT), such as patches, gums and lozenges, are not covered as part of this benefit				

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Supplemental Benefits (cont'd)

	Hearing	Non-Emergent Transport	Dental			
Vendor	Hearing Care Solutions	Access2Care	DentaQuest			
Coverage	1 routine exam, 1 fitting, $500 per ear for hearing aids	24 one-way trips to approved locations	$500 max benefit for preventative and comprehensive care			
Important Notes						

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Prior Authorizations

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Prior Authorization: Overview

Providers are responsible for complying with Aetna's prior authorization (PA) requirements, policies and request procedures as well as for obtaining an authorization number to be reported on their claims.

A list of services that require prior authorization can be found on our website at https://www.aetnabetterhealth.com/texas-hmosnp

The Secure Provider Portal Authorization Tool gives providers the ability to

- Search PA requirements by individual or multiple Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) codes simultaneously.
- Review PA requirements by specific procedures or service groups.
- Receive immediate details as to whether the codes are valid, expired, a covered benefit, have PA requirements, and any noted PA exception information.
- Export CPT/HCPS code results and information to Excel.
- Ensures staff works from the most up-to-date information on current PA requirements

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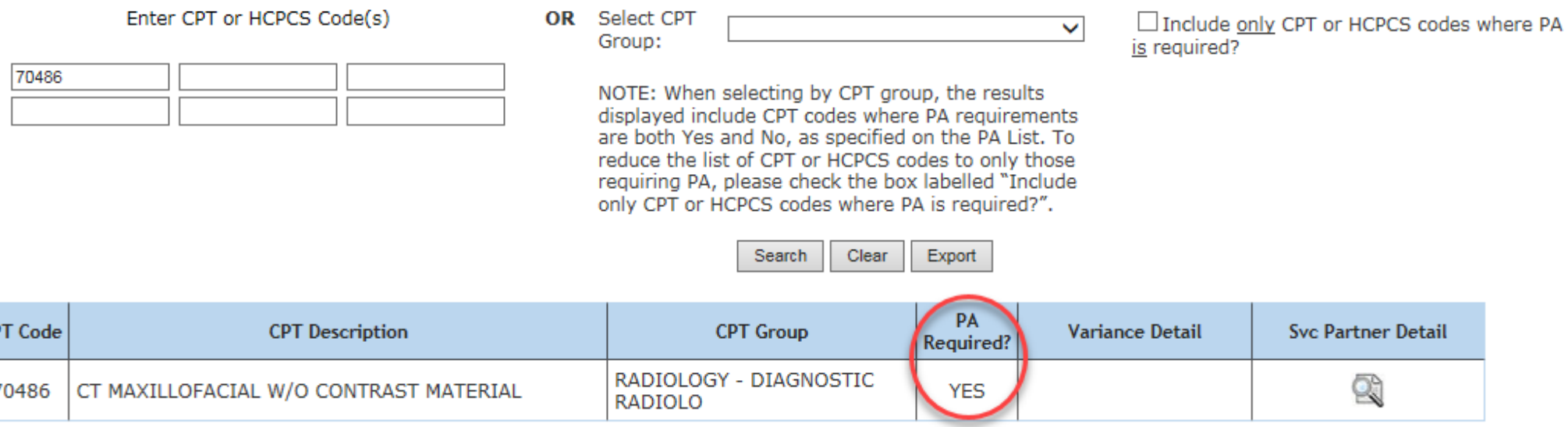
Prior Authorization: Search Tool

The "PA Requirement Search Tool" is used to determine if prior authorization (PA) is required.

Authorizations must be obtained in advance of services being provided.

Enter up to six CPT/HCPCS codes or a CPT group and select SEARCH.



CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc Partner Detail
70486	CT MAXILLOFACIAL W/O CONTRAST MATERIAL	RADIOLOGY - DIAGNOSTIC RADIOLO	YES		

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Prior Authorization: Search Tool Definitions

Search result definitions

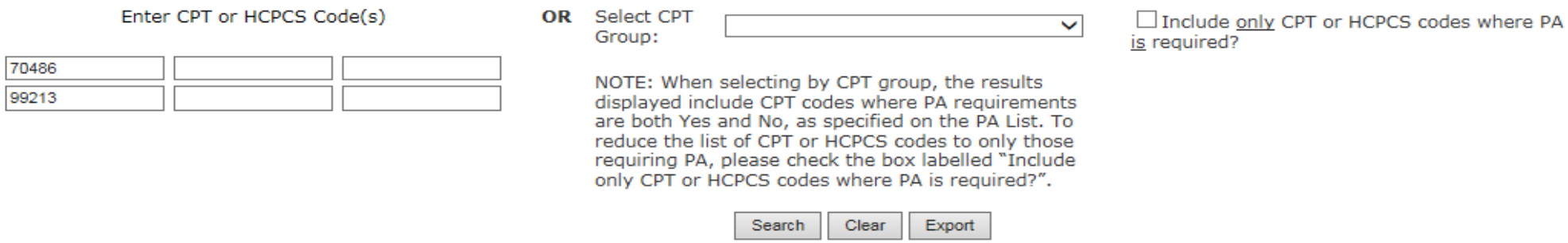
YES - Prior authorization request is required for this service.

NO - Health plan does not require a prior authorization request for this service.

NON-COV - CPT or HCPCS code entered is not a covered benefit by health plan.

INVALID - CPT or HCPCS code entered was invalid, not found.

EXPIRED - CPT or HCPCS code entered is no longer valid for use by health plan providers.



CPT Code	CPT Description	CPT Group	PA Required?	Variance Detail	Svc Partner Detail
70486	CT MAXILLOFACIAL W/O CONTRAST MATERIAL	RADIOLOGY - DIAGNOSTIC RADIOLO	YES		
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	E & M - OTHER E/M SERVICES	NO		

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How to Request a Prior Authorization

A prior authorization request may be submitted in one of three ways

1. Submitting the request through the 24-hours-a-day, 7-days-aweek Secure Provider Web Portal located on our website (only available to contracted providers)

2. Faxing the request form to 1-855-870-8009 (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.

3. Calling us directly at 1-800-371-8614.

Other helpful information

DSNP UM/FAX Lines	Toll Fax number	Toll Free Fax Number
TX DSNP IP/ Concurrent Review	959-282-8788	866-277-7036
TX DSNP NOMNC	959-282-8800	855-490-6553

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Claims Submission

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How to Bill

A claim may be submitted in one of two ways

1. Electronic claims through provider's own clearinghouse.
    - Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare, using the 837 file format.
    - Please use Submitter ID #38692 when submitting electronic claims.
2. Paper claims
    - Mail to Aetna Medicare Dual Core (HMO SNP)
PO Box 60938
Phoenix, AZ 85082-4205

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Claims Submission Timeframes

To best ensure timely and accurate payment of your claim, submit a "clean claim".

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Clean claims are processed according to the following timeframes:

- 90% of clean EDI claims adjudicated within 30 days of receipt
- 99% of clean paper claims adjudicated within 90 days of receipt

Timely filing of claim submissions

- In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:
  - *New Claim Submissions* –Please consult your contract for your contractual timely filing limit for new claims.
  - *Claim Disputes & Resubmissions* – Please consult your contract for your contractual timely filing limit for disputes and corrected claims.
- Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial

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Claims Submission Nomenclature

- Claim numbers are assigned using the year and then the Julian date.
  - For example, 19001 at the beginning of a claim would indicate that claim was received on the First day of 2019.
- A claim beginning with 19365 would indicate that claim was received on the last day of 2019.
- Claim Indicators:
  - "R" indicates a reversal of a claim and proceeds the adjustment (if applicable) of the claim. The number following "R" represents the number of times the claim has been reversed.
    - Example: 19001E999999R1
  - "A" indicates an adjusted claim and follows the original claim number. This claim is created after the reversal of the original claim. The number following "A" represents the number of times the claim has been reprocessed.
    - Example: 19001E999999A1

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Participating Provider Disputes

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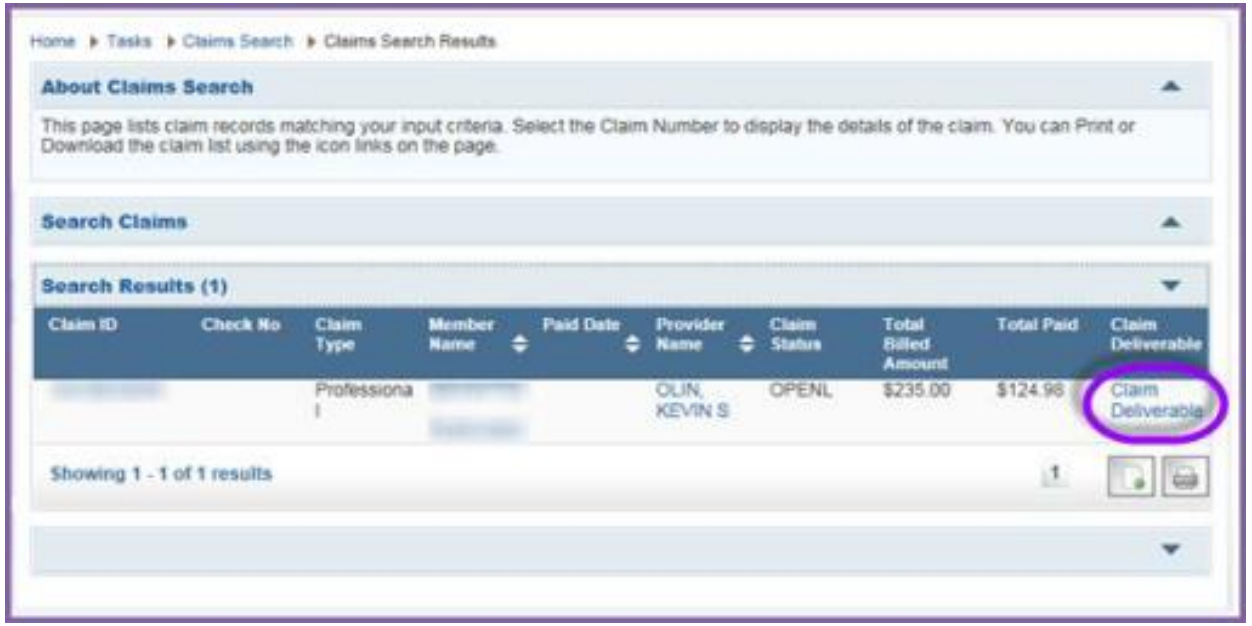
Dispute Process for Contracted Providers

As a contracted provider, if you disagree with a claim decision Aetna Medicare Dual Core (HMO SNP) has made, there are two options:

1. Use the Secure Web Portal to dispute the claim electronically after locating the claims on the right
2. Fill out the and return the Provider Dispute form and mail to our P.O. box.



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Dispute Process for Retro Authorization Requests

- Aetna is willing to consider a retro authorization, but each case is reviewed separately by our UM department for final determination.
- Retro authorizations will not be considered for a claim with a date of service (DOS) more than six months old, unless the provider's contract states differently.
- Participating providers must submit a dispute with all required supporting documentation to have a retro authorization considered.
- The dispute form must be marked as "retro authorization request".

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Provider Responsibilities

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Provider Responsibilities: Overview

Providers are contractually obligated to adhere to and comply with all terms of their contract as well as their provider manual.

Providers are required to:

- Act lawfully in their scope of practice for the treatment, management, and discussion of medically necessary care
- Make certain to use the most current diagnosis and treatment protocols and standards.

Providers cannot:

- Refuse treatment to qualified individuals with disabilities.
- Discriminate against enrollees based on their payment status, e.g., QMB. Specifically, providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing
- Providers and suppliers, including pharmacies, must refrain from collecting Medicare cost sharing for covered Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability.
- Become a part of the network if they have been excluded from participation in any federal or state funded healthcare program.

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Provider Responsibilities: FDR

First-Tier, Downstream and Related Entities (FDR) Training

If you are a participating provider in our network, and you have not already done so, you and your staff must complete the *Medicare Compliance FDR Attestation*.

All contracted providers of Medicare (Parts C and/or D) or Medicaid must complete an annual *Medicare Compliance Attestation* by December 31st of each year.

If you do not comply each year, your participation status could be affected.

To complete your attestation, please visit our website at https://www.aetna.com/health-care-professionals/medicare.html and click the "*Medicare Compliance FDR Attestation*" link.

Provider Responsibilities: Telephone Accessibility

After hours coverage is defined as being available (or having on-call arrangements in place) for determining the need for emergency and other after hours services, such as authorizing care and verifying member enrollment, as well as offering medical advice.

- It is our policy that network providers cannot use an answering service as a replacement for on-call coverage.
- All providers must have a published after hours telephone number and maintain a system that will provide access to primary care 24-hours-a-day, 7-days-a-week.

Please notify Aetna's Provider Services department if a covering provider is not contracted or affiliated with Aetna.

- Notification must occur in advance of providing authorized services.
- Failure to notify our Provider Services department of the covering provider's affiliation may result in claim denials and the provider may be responsible for reimbursing the covering provider.

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Cultural Competency

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Cultural Competency

Provider relation liaisons (PRLs) will conduct initial cultural competency training during provider orientation meetings. Our *Quality Interactions*® course series is available to providers who wish to learn more about cultural competency. This course is designed to help you with the following:

- 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:

https://www.hrsa.gov/culturalcompetence/index.html

To get Cultural Competency training credit, send the provider's information to TX_DualCore_ProviderServices@aetna.com upon completion of the course.

Completion of this training may also be included in the provider directory for members to see.

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Secure Provider Portal

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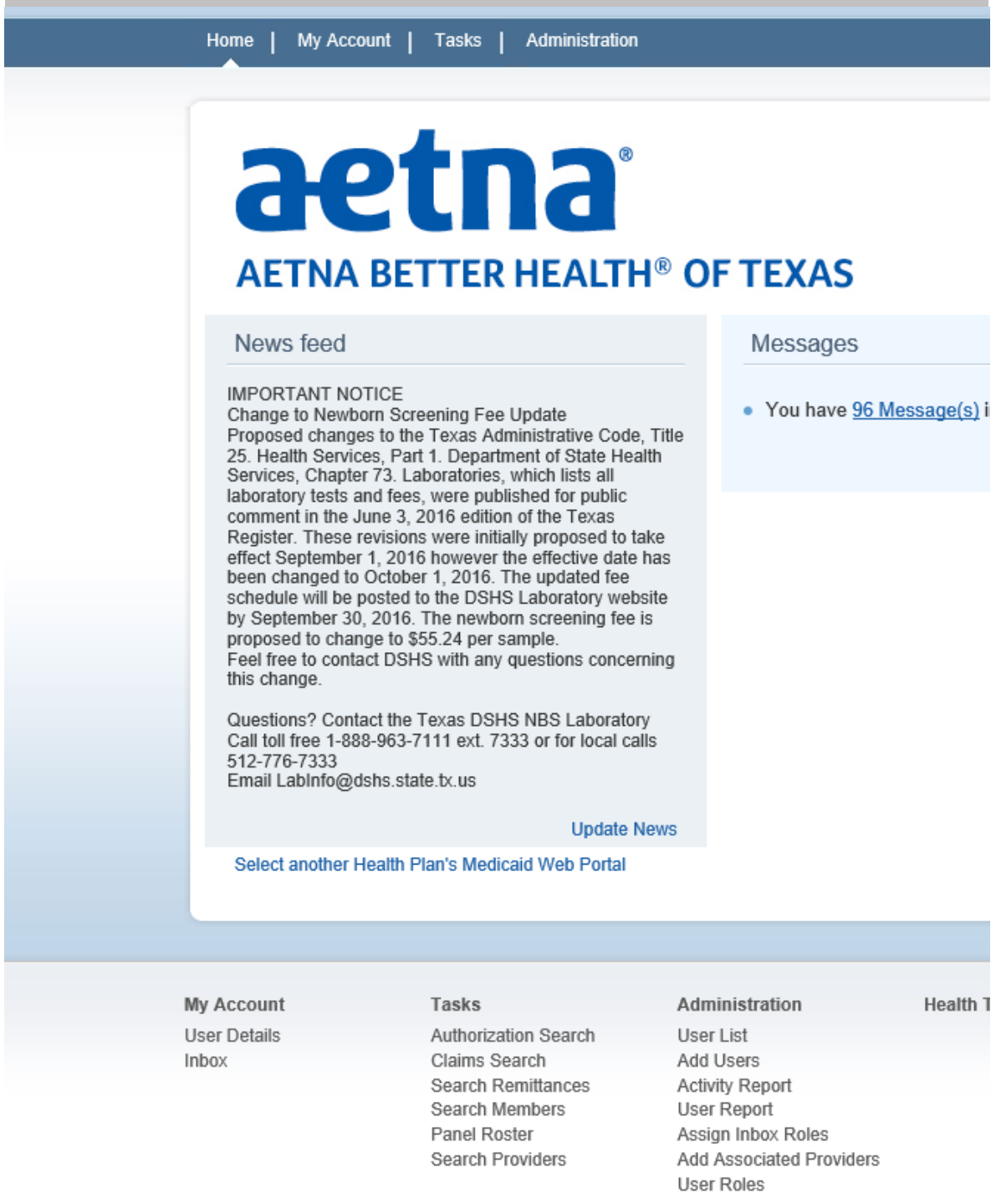
Secure Provider Portal

- This is an examples of our Secure Provider Portal.
- Contracted providers can sign up for this self service site online or using a paper registration form.
- Different levels of access can be assigned to designated staff using different roles.
- Under the “Tasks” menu, providers can review member eligibility, review and submit authorizations, review claims status & payment, and remittances.



Secure Provider Portal: Overview of Contents

The Secure Provider Portal contains

- Enrollee eligibility search
- Panel roster
- Provider list
- Claims status search
- Remittance advice search
- Provider Prior Authorization Look up Tool (PROPAT)
- A place to submit authorizations; three authorization types are available (1) Medical inpatient (2) Outpatient (3) Durable Medical Equipment (DME) – *rental*
- Healthcare Effectiveness Data and Information Set (HEDIS®)

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website or call our Provider Services department at 1-800-371-8614.

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Secure Provider Portal: Verifying Member Eligibility

Enrollee eligibility can be verified in two ways:

1. Telephone Verification
   - Call our Member Services department to verify eligibility at 1-800-371-8614.
   - To protect the member's confidentiality, providers are asked for at least three pieces of identifying information before any eligibility information can be released.
2. Secure Portal Verification:
   - Member eligibility search & panel rosters are found on our Secure Provider Portal.
   - Contact our Provider Services department for additional information about access to the Secure Provider Portal

Note: Eligibility files are only updated once a month and are only available to PCPs and those providers acting as PCPs.

Additional enrollee eligibility requirements are noted in the Provider Manual

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Contacts and Resources

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Resources

Electronic Funds Transfer (EFT)

- The “Register for EFT” option can be used to start receiving direct deposit for payments, instead of paper checks in the mail.
- If you are non-contracted or prefer to enroll/change/cancel on paper, please go to our website https://www.aetnabetterhealth.com/texas-hmosnp/providers/forms to print the form and instructions.
- If you have questions about the authorization agreement form or the enrollment process, please call the Provider Services department at 1- 800-371-8614 or email us at TX_DualCore_ProviderServices@aetna.com

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Resources

Electronic Remittance Advice (ERA)

- The “Register for ERA” option can be used to receive electronic remittances, instead of paper remittances in the mail.
- If you are non-contracted or prefer to enroll/change/cancel on paper, please go to our website at https://www.aetnabetterhealth.com/texas-hmosnp/providers/forms for the electronic form and instructions.
- If you have questions about the authorization agreement form or the enrollment process, please contact the Provider Services department at 1-800-371-8614 or email us at TX_DualCore_ProviderServices@aetna.com

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Working with Us: Helpful Hints

Providers can best utilize their contacts and resources by

- Knowing your member's care manager (CM) or Facility Care Manager (Skilled Nursing centers) to help collaborate care.
- Knowing your provider relations liaison (PRL) for ongoing support, claims projects and provider updates. *see the last slide for PRL information*
- Utilizing the provider services mailbox for general questions and contracting requests TX_DualCore_ProviderServices@aetna.com
- Accessing the Aetna Better Health web-page for provider News & Notices and additional resources http://www.aetnabetterhealth.com/texas-hmosnp

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Contacts by Department

Aetna Medicare Dual Core
1-800-371-8614

CLAIMS	PRIOR AUTHORIZATION	PROVIDER SERVICES
Option 2,	Option 2,	Option 2,
then Option 3	then Option 4	then Option 5

E-Mail: TX_DualCore_ProviderServices@aetna.com

Website: http://www.aetnabetterhealth.com/texas-hmosnp

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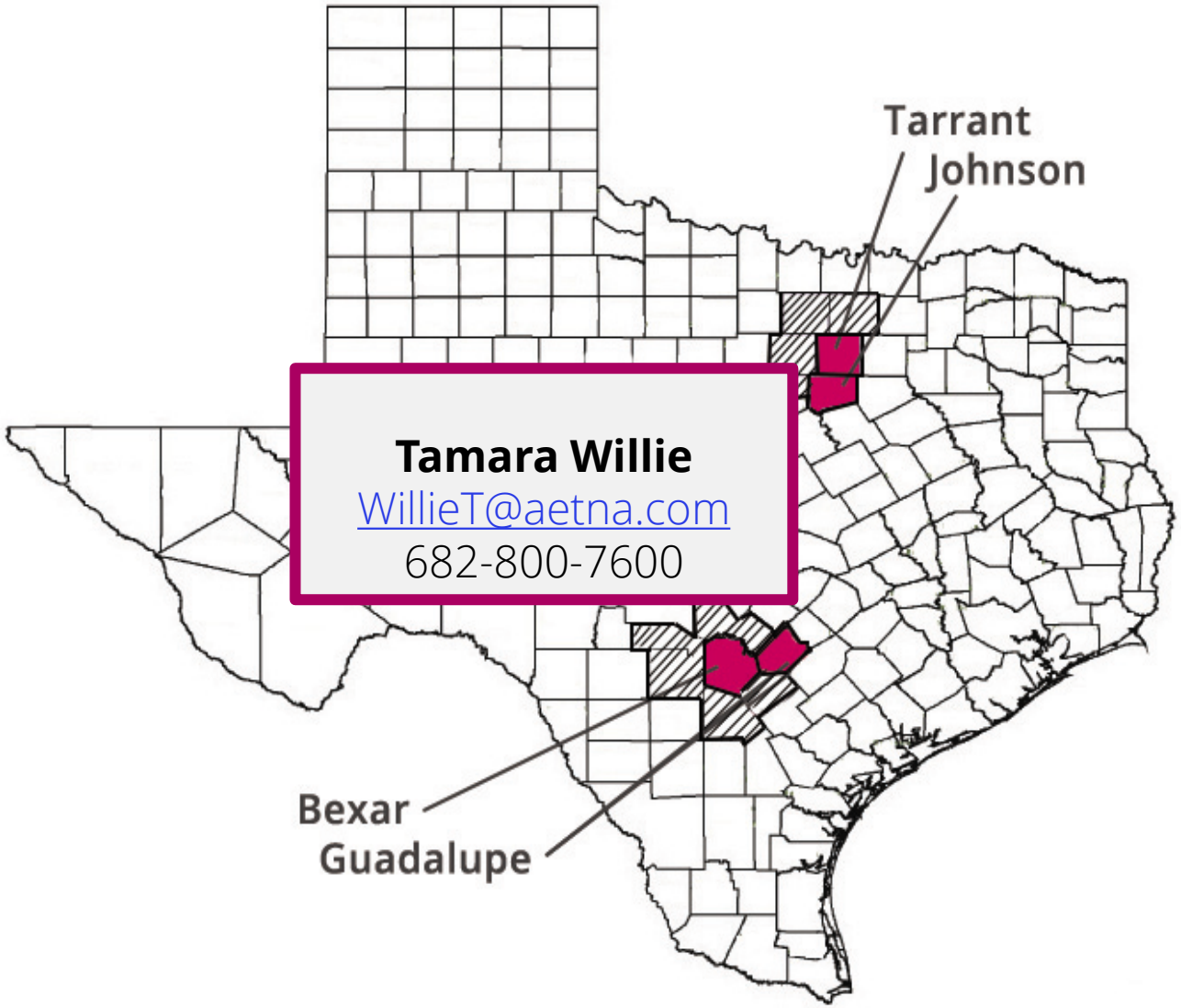
PRL Contact Information



Tamara Willie
WillieT@aetna.com
682-800-7600

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