



AETNA BETTER HEALTH[®]

d/b/a Aetna Better Health

Medallion, FAMIS, D-SNP & CCC Plus

Provider Manual



Contact Information:

Website: <https://www.aetnabetterhealth.com/virginia/>

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Chapter 1 – Welcome to Aetna Better Health

We are pleased that you are part of our network of providers. At Aetna Better Health, we are committed to providing accessible, high quality service to our members in Virginia, and we greatly appreciate all our providers' efforts in helping us achieve that goal.

To ensure that we communicate effectively with providers, we have developed this Provider Manual. This document will help guide providers through our administrative processes. As changes occur, we will continue to update providers with letters, the provider website, newsletters, and regular contact with Provider Relations Representatives. Thank you for your participation and interest in caring for our members.

About Aetna Better Health

For 30 years, Aetna Medicaid has honed our approach to serving high-acuity, medically frail and low-income populations with diverse benefits. Our goal is to improve the functional status and quality of life for members, while providing budget predictability to our state partners. Our experience in implementing, managing, and caring for high-acuity Medicaid beneficiaries results in improved access to care, higher quality care in appropriate settings, and a simplified consumer experience in a culturally competent manner. We take seriously our responsibility as a steward of public programs.

Today, Aetna Medicaid serves more than 3 million members through Medicaid managed care plans in 16 states: Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nevada, New York, New Jersey, Ohio, Pennsylvania, Texas, Virginia, and West Virginia. We serve ABD, dual eligible members, and other populations similar to those in the SoonerHealth+ program in 13 of those states. In addition, we recently were awarded new contracts to serve Virginia Medicaid's LTSS program, California's Medi-Cal geographic managed care expansion in San Diego and Sacramento counties, and Nevada's TANF/CHIP program. In partnership with providers, community resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our most vulnerable members. While our programs and services continue to evolve and expand, our mission remains the same—building a healthier world by improving the lives and well-being of every member, we are privileged to serve.

Model of care

Our model of care offers an integrated care management approach. This means enhanced assessment and management for enrolled members. The processes, oversight committees, provider collaboration, care management and coordination efforts applied to address member needs result in a comprehensive and integrated plan of care for members.

Many components of our integrated care management program influence member health. These include:

- Comprehensive member health assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status, and allow members to reside in the least restrictive environment possible.
- Assessments and care plans that identify a member's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.

Care Manager Referral and predictive modeling software that identify members at increased risk, functional decline, hospitalization, and emergency department visits. Our combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across healthcare settings and providers
- Promote appropriate utilization of services and cost-effective service delivery

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:

- Review of network for adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care services

Service areas

FAMIS and Medallion:

Our service areas include the following cities and counties:

Alleghany	Charles City	Hanover	Middlesex	Rockbridge
Amelia	Chesterfield	Henrico	Montgomery	Russell
Amherst	Colonial Heights	Henry	New Kent	Salem
Appomattox	Covington	Highland	Northumberland	Scott
Bath	Craig	Hopewell	Norton	Smyth
Bedford	Cumberland	King & Queen	Nottoway	Surry
Bedford City	Dickenson	King William	Patrick	Sussex
Bland	Dinwiddie	Lancaster	Petersburg	Tazewell
Botetourt	Essex	Lee	Powhatan	Washington
Bristol	Floyd	Lexington	Prince George	Westmoreland
Buchanan	Franklin	Lunenburg,	Pulaski	Wise
Buena Vista	Galax	Lynchburg (City)	Radford	Wythe
Campbell	Giles	Martinsville	Richmond City	
Caroline	Goochland	Mathews	Richmond County	
Carroll	Grayson	Mecklenburg	Roanoke City	

CCC Plus:

Our service areas includes the entire Commonwealth of Virginia (all 95 counties and 38 independent cities). **For information surrounding enrollment dates by county, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).**

About this provider manual

This provider manual serves as a resource to providers and outlines operations for Aetna Better Health. Through the provider manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. Questions, problems, or concerns that the provider manual does not fully address can be directed to the Provider Relations department. Additional information for providers and members is available online at:

www.aetnabetterhealth.com/virginia

References throughout the provider manual to “Aetna,” the “health plan”, or Aetna Better Health are intended to represent Aetna Better Health.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of Aetna Better Health's provider agreement, including requirements described in this manual, and all federal and state regulations governing the provider. 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.

Chapter 2 – Contacts

Our standard business hours are Monday - Friday from 8 a.m. to 5 p.m., Eastern Standard Time.

Our office is closed on these holidays:

New Year's Day	Independence Day	Day after
Martin Luther King, Jr. Day	Labor Day	Thanksgiving
Memorial Day	Thanksgiving Day	Christmas Day

Important phone numbers

Aetna Better Health	Toll-free
FAMIS and Medallion	800-279-1878
CCC PLUS	855-652-8249

Important fax numbers

Aetna Better Health	Fax
Member Services Department	866-207-8901
Prior Authorizations for FAMIS and Medallion	866-669-2454
Prior Authorizations for CCC+	855-661-1828
Provider Relations Department	844-230-8829
Behavioral Health Services	844-230-8829
Appeals	866-669-2459
Care Management/Disease Management	866-261-0581

Important addresses

Department	Address
Claims	Electronic Payor ID: 128VA Aetna Better Health of Virginia P.O. Box 63518 Phoenix, AZ 85082-3518
Reconsiderations	Aetna Better Health of Virginia Attn: Reconsiderations P.O. Box 63518 Phoenix, AZ 85082-3518

Appeals	Aetna Better Health of Virginia Attn: Appeals Coordinator PO Box 818070 Cleveland, OH 44181
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Managed Care Enrolled Members

This section provides information to providers regarding Medicaid/FAMIS individuals who are enrolled in a managed care program

Websites

In addition to the telephone numbers and addresses above, participating providers may access the Aetna Better Health website 24 hours a day, 7 days a week at www.aetnabetterhealth.com/virginia for up-to-date information, forms, and other resources.

Within the website, a secure provider web portal is maintained; the web portal can be accessed directly at: www.aetnabetterhealth.com/virginia

The secure provider web portal provides a platform for Aetna Better Health to communicate health care information directly to providers.

The health plan's eligibility and claims information can be accessed via the web portal. Additional information regarding the website and secure web portal is available in the Provider Relations chapter.

Commonwealth of Virginia Medicaid Program

General information regarding the Virginia Medicaid Programs and The Department of Medical Assistance Services can be found online at: www.dmas.virginia.gov

Topics	For additional information
Provider Information	www.dmas.virginia.gov Toll Free: 800-772-9996, 800-884-9730 or for Richmond and Surrounding Counties: 804-965-9732 or 804-965-9733
Provider Bulletins	www.virginiamedicaid.dmas.virginia.gov/wps/portal
Provider Enrollment	www.virginiamedicaid.dmas.virginia.gov (to access the online enrollment system or to download a paper application) Phone: 888-829-5373 or 804-270-5105
Virginia Medicaid Eligibility	www.coverva.org Phone: 855-242-8282
Adult and Child Abuse & Neglect Hotline	Child Abuse: www.dss.virginia.gov/family/cps/index2.cgi Phone: 800-552-7096 Adult abuse: www.dss.virginia.gov/family/as/aps.cgi Phone: 888-832-3858

Reporting suspected fraud and abuse

Participating providers are required to report to Aetna Better Health and to the State of Virginia all cases of suspected fraud and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud or abuse to Aetna Better Health in the following ways:

- Write us:
Aetna Better Health of Virginia
ATTN: Compliance Department
9881 Mayland Drive
Richmond, VA 23233-1458
- Call Aetna Better Health's Fraud, Waste and Abuse toll-free number at **844-317-5825**
- Visit Aetna Better Health's website and complete the requested information:
<https://www.aetnabetterhealth.com/virginia/fraud-abuse>

Chapter 3 – Provider Relations department

The Provider Relations department serves as a liaison between Aetna Better Health and the provider community. This department also supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards.

Provider Relations

Provider Relations assists providers by providing education and assistance regarding a variety of topics. Provider Relations will:

- Provide education to provider offices
- Provide support on Medicaid policies and procedures
- Clarify provider contract provisions
- Assist with demographic changes, terminations, and initiation of credentialing
- Monitor compliance with applicable State and Federal agencies
- Conduct an annual Provider Satisfaction Survey
- Conduct member complaint investigation
- Maintain the provider directory
- Assist practices obtain secure web portal or member care login information
- Be a point of contact for any provider concern

The Provider Relations department is responsible for the ongoing education and training of Aetna Better Health's provider community. We maintain a strong commitment to meeting the needs of our providers. In order to accomplish this, a Provider Relations Representative is assigned to specific groups of participating providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of our health plan operations and is well versed in the managed care program.

A Provider Relations representative will visit or phone provider offices periodically to ensure providers' experiences with us are seamless. Representatives meet routinely with office staff and providers upon request, and are available upon request. Provider news, electronic messages, and specialized mailings are sent to providers periodically that include

updates to the provider manual, changes in policies or benefits, and general news or information of interest to our provider community. To contact a local Provider Relations Representative, please call **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Joining the network

Providers interested in joining the Aetna Better Health network should contact Provider Relations for additional information regarding contracting and credentialing.

Provider orientation

We provide initial orientation for newly contracted providers after joining our network. In follow up to initial orientation, we provide a variety of forums for ongoing provider training and education, such as routine site visits, group or individualized training sessions on select topics (i.e., member benefits, Aetna Better Health website navigation), distribution of provider newsletters and bulletins containing updates and reminders, and online resources through our website at: www.aetnabetterhealth.com/virginia

Informed Health® Line (IHL) – 24-hour nurse line

Aetna Better Health provides a free 24-hour Informed Health Line for members. The Informed Health Line is a clinical triage service consisting of a package of health care information services, call center services, triage, and other services. In providing the clinical triage services, the program uses algorithms, clinical tools, and supporting software designed to enable Registered Nurses to assess a member's level of health risk based on the presenting symptoms and to route them to an appropriate level and timing of care.

Informed Health Line services are provided based on the answers to the questions in the algorithms, the nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or their doctor -or- if the member can care for him or herself or family member at home. The Informed Health Line does not provide benefit information. The Informed Health Line call center is staffed seven (7) days a week, twenty-four (24) hours a day, including holidays and can be reached at **877-878-8940** or TTY/TDD: **711** or **800-828-1120**.

Chapter 4 – Provider responsibilities and important information

This section outlines general provider responsibilities; additional responsibilities are included throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with the terms of the Virginia Medicaid program, provider contract, and requirements in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than the provider contract and this manual.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Advice given to potential or enrolled members should always be given in the best interest of the member.

For additional information surrounding CCC PLUS provider responsibilities, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).

Commonwealth of Virginia Medicaid provider enrollment

Providers who provide services to Aetna Better Health members must be enrolled as a Medicaid provider at each practice location with the Commonwealth of Virginia and credentialed by Aetna Better Health before they can provide health care to our members. To access online enrollment information or to download a paper application for the Commonwealth of Virginia, please refer to the department’s website at: www.viriniamedicaid.dmas.virginia.gov or phone: 888-829-5373 or 804-270-5105.

National Provider Identifier (NPI) number

The National Provider Identifier (NPI) number is a ten (10) digit number that is provider specific assigned by CMS. For additional information, please visit the National Plan/Provider Enumeration System (NPPES) website at: <https://nppes.cms.hhs.gov/>

NPI numbers are required for claims submission to Aetna Better Health. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information. On the CMS 1500 form, the rendering provider’s (box 31) NPI number is placed in the bottom half of the 24 J fields. The NPI for the billing provider in box 33 is placed in the 33A field.

FAMIS and Medallion Access and availability standards

Timely access		
Timely access-standards for hours of operation for PCP’s:		
<ul style="list-style-type: none"> General appointment availability -- twenty hours per week per practice location 		
Physician type	Appointment type	Availability standard
Primary Care Physician (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 48 Hours
	Initial Visit Routine care	Within 10 working days
Prenatal	First (1st) Trimester	Fourteen (14) calendar days
	Initial Second (2nd) Trimester	Seven (7) calendar days
	3 rd Trimester & High Risk	Three (3) working days from date of referral

Notes:

- Primary Care Provider (PCP) is defined as Family Practice, Internal Medicine, Pediatrics, and General Practice, Nurse Practitioners, Obstetricians/Gynecologists, Pediatricians, and Specialists who perform primary care functions.
- High Volume Specialists are determined by the Health Plan through annual High Volume Specialist Reports. OB/GYN Providers and Oncologists-are considered mandatory High Volume/High Impact Specialist providers and will be added to the annual High Volume Specialist listing.
- When developing the network, Aetna Better Health takes into account the linguistic and cultural preferences of health plan membership. Member access to more than one PCP that is multi-lingual and culturally diverse is required for Medicaid.
- Selection of Ancillary Provider access as determined by the State.

Providers must be available to members 24 hours a day, 7 days a week. When the provider is unavailable, arrangements must be made for another primary care physician to cover services.

Providers must offer hours of operation to members of Aetna's Virginia Medicaid managed care program ("Virginia Medicaid members") that are no less (in number or scope) than the hours of operation offered to other non-Medicaid patients, or if a provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to members of the Commonwealth of Virginia's Medicaid Fee for Service Program. Provider agrees to provide covered services to Virginia Medicaid members on a twenty-four (24) hour per day, seven (7) day per week basis. Further, provider agrees to meet Virginia state standards for timely access to care and services, taking into account the urgency of need for services.

For information surrounding CCC PLUS Access and Availability Standards, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).

Monitoring of standards

Monitoring of network provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members for Primary Care Physicians (PCPs), specialists and CCC Plus providers, as appropriate. To monitor compliance with the Access and Availability Standards the health plan will:

- Review at least annually results of the Geo-access reports, completed by utilizing industry-standard software, to monitor compliance with the Availability standards.
- Review the annual results of the Consumer Assessment of Health Plans Study (CAHPS), a member satisfaction survey, to monitor compliance with the Accessibility standards.
- Routinely monitor member complaints.
- Routinely monitor after-hour telephone accessibility through member complaints and member and/or provider surveys or after hours phone audits to ensure that, the physician or an associate is available 24 hours per day, 7 days per week.
- Announced and adhoc site visits to the providers office by Provider Relations Representative for any practices identified as meeting the threshold for member complaints.

Resolution of deficiencies

- In the event that a participating network provider fails to meet provider access standards, the Provider Relations representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards and work to correct the barrier to care.
- If there is a serious breach of the participating network providers' commitment to members and non-compliance with access to care Physicians may be required to submit a Corrective Action Plan (CAP) and will be monitored until the CAP enables them to be compliant.
- If any network deficiencies are identified through the quarterly Geo-access review, applications or requests for participation will be sent to non-contracted facilities or providers in the affected service area(s).
- The health plan will also monitor and trend any member complaints regarding accessibility and availability of providers by product. If trends are identified, the health plan will promptly begin the recruiting process.

Covering providers

Aetna Better Health must be notified of practitioners who serve as covering providers for any of our panel providers. This notification must occur in advance of the provision of any authorized services. Reimbursement to a covering provider is based on Virginia Medicaid Fee Schedule and dependent on enrollment as a provider with both Aetna Better Health and the State of Virginia Medicaid program. Failure to notify Provider Relations of covering providers may result in claim denials.

Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. Providers are not reimbursed for services rendered to members who lost eligibility.

Member eligibility can be verified through one of the following ways:

- DMAS Website: www.coverva.org
- Aetna Better Health's Secure Web Portal: <https://www.aetnabetterhealth.com/virginia/providers/portal>
- Aetna Better Health Member Services: **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

The Commonwealth of Virginia Medicaid Eligibility Line **855-242-8282** will also have helpful information regarding the member's assigned managed care company and program eligibility.

Secure Web Portal

The Secure Web Portal is a web-based platform that allows us to communicate member healthcare information directly with providers and in real time. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- Member Eligibility Search – Verify current eligibility of one or more members
- Member ID Card - View a full version of the member ID card (front and back)
- Panel Roster – View the list of members currently assigned to the provider as the PCP
- Provider List – Search for a specific provider by name, specialty, or location
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Look up Tool – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
 - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
 - Review Prior Authorization requirement by specific procedures or service groups
 - Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
 - Export CPT/HCPCS code results and information to Excel
 - Ensure staff works from the most up-to-date information on current prior authorization requirements
- Submit Authorizations – Submit an authorization request on-line. Three types of authorization types are available:
 - Medical Inpatient
 - Outpatient
 - Durable Medical Equipment – Rental
- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member's compliance with any of the HEDIS measures. A "Yes" means the member has measures that they are not compliant with; a "No" means that the member has met the requirements.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

If you're interested in using this secure online tool, you can register on our "For Providers" page at www.aetnabetterhealth.com/virginia or you can also contact our Provider Relations department to sign up over the

phone. To submit your registration via fax, you can download the form from our website or request a copy from Provider Relations. Please note that Internet access and a valid email is required for registration.

Note: Provider groups must first register a principal user known as the "Provider Representative." Once registered, the "Provider Representative" can add authorized users within each entity or practice. For instructions to add authorized users, go to www.aetnabetterhealth.com/virginia and select Secure Web Portal Navigation Guide.

Overview of features for members

Members can register for their own secure member portal accounts at:
<https://www.aetnabetterhealth.com/virginia/members/>

We have customized the member portal to meet their needs better. Members will have access to:

- Health and Wellness Appraisal – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- Educational resources and programs – members are able to access self-management tools for specific topics such as smoking cessation and weight management.
- Claim status – members and their providers can follow a claim from the beginning to the end, including current stage in the process, amount approved, paid, member cost (if applicable) and the date paid.
- Pharmacy benefit services – members can find out if they have any financial responsibility for a drug, learn how to request an exception for a non-covered drug, request a refill for mail-order medications, and find an in-network pharmacy by zip code. They can also figure out drug interactions, side effects and risk for medications and get the generic substitute for a drug.
- Personalized health plan services information – Members can now **view and** request a member ID card, change PCPs and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain referral and information on authorization requirements; and they can find benefit and financial responsibility information for a specific service.
- Innovative services information – Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
- Informed Health Line – The Informed Health Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- Wellness and prevention information – We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources and automated outreach efforts with references to web-based self-management tools.

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online www.aetnabetterhealth.com/virginia or they can call Member Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health that allows providers access to the member's care plan, other relevant member clinical data, and securely interact with Care Management staff.

Providers are able to do the following via the Member Care Web Portal:
For their Practice:

- Providers can view their own demographics, addresses, and phone and fax numbers for accuracy.
- Providers can update their own fax number and email addresses.

For their Patients:

- View and print member's care plan* and provide feedback to Care Manager via secure messaging.
- View a member's profile which contains:
 - Member's contact information
 - Member's demographic information
 - Member's clinical summary
 - Member's gaps in care (individual member)
 - Member's care plan
 - Member's service plans
 - Member's assessments responses*
 - Member's care team: List of member's Health Care Team and contact information (e.g., specialists, caregivers)*, including names/relationship
 - Detailed member clinical profile: Detailed member information(claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*
 - High-risk indicator* (based on existing information, past utilization, and member rank)
 - Conditions and medications reported through claims
 - Member reported conditions and medications* (including Over-the-Counter (OTC), herbals, and supplements)
- View and provide updates and feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their member panel*
- Secure messaging between provider and Care Manager
- Provider can look up members not on their panel (provider required to certify treatment purpose as justification for accessing records)

* Any member can limit provider access to clinical data except for: Members flagged for 42 C.F.R. Part 2 (substance abuse) must sign a disclosure form and list specific providers who can access their clinical data.

For additional information regarding the Member Care Web Portal, please access the Member Care Web Portal Navigation Guide located on our website.

Educating members

The federal Patient Self-determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Aetna Better Health shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Virginia Medicaid member who is his or her patient:

- For the Virginia Medicaid member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information, the Virginia Medicaid member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the Virginia Medicaid member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Aetna Better Health shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each managed care member is guaranteed the right to request and receive a copy of his medical records, and to request that they be amended or corrected as specified in 45 CFR Part 164.

Primary care providers (PCP)

PCPs are defined as physicians who specialize in:

- Family practice, General practice, Internal Medicine, Pediatrics, or Obstetrics/Gynecology
- Certified Nurse Practitioners(CNP, under direct supervision of a physician)
- Certified Nurse Midwife (under the supervision of a physician)

The PCP's role is to:

- Manage and coordinate the overall health care of members
- Make appropriate referrals to participating providers
- Obtain prior authorization for any referrals to non-participating providers
- Provide or arranging for on-call coverage 24 hours/day, 7 days/week
- Accept new members unless Aetna Better Health has been provided with written notice of a closed panel
- Maintain comprehensive and legible medical records

Specialist providers

- Agree to discuss treatment of members with the PCP
- Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment authorized by the PCP
- Communicate any assessments or recommended treatment plans to the PCP
- Obtain prior authorization for specified non-emergent inpatient and specified outpatient covered services
- Maintain comprehensive and legible medical records

Specialist providers acting as PCP

In limited situations, a member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Specialists who perform primary care functions within certain provider classes, care settings, or facilities include but are not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or other providers.

Emergency services

Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs emergent care, or if they call after hours, the member should be referred to the closest emergency department.

Urgent care services

Providers serve the medical needs of our members and are required to adhere to all appointment availability standards. In some cases, it may be necessary to refer members to a network urgent care center (after hours in most cases). Please reference the online directory on the Aetna Better Health website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in the network.

Periodically, Aetna Better Health will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Medical Home

The National Center for Medical Home Implementation defines a medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered: health promotion, acute illness care, and chronic condition management. Performance/care coordination requirements of a medical home include the ability to:

- Provide comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited to electronic contacts and ongoing care coordination and health maintenance tracking;
- Provide primary health care services for members and appropriate referral to other health care professionals or behavioral health professionals as needed;
- Focus on the ongoing prevention of illness and disease;
- Encourage active participation by a member and the member's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development;
- Facilitate the partnership between members, their personal physician, and when appropriate, the member's family; and
- Encourage the use of specialty care services and supports.

Self-Referral/Direct Access

Aetna Better Health has an open-access network, where members may self-refer, or directly access services without notice from their PCP. Aetna Better Health encourages all members to discuss specialty care with their PCP, who can coordinate needed services.

Services must be obtained from an in-network Aetna Better Health provider. There are exceptions to this, however; emergency, family planning, federally qualified and rural health centers, and tribal clinic services do not require prior authorization for in-network or out-of-network providers. Members may access these services from a qualified provider enrolled with the State of Virginia Medicaid program.

Second and third opinions

Aetna Better Health members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion.

The member has a right to a third opinion when the recommendation of the second opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion.

Aetna Better Health members will incur no expenses other than standard co-pays for a second and or third opinion provided by a participating provider, as applicable under the member Certificate of Coverage. Out-of-network services must receive prior authorization and are approved only when an in-network provider cannot perform the service.

Procedure for closing a PCP panel

A PCP who no longer wishes to accept new Aetna Better Health members may submit a written notification to Provider Relations to close his or her panel. In this situation, any new member who is not an established patient of that PCP cannot select that PCP's office with an approved closed panel.

A PCP may re-open a "closed" panel by submitting a written notification to Provider Relations. This change will be made on the first of the month following submission of the request, no less than thirty days from receipt of the written request. Additional time may be necessary to update printed marketing materials.

When an Aetna Better Health member chooses a PCP who has a "closed" panel, Member Service will notify the subscriber of the physician's panel status. If the physician chooses to make an exception to accept the member, they should contact Member Services for assistance in facilitating an over-ride to assign members to their practice on a case-by-case basis.

Non-compliant members/PCP transfer (termination)

Providers are responsible for delivering appropriate services to facilitate member understanding their health care needs. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. Aetna Better Health will assist in the resolution of member specific compliance issues, by providing comprehensive member education and care management protocols. Please contact Provider Relations for additional assistance in resolving member issues.

If member non-compliance issues persist, additional steps can be taken to address these situations including transfer of the member from a provider practice. The Virginia Department of Medical Assistance Services (DMAS) Managed Care Program has a process in place for the PCP, as well as Aetna Better Health to request transfers of members to another PCP. The PCP or Health Plan may request that the member be transferred to another PCP, based on the following or similar situations:

- The PCP has sufficient documentation to establish that the member/provider relationship is not mutually acceptable, e.g., the member is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;
- Travel distance substantially limits the member's ability to follow through the PCP services/referrals; or
- The PCP has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the service by the member. (Note: Fraud and abuse investigation protocols are activated accordingly to investigate all identified potential cases).

The PCP and Health Plan must not request a transfer due to an adverse change in the member's health, or adverse health status. The above reasons do not include a situation where a PCP has terminated a PCP-member relationship prior to managed care enrollment, unless the PCP can establish that the reason(s) for termination still remains an issue. The criteria for terminating a Medicaid member from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid members.

Member transfer from provider guidelines

Except in the case of death or illness, the Provider agrees to notify the Health Plan at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel members for up to thirty (30) days after such notification, until another PCP is chosen or assigned. It is recommended that your practice have an established policy for dismissing patients from the practice. Aetna Better Health members should be seen and treated in the same manner as other patients you see. Services or appointments cannot be refused in emergency or urgent care situations unless you have provided a member with at least 30 days' notice and requested that they select another physician. In the event of a member dismissal from your practice, the member should be notified in writing. It is recommended that the practice submit a copy to the Health Plan of the dismissal notification letter sent to the member. If requested, Aetna Better Health can assist the member in selecting a new physician. This policy is to be used for special situations with specific patients only where just cause exists for dismissing the patient.

Medical records review

All participating Primary Care Practitioners (PCP); defined as family practice, general or internal medicine, OB/GYN and pediatrics, who provide medical care in ambulatory settings must comply with the Health Plan's Medical Record Documentation standards. The following standards are required:

Medical Record Documentation

- | | |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Past medical history is completed (for members seen three or more times) and is easily identified. It includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses. |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

2	History and Physical (H&P) documents have subjective/objective information for presenting problem.
3	For members 14 years and older, there is appropriate notation about cigarettes, alcohol and substance use. (For members seen three or more times, ask about substance abuse history.)
4	Note about follow-up care, calls, and visits. Specific time of return is noted in weeks, months or as needed.
5	An immunization record has been initiated for children and history for adults.
6	Preventive screenings and services are offered according to preventive services guidelines.
7	Prescribed medications are listed including dosages and dates of fill or refill.
8	Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for under age 18).
9	Treatment plan current problem list is documented.
10	Working diagnoses are consistent with findings.
11	Evidence member is not at inappropriate risk relevant to particular treatment:
12	Blood pressure, weight, BMI percentile, and height measured/recorded at least annually, if member accesses care.
13	Lab and other studies are ordered, as appropriate.
14	Evidence that physician has reviewed lab, X-ray or biopsy results (signed or initialed reports and the member has been notified of results before filing record).
15	Documentation of communications/contact with referred specialist and discharge summaries from hospitals
16	The patient's name and ID number must be on each page. All entries are dated and legible.

The Quality Management (QM) department will audit PCP practices for compliance with the documentation standards. Written notification of aggregated review results are provided to physician offices after the Medical Record audit has been completed.

The Health Plan will provide routine education to practitioners and their respective clinics. This may include but is not limited to, articles in our Provider Newsletter on the medical record review (MRR) process, highlights of low compliance, adaptation of any universal forms by Aetna Better Health and updates of any changes within the process and standards. Tools utilized to implement and maintain education may include emails, fax alerts, provider website, provider manual, and mailings.

Providers understand and agree that members shall not be required to reimburse them for expenses related to providing copies of patient records or documents to any local, State or Federal agency (i) pursuant to a request from any local, State or Federal agency (including, without limitation, the Centers for Medicare and Medicaid Services ("CMS")) or such agencies' subcontractors; (ii) pursuant to administration of Quality Management, Utilization Review, and Risk Management Programs, including the collection of HEDIS data; or (iii) in order to assist Aetna in making a determination regarding whether a service is a Covered Service for which payment is due hereunder.

All records, books, and papers of providers pertaining to members, including without limitation, records, books and papers relating to professional and ancillary care provided to members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by Aetna, its designee and/or authorized State or Federal authorities during Provider's normal business hours. In addition, Provider shall allow Aetna to audit Provider's records for payment and claims review purposes. Provider further agrees to maintain all such members' records for services rendered for a period of time in compliance with state and federal laws.

Medical record audits

Aetna Better Health or DMAS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers should respond to these requests promptly. Medical records must be made available to Aetna, Department of Medical Assistance Services, CMS, and Federal or state authorities and their agents for quality review and/or audit upon request. Records must be stored in a secured HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant manner.

Access to facilities and records

Federal and local laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of six years from the end of the contract with Aetna Better Health;
- The date the State of Virginia or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Documenting member appointments and eligibility

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at an office without an appointment), providers must verify eligibility and document the member's information in the medical record. Please access the Aetna Better Health website to electronically verify eligibility or call the Member Services Department at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Missed or cancelled appointments

Providers should:

- Document in the member's medical record, and follow-up on missed or canceled appointments;
- Conduct affirmative outreach to a member who misses an appointment by performing minimum reasonable efforts to contact the member.
- Notify Member Services when a member continually misses appointments.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit: www.hhs.gov/ocr/hipaa/

In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train office staff on HIPAA;
- Consider the patient sign-in sheet – its location and handling;
- Keep patient records, papers and computer monitors out of view and in secure (locked) locations; and
- Have electric shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
 - The individual's past, present or future physical or mental health, or condition.
 - The provision of health care to the individual.
 - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
 - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
 - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.
 - Release of data to third parties requires advance written approval from the member, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. For additional information, please visit:

www.aspe.hhs.gov/admnsimp/final/pvcguide1.htm

Member privacy rights

Aetna Better Health privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 CFR (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health practices regarding their PHI
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken

Member privacy requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set

- Request amendments/correction to records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communication.
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health in writing.

Cultural competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, sexual preference, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health expects providers to treat all members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement proven methods for responding to those challenges. To access Aetna Better Health's Provider Cultural Competency training document, please visit: <https://www.aetnabetterhealth.com/virginia>

Health Literacy – Limited English Proficiency (LEP) or reading skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health is required to ensure members with Limited English Proficient (LEP) have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons identified with LEP are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, sexual preference, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

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.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health Member Services Representatives will assist the provider via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services dials the language interpretation service and uses an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health staffs (e.g., Care Managers or Member Services) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health Member Services to link with an interpreter.

Aetna Better Health provides alternative methods of communication for members who are visually impaired, including large print and/or other formats. Alternative methods of communication are also available for hearing impaired members, which include accessing the state Relay line (711). Contact our Member Services for more information on how to access alternative formats/services for visually or hearing impaired.

Aetna Better Health requires the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member. If interpreter services are declined, please document this in the members' medical record. This documentation could be important if a member decides that the interpreter he or she has chosen has not provided him/her with full knowledge regarding his/her medical history, treatment, or health education.

During the credentialing process for Aetna Better Health, we ask what other languages are spoken in the office so we may refer our members with special language needs.

Individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Site visits will be conducted by our Provider Relations staff to ensure that network providers are compliant.

Receipt of federal funds, compliance with federal laws and prohibition on discrimination

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act;
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law;
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.);
- The anti-kickback statute (section 1128B(b) of the Social Security Act); and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network providers must comply with all applicable CMS laws, rules and regulations for, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member on the basis of health status.

Providers shall provide covered services to members that are generally provided by a provider and for which the provider has been credentialed by Aetna Better Health. Such covered services shall be delivered in a prompt manner, consistent with professional, clinical and ethical standards and in the same manner as provided to provider's other patients. Provider shall accept members as new patients on the same basis as Provider is accepting non-members as new patients. Provider shall not discriminate against a member on the basis of age, race, color, creed, religion, gender, gender identity, sexual preference, national origin, health status, use of covered services, income level, or on the basis, that member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary.

Out-of-network services

If Aetna Better Health is unable to provide necessary medical services, covered under the contract, within the network of contracted providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network providers, for as long as the organization is unable to provide the services. Aetna Better Health will provide any necessary information for the member to be able to arrange the service. The member will not incur any additional cost for seeking these services from an out-of-network provider.

Practice guidelines

Aetna Better Health has practice guidelines and treatment protocols available to providers to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member;
- Constitute procedures for or the practice of medicine by the party distributing the guidelines; or,
- Guarantee coverage or payment for the type or level of care proposed or provided.

Practice guidelines are available on our website at: <https://www.aetnabetterhealth.com/virginia/providers/guidelines>

For Behavioral Health practice guidelines, Virginia adopted the American Psychiatric Association guidelines.

Financial liability for payment for services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a network provider may collect deductibles, co-insurance, or co-payments from members in accordance with the terms of the member's Certificate of Coverage or their Member manual. Providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved member Certificate of Coverage (COC) and or their member handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services.
- Agreeing that when referring a member to another provider for a non-covered service must ensure that the member is aware of his or her obligation to pay in full for such non-covered services.

Health Care Acquired Conditions (HCAC)

Procedures performed on the wrong side, wrong body part, wrong person or wrong procedure are referred to in this policy as “Wrong Site/Person/Procedure”, or WSPPs. The Centers for Medicare and Medicaid Services (CMS) has adopted a national payment policy that all WSPP procedures are never reimbursed to facilities. CMS prohibits providers from passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse providers for WSPPs or for any WSPP-associated medical services. In addition, Aetna Better Health prohibits passing these charges on to patients.

HCACs are preventable conditions that are not present when patients are admitted to a hospital, but become present during the course of the patient’s stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria:

- 1) The conditions are high cost or high volume or both;
- 2) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; Could reasonably have been prevented through the application of evidence-based guidelines.

Effective October 1, 2008, CMS will end payment for the extra care resulting from HCACs. CMS also prohibits passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse hospitals for the extra care resulting from HACs. In addition, Aetna Better Health prohibits passing these charges on to patients.

General reminders to all providers

- Obtain prior authorization from Aetna Better Health for all services requiring prior authorization.
- Referrals to non-participating providers, regardless of level-of-care must be pre-authorized, unless specifically exempted from authorization, such as Family Planning and Emergency services.
- Authorization approval does not guarantee authorized services are covered benefits
- Benefits are always contingent upon member eligibility at the time of service.
- Understand that prior authorization is approved by Aetna Better Health based upon the present information that has been made available to the health plan. Payment for prior-authorized, covered services is subject to the compliance with Aetna Better Health’s Utilization Management Program, contractual limitations and exclusions, and coordination of benefits.
- Accept medical necessity and utilization review decisions; refer to the Grievance and Appeal Section of this provider manual if a provider disagrees with a review decision or claim that has been processed.
- Agree to collect only applicable copayments, coinsurance, and/or deductibles, if any, from members. Except for the collection of copayments, coinsurance, and/or deductibles, providers shall look only to Aetna Better Health for compensation for medically necessary covered services.
- Agree to meet credentialing and recredentialing requirements of Aetna Better Health.
- Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner.
- Providers shall provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services.
- Providers must obtain authorizations for all hospitalizations and confinements, as well as services specified in this manual and other provider communications as requiring prior authorization.
- Providers must fully comply with the terms of their agreement and maintain an acceptable professional image in the community.
- Providers must keep their licenses and certifications current and in good standing and cooperate with Aetna Better Health’s recredentialing program. Aetna must be notified of any material change in the provider’s qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health.

- Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/recredentialing process. Providers must furnish Aetna Better Health with evidence of coverage upon request and must provide the plan with at least thirty (30) days' notice prior to the cancellation, loss, termination, or transfer of coverage.
- Providers shall ensure the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna Better Health including medical records data required and ensure the information is submitted on the applicable claim form.
- In the event that the provider or Aetna Better Health seeks to terminate the agreement, it must be done in accordance with the contract.
- Providers must submit demographic or payment data changes at least sixty (60) days prior to the effective date of change.
- Providers shall be available to Aetna Better Health members as outlined in the Access and Availability Standards section of this manual. Providers will also arrange 24-hour, on-call coverage for their patients by providers that participate with Aetna Better Health, as outlined within this manual.
- Providers must become familiar and to the extent necessary, comply with Aetna Better Health members' rights as outlined in the "Members Rights and Responsibilities" section of this manual.
- Participating providers agree to comply with Aetna Better Health's Provider Manual, quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures and any other policies that Aetna Better Health may implement, including amendments made to the mentioned policies, procedures, and programs from time to time.
- Providers will ensure they honor all Aetna Better Health members' rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.
- Providers of all types may be held responsible for the cost of service(s) where prior-authorization is required, but not obtained, or when place of service does not match authorization. The member shall not be billed for applicable service(s).
- Aetna Better Health encourages providers to contact Provider Relations at any time if they require further details on requirements for participation.

Provider responsibilities to Aetna Better Health

Federal Law and Statutes (as outlined in the contract) are detailed below.

Civil rights, equal opportunity employment, and other laws

Provider shall comply with all applicable local, State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Provider recognizes that the Virginia Fair Employment Practice Act prohibits Provider, in connection with its provision of services under this Amendment, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, or privileges of employment because of race, color, religion, sex, disability, or national origin. Provider guarantees its compliance with the Virginia Fair Employment Practice Act. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and prohibited relationships

Provider acknowledges that Aetna Better Health is prohibited from contracting with parties listed on the non-procurements portion of the Commonwealth of Virginia's General Services Administration's "Lists of parties Excluded for Federal Procurement or Non-procurement Program." This list contains the names of parties debarred, suspended, or otherwise excluded by State agencies, and contractors declared ineligible under State statutory authority. Provider

warrants that it is not on this list at the time of entering into this Amendment. Should Providers status with respect to this list change, Provider agrees to notify Aetna Better Health immediately.

Provider acknowledges that Aetna Better Health may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Provider warrants that it is not so excluded. Should Provider's exclusion status change, Provider agrees to notify Aetna Better Health immediately. Further, Provider shall not employ or contract for the provision of health care, utilization review, medical social work, or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Provider acknowledges that Aetna Better Health is prohibited from maintaining a relationship with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, and that Aetna Better Health is prohibited from having relationships with "affiliates" as the term is defined under the Federal Acquisition Regulation. Provider warrants that Aetna Better Health is not prohibited from maintaining a relationship with Provider on these grounds, and Provider agrees to notify Aetna Better Health immediately should its status change.

Federal sanctions

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. The Centers for Medicaid and Medicare Services (CMS) requires Aetna Better Health and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. The Controlling Interest Worksheet will be included with the credentialing application, as well as, the recredentialing application. This Form must be completed, signed, and dated when returned from the provider.

Medically necessary services

All Services provided to Medicaid members must be medically necessary and reflect:

- Health care services and supplies which are medically appropriate;
- Necessary to meet the basic health needs of the member;
- Rendering in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or government agencies;
- Consistent with the diagnosis of the condition;
- Provision of services required for means other than convenience of the member his/her provider;
- Provision that is no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Provision of services of demonstrated value;
- Provision of services that is no more intense level of service than can be safely provided.

New technology

Emerging technologies are a daily occurrence in health care. Aetna has a Medical Technology Committee (MTC) to review new and emerging technology. The committee uses evidenced based clinical research to make determinations

regarding the efficacy of the new technologies. Providers are advised of new technologies approved for coverage by Aetna's MTC via routine communications including the Provider Newsletter, bulletins, and ongoing provider relations.

Notice of provider termination

Aetna Better Health will make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. It is the provider's responsibility to provide timely notification as indicated in the provider contract if they are requesting a termination from the network.

Health care reform update payments outside the United States

Effective January 1, 2011, Section 6505 of the Patient Protection and Affordable Care Act prohibits Medicaid health plans from making payments to financial institutions or entities located outside of the United States. This includes payments to physicians, hospitals, and ancillary healthcare providers for items or services provided to Medicaid members through the Aetna Better Health contract with the State of Virginia. If you or your organization are located outside of the United States, or utilize a financial institution located outside of the United States, your payments will not be sent until you are located in the United States, or in the latter instance, establish a relationship with an entity located in the United States.

Provider responsibilities to members

This section outlines the provider responsibilities to Aetna Better Health members. This information is provided to providers to assist in understanding the requirements in place for the Medicaid Program.

Establishing an early primary care physician relationship is the key to ensuring that every Aetna Better Health member has access to necessary health care and to providing continuity and coordination of care. The member will already have chosen a primary care physician on the date their enrollment is effective. If necessary, Aetna Better Health will assign a primary care physician in the event that no selection is made.

PCP qualifications and responsibilities

To participate as a Virginia Managed Medicaid provider, the PCP must:

1. Be a Medicaid-enrolled provider and agree to comply with all pertinent Medicaid regulations;
2. Sign a contract with Aetna Better Health as a PCP which explains the PCP's responsibilities and compliance with the following Managed Medicaid requirements:
 - a. Treat Managed Medicaid members in the same manner as other patients;
 - b. Provide the Managed Medicaid member with a medical home including, when medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services.
 - c. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.;
 - d. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;

- e. Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;
 - f. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's office, e.g., TTD/TDD and language services, to accommodate the member's special needs.
 - g. Maintain a medical record for each member and comply with the requirement to coordinate the transfer of medical record information if the member selects another PCP;
 - h. Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the member's needs. Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services, include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans.
 - i. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;
 - j. Comply with all disease notification laws in the Commonwealth;
 - k. Provide information to the Department as required;
 - l. Inform members about all treatment options, regardless of cost or whether such services are covered by the Virginia Medical Assistance Program
3. Provide accurate information to the Health Plan in a timely manner so that PCP information can be exchanged with DMAS and Aetna Better Health Provider Relations via the Provider Network File

Advanced directives

Aetna Better Health maintains written policies and procedures related to advance directives that describe the provision of health care when the member is incapacitated. These policies ensure the member's ability to make known his/her preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health's policy defines advance directives as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (statutory or as recognized by the courts of the State) relating to the provisions of health care when the individual is incapacitated. The Advance Directive policy details our obligation for Advance Directives with respect to all adult individuals receiving medical care by or through the health plan. These obligations include, but are not limited to:

- Providing written information to all adult individuals concerning their rights under state law to make decisions concerning their medical care, accept or refuse medical or surgical treatment and formulate Advance Directives for health care.
- Documenting in a prominent part of the individual's medical record whether the individual has executed an Advance Directive.
- Not conditioning the provision of care or otherwise discriminating against an individual based on whether that individual has executed an Advance Directive.
- Ensuring compliance with requirements of state law concerning Advance Directives.
- Educating Health Plan staff and providers on Advance Directives.

Aetna Better Health's policies provide guidance on Aetna's obligations for ensuring the documentation of any Advance Directive decisions in the provider's member records, and monitoring provider compliance with advance directives including the right of the member to note any moral or religious beliefs that prohibit the member from making an advance directive.

Aetna Better Health will ensure that our providers are informed of their responsibilities in regards to advance directives. Our Provider Relations staff educates network providers on information related to advance directives through the Provider Contract, Provider Manual, Provider newsletters and during Provider Relations' on-site office visits.

Aetna Better Health Network Management is responsible for:

- Ensuring provider contracts contain requirements that support members' opportunity to formulate advance directives.
- Ensuring the Provider Manual contains guidance on Advance Directives for Aetna Better Health members.

Aetna Better Health's Quality Management (QM) staff distributes Medical Record Documentation Standards annually to the providers. One of the Medical Record Documentation standards requires that if a member has an executed Advance Directive, a copy must be placed in the member's medical record. If the member does not have an executed Advance Directive, the medical record would provide documentation that a discussion regarding Advance Directives has occurred between the provider and the member.

Aetna Better Health is committed to ensuring that adult members understand their rights to make informed decisions regarding their health care. Aetna Better Health's Advance Directives Medicaid Policy and Procedure provides guidance on our obligations for educating members and providers. Aetna Better Health educates providers on advance directives processes to ensure our members have the opportunity to designate advance directives.

At the time of enrollment, the Health Plan distributes written information to members on advance directives (including Virginia State law) through the Member Manual. The information in the materials includes:

- Member's rights under State law, including a description of the applicable State law.
- Aetna Better Health's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- The member's right to file complaints regarding non-compliance with the State.

Aetna Better Health is responsible for educating members and providers about advance directives rights. The Compliance Officer is responsible for ensuring advance directives information appears, no less than annually, in our materials. Advance directives information is available in the:

- Member Handbook
- Member Newsletter
- Website
- Provider Manual
- Provider Newsletters

Our care managers educate and offer advance directives information when appropriate. Additionally, providers are audited during on-site reviews to ensure policy and procedure compliance.

Chapter 5 – Credentialing and provider changes

Aetna's credentialing policy

Aetna's credentialing policy has adopted the highest industry standards, which are a combination of URAC/NCQA/CMS plus applicable state and federal requirements. Exceptions to these standards are reviewed and approved based on local access issues determined by the local health plan. Aetna must follow and apply the provisions of state statutes, federal requirements, and accreditation standards that apply to credentialing activities.

Statement of confidentiality

Provider information obtained from any source during the credentialing/recredentialing process is considered confidential and used only for the purpose of determining the provider's eligibility to participate with in the Aetna Better Health network and to carry out the duties and obligations of Aetna operations, except as otherwise required by law.

Provider information is shared only with those persons or organizations who have authority to receive such information or who have a need to know in order to perform credentialing related functions. All credentialing records are stored in secured/locked cabinets and access to credentialing records is limited to authorized personnel only. Individual computer workstations are locked when employees leave their workstation. Access to electronic provider information is restricted to authorized personnel via sign-on security. All employees are trained and acknowledge training in accordance with federal HIPAA regulations. Disposal of all confidential documents must be via the locked confidential shred receptacles placed throughout the work area.

Credentialing/Recredentialing

CAQH

Aetna Better Health uses current National Committee for Quality Assurance (NCQA) standards and guidelines for the review, credentialing and recredentialing of providers and uses the CAQH ProView. CAQH is a nonprofit alliance of America's leading health plans. CAQH ProView allows providers to submit one application to meet the needs of all of the health plans and hospitals participating in the CAQH effort. To maintain the accuracy of the data, CAQH sends providers a reminder every 90 days to re-attest to their information. Health plans and hospitals designated by providers obtain application information directly from the CAQH database. This eliminates the need for multiple organizations to contact the provider for the same information. CAQH gathers and stores detailed data for more than 1 million providers nationwide. Aetna uses CAQH ProView for credentialing all provider types and CAQH Proview is compliant with state-required credentialing applications.

Initial Credentialing Individual Practitioners

Initial Credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, (with the exception of hospital-based providers) including practitioners joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee.

Practitioners may not treat members until they become credentialed.

Recredentialing Individual Practitioners

Aetna Better Health re-credentials practitioners on a regular basis (every 36 months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA) requirements. Termination of the provider contract can occur if a provider misses the 36-month timeframe for recredentialing.

Facility licensure and accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Ongoing monitoring

Ongoing Monitoring consists of monitoring practitioner and or provider sanctions, or loss of license to help manage potential risk of sub-standard care to our members.

Additions or provider terminations

In order to meet contractual obligations and state and federal regulations, providers who are in good standing are required to report any terminations or additions to their agreement at least ninety (90) days prior to the change in order for Aetna Better Health to comply with CMS and/or accreditation requirements. Providers are required to continue providing services to members throughout the termination period.

Providers are responsible to notify Provider Relations of any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact Provider Relations to discuss staff training, if needed.

State and accreditation guidelines require Aetna Better Health to make a good faith effort to provide written notice of a termination of a network provider at least thirty (30) days before the termination effective date to all members who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all members who are patients of that PCP must be notified when a provider termination occurs.

Continuity of care

Providers terminating their contracts without cause are required to provide ninety (90) days' notice (or otherwise determined by their contract) before terminating with Aetna Better Health. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Providers may also contact our Care Management Department for assistance with continuity of care.

Non-discrimination

Aetna does not discriminate against any qualified applicant based on race, color, creed, ancestry, religion, age, disability, sex, national origin, citizenship, sexual orientation, disabled veteran, or types of procedures performed or types of patients the practitioner specializes, or Vietnam veteran status, in accordance with Federal, State, and Local laws.

All employees of Aetna Better Health are required to attend online training within sixty (60) days of hire and annually thereafter, which requires passing a comprehensive quiz at the end of each training module. This training includes our Code of Business Conduct and Ethics, and Unlawful Harassment, both of which address our non-discrimination policies and practices.

Aetna maintains a compliance line **844-317-5825**, which is available 24 hours per day, 7 days for all employees, as well as members and providers to call to report compliance matters. All Aetna Better Health employees have been educated on the compliance line and are encouraged to call if they suspect discrimination.

For any questions regarding the credentialing or recredentialing status of a provider, please contact Provider Relations.

Chapter 6 – Member Benefits (Medallion and FAMIS)

Aetna Better Health believes that the essence of a successful Medicaid program is the extent that members understand their benefits and how to access them. We also go beyond simply educating members about covered services, and put incentive programs in place to encourage benefit utilization.

For information surrounding CCC Plus member benefits, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).

Medallion and FAMIS - Covered services

General areas of covered services under Aetna Better Health include:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids (for members under 21 years of age)
- Home Health services
- Immunizations
- Inpatient and outpatient hospital services
- Rehabilitative services
- Medically necessary weight reduction services
- Mental health care –in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- Outreach for included services, especially pregnancy-related and Well child care
- High-risk birthing and Infant Services classes
- Pharmacy services
- Practitioners' services
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding school based services
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for members under 21 years of age

The covered services provided to Aetna Better Health members include all those listed above and the following additional services:

- Diagnosis and treatment for defects in hearing including hearing aids for members under 21 years of age
- Dental services medically needed because of an accidental injury when the member's doctor submits a plan of treatment to us within sixty (60) days of the date of the member's injury and receives our preauthorization for the plan of treatment and the injury did not occur during the act of biting or chewing

Enhanced services

In conjunction with the provision of covered services noted, Aetna Better Health is also responsible for the following:

- Placing a strong emphasis on programs to enhance the general health and well-being of members. Specifically, we develop and implement programs that encourage members to maintain a healthy diet, engage in regular exercise, get an annual physical examination, and avoid all tobacco use
- Making health promotion programs available to the members
- Promoting the availability of health education classes for members
- Providing education for members with, or at risk for, a specific disability or illness
- Providing education to members, members' families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities
- Upon request from DMAS, collaborate with on projects that focus on improvements and efficiency in the overall delivery of health services.

Member communications

Aetna Better Health has numerous ways to inform members about covered health services. No program information document shall be used unless it achieves a Flesch total readability score of forty (40) or better (at or below a 12th grade educational level). The document must set forth the Flesch score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

Some documents are available in alternate formats and in non-prevalent languages, including

- Member Handbook — A comprehensive members document that explains all covered benefits and services and exclusions and limitations.
- Public Website — General information and member handbook are available online.
- Member online portal — A web portal providing members easy access to health care information and materials. The member portal is a secure, password-protected site that ensures confidential information is only available to the member.
- Member newsletter — member publication featuring articles about covered services such as immunizations, well-child checks, urgent and emergency care, mammograms, etc.

Aetna Better Health's teams also communicate covered benefits and services to members on a regular basis.

- Member Services – representatives are trained and dedicated to Virginia's Medicaid line of business. Service representatives describe benefits to members and answer questions. Interpretation services are available in several languages.
- Appeals and Grievances – assists members with completing the grievance and appeal process when dissatisfied with services or benefit reductions.
- Care Management – works closely with individual members to develop and execute care plans.
- Prior Authorization (PA) – PA staff work with the provider community to process referral and prior authorization requests.
- Outreach Coordinators — our community partners help support our members' understanding of Medicaid covered services.
- Network Providers — training materials and the Provider Manual include Virginia Medicaid covered services information.
- Enrollee Advisory Board — an integrated health plan and member committee that meets regularly to learn about Aetna Better Health benefits and services, and to provide feedback on Aetna Better Health materials, providers, and service.

Copayments

Medallion members

Aetna Better Health does not require co-pays for Medicaid members. Aetna Better Health will pay for all of their covered services. There are no co-payments, deductibles, or any other out of pocket cost for covered services. Members should not sign or agree to pay for any services that are covered by the health plan. Members may be required to pay for services if they ask to receive services that are not covered by Aetna Better Health. If at any time Aetna Better Health submits requests to DMAS to allow for member co-pays, providers and members will be notified in advance of this change.

FAMIS members

FAMIS members have co-payments (also called co-pays). Co-pays are amounts of money that members will pay to Aetna Better Health, not to the provider or doctor. Co-pays are a way for members to share in the cost of their care. To determine the co-pays for FAMIS members, please refer to the member's ID card.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early and periodic screening, diagnosis, and treatment (EPSDT) is a federally mandated comprehensive child health program for Medicaid members. Aetna Better Health provides or arranges for EPSDT services for Aetna Better Health Medicaid members under the age of 21.

EPSDT care provides comprehensive, periodic evaluations of the member's health, development, nutrition, vision, hearing, and dental status. Health Departments and Primary Care Providers (PCPs) such as pediatricians, family practice physicians, and general practice professionals, as well as by community health and head-start agencies provide EPSDT services. The goal of preventive health care is to recognize and treat health conditions that could have significant developmental consequences for children and adolescents.

Our members are educated about EPSDT through the member handbook, the member newsletter, and a member reminder system.

Network providers are subject to Aetna Better Health's documentation requirements for EPSDT services. EPSDT services shall also be subject to the following additional documentation requirements:

- The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule.
- Documentation of a comprehensive screening shall at a minimum, contain a description of the components described below. Aetna Better Health recommends that providers send reminders to parent when screenings, immunizations, and follow-up services are due.

Screenings

Providers should use the following guidelines to provide comprehensive EPSDT services to Aetna Better Health members.

Comprehensive, periodic health assessments or screenings, from birth through age twenty (20) at intervals, which meets reasonable standards of practice, as specified in the EPSDT medical periodicity schedule established by DMAS. The medical screening shall include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development.

- A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection, height, weight and BMI assessment and a nutritional assessment.
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations must be administered
- Appropriate laboratory tests at participating lab facilities. The following recommended sequence of screening laboratory examinations should be provided by Aetna Better Health participating providers; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
- Hemoglobin/hematocrit
- Urinalysis
- Tuberculin test
- Blood lead assessment using blood level determinations as part of scheduled periodic health screenings appropriate to age and must be done for children according to the following schedule:
 - Between 12 months and 24 months of age.
 - Between 24 and 72 months of age if the child has not previously been screened for lead poisoning.
- All screenings shall be done through blood lead level determinations.
- Results of lead screenings, both positive and negative, shall be reported to the Virginia Immunization Registry
- Health education/anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.
- EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:

Neonatal exam	9 months	3 years
Under 6 weeks	12 months	4 years
2 months	15 months	5 years
4 months	18 months	Bi-annually from age 6 through 20 years for Medicaid
6 months	2 years	

For children who have been tested, the following questions are intended to assist physicians and nurse practitioners in determining if further testing is necessary in addition to that completed at the mandated ages.

- Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint?
 - This could include day care, preschool, or home of a relative.
- Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
- Does the child have a brother or sister (or playmate) with lead poisoning?
- Does the child live with an adult whose job or hobby involves lead?
- Does the child’s family use any home remedies that may contain lead?

For further information on lead screening, please contact the Centers for Disease Control (CDC) at 800-232-4636. Publications and other materials concerning blood lead screening may be obtained from the Virginia Department of Medical Assistance Services (DMAS) Childhood Lead Poisoning Prevention Program.

Vision services

Participating providers should perform periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to DMAS’ EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination, and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

Hearing services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who do not pass the newborn hearing screening, those who are missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Participating providers should perform periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in DMAS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

Dental services through the Smiles for Children program

Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her one-year screening. A referral to a dentist shall be mandatory at three years of age and annually thereafter, through age twenty (20) for Medicaid members and through the age of 18 for children with FAMIS.

Oral examination includes visual and tactile examination of all intra-oral hard and soft tissues and teeth for all children for obvious abnormalities, such as cavities, inflammation, infection, or malocclusion. Children should be referred to dentists for the following reasons:

- Over the age of one year
- Evidence of infection, inflammation, discoloration, malformation of the dental arches,
- malformation or decay of erupted teeth

As of March 1, 2015, dental benefits were also extended to pregnant women who are 21 years old and older. These dental benefits will be available through the Smiles For Children program. Benefits include cleanings, exams, fillings, and crowns. Root canals, x-rays, and anesthesia are also covered. Braces are not covered. These benefits will stop at the end of the month following the 60th day after you have had the baby. For example, if you give birth on May 15, your dental benefits will end on July 31.

Pregnant members who are under 21 years old can get full benefits through Virginia's Smiles For Children dental program. Braces are included.

To schedule a dental appointment with a participating "Smiles for Children" provider, members should call DentaQuest at **888-912-3456**.

Oral health screening and fluoride varnish

Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form shall be covered. This program is intended for medical providers, such as pediatricians, family practitioners, and nurse practitioners who treat beneficiaries up to age three (0 – 35 months). Fluoride varnish can be applied to teeth up to four times a year. The procedure code for fluoride varnish application is D1206. The fluoride varnish application is a separate reimbursement. The oral health screen is part of the well-child visit performed by the medical provider. For more information about how to apply fluoride varnish, providers should contact their local health departments.

Other services

Participating providers should perform such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or ameliorate defects and physical, mental, and substance abuse illnesses and conditions discovered by the screening services.

Referrals

If a problem is found or suspected during a well-child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another provider or self-referral for further diagnosis and treatment.

It is not always possible to complete all components of the full medical screening service. For example, immunizations may be medically contraindicated or refused by the caregiver. The caregiver may also refuse to allow their child to have a lead blood level test performed. When this occurs, an attempt should be made to educate the caregiver with regard to the importance of these services. If the caregiver continues to refuse the service, the child's medical record must document the reason the service was not provided. By fully documenting in the child's medical record the reason these services were not provided, the Provider may bill a full medical screening service even though not all components of the full medical screening service were provided.

Women's health specialists

Aetna Better Health provides female members direct access to women's health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to prenatal care, breast exams, mammograms, and pap tests. Direct access means that Aetna Better Health cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent Aetna Better Health from requesting or requiring notification from the practitioner for data collection purposes. They may also seek these services from a participating provider of their choice, if their primary care provider is not a women's health specialist.

Women's health specialists include, but are not limited to, obstetricians, gynecologists, nurse practitioner, and certified nurse midwives.

Family planning services

Aetna Better Health members have direct access for family planning services without a referral and may also seek family planning services at the provider of their choice (in or out of network).

The following services are included:

- Annual gynecological exam
- Annual pap smear
- Lab services
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling

Treatment for STDs

Aetna Better Health members can access any participating provider or Virginia Medicaid provider for treatment of a sexually transmitted disease without prior approval from Aetna Better Health.

Newborns

For Aetna Better Health and Virginia Medicaid, claims for a newborn must be billed under his/her own member ID number and not the mother's number. To determine a newborn's temporary member identification number for Aetna Better Health, please call Member Services. Until the State and Aetna Better Health issue their permanent Medicaid

numbers for the newborn, the temporary number must be used to bills claims. If Aetna Better Health doesn't have the newborn's name, the child is loaded in our system as baby girl/boy – with the mother's last name. Parents must contact DMAS to have the newborn added as permanent. For FAMIS members, the parents need to contact FAMIS to add the newborn. If permanent enrollment has not been established within the 30-90 day period and the newborn policy is termed, the member is no longer eligible for coverage.

Transportation service

Transportation service is a covered benefit for eligible Aetna Better Health members when necessary to receive non-emergent medically necessary health services. Transportation includes: public transportation; taxicab; ambulance, gas reimbursement, and a wheelchair van.

FAMIS members do not have transportation benefits through Aetna Better Health. These Guidelines to determine transportation necessity:

- Members are asked to give a three day notice when requesting non-urgent transportation.
- Members must be eligible with Aetna Better Health on date of the scheduled appointment.

Providers or members may contact transportation vendor to arrange for transportation for medically necessary non-emergent health services. Non-emergent transportation arrangements may be made twenty-four (24) hours a day.

Criteria for non-emergent transportation:

- Transportation is a covered benefit for covered non-emergent medical appointments, trips to the pharmacy associated with a medical appointment, and specified Aetna Better Health/Case
- Management outreach events.
 - More than one (1) additional passenger will require member Service Supervisor approval.
- If the member is a single caregiver with more than one minor child in his/her care the Plan authorizes vendor to transport the additional minor children.
 - Members under age 16 must be accompanied by an adult at least 21 years or older, with the exception of pregnant members whose trip will not require Member Service Supervisor approval.
- Transportation is a covered benefit for up to twenty (20) outpatient mental health visits per calendar year.
- Trips to a PCP that exceed thirty (30) miles or trips to a specialist that exceed fifty (50) miles one way require prior approval from Aetna Better Health Member Services Supervisor.
- Out-of-state trips require approval from the health plan. Fax request for authorization to Health Services **844-797-7601**.

Sterilizations

Providers shall comply with the requirements set forth in 42 CFR § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in *Code of Virginia*, § 54.1-2974. The consent form of 42 CFR § 441.258 (see attachments) must be documented prior to the performance of any sterilization. Specifically, there must be documentation of the member being informed, the members giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed.

The patient must be at least 21 years of age, mentally competent and must wait a minimum of 30 days after signing the consent form but no longer than 180 days. This form is available in English and Spanish.

Sterilization consent forms

The Virginia Department of Medical Assistance Services Sterilization Consent Form is included in this manual. Please see the Attachments Section. It may also be ordered by the physician directly from the DMAS. The surgeon shall submit a properly completed and legible form to Aetna Better Health before payment of claims can be considered. For

additional information, contact the Prior Authorization Department at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Hysterectomies

All hysterectomies require preauthorization. Federal regulations require that members be informed before the operation that a hysterectomy will leave them sterile. As a result, all patients scheduled for a hysterectomy must sign the Acknowledgment of Receipt of Hysterectomy Information form. A copy of this form is included in the Attachment Section or can be obtained through DMAS or through your Provider Relations Representative. The Hysterectomy Acknowledgment Form must be submitted with claims relating to hysterectomies to ensure reimbursement. In the event of an emergency surgery in which the required forms were not signed, a physician's statement that prior acknowledgment was not possible is required for claims reimbursement.

Maternity services/Child Care Management

Baby Matters is a program dedicated to promoting healthier babies and protecting the well-being of the mother. As a member of Aetna Better Health, all expectant mothers are eligible to receive our pregnancy health guide. *Baby Matters'* educational information follows an expectant mother through prenatal care, delivery, and postpartum care. At the member's first prenatal visit, the physician will complete and fax a **Maternity Notification Form**. The OB Care Manager will evaluate the risk factors on this form. Care Management and educational interventions will be provided to the member, as appropriate. This care is designed to serve as a health benefit and is not a substitute for or intended to interfere with the mother's current medical care.

Home health care and durable medical equipment (DME)

Home health care, DME, Home Infusion and Orthotics/Prosthetic Services may require prior authorization. All services should be coordinated with the member's PCP or the referring physician specialist in accordance with his/her plan of treatment based on medical necessity, available benefit, and appropriateness of setting and network availability.

Emergency services

Prior-approval by the member's primary care physician and medical/surgical plan is not required for receipt of emergency services. Education of the member is necessary to ensure they are informed regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the member to contact the PCP and plan before accessing emergency services. Aetna Better Health Member Services and Care Management will also assist in educating members regarding Emergency Services.

An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity, (including severe pain), that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in

- a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b. Serious impairment to bodily functions; or
- c. Serious dysfunction of any bodily organ or part;
- d. Serious harm to self or others due to an alcohol or drug abuse emergency.

Aetna Better Health must be notified of an emergency admission within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. However, earlier notification greatly facilitates the utilization review process and allows Aetna Better Health to determine during the stay whether or not a medical criterion for coverage is met.

If you are unsure regarding the necessity for preauthorization, please call Health Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS). For weekend or after-hours admissions, you can call Health Services on the next working day at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS). For urgent/emergent issues after hours, call **800-272-1878 (FAMIS or Medallion) or 855-652-8249 (CCC PLUS) and follow the prompts for afterhours preauthorizations** and you will be directed to an on-call nurse that can assist you.

You may also fax to **844-797-7601**.

Members that inappropriately seek routine and/or non-emergent services through emergency department visits will be contacted by Aetna Better Health and educated on visiting their PCP for routine services and/or treatments. Use of ground ambulance transportation under the prudent layperson's definition of emergency will not require authorization for the ambulance service.

Pharmacy

Aetna Better Health pharmacy benefit is intended to cover medically necessary prescription products for self-administration in an outpatient setting. The pharmacy benefit provides for outpatient prescription services that are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. Providers may fax a request to Aetna Better Health Formulary by contacting the Pharmacy Prior Authorization at **855-799-2553**.

The Aetna Better Health formulary is a key component of the benefit design. The goal of our formulary is to provide cost-effective pharmacotherapy based on prospective, concurrent, and retrospective review of medication therapies and utilization. The principal consideration in the selection of covered drugs is to provide safe and effective medications for all disease states.

Vaccines For Children (VFC) program

Aetna Better Health facilitates the payment of allowable fees for the administration of childhood immunizations to see that vaccines administered to enrolled and eligible members under the Vaccines For Children (VFC) program are appropriately reimbursed. Aetna Better Health will reimburse participating providers for administration costs for vaccines provided to eligible members under the VFC program. Please check VFC program eligibility with the State of Virginia.

What is the Vaccine for Children Program?

VFC helps families by providing free vaccines to doctors who serve eligible children. The program is administered at the national level by the CDC through the National Immunization Program (NIP). CDC contracts with vaccine manufacturers to buy vaccines at reduced rates.

States and eligible U.S. projects enroll physicians who serve eligible patients up to and including age 18 years, providing routine immunizations with little to no out-of-pocket costs.

For more information about the Virginia Vaccines For Children (VVFC) Program, and how to join, please contact the VVFC office at **800-568-1929**, email: VVFC@vdh.virginia.gov or access the following web site: www.vdh.state.va.us/epidemiology/immunization/vfc/vfccontacts.htm

Women, Infants and Children (WIC) nutrition program

Aetna Better Health benefits do not include WIC (the Special Supplemental Nutrition Program for Women, Infants and

Children). Aetna Better Health benefits do not provide transportation for you to pick up WIC checks. The Virginia Department of Health provides the WIC Program. We will send expectant mothers information on WIC in their Baby Matters material. If you want to find out more about WIC, call your local health department, or call toll-free **888-942-3663**.

How can you obtain WIC materials, forms, and information?

For WIC materials and forms or for more information, you can download many of the WIC program forms and education materials at:

- www.vdh.virginia.gov/ofhs/dcn/wic/WICVA/index.html
- <https://wicworks.fns.usda.gov/topics.html>

Foster care program

Effective September 1, 2013, the Commonwealth of Virginia began mandating Foster Care Children to be assigned to Managed Care Health Plans. The benefit of being assigned to a Managed Care Organization includes such additional services as one-on-one care management, coordination of health care services, 24-hour-nurse advice line, comprehensive health risk assessments, and translation services. Current foster care policy provides general health requirements for supervising agencies to ensure that each child has:

- A physical examination (well child visit, including behavioral health screening) within thirty (30) days of initial foster care placement
- A dental exam within ninety (90) days of initial foster care placement
- Current immunizations
- Children under the age of 3 are referred to Early Intervention for an assessment

There are also policy requirements to document all medical, dental, and mental health services received, including information regarding prescriptions, and to maintain a medical passport for each child that is provided to caregivers. Documentation of a child's present health status and medical needs is required from the onset of a child's placement into foster care.

Therefore, the Plan is going to need your assistance in ensuring timely access to care within your office for these children. If you are asked to provide an exam for a child in Foster Care and are unable to meet the above stated guidelines, please contact our Member Services department. We will work with the caregiver to have the child seen at another provider's office.

Your current provider contract with us will enable Aetna Better Health and our foster care membership to utilize you as a network provider. There is no contract amendment necessary to reflect your participation. All terms and conditions of your existing agreement with Aetna Better Health, including but not limited to those regarding your reimbursement, will remain the same for the foster care program.

Dental

Dental care for children is provided through the Smiles for Children Program. The toll-free number is **888-912-3456**. Aetna Better Health covers hospitalization and anesthesia-related services for medically necessary dental services, if preauthorized.

Interpretation services

Aetna Better Health provides interpreter services for non-English speaking or hearing and visually impaired members. DMAS is responsible for notifying Aetna Better Health at the time of the member's enrollment about this need. Aetna will also screen during member contacts if interpretation services are needed to provide assistance more efficiently.

Aetna Better Health will provide, upon request, alternative formats of all member related materials. Providers and members may inquire about interpretive services in their community by contacting Member Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Aetna Better Health offers a TDD line for hearing-impaired members. Aetna Better Health Member Services Department can establish interactions with other TDD lines and/or be available to mediate a TDD line. When a member prefers that available family or friend interpret for them or decides not to utilize Aetna Better Health' hearing impaired support service line, this preference must be noted in the member's medical record.

Behavioral health and substance abuse covered services

- Outpatient services in a psychiatrist's or licensed clinical psychologist's private office, certified hospital outpatient departments, and in the community mental health clinics approved and/or operated by the Virginia Department of Behavioral Health and Developmental Service.
- Medically necessary outpatient individual, family and group mental health and substance abuse treatment services. Short-term inpatient hospital services are covered for members under the age of 21 in participating hospitals when preauthorized by the Aetna Better Health mental health provider.
- Hospital stays for the treatment of medical conditions that relate to substance abuse (like acute gastritis, seizures, pancreatitis, and cirrhosis) need to be preauthorized by us.
- Psychological tests, when related to an apparent or diagnosed psychiatric illness and as part of the doctor's plan for deciding what the mental illness or disease is and how to treat it.
- Children who have special needs for medically necessary assessment and treatment services, including children who have been victims of child abuse and neglect, can get this care if: (1) the services are delivered by a doctor or provider whose specialty is in the diagnosis and treatment of child abuse and neglect; (2) the services are provided by a doctor or provider who has similar expertise. A provider who meets these standards will be verified by DMAS. Services required by a Temporary Detention Order (TDO) are covered for members up to 96 hours.
- All care given in a free-standing psychiatric hospital is covered for members up to the age of 21 and over the age of 64. When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by federal and state law.
- Outpatient substance abuse services.

Limits

Inpatient hospital stays for:

- Treatment of mental illness
- Functional nervous disorder(s) of any type or cause
- Psychiatric or psychoanalytic care for adults

Prior authorization

Some behavioral health services need to be approved as "medically necessary" by Aetna Better Health. To request and secure prior authorization for any of these services, please call us for approval at least 3 working days before the scheduled care. We may ask to see written notes showing that the care was medically needed before it is preauthorized. Our staff is available from 8 a.m. – 5 p.m. (ET). If you have questions, call Aetna Better Health Member Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Aetna Better Health of Virginia (HMO D-SNP) Basic Benefits

Aetna Better Health of Virginia's Special Needs Plan for Dual Eligible individuals (D-SNP) includes at a minimum basic benefits (Medicare-covered services), and also may include additional mandatory and optional supplemental benefits.

(1) Basic benefits are all Medicare-covered services, except hospice services.

(2) Supplemental benefits, which consist of—

(i) Mandatory supplemental benefits: services not covered by Medicare that an enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost-sharing.

(ii) Optional supplemental benefits: health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually.

CMS reviews and approves plan benefits and associated cost sharing to ensure all of the following:

(1) Medicare-covered services meet CMS fee-for-service guidelines.

(2) Benefits are not designed to discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services. And,

(3) Benefit design meets other MA program requirements.

(4) Cost sharing for Medicare Part A and B services specified by CMS does not exceed levels annually determined by CMS to be discriminatory for such services.

(5) Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine are directly accessible (through self-referral) for all enrollees.

NOTE: Medicare Advantage organizations may not impose, and providers must not attempt to collect, cost-sharing for influenza vaccine and pneumococcal vaccine on their MA plan enrollees.

Chapter 7 – Member eligibility and enrollment

Member Services

Member Services provides information for Members on eligibility, benefits, grievances, education, and available programs. Member advocates can provide services for Members having trouble with their health care needs, finding providers, filing grievances, or appeals, as well as assist providers with non-compliant Members and/or discharges. Member Services can be reached at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

For information surrounding CCC Plus member eligibility and enrollment, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).

Eligibility

Eligibility determinations are made by the Commonwealth of Virginia Medicaid program prior to enrollment with a managed care plan, including Aetna Better Health. The Commonwealth of Virginia Medicaid program also determines any coverage prior to the enrollment effective date with Aetna Better Health. DMAS pays us a monthly premium for

member Aetna Better Health coverage. If members are found not eligible for Aetna Better Health coverage for past months because they did not give truthful information to their case worker or tell their case worker about changes in their circumstances, they may have to pay DMAS back for these premiums even if they do not get medical services under Aetna Better Health benefits during these months.

Virginia operates a program of mandatory participation in a managed care program for the following groups of Members:

- Children in foster care
- Persons under age twenty-one (21) who are receiving Medicaid
- Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
- Persons receiving Medicaid for the blind or disabled
- Persons receiving Medicaid for the aged
- Pregnant women

Within the groups identified above, the following groups of members are currently excluded from managed care:

- Persons who were inpatient in State mental hospitals
- Persons who are approved by the Department as inpatients in long-stay hospitals
- Persons who are placed on spend-down
- Persons who are participating in Federal Waiver Programs for home-based and community based Medicaid coverage prior to Managed Care enrollment. Persons enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver, if determine to be Medallion 3.0 managed care eligible, shall not be excluded.
- Persons other than students who permanently live outside their area of residence for greater than (60) consecutive days, except those members placed there for medically necessary services funded by the Contractor or other MCO.
- Persons who receive hospice services in accordance with Department criteria
- Person with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents and any insurance purchased through the Health Insurance Premium Payment Program. Veteran's Affairs (VA) benefits are not considered "other insurance"
- Newly eligible members who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective.
 - Exclusion may be granted only if the member's obstetrical provider (physician, certified nurse midwife, or hospital) does not participate with any of the state-contracted MCOs. Exclusion requests within this paragraph shall be made by the member, MCO, or obstetrical provider.
- Person under the age of 21 who are approved for DMAS residential facility Level C Programs
- Persons who have been assigned to the Contractor but whose physician certifies a life expectancy of six (6) months or less may request exclusion. Requests must be made during the assignment period.
- Persons who are eligible and enrolled in the Virginia Birth-Related Neurological Injury compensation Fund, commonly known as the Birth Injury Fund.
- Persons who are inpatients in hospitals at the scheduled time of enrollment who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This does not apply to newborns unless there is a break in coverage.
- Certain persons between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act, who are granted an exception by the Department.
- Persons who are enrolled in the Commonwealth's Title XXI SCHIP program.
- Persons who have an eligibility period that is only retroactive.

Enrollment

Upon initial eligibility determination and during the annual enrollment period for Medicaid, members who want to be enrolled into managed care plan can contact the enrollment broker for the State of Virginia.

Verification of eligibility

Member eligibility and enrollment can and should be confirmed by utilizing one of several methods:

- Virginia Medicaid Eligibility System at **800-772-9996** or **800-884-9730** (outside of Richmond), or **804-965-9732** or **804-965-9733** for Richmond and the surrounding counties
- Provider web portal eligibility search at **www.viriniamedicaid.dmas.virginia.gov**
- Aetna Better Health Member Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS)

Commonwealth of Virginia-automated eligibility information

Providers may obtain Medicaid eligibility and plan assignment information for members by calling Virginia's MediCall Automated Voice Response System (toll-free numbers are available 24-hours-per-day, seven days a week): **800-772-9996** or **800-884-9730** or via the online Automated Response System (ARS) accessed through the Virginia Medicaid Web portal at: www.viriniamedicaid.dmas.virginia.gov

Identification Cards (ID)

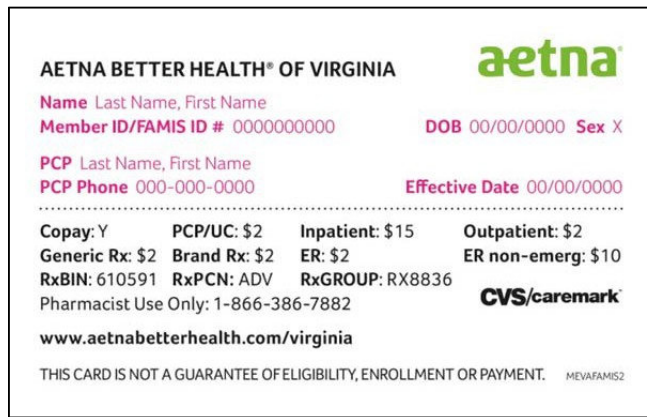
Members are provided a Medicaid ID card from the Commonwealth of Virginia. Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in the Aetna Better Health plan. An ID card will be mailed to each new member when a PCP is selected or assigned.

Members are encouraged to keep the identification card with them at all times. If the card is lost or stolen, the member should call Member Services immediately to get a new card. Should a member present without a card or present with a State of Virginia Medicaid ID card, services should not be denied. To confirm the Aetna Better Health member's PCP selection, call Member Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

The Aetna Better Health identification card will include the following information:

- Aetna Better Health' name
- Member name
- Member/State Medicaid ID number
- Primary care provider name and telephone number
- Member Services telephone number
- Claim submission information
- 24-hour Informed Health Line telephone number
- Behavioral Health/Crisis telephone number

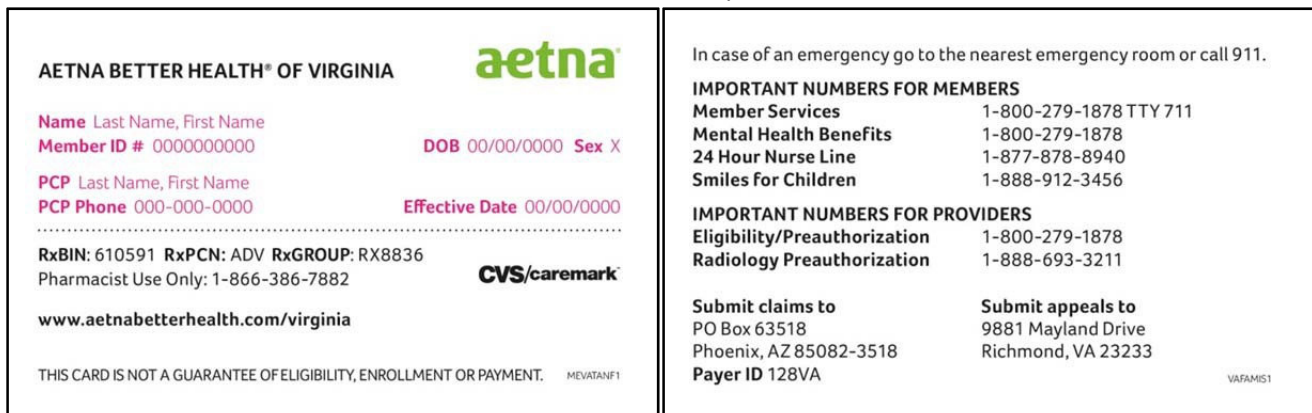
Example of Medallion ID Card



There are four different Member ID cards (three FAMIS and Medallion) with product identifiers in the lower right hand corner of each card:

1. MEVAFAMIS1 – Copay No / \$0
2. MEVAFAMIS2 – Copay Yes / \$2 – (see above example)
3. MEVAFAMIS5 – Copay Yes / \$5
4. MEVATANF1 – (Medallion) Copay Non Applicable -- (see below example)

Back information - same for all Member ID Cards – see example below



Member rights and responsibilities

For information surrounding CCC Plus member rights and responsibilities, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).

Member rights

Aetna Better Health members have the right to:

- Be informed of Aetna Better Health and all covered services.
- Receive information about Aetna Better Health, our services, doctors, other providers, and member rights and responsibilities.
- Be treated with respect, dignity and the right to privacy.
- Choose their personal Aetna Better Health doctor/primary care provider (PCP).
- Change their Aetna Better Health primary care provider (PCP).
- Be treated regardless of race, gender, gender identity, sexual preference, religion, disability, ethnicity, national origin, or source of payment.

- Expect all information about their health to be confidential and to have your privacy protected.
- Not have their medical records shown to others without their approval, unless allowed by law.
- Receive information from their doctor about treatment options or other types of care available to you, appropriate to your condition, and explained in a way you can understand.
- Receive services from out of network doctors/providers.
- Receive a second opinion on a medical procedure from an in-plan doctor/provider. If an Aetna Better Health provider is not available, we will help members get a second opinion from a non-participating provider at no cost to them.
- Participate with their doctor/provider in making decisions about their health care.
- Tell the doctor/provider that you do not want treatment, and be told what may happen if they do not have the treatment. Members can continue to get Medicaid and medical care without any repercussions even if they say no to treatment.
- Make an official complaint or grievance about Aetna Better Health or file an appeal if they are not happy with the answer to their question, complaint/grievance, or care given.
- Appeal a medical decision made by Aetna Better Health directly to the Department of Medical Assistance Services (DMAS).
- Know the cost to them if they choose to get a service that Aetna Better Health does not cover.
- Be told in writing by Aetna Better Health when any of their health care services requested by their PCPs are reduced, suspended, terminated, or denied. They must follow the instructions in their notification letter.
- Have members and/or the members' doctors tell them about treatment choices, no matter what the cost or benefit coverage.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Find out what is in their medical records and request that they be corrected or amended.
- Request a copy of their medical records.
- Exercise their rights and know that they will not have any retaliation against them by Aetna Better Health, any of our doctors/providers or state agencies.
- Access to health care services and medical advice twenty-four (24) hours a day, seven (7) days a week, including urgent and emergency services.
- Get family planning services from any participating Medicaid provider without prior authorization.
- Get information in different formats (i.e., large print, Braille, etc.), at no cost to them, if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.
- Get interpretation services if they do not speak English or have a hearing impairment to help them get the medical services they need.
- Make recommendations or suggestions regarding Aetna Better Health's member rights and responsibilities.
- Develop Advance Directives or a Living Will, which tell how to have medical decisions made for them if they are not able to make them for themselves.
- To ask for a description of all types of payment arrangements that we use to pay providers for health care services.

Member responsibilities:

Aetna Better Health members are responsible for:

- Reading the member handbook. It tells them about Aetna Better Health services and how to file a complaint or grievance
- Schedule wellness check-ups. Members under twenty-one (21) years of age need to follow the Early Periodic Screening Diagnosis and Treatment [EPSDT] schedule.
- Get care as soon as they know they are pregnant. Keep all prenatal appointments.

- Carrying with them and showing their Aetna Better Health identification (ID) card to each doctor before getting health services.
- Protecting their member ID card and not sharing it with others.
- Getting medical care from providers in our network.
- Knowing the name of their assigned PCP.
- Telling the doctor that they and/or their child are/is a member of Aetna Better Health at the time that they speak with the doctor's office.
- Keeping doctor's appointments or calling to cancel them at least twenty-four (24) hours ahead of time.
- Using the emergency room (ER) for true emergencies only.
- Learning the difference between emergencies and when they need urgent care.
- Treating the doctors/providers, staff and people providing services to them with respect.
- Giving all information about their health to Aetna Better Health and their doctor in order to provide care.
- Telling the doctor if they do not understand what they tell them about their health so that they and their doctor can make health plans and treatment goals together.
- Following what they and their doctor agree to do including making follow up appointments, taking medicines and following their doctor's care instructions.
- Telling Aetna Better Health and DMAS when their address changes.
- Telling Aetna Better Health about changes in their family that might affect their eligibility or enrollment such as family size, employment, and moving out of the commonwealth of Virginia.
- Telling Aetna Better Health if they have other health insurance, including Medicare.
- Giving their doctor a copy of their Living Will and/or Advance Directive.
- Learning about prescription drugs and reasons for taking them.
- Letting Aetna Better Health know how we can work better for them.

Aetna Better Health distributes its member rights and responsibility statement to new members in enrollment kits and to existing members via newsletter and website access each year. Members can request a copy be mailed to them by contacting Member Services. We also distribute the member rights and responsibility statement to new practitioners when they join our network and to existing practitioners each year via the website.

Persons with special health care needs

The Health Plan is required to do the following for members identified as persons with special health care needs:

- Conduct an assessment in order to identify any special conditions of the member that require ongoing care management services
- Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs
- For individuals determined to require care management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the member

Primary care provider (PCP) assignment

Each Aetna Better Health member is assigned a PCP. Members are allowed to select a PCP at the time of enrollment and may change their PCP voluntarily at any time by contacting Member Services. For involuntary termination of a PCP, please see Non-Compliant members/PCP Transfer in Provider Responsibilities and Important Information chapter.

PCP selection

Primary care physicians include physicians in the following specialties:

- Family practice,
- General practice,

- Internal Medicine, or
- Pediatrics
- Obstetrics/Gynecology
- Certified Nurse Practitioners(CNP, under direct supervision of a physician)
- Certified Nurse Midwife (under the supervision of a physician)

Every family member enrolled in the Plan must choose a primary care physician, although it does not have to be the same physician. All members have the option of changing their primary care physician. Members may request to change their PCP following the initial visit without cause. PCP change requests made before the 15th of the month are made effective the first of the same month. PCP change requests made after the 15th of the month are made effective the first of the next month (i.e., request received 10/15 effective 11/1).

- Aetna Better Health members are given the opportunity to select a Primary Care Provider (PCP).
- If a member has NOT selected a PCP upon enrollment, Aetna Better Health shall assign one for them. Aetna Better Health shall consider factors such as age, gender, language(s) spoken, location, and special needs.
- Upon notice of the current automatically assigned PCP by Aetna Better Health, the member has the opportunity to request a PCP change if not satisfied with the assigned PCP.
- A list of PCPs is made available to all Aetna Better Health members. Member Service representatives are available to assist members with selecting a PCP.
- Members have the freedom to select participating PCPs based on age/gender limit restrictions.
- Members are encouraged to choose a PCP that is geographically convenient to them; however, members are not restricted by any geographic location.

Aetna Better Health members may change their PCP at any time, by contacting Member Services at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Members with a disabling condition and/or chronic illness may request that their PCP be a specialist. These requests will be reviewed by the Aetna Better Health Medical Director to ensure that the specialist requested agrees to accept the role of PCP and assume all the responsibilities associated with this role. Members need to contact Member Services directly for such requests. Member Services will route the request directly to the Medical Director for review.

Aetna Better Health may initiate a change in a member's primary care physician under the following circumstances:

- The member's primary care physician ceases to participate in Aetna Better Health's network.
- The physician/patient relationship will not work to the satisfaction of either the physician or the patient.
- The physician requests the patient select another primary care physician and sends written notification to the member and to Aetna Better Health, giving a minimum of 30-days' notice.

Members are advised to get to know and maintain a relationship with their primary care physician. They are instructed to always contact their primary care physician before obtaining specialty services or going to the emergency room. It is the responsibility of all primary care physicians to manage the care of each patient, directing the patient to specialty care services as necessary. It is the responsibility of the specialist physician to work closely with the primary care physician in the process.

Newborn enrollment

Newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health, by the Medical Service Administration. Unless the mother selects a different Medicaid Managed Care Plan, newborns born during the mother's Aetna Better Health enrollment are eligible to receive services from Aetna Better Health. Hospital social service coordinators or local caseworkers usually initiate the process of educating and facilitating the mother of an Aetna Better Health newborn to complete the Medicaid enrollment process. To notify Virginia Medicaid or FAMIS of the child's birth, a Newborn Eligibility Notification form (DMAS 213) will be submitted to Virginia Medicaid or FAMIS by Aetna Better Health's Enrollment Department.

Newborns are retrospectively enrolled with Aetna Better Health back to the date of birth by the state. Delayed newborn enrollment may cause a delay in claim reimbursement for Providers. Once the file is received from the state with the newborn enrolled, your claim will be processed.

If the mother has not selected a PCP for her newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member.

Member removal from PCP panel

The PCP may request removal of a member from their panel upon submission of supporting documentation verifying circumstances that warrant removal. Circumstances that may warrant a disenrollment request include, but are not limited to:

- Failure to follow a recommended health care treatment plan. (This can occur after one (1) verbal or one (1) written warning of the implication and possible effect of non-compliance.)
- Documented chronic missed appointments
- Documented behavior, which is consistently disruptive, unruly, abusive, or uncooperative
- Documented behavior which constitutes a threat or danger to the office staff or other patients

To remove a member from their panel, PCPs should:

- Notify the member in writing to choose another PCP and of the reason for termination with 30-days' notice and by certified mail.
- Manage care for emergent services during this time period.
- FAX termination notification with supporting documentation to the Provider Relations Department.

Provider Relations Department will review the notification to determine whether the termination needs to be addressed for care management intervention, or be forwarded to the Compliance Department for direct action with DMAS.

Member disenrollment from Aetna Better Health

The Virginia Department of Medical Assistance Services (DMAS) has sole authority for dis-enrolling members. DMAS may dis-enroll members for any of the following reasons:

- Loss of eligibility
- Placement of the member in a long-term nursing facility, state institution or intermediate care facility for individuals with intellectual disabilities for more than thirty (30) days
- Member selection of a different Medicaid Managed Care Plan
- Member change of residence outside of the Aetna Better Health service area
- Profound noncompliance of a member to follow prescribed treatments or requirements that are consistent with state and federal laws and regulations when agreed upon by the DMAS
- Abuse of the system, threatening or abusive conduct/behavior that is disruptive and unruly which seriously impairs Aetna Better Health ability to provide service to either the member or others
- Commitment of intentional acts to defraud Aetna Better Health and/or DMAS for covered services

Violent or life-threatening behavior

The provider must provide written notification that a member has demonstrated one or more of the above behaviors, in addition to the following supportive documentation as appropriate:

- Police Report and or incident Report from staff involved or threatened
- Copy of member's chart documenting member was previously counseled on the behavior by the PCP (if applicable)
- Any other documentation to support request for disenrollment

Fraud or misrepresentation

- Police Report or if no police report:
 - Documentation as to why it was not reported
 - Documentation that indicates the case was referred to the Commonwealth of Virginia's Office of the State Inspector General, phone: **804-625-3255**, FAX: **804-786-2341**, email: osig@osig.virginia.gov
- Incident Report on the fraudulent activity
- Copies of altered prescription and/or copies of original prescription
- Copy of Patient Signature Log from the Pharmacy, along with the Pharmacy Profile
- Copies of any member correspondence (i.e., PCP dismissal letter to the member, letter from Aetna Better Health to the member, explaining our policies, etc.)
- Additional documentation to support request for disenrollment, especially if there is no police report to show patterns of past questionable behaviors involving drugs, changing doctors, etc.

Member education - New member Information

Educational and informational materials are frequently sent to our members. Aetna Better Health members are sent a welcome packet upon enrollment. The welcome packet contains the following:

- Welcome letter
- Member handbook which contains but is not limited to an explanation of Rights and Responsibilities as an Aetna Better Health member, Benefits, and information on how to make appointments
- Certificate of Coverage which contains a comprehensive explanation of covered services, limitations and exclusions
- Notice of Privacy Practices which contains Aetna Better Health protocols relative to ensuring member privacy of records

Member identification cards are sent separately via first class mail service prior to the mailing of a new member welcome packet. Aetna Better Health identification cards indicate the PCP's name and telephone number.

Medicaid beneficiaries must sign a Medical Release of Information Form when they enroll with the Virginia Medicaid Program. This release authorizes the release of medical records to Aetna Better Health and any representative of Aetna Better Health to promote:

- Continuity of care
- Assist in the coordination of care
- Clinical review
- State and Federal sponsored audit
- Accreditation Agency

Member outreach activities

The Aetna Better Health Member Outreach Department and Quality Management is responsible for making contact with members to assist with coordinating gaps in care. The Member Outreach Department frequently coordinates activities within the community to provide member education and information regarding Aetna Better Health member initiatives.

Advanced directives

Please see the Provider Responsibilities and Important Information chapter for additional information.

Member grievance and appeal process

Members have the right to file a complaint (grievance) or dispute an adverse determination (appeal). The health plan asks that all providers cooperate and comply with all Aetna, Medicaid, and/or CMS requirements regarding the processing of member complaints and appeals, including the obligation to provide information within the timeframe

reasonably requested for such purpose. For further guidance on the member grievance and appeal process, please contact Member Services.

Member handbook

A member handbook is provided to our actively enrolled members upon enrollment. Changes to any program or any service site changes are provided to members in a timely manner. The member handbook includes information about covered and non-covered services and covers key topics such as how to choose and change a PCP, copays, and guidance to emergency care. The member handbook is available electronically on the Aetna Better Health website.

Chapter 8 - Care Management

The purpose of Care Management is to identify, assess, and provide intervention in cases that due to their chronicity, severity, complexity, and/or cost, require close management to affect an optimal member outcome in a cost effective manner. The Care Manager will review medical management/utilization management data such as, but not limited to, specific high-risk diagnosis, multiple admissions, or ER visits length of stay admissions greater than seven (7) days, and/or multiple disciplines/therapies required for a treatment.

Providers, nurses, and plan staff work together to identify those who may benefit from care management. Aetna Better Health identifies members by several means, including health risk assessments and data screening. We may receive a referral from a health information line nurse, chronic condition management program staff, discharge planner or other UM staff. Referrals can also be made by members and their families or caregivers. All members have access to a care manager. Care managers (CM) typically are registered nurses or social workers. The CM works with you, the member, caregiver and/or family to come up with a plan of care that meets the member's needs. How much help a member receives depends on the individual.

If you have a member who has a chronic condition, you or your staff can make a referral to Aetna Better Health's chronic condition management program at any time. To make a referral or to find out more information call Member Services and ask for the Integrated Care Management Department. Additional information and instructions regarding how to use chronic condition management services are available on our website under For Members then clicking Special Programs then Disease Management tabs

The Care Manager requests information to assess the member's current medical status, treatment plan, and potential medical treatment requirements and identify those non-medical issues that may impact the member's medical outcome. The Care Manager will collaborate with specialty consultants, attending physician, the PCP, the member, the member's "family," and other members of the health care team in order to facilitate the highest quality of service, at the most cost effective level, that support the goals established to achieve the member's best long term outcome. The Care Manager will attempt to identify and direct the use of alternative resources within the community that serve to support achieving established goals in the event a benefit is not available.

The Care Manager serves as a liaison for Providers, members, family, and/or alternate payers to insure compliance to the treatment plan, facilitate the appropriate use of cost effective alternative services, as well as assess effectiveness of the treatment plan based on goals achieved.

Cases will be considered closed upon the termination of the member, refusal of the member or family to participate with the case management process; and/or if the physician and/or member agree that the reassessment, current

treatment plan and/or progress of the member is such that case management intervention is no longer required to maintain the member at his/her optimum level of wellness. To request an evaluation for complex care management support, providers may contact Aetna Better Health at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Aetna Better Health implements a population-based approach to specific chronic diseases or conditions. All ABH members with identified conditions are auto enrolled in the program based on claims date. Members that do not wish to participate can call member services and notify the Plan of their desire not to participate and they will be dis-enrolled from the program. All members are sent educational material to promote better member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care, and testing which are supported by evidence based practices and tools. Additionally, auto alert flags to the care manager's desk top identifying members with significant "gaps" in their care and/or disease/condition education. Care managers reach out to those members in an effort to educate and assist the members in obtaining needed services including lifestyle modifications and health resource access.

Our goal is to assist our members/your patients, to better understand their chronic conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Providers can contact the Plan at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS), and follow the prompts to enroll a member in our Care Management program.

The following services are offered by the program:

- Support from health plan nurses and other health care staff to ensure that patients understand how to best manage their condition and periodically evaluate their health status,
- Periodic newsletters to keep them informed of the latest information on conditions and their management,
- Educational and informational materials that assist patients in understanding and managing medications prescribed by practitioners, how to effectively plan for visits to see practitioners and reminders as to when those visits should occur

Membership in our care management program is voluntary, which means at any time members can request withdrawal from the program, they need only call the health plan's Member Services department.

For information surrounding CCC PLUS care management, please refer to Chapter 15; Commonwealth Coordinated Care Plus (CCC Plus).

Chapter 9 – Pharmacy

Aetna Better Health covers prescription medications and certain over-the-counter medicines when you write a prescription for members enrolled in Virginia Medicaid managed Care. Pharmacy benefits are administered through CVS Caremark. CVS Caremark is responsible for pharmacy network contracting, mail order delivery, and network Point-of-Sale (POS) claim processing. Aetna Better Health is responsible for formulary development, drug utilization review, and prior authorization.

Prescriptions, drug formulary and specialty injectables

Pharmaceutical and pharmaceutical management procedures are provided on our website by selecting "For Providers" then clicking on the Pharmacy tab. Information provided includes covered pharmaceuticals, formulary updates, mail

order prescriptions, limits on refills, doses or prescriptions, use of generic substitution and step-therapy protocols, and prior authorization guidelines.

Check the current Aetna Better Health formulary before writing a prescription for either prescription or over-the-counter drugs.

How can you find a drug on the Formulary?

There are three ways to find a drug on www.aetnabetterhealth.com/virginia:

- You can search alphabetically, or
- You can search by brand and generic name, or
- You can search by therapeutic class

If the drug is not listed, or you need to provide information to support an exception request, a Pharmacy Prior Authorization Request form must be completed before the drug will be considered. Please also include any supporting medical records that will assist with the review of the prior authorization request. Pharmacy Prior Authorization forms are available on our website and requests may be made telephonically: **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS), or fax: **855-799-2553**.

Aetna Better Health members must have their prescriptions filled at an in-network pharmacy.

Prior authorization process

Aetna Better Health's pharmacy prior authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State's Medicaid program
- Prescriptions that do not conform to Aetna Better Health's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when a "A" rated generic equivalent is available

Aetna Better Health's Medical Director is responsible for adverse decisions, including a complete denial or approval of a different medication. Using specific, evidence-based PA pharmacy review guidelines, Aetna Better Health's Medical Director may require additional information prior to making a determination as to the medical necessity of the drug requested, such as:

- Formulary alternatives that have been tried and failed or cannot be tolerated (i.e., step therapy)
- There are no therapeutic alternatives listed on the formulary
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the Federal Drug Administration (FDA) or as accepted by established drug compendia)
- For brand name drug requests, a completed FDA MedWatch form documenting failure or intolerance to the generic equivalents is required

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Medical Director may contact the prescriber to discuss the case or consult with a board certified physician from an appropriate specialty area such as a psychiatrist.

Aetna Better Health will fill prescriptions for a seventy-two (72) hour supply if the member's prescription has not been filled due to a pending PA decision and the drug is prescribed for an "emergency medical condition".

Step therapy and quantity limits

The step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs. Drugs having step therapy are identified on the formulary with "STEP." Certain drugs on the Aetna Better Health formulary have quantity limits and are identified on the formulary with "QLL".

The QLLs are established based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat.

To request an override for the step therapy and/or quantity limit, please fax a Pharmacy Prior Authorization Request form and any supporting medical records that will assist with the review of the request to **855-799-2553**.

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis, and rheumatoid arthritis, which are not often available at local pharmacies. Specialty medications require prior authorization before they can be filled and delivered. Providers can call **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS) to request prior authorization, or complete the applicable prior authorization form and fax to **855-799-2553**.

Specialty medications can be delivered to the provider's office, member's home, or other location as requested.

Mail order prescriptions (FAMIS only)

Aetna Better Health offers mail order prescription services through CVS Caremark. FAMIS members can access this service in one of three ways.

- By calling CVS Caremark, toll free at **855-271-6603/TDD 800-231-4403**. Monday to Friday between 8 a.m. and 8 p.m., Eastern Time. They will help the member sign up for mail order service. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By going to: www.caremark.com FAMIS members can log in and sign up for Mail Service online. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then the member calls CVS Caremark and asks CVS Caremark to mail them a Mail Service order form. When the member receives the form, the member fills it out and mails CVS Caremark the prescription and the order form. Forms should be mailed to:

CVS CAREMARK
PO BOX 2110
PITTSBURGH, PA 15230-2110

Chapter 10 – Concurrent review

Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the

admission, and appropriateness of the level of care, using the Hearst Corporation's MCG evidence-based care guidelines (formerly Milliman Care Guidelines). Admission certification is normally conducted within one business day of receiving medical information but no later than three (3) days of notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of additional days. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

Medical criteria

Criteria sets and the procedures for applying them are reviewed annually and updated in accordance with policy: Process for Approving and Applying Medical Necessity Criteria. The annual review process involves appropriate practitioners in developing, adopting, or reviewing criteria.

Aetna Better Health uses the Hearst Corporation's MCG evidence-based care guidelines to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. These guidelines are updated regularly as each new version is published. A free copy of individual guidelines pertaining to a specific case is available for review upon request by phone **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating of discharge planning for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Chapter 11 – Prior authorization

The requesting practitioner or provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Access to our Utilization Medical team

For members and practitioners who may need access to one of our nurses:

- During business hours (8 a.m. to 5 p.m.), they can call in-bound collect, or **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS) and ask to be connected to a nurse. This number also applies to case or disease management nurses. If case or disease management nurses are not available, callers have the option of leaving a message, and they will be called back by the end of the next business day. Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues.
- After business hours, members can call **800-609-4163** option **6** or TTD **800-828-1120**, and they will be connected to the 24-hour nurse line.
- Members with special communication needs:
 - Who have access to TDD telephones, may call **800-828-1120** or **711**. If they cannot reach us at this number, they may contact us through Virginia Relay, toll-free at TDD **800-828-1120** or Voice **800-828-1140**.
 - Language translation services are also provided free of charge by calling **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS).

Providers may call **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS) to request prior authorization, and these requests must include the following:

- Current, applicable codes (may include):
 - Current Procedural Terminology (CPT),
 - International Classification of Diseases, 10th Edition (ICD-10),
 - Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
 - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Name, address, phone and fax number of the treating practitioner
- Problem/diagnosis, including the ICD-10 code
- Presentation of supporting objective clinical information, such as:
 - Clinical notes
 - Laboratory and imaging studies
 - Prior treatments

All clinical information should be submitted with the original request.

Timeliness of decisions and notifications to practitioners, providers and/or members

Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable members in a timely manner. Unless otherwise required by DMAS, Aetna Better Health adheres to the following decision/notification time standards.

Decision	Decision timeframe	Notification to	Notification method
Urgent pre-service approval	Based on members need but no more than seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral and Electronic/Written
Urgent pre-service denial	Based on members need but no more than seventy-two (72) hours from receipt of request	Practitioner/Provider and Member	Oral and Electronic/Written
Non-urgent pre-service approval	Based on members need but no more than fourteen (14) calendar days from receipt of the request	Practitioner/Provider	Oral and Electronic/Written

Non-urgent pre-service denial	Based on members need but no more than fourteen (14) calendar days from receipt of the request	Practitioner/Provider and Member	Oral and Electronic/Written
Urgent concurrent approval	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Urgent concurrent denial	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral and Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider and Member	Electronic/Written
Termination, Suspension Reduction of a Previously Authorized Service	At least ten (10) Calendar days before the date of the action.	Practitioner/Provider and Member	Electronic/Written

If Aetna Better Health approves a request for expedited determination, a notification will be sent to the member and the physician involved, as appropriate, of its determination as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receiving the request.

If Aetna Better Health denies a request for an expedited determination, the request will automatically be transferred to the standard time frame. Aetna Better Health will promptly provide the member oral notice of the denial of an expedited review and of their rights. Aetna Better Health will send to the member within seventy-two (72) hours, a written letter of the members' rights.

Out-of-network providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the decision. Aetna Better Health sends documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by-case basis in consultation with Aetna Better Health's medical director(s).

Prior authorization list

Treating practitioner/providers must request authorization for certain medically necessary services. (See attachments.) A complete and current list of services that require prior authorization can be found online at www.aetnabetterhealth.com/Virginia. Unauthorized services will not be reimbursed and authorization is not a guarantee of payment.

Prior authorization and coordination of benefits

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is required. If the service is not covered by the primary payer, the provider must follow Aetna Better Health's prior authorization rules.

How to request prior authorizations

A prior authorization request may be submitted by:

- 24/7 Secure Provider Web Portal located on the Aetna Better Health's website
- Fax the request form to **866-669-2454** (forms are available on the health plan website).

- Please use a cover sheet with the practice’s correct phone and fax numbers to safeguard the protected health information and facilitate processing,
- Call Prior Authorization directly at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS)

Chapter 12 – Quality Management

Aetna Better Health’s quality management program is designed to continuously improve and monitor the medical care, member safety, behavioral health services, and the delivery of services to members, including ongoing assessment of program standards to determine the quality, accessibility and appropriateness of care, case management and coordination. A key focus of our quality program is improving the member’s biological, psychological, and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. Where the member’s condition is not amenable to improvement, our goal is to maintain the member’s current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated throughout Aetna Better Health and the provider network. We promote the integration of our quality management activities with other systems, processes, and programs throughout Aetna Better Health.

Quality management is a company-wide endeavor, with crosscutting teams who work together to integrate by interdepartmental monitoring processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, grievances and appeals), business application systems, and databases that are accessible to all areas. Our quality program also includes a structure of oversight committees with representation not only from across Virginia, but from the provider network and member population as well.

Program purpose

The Aetna Better Health QM Program allows Aetna Better Health the flexibility to target activities that focus on patterns identified at the local market level. The QM Program provides a structure for promoting and achieving excellence in all areas through continuous improvement. It provides the framework for Aetna Better Health to continually monitor, evaluate, improve the quality of care, safety, and services provided to all members, employers, practitioners/providers, and external/internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services. Core values of the program include maintaining respect and diversity for members, providers, and employees.

The QM program is a commitment to innovation, affordability, professional competence and continuous learning, teamwork and collaboration. The clinical aspects of the QM Program are structured from evidence-based medicine. The QM Program also ensures health services needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds are met. The QM Program supports efforts to attain an understanding of the populations served, in terms of age groups, disease categories, and special risk status through analysis, monitoring, and the evaluation of processes. The quality of care and services are optimized and continuously improved while maintaining cost effective utilization of health care resources. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement. The program addresses activities related to QM, utilization management (UM), customer service, member rights and responsibilities, member experience, practitioner/provider credentialing and re-credentialing, risk management and delegation vendor/entity oversight.

The QM Program promotes member compliance with recommended preventive health services. Standards are set and monitoring is done to ensure these services remain a focus. Preventive health care remains the key to the attainment of

improved member health and satisfaction and a cost effective health plan. Members are educated about age specific preventive care.

The process of Unitization Management plays a vital role in the QM program including, but not limited to, concurrent review and pre-authorization programs; identification of potential quality of care issues and potential under and over-utilization.

The QM Program consists of the following elements:

- QM Program Description Summary
- Policies & Procedures
- Annual QM Program Evaluation
- Annual QM Work Plan
- Quality Improvement Activities
- QM Committee Structure

Employees must avoid situations where their personal interest could conflict or appear to conflict with their responsibilities, obligations, or duties to the Health plan's interest or present an opportunity for personal gain apart from the normal compensation provided through employment. Aetna Better Health does not use incentives to reward restrictions of care. Utilization management decision making is based only on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. No reviewing physician may perform a review on one of his/her patients, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

It is Aetna Better Health's policy to conduct business in a manner that protects the privacy of our members. Confidentiality will be maintained in accordance with federal and state laws. Confidential information requested, used and disclosed in the course of an investigation, is limited to the minimum amount necessary to accomplish the intended purpose; and controlled to maintain confidentiality and to minimize Health plan access to a "need to know" basis. [Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.](#)

[Contracted participating practitioners and providers are required by contract to:](#)

- [Cooperate with QI activities](#)
- [Maintain the confidentiality of member information and records](#)
- [Allow the plan to use practitioner performance data](#)

All committee minutes and reports are considered confidential. All external committee members are required to sign a confidentiality and conflict of interest statement prior to serving on a committee. All Health plan employees sign a confidentiality agreement as a condition of employment and receive annual training HIPAA and confidentiality policies.

Aetna Better Health's quality management program goals are to:

- Promote collaboration among Aetna Better Health departments and systems to allow for the collection and sharing of quality management data and monitoring of outcomes
- Work in collaboration with providers to actively improve the quality of care provided to members
- Maintain compliance with federal and state regulatory requirements and consistency with the State's quality strategy/quality plan and all other requirements of the contract
- Evaluate identified quality, risk and utilization issues, and develop follow-up measures (including action plans) to resolve the issues and prevent recurrences
- Define criteria for measuring clinical and non-clinical performance and assessing the outcomes against established standards and benchmarks, including HEDIS® measures
- Assess and identify opportunities for improvement by performing quality management and performance improvement activities as requested by internal and external customers (including regulatory agencies). This assessment process will ideally be based on solid data and focused on high volume/high risk procedures or other

services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided.

- Identify, monitor and evaluate high-volume, problem-prone or high-risk aspects of health care and service
- Provide feedback to members and their family/representative and/or caregiver, advocates, practitioners, providers and Aetna Better Health staff
- Maintain mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member (e.g., annual population assessment)
- Monitor the provider network's capacity to accommodate the diverse needs of the member population, including special health care needs as well as specific language or cultural needs and preferences. The evaluation of access includes analysis of services to members with disabilities.
- Monitor outpatient and inpatient services to identify deviations from standard of care/service
- Identify opportunities to educate members and their family/representative and or caregiver, advocates, practitioners, providers, and Aetna Better Health staff about quality management and performance improvement activities and outcomes and ways to improve members' health
- Develop, maintain, and increase awareness of prevention and wellness and outreach programs available to members (to include programs addressing chronic and catastrophic illness, behavioral health, long term care and care management)
- Incorporate an awareness of member safety into all quality activities
- Maintain technical business information systems to support quality management and performance improvement activities and improve them as necessary to meet program needs
- Inform members and practitioners of members' rights and responsibilities

Our objectives in the administration of our quality management program are to:

- Take action on identified opportunities for improving health care outcomes for members and monitor for continued effectiveness
- Educate providers and members and their family/representative and/or caregiver on appropriate and efficient utilization of health care services and facilities
- Maintain systems for monitoring and tracking practitioner and provider quality management and performance improvement trends and medical record keeping practices
- Maintain integrated processes to support quality management and performance improvement activities
- Manage quality and risk management referrals in order to promote optimum quality of care and service
- Evaluate practitioner and ancillary provider quality and utilization management and take action to improve areas showing opportunities for improvement
- Credential and re-credential practitioners and other network providers in a thorough and timely manner, in accordance with state and NCQA standards
- Inform and educate members and their family/representative and/or caregiver, practitioners, providers, and other stakeholders about quality and health improvement programs in order to increase the utilization of preventive health care, care management and other services
- Monitor and evaluate the continuity, availability, and accessibility of care or services provided to members
- Compile practitioner and provider information (such as quality or risk management trends, outcomes, and other information) into practitioner and provider information files
- Provide feedback to members and their family/representative and/or caregiver, practitioners and providers on the success of quality management and performance improvement activities, including health outcomes
- Improve the satisfaction of members, practitioners and providers with health care delivery
- Assist members with navigating the health care delivery system
- Establish standards of clinical care and service utilizing objective criteria and processes to evaluate and continually monitor for improvement
- Develop and maintain integrated systems and processes for collecting and disseminating quality data and information

- Integrate oversight of practitioner/provider quality and utilization management and take action if needed to promote improvement
- Promote involvement of members and their family/representative and/or caregiver and practitioners in the quality management program and related activities by encouraging feedback (e.g., through member/provider satisfaction surveys, telephone calls, participation on committees, as applicable)

Additional information about the QM program goals and outcomes as they relate to member care and services can be found on our website by clicking “For Providers”, then “Quality” tabs. An annual QM Summary highlights our accomplishments and can be obtained by contacting Provider Services. We also communicate outcomes in the Provider Newsletters.

Patient safety

Aetna has a patient safety program in place which is intended to support practitioners and providers (e.g., hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, behavioral health facilities), in their efforts to monitor for and reduce the incidence of medical errors. The program may include one or more of the following; prescription drug utilization review and tracking and trending of adverse events; prior authorization of pharmacy claims to ensure medical appropriateness and prevent unsafe prescribing; analysis of procedure and/or diagnosis codes to identify opportunities for improvement in medical practices and communicate any findings directly to the practitioner and/or provider involved; and education of providers and members about prevention and detection of unsafe practices.

Governing body

The Aetna Better Health Board of Directors has delegated ultimate accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO). The CMO is responsible for providing national strategic direction and oversight of the QM Program for Aetna Better Health members. The Board of Directors delegates responsibility of the health plan quality improvement process to the Quality Management Oversight Committee (QMOC), which oversees the quality program.

Program accountability – Board of Directors

Aetna Better Health Board of Directors has ultimate accountability for the QAPI and related processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network. The chief executive officer on behalf of the Quality Management Oversight Committee submits the QAPI and any subsequent revisions to the board of directors for approval. In addition, the chief executive officer annually submits to the board of directors an evaluation of the previous year’s QAPI activities, summary reports, data, outcomes of studies and credentialing activities (i.e., annual evaluation). The proposed annual QAPI work plan is also submitted to the board of directors for approval. After evaluating the information, the board of directors may provide further direction and recommendations to the Chief Executive Officer for enhancements to the QAPI and work plan.

Committee structure

Quality management and performance improvement activities are reported to the board of directors through the following committees:

- Quality Management Oversight Committee (QMOC)
- Quality Management/Utilization Management Committee (QM/UM)
- Delegation Committee
- Aetna Credentialing and Performance Committee (CPC)

- Aetna Practitioner Appeal Committee (PAC)
- Aetna Quality Oversight Committee (QOC)
- Pharmacy and Therapeutics Committee (P&T)
- Service Improvement Committee (SIC)
 - Grievance Committee
 - Appeals Committee
- Enrollee Advisory Committee (EAC)
- Member Advisory Committee
- Compliance Committee (CC)
- Policy Committee (PC)

Quality Management Oversight Committee (QMOC)

The Quality Management Oversight Committee's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee is designated to provide executive oversight of the QAPI and make recommendations to the board of directors about Aetna Better Health's quality management and performance improvement activities, including the annual QAPI, work plan and evaluation and work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers.

Quality Management/Utilization Management Committee (QM/UM Committee)

The Quality Management/Utilization Management (QM/UM) Committee's primary purpose is to advise and make recommendations to the Chief Medical Officer on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management program. Summary reports are submitted to the Quality Management Oversight Committee for review/approval and board of directors.

Delegation Committee

Aetna Better Health does not delegate QAPI activities. Aetna Better Health may delegate limited health plan activities. The Delegation Committee advises and makes recommendations to the QMOC about delegated relationships.

Aetna Credentialing and Performance Committee (CPC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated decision-making authority to the Aetna Credentialing and Performance Committee's (CPC). This committee is responsible for credentialing and recredentialing individual providers (i.e., practitioners) who deliver services to members. This committee is also responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect the health or welfare of members.

Aetna Practitioner Appeals Committee (PAC) - subcommittee to CPC

The purpose of the Aetna Practitioner Appeals Committee (PAC) is to conduct professional review hearings of providers who appeal decisions made by the Aetna Credentialing and Performance Committee involving professional competence or conduct of the provider. The committee, which is facilitated by an Aetna medical director, consists of providers who are appointed on an ad hoc basis by the Aetna Credentialing and Performance Committee. The committee reports through CPC and to the Aetna Better Health QMOC.

Aetna Quality Oversight Committee (QOC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated authority to the Aetna Quality Oversight Committee (QOC) to conduct the credentialing/recredentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.

Committee for Service Improvement

The Committee for Service Improvement advises and makes recommendations to the Quality Management Oversight Committee and/or Aetna Better Health management about customer (member and provider) issues.

Grievance Committee

The Grievance Committee reviews issues of expression of dissatisfaction by members, including complaints.

Appeals Committee

The Appeals Committee reviews and issues decisions on appeals that are filed by members or providers on behalf of members.

Enrollee Advisory Committee (EAC)

The Enrollee Advisory Committee (EAC) provides feedback to Aetna Better Health regarding strategies for improving member care and services; including health education and other member materials. Aetna Better Health member representatives, enrollees, family members, and other caregivers that reflect the diversity of the CCC Plus population, including individuals with disabilities and individuals residing in nursing facilities are invited to this meeting.

Member Advisory Committee (MAC)

The Member Advisory Committee (MAC) solicits enrolled member feedback and opinion regarding issues related to access and the quality of care and services provided to members as well as potential programs, activities and educational materials. Members provide feedback to Aetna Better Health aimed at improving member care and services.

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy and Therapeutics Committee is responsible for advising and making recommendations to the QMOC and/or Aetna Better Health Medical Director regarding the Aetna Better Health pharmacy program.

Compliance Committee (CC)

The Compliance Committee (CC) reviews, monitors, and assesses the effectiveness of Aetna Better Health compliance plan.

Policy Committee (PC)

The Policy Committee purpose is to provide a forum for the consistent development, implementation, approval, and communication of all Aetna Better Health policies.

Member profiling

Member profiles play a pivotal role in the management of member care both by Aetna Better Health's integrated care management team, as well as by the member's medical home/PCP. Member profiles are used to:

- Identify members who have under-or-over utilized health services, including emergency department services, hospital admissions and prescribed medications, and could benefit from integrated care management services
- Identify members who may lack appropriate access to needed services or could benefit from education about how to best utilize the health care system (e.g., persons with high emergency room utilization, or lack of preventive service utilization)
- Identify medical homes/PCPs that do not appear to be following recommended clinical practice guidelines or need to more effectively reach out to their assigned members and facilitate better management of the member's care
- Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection

Provider profiles

Aetna Better Health uses the provider profile to monitor a provider's utilization practices along with members' health outcomes to identify opportunities for improvement. The objectives of the provider profiles are to identify provider utilization patterns that vary significantly from peer network provider groups; identify trends that can be addressed through provider outreach; provide information to network providers about their practice patterns; safeguard confidentiality by maintaining secure access to the profile interface; provide information to be used as a component of quality management oversight; and provide information to be used as a component of provider incentive compensation.

Member, practitioner and provider satisfaction surveys

Member and provider satisfaction with health care services is assessed to discover areas that are working well and identify opportunities for improvement. Member surveys are conducted by an Aetna Better Health approved vendor using nationally standardized survey items. Distribute the results to members, providers, and the DMAS. Additional focused surveys of specific populations or users of identified services may be conducted at the discretion of the Chief Executive Officer. Member surveys include but are not limited to questions related to availability and accessibility of healthcare, practitioners, utilization, quality of care and service, quality of member services, requests to change practitioners and/or sites, and cultural competency. Provider surveys address satisfaction with Aetna Better Health's utilization management procedures (prior authorization, concurrent review), claims processing, and Aetna Better Health's response to inquiries.

When areas for potential improvement are identified from member or provider surveys or other sources (such as member complaints, grievances/appeals or PIPs), Aetna Better Health uses a formal process to evaluate the areas identified. The identified issues are prioritized and the concerns addressed, interventions are implemented, and the issue is reassessed to determine change and satisfaction.

Clinical practice guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of members, opportunities for improvement identified through our QM Program, and feedback from participating providers. Guidelines are updated as appropriate, but at least every two years. Aetna Better Health adopts and distributes clinical practice guidelines. The link is available on our website. Aetna Better Health also adopts behavioral health guidelines from the American Psychiatric Association. We provide information about updated guidelines in the Provider Newsletters.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to compare performance of managed health care plans reliably. Aetna Better Health collects this data routinely.

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by the Center for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS). Accrediting bodies such as the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS data. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes, and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

Why does the plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings, and results of test that may not be available in claims/encounter data. Typically, a plan employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan will ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the plan?

The HIPAA Privacy Rule permits a provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506 (c) (4). Thus, a provider may disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the provider bill the plan for providing copies of records for HEDIS?

According to the terms of their contract, providers may not bill either the plan or the member for copies of medical records related to HEDIS.

How can provider reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to provider electronic medical records (EMRs) and setting up electronic data exchange from the provider EMP to the plan. Please contact a Provider Relations Representative or the QM department for more information.

How can providers obtain the results of medical record reviews?

The plan's QM department can share the results of the medical record reviews performed at provider offices and show how results compare to that of the plan overall. Please contact a Provider Relations Representative or the QM department for more information.

Chapter 13 – Encounters, billing, and claims

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in the Virginia Medicaid program.

Aetna Better Health uses the Trizetto QNXT® system to process and adjudicate claims. Both electronic and paper claims submissions are accepted. To assist Aetna Better Health in processing and paying claims efficiently, accurately and timely, the health plan highly encourages providers to submit claims electronically, when possible. To facilitate electronic claims submissions, Aetna Better Health has developed a business relationship with Change Healthcare formerly Emdeon. Aetna Better Health receives EDI claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, member enrollment, and then uploads them into QNXT each business day. Within 24 hours of file receipt, Aetna Better Health provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

When to bill a member

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

When to file a claim

All claims and encounters with Aetna Better Health members must be reported to Aetna Better Health, including prepaid services.

Timely filing

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- New Claim Submissions – Claims must be filed on a valid claim form within 365 days from the date services were performed (unless there is a contractual exception). For hospital inpatient claims, date of service means the date of discharge of the member.
- Providers have 365 days from the date of the remittance advice to submit a Coordination of Benefits (COB) Claim.
- Claim Resubmission – Claim resubmissions must be filed within 365 days from the date of service. Please submit any additional documentation that may effectuate a different outcome or decision.)
- Providers have 365 from the date of service for reconsiderations.

Failure to submit accurate and complete claims within the prescribed time period may result in payment delay and/or denial.

How to file a claim

- 1) Select the appropriate claim form:
 - a. Medical and professional services use current version of the CMS 1500 Health Insurance Claim Form
 - b. Hospital inpatient, outpatient, skilled nursing and emergency room services use UB-04
 - c. Rural Health Clinics and Federally-Qualified Health Centers use UB-04 or CMS 1500, as appropriate for the services rendered. Please contact Provider Relations with additional questions.
- 2) Complete the claim form
 - a. Claims must be legible and suitable for imaging for record retention. Complete ALL required fields and include additional documentation when necessary
 - b. The claim may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
- 3) Submit claims electronically or original copies through the mail (faxed claims are not routinely accepted).
 - a. Payer ID: 128VA
 - b. Electronic Clearing House - Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to vendors, which is the only accepted proof of timely filing for electronic claims.
- 4) Change Healthcare formerly Emdeon is the EDI vendor we use.
- 5) Contact the software vendor directly for further questions about electronic billing.
- 6) Contact our Provider Relations Department for more information about electronic billing.
- 7) Through the mail
 - a. To include supporting documentation, such as members' medical records, clearly label and send to: Aetna Better Health
P.O. Box 63518
Phoenix, AZ 85082-3518

Claim filing tips

- Corrected claims must be clearly identified as a resubmission by stamping/writing "corrected claim" or "resubmission" on the paper claim form.
- Altered claims must be clearly initialed at the correction site. Initialing corrections insures the integrity of a corrected claim.
- Corrected claims must include all original claim lines, including those previously paid correctly. Resubmitted claims without all original claim lines may result in the recoupment of correct payments.
- Dates of service on the claim should fall within the prior authorized service date range. Including dates of services outside the authorized range may result in denials.
- Claims for services requiring an authorization should include the authorization number in block 23 on the CMS-1500 form and block 63 on UB-04 forms or in the appropriate field on EDI claims.
- The authorization number should not contain any prefixes or suffixes like "R12345", "#7890," or "3456 by Mae".
- Claims must have current, valid, and appropriate ICD diagnosis codes.
- The diagnosis codes must be coded to the highest degree of specificity (fifth digit) to be considered valid.
- Claims must be submitted with valid CPT, HCPCS, and/or revenue codes.
- Claims submitted with nonstandard CPT, HCPCS, revenue codes, or modifiers will NOT be processed and will be returned to the provider. These claims should be reworked and submitted timely to the initial claims address.
- Each CPT or HCPCS code line must have a valid place of service (POS) (block 24B) code when billing on a CMS-1500 form.
- Accident details should be provided when applicable (Block 10B of CMS-1500 Form).
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500 Form).
- Providers must submit the appropriate NPI numbers in Block 33A of the CMS-1500 and Block 56 of the UB-04.

- Billing provider taxonomy information should be submitted (Block 33B of the CMS-1500 form)
- All providers, including FQHCs and RHCs, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.

NDC requirements

Federal regulations require States and Managed Care Organizations (MCOs) to collect NDC numbers from providers on claims for the purposes of billing manufacturers for drug rebates. As a result, providers will not be reimbursed for drugs unless a valid 11-digit NDC number, Unit of Measure, and quantity administered are reported on the UB 04 or CMS 1500 claims.

A complete NDC data set consists of:

- An 11 Digit National Drug Code (NDC) Number
- Unit of Measure code
 - F2-International Unit
 - GR-Gram
 - ML-Milliliter
 - UN-Unit
 - ME-Milligrams
- If the NDC data set is missing, incomplete, or invalid, Aetna Better Health will deny the affected claim line.

Encounter data

Aetna Better Health requires the submission of certain data for encounter data collection by the Commonwealth of Virginia. Please be sure to include the current, valid information below that corresponds to each provider's enrolled location with the Commonwealth of Virginia Medicaid program. Failure to submit this information correctly will result in a denial of the claim.

Paper billing

CMS 1500 Paper Claims (professional):

- Box 33 - Billing Provider Physical Address
- Box 33A - Billing Provider NPI
- Box 33B - Billing provider taxonomy
 - Enter the 2-digit qualifier of "ZZ" followed by the taxonomy code
 - Do not enter a space, hyphen, or other separator between the qualifier and number (e.g. ZZ207Q00000X)
- Box 24J - Rendering NPI - (bottom of box, non-shaded area)
- UB-04 Paper Claims (institutional):
- Billing Provider NPI submitted in field 56, top row
- Billing provider taxonomy submitted in field 81
 - Enter the 2-digit qualifier of "B3" in the first column and then the taxonomy code immediately following

If there are questions regarding this information, please contact Provider Relations.

Multiple procedures

Multiple procedures performed on the same day and/or at the same session are processed at 100% of the contracted rate for the primary procedure, 50% of the contracted amount for the secondary procedure, and 50% of the contracted amount for any subsequent procedures; or as defined by a provider's current contract with Aetna Better Health or Medicaid guideline changes.

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Certain modifiers may

affect payment amounts as defined by the State of Virginia Medicaid Fee Schedule or contract with Aetna Better Health. Common modifier issue clarification is below:

- Modifier 59 – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499).
- Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, a provider may bill the component code with modifier 50. Services should each be billed on one line reporting one unit with a 50 modifier.
- Modifier 57 – Decision for Surgery – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period.

Please refer to the Current Procedural Terminology (CPT) Manual for further detail on proper modifier usage.

Correct coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect coding

Examples of incorrect coding include:

- “Unbundling” - Fragmenting one service into components and coding each as if it were a separate service or billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when a higher level, more comprehensive code is appropriate.

Correct coding initiative

Aetna Better Health utilizes claims editing systems designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Our edit guidelines are based on, but not limited to NCCI, CPT-4, HCPCS, and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy, and literature research input from academic affiliations.

The major areas of reviews are:

- Procedure Unbundling - Billing two or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure.
- Incidental Procedures - A procedure that is performed at the same time as a more complex procedure, however, the procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.
- Mutually-Exclusive Procedures - Two or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service.

- Multiple Surgical Procedures - Surgical procedures are ranked according to clinical intensity and paid following percentage guidelines.
- Duplicate Procedures - Procedures that are billed more than once on a date of service.
- Assistant Surgeon Utilization - Determination of reimbursement and coverage.
- Evaluation and Management Service Billing - Review the billing for services in conjunction with procedures performed.

When reviewing a remittance advice, any CPT code that has been changed or denied by the editing system will be noted by the appropriate disposition code.

Submission of itemized billing statements

Aetna Better Health may require that Providers submit an Itemized Billing Statement along with their original claims. Claims billed in excess of \$50,000.00 may require an Itemized Billing Statement. If an Itemized Billing Statement is required, the claim will be denied for an Itemized Billing Statement if one is not supplied.

Balance billing

Aetna Better Health participating Providers are prohibited, by contract, from billing members for any balance of payment other than co-pays for covered services, or as otherwise permitted under applicable law. Providers accept reimbursement from Aetna Better Health in full.

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.

Coordination of benefits (COB)

By law, Medicaid is the payor of last resort. Aetna Better Health, as an agency of the Commonwealth of Virginia is considered the payor of last resort when other coverage for a member is identified. Aetna Better Health shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

COB claims must be received by Aetna Better Health within 365 days from the member's primary carrier remittance advice date. A copy of the primary carrier RA and disposition detail must accompany the claim.

Aetna Better Health pursues Third Party Liability (TPL) claims based on requirements and/or limitations under Aetna Better Health's contract with the State of Virginia.

Participating and/or non-participating Providers are required to follow Aetna Better Health's policies on authorization requirements even when Aetna is not the primary payor.

Other general claims instructions

Aetna Better Health claims are paid in accordance with the terms outlined in the provider contract for this product.

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use CMS UB-04 Form. Providers should bill Aetna Better Health using Level of Care HCPCS coding (e.g. level of care 101 is billed under HCPCS code LC101). Please bill with the corresponding HCPCS code for services rendered. Please contact Claims Inquiry/Claims Research with additional questions or concerns.

Hospice

Aetna Better Health members currently receiving hospice services are routinely transitioned back to State of Virginia Fee-For-Service Medicaid coverage. Please contact a Case Manager or Provider Relations to discuss these services in greater detail.

Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that providers keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call Provider Relations for more information about electronic remittance advices.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), a provider must currently submit claims through EDI and receive payment for claim by EFT. Providers must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for providers to receive payment and reconcile outstanding accounts. Please contact our Provider Relations Department for assistance with this process.

Home Health Care

Providers submitting claims for Home Health should use CMS 1500 Form. Providers must bill in accordance with their contract and/or State of Virginia Medicaid guidelines.

Durable medical equipment (DME)

Providers submitting claims for DME Rental should use CMS 1500 Form. DME rental claims are only paid up to the purchase price of the durable medical equipment.

Checking status of claims

Providers may check the status of a claim by accessing our secure provider portal website or by calling Claims Inquiry and Claims Research.

- Online Status through Aetna Better Health's Secure Provider Portal Website
 - Aetna Better Health encourages providers to take advantage of using online status, as it is quick, convenient, and can be used to determine status for multiple claims.
- Claims Inquiry and Claims Research can:
 - Answer questions about claims
 - Assist in resolving problems or issues with a claim
 - Provide an explanation of the claim adjudication process
 - Help track the disposition of a particular claim
 - Correct errors in claims processing

Corrected claims and resubmissions

Providers have 365 days from the date of service to resubmit a corrected version of a processed claim. The review and reprocessing of a corrected claim does not necessarily constitute reconsideration or claim dispute. Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Ways to submit:

Form

Please submit the Reconsideration/Resubmission Form located on our website along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriate on initial submission.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction. Please remember corrections must be made on the claim form.
- Clearly label as “Resubmission” or “Corrected Claim” at the top of the claim in black ink and mail to appropriate claims address.

Failure to mail and accurately label the resubmission to the correct address may cause the claim to deny as a duplicate.

Secure Web Portal

Please log into the Secure Web Portal and follow the resubmission process located in the help feature. Note: Upload any and all supporting documentation as needed.

Claim reconsiderations

Providers have 365 days from the date of service to correct and resubmit claims.

- Resubmission: A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information.
- Reconsideration: A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors.

A resubmission or reconsideration should be submitted with the Provider Claims Resubmission/Reconsideration Form (available on the Aetna Better Health website) to the following address:

Aetna Better Health of Virginia
Attn: Reconsiderations
P.O. Box 63518
Phoenix, AZ 85082-3518

Note: Resubmissions may also be submitted through the Secure Web Portal.

Examples of reconsideration requests:

- Contract interpretation issues
- Timely Filing (please submit acceptance report if billed electronic)
- Entire claim denied for no authorization due to the member providing the incorrect insurance information
- Rejected as cosmetic and submitting medical records/documentation
- No authorization when it is required
- Coding edit reconsideration

Timely filing denials

It is the responsibility of the provider to maintain their account receivables records, and Aetna Better Health recommends that providers perform reviews and follow-up of their account receivables on at least a monthly basis to determine outstanding Aetna Better Health claims. Aetna Better Health will not be responsible for claims that were received outside timely filing limits.

Recognizing that providers may encounter timely filing claims denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by providers. If a claim is denied for timely filing, complete the Provider Claim Resubmission/ Reconsideration Form available on the Aetna Better Health’s website and attach proof of timely filing.

Electronic submission

Electronic claim submission (EDI) reports are available from each provider's claims clearinghouse after each EDI submission. These reports detail the claims that were sent to and received by Aetna Better Health. Providers must submit a copy of the acceptance report from the provider's respective clearinghouse that indicates the claim was accepted by Aetna Better Health within timely filing limits to override timely filing denial and pay the claim. Please confirm that the claim did not appear on a rejection report. If Aetna determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the provider.

Paper submission

Providers must submit a screen print from the provider's respective billing system or database with documentation that shows the claim was generated and submitted to Aetna Better Health within the timely filing limits.

Documentation should include:

1. The system printout that indicates:
 - a. Claim was submitted to Aetna Better Health
 - b. Name and ID number of the member
 - c. Date of service
 - d. Date the claim was filed to Aetna Better Health
2. A copy of the original CMS-1500 or UB-04 claim form that shows the original date of submission

Remittance advices

Aetna Better Health generates checks weekly. The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates. Claims processed during a payment cycle will appear on a remittance advice as paid, denied, or reversed. Information provided on the remit includes:

- Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- Remit Date represents the end of the payment cycle.
- Beginning Balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- Processed Amount is the total of the amount processed for each claim represented on the remit.
- Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- Refund Amount represents funds that the provider has returned to Aetna Better Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- Ending Balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative Amount Paid.
- Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- Claim Header area of the remit lists information pertinent to the entire claim. This includes:
 - Member Name
 - Provider Name

- Member ID number
- Date of Birth
- Account Number
- Authorization ID, if obtained
- Claim Status
- Claim Number
- Refund Amount, if applicable

- Claim Totals are totals of the amounts listed for each line item of that claim.
- Code/Description area lists the processing messages for the claim.
- Remit Totals are the total amounts of all claims processed during this payment cycle.
- Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

Please refer to **Attachments** to view a sample remittance advice and check.

Chapter 14 – Inquiry, grievance and appeals

Aetna Better Health has an Inquiry, Grievance, and Appeals process for members and providers to dispute a claim authorization or an Aetna Better Health decision. This includes both administrative and clinical decisions of Aetna Better Health. A provider has sixty (60) days (which must be done in writing) and a member has sixty (60) days from the Notice of Action to file an Appeal. A provider has sixty days to file a Grievance and a member can file a grievance at any time, a grievance may be filed in writing or by calling Customer Service. Members have a one-level internal appeal process through Aetna Better Health.

There are no punitive actions to members or providers for filing a complaint. Members and providers have the right to submit written comments with all levels of the process.

Provider inquiries and grievances

In order to ensure a high level of satisfaction, Aetna shall provide a mechanism for Providers to express dissatisfaction with Plan decisions. Providers may express questions or dissatisfactions through our Provider Inquiry and Grievances Process.

If a provider has questions regarding member benefits/eligibility, claim status/payment, remittance advices, authorization inquiries, etc. please access the provider portal or contact with Claims Inquiry and Claims Research (CICR). Inquiries are handled on a daily basis and are normally resolved on the initial contact.

To submit a dissatisfaction regarding an issue in the Health Plan, you may contact Provider Relations at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS). Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be documented within our internal system and conveyed to the complainant.

After following these steps, if you are still dissatisfied you may have the right to file an appeal. Please refer to the Appeals section for instructions on filing an appeal.

Members and Providers also have the right to request and receive a written copy of Aetna Better Health utilization management criteria along with the entire appeal file used when making our determination, in cases where the Appeals are related to a clinical decision/denial. Aetna Better Health members will receive assistance, if required, to file either a Grievance or an Appeal. Aetna Better Health also provides a toll-free number for members at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS). Interpretive services are also available to members by calling the telephone numbers above.

The member may request continuation of benefits during the Health Plan Appeal review or a State Fair Hearing. The request must be filed within ten (10) days of the mail date of the Notice of Action. If the Health Plan's action is upheld in

a hearing, the member may be liable for the cost of any disputed services furnished while the Appeal was pending determination.

Claim reconsideration vs. claim appeal

Aetna Better Health has two separate and distinct processes designed to assist providers with issue resolution. The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal. If the provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing an appeal. However, before filing an appeal, the provider should verify the claim does not qualify to be submitted as a claims resubmission or reconsideration.

	Reconsideration	Appeal
Form (available online)	Resubmission/Reconsideration Form	Appeal form
Address	Aetna Better Health of Virginia Attn: Reconsiderations P.O. Box 63518 Phoenix, AZ 85082-3518	Aetna Better Health of Virginia Attn: Appeals Coordinator PO Box 818070 Cleveland, OH 44181
Appropriate Categories	1) Claim resubmissions 2) Corrected claims (including missing/ incomplete/ invalid diagnosis, procedure or modifier denials) 3) Timely Filing 4) COB (missing/ illegible primary explanation of benefits)	1) Denied days for IP (inpatient) stays 2) Authorization denials for late notification 3) Claim denial for no authorization/ pre-certification/ medical necessity not met/non-covered charges/benefit exhausted 4) Services denied per finding of a review organization
Timeframe	365 days from the date of service	Claim denial appeals must be submitted within 60 days of the date of denial.

Provider appeal of claim action

Providers may appeal any adverse claim action. Prior to appealing a claim action, providers may contact Claims Inquiry/Claims Research (CICR) for claim information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections as well as the steps below, in order to minimize claims issues:

- Contact Claims Inquiry and Claims Research at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS) as the first step is to clarify any denials or other actions relevant to the claim. A representative will be able to assist a provider with a possible resubmission of a claim with modifications.
- If an issue is not resolved after speaking with Aetna representatives or by submitting a claims resubmission/reconsideration, providers may challenge actions of a claim denial or adjudication by filing a formal appeal with the Aetna Better Health Appeals department.
 - The appeal must be filed in writing and must specifically state the factual and legal basis for the appeal, including a chronology of pertinent events and a statement as to why the provider believes the action by Aetna Better Health was incorrect.
 - Providers must attach copies of any supporting documents, such as claims, remittance advices, medical records, correspondence, etc. If additional copies of medical records are requested for appeal consideration, such copies are created at the provider's expense.
- Appeals should state Formal Provider Appeal on the document(s) and should be mailed to:
 - Aetna Better Health of Virginia
 - Attn: Appeals Coordinator

PO Box 818070
Cleveland, OH 44181

Examples of appeals:

- Denied as not medically necessary
- If a cosmetic denial is upheld and would like it reviewed a second time

Tips to writing an effective appeal

In the event that a provider does not agree with Aetna Health Care of Virginia's decision regarding requested services or benefit coverage, we have provided tips to writing an effective grievance or appeal letter:

- Include the name, address, and phone number where the appellant can be reached in case there are any questions
- Include the patient's name, date of birth, and insurance I.D. number
- Describe the service or item being requested
- Address issues raised in our denial letter
- Address the medical necessity of the requested service
- Include information about the patient's medical history:
 - Prior treatments
 - Surgery Date
 - Complications
 - Medical condition and diagnosis

If applicable to an appeal situation, please also provide:

- Any unique patient factors that may influence our decision
- Why alternate methods or treatments are not effective or available
- The expected outcome and/or functional improvement
- An explanation of the referral to an Out-of-Network provider

When submitting an appeal, be sure to provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

Expedited appeal requests

Expedited requests are available for circumstances when application of the standard Appeal time frames would seriously jeopardize the life or health of the member or the member's ability to attain, maintain, or regain maximum function. A verbal request indicating the need for an expedited review should be made directly to Prior Authorization at **800-279-1878** (FAMIS and Medallion), or **855-652-8249** (CCC PLUS). Those requests for an expedited review that meet the above criteria will have determinations made within seventy-two (72) hours or earlier as the member's physical or mental health requires.

Process definitions and determination timeframes

Process	Definition	Determination
Inquiry	Any question from a provider regarding issues such as benefits information, claim status, or eligibility.	Ten (10) working days from receipt of the Inquiry

Grievance	A complaint/grievance is any expression of dissatisfaction expressed by a provider regarding an issue in the Health Plan. If a provider is dissatisfied with any issue regarding the Health Plan, the provider may contact the respective Customer Service Departments at the number(s) listed above. Complaints/ grievances must be received within sixty 60 calendar days of the date of the incident that gave rise to the complaint.	Within 30 calendar days of receipt of the complaint/grievance
Appeal	An appeal is a request by the provider when the resolution of a complaint or reconsideration is not resolved to the provider's satisfaction and the	72 hours from receipt of the Expedited Appeal;

Process	Definition	Determination
	provider appeals the Health Plan’s decision within the prescribed time frames. Examples: a denial or a limited authorization of a requested service, including the type or level of service, that the service is determined to be experimental, investigational, cosmetic, not medically necessary or inappropriate. The Appeal must be received within sixty (60) calendar days after the date of the Health Plan’s Notice of Action.	within 30 working days from receipt of the standard Appeal request

Written inquires and grievances can be mailed to:	Written appeals can be mailed to:
Aetna Better Health of Virginia Attn: Inquiries 9881 Mayland Drive Richmond, VA 23233-1458	Aetna Better Health of Virginia Attn: Appeals Department PO Box 818070 Cleveland, OH 44181

Fraud, Waste and abuse

Aetna Better Health will not tolerate health care fraud, waste, or abuse in any of its relationships with either internal or external stakeholders. Aetna Better Health will identify, report, monitor, and, when appropriate, refer for prosecution situations in which suspected fraud, waste, or abuse occurs.

Medicaid managed care fraud is defined as the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some payment or unauthorized benefit to himself and some other person. This includes any act that constitutes fraud under applicable Federal or State law.

Medicaid managed care waste is defined as the rendering of unnecessary, redundant, or inappropriate services and medical errors and incorrect claim submissions. Generally not considered criminally negligent actions, Medicaid managed care waste is rather the misuse of resources and involves taxpayers not receiving reasonable value for their money in connection with any government-funded activities due to inappropriate act or omission by players with control over or access to government resources. Waste goes beyond fraud and abuse and most waste does not involve a violation of law; it relates primarily to mismanagement, inappropriate action, and inadequate oversight.

Medicaid managed care abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary costs to the Medicaid Plan, Federal, or State programs.

To report fraud, waste and abuse, please contact the Compliance, Fraud, Waste, and Abuse line at **844-317-5825**.

Aetna Better Health follows a mandatory corporate compliance plan that incorporates annual employee training, system controls, data mining tools, internal auditing, and a designated Special Investigations Unit (SIU) to monitor, detect, investigate, and report potential fraud, waste and abuse. All Aetna staff complete required training in identifying potential fraud, waste and abuse and are provided the tools for reporting questionable situations upon hire and annually thereafter. Training includes how to detect and prevent member, provider and employee fraud, waste and abuse. Additionally, the Customer Service staff receives thorough training for fraud, waste, and abuse. At Aetna, our goal is to operate at the highest level of ethical standards.

The Special Investigations Unit (SIU) detects and investigates cases of potential health care fraud, waste, and abuse. Examples of fraud and abuse include but are not limited to the following:

- Submitting a Claim for services not furnished either by using genuine patient information to fabricate entire Claims or by padding Claims with charges for procedures or services that did not take place;

- Submitting a Claim with inaccurate diagnosis or procedure codes with the intent of maximizing payments or obtaining Coverage that the member is not entitled to;
- Submitting a Claim knowing reimbursement has previously been remitted;
- Misrepresenting dates of services, description of service, or identity of member or Provider in order to obtain reimbursement to which the Provider or member is not entitled;
- Submitting a Claim for Non-Covered Services in a manner that categorizes them as Covered Services;
- Submitting a Claim for a more costly service than the one actually performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code);
- Submitting unbundled Claim(s) for the purpose of avoiding these Claim policies and procedures;

The SIU utilizes state-of-the-art data analysis tools to detect irregularities, which could be indicators of possible fraud, waste, and abuse. Clinical Investigators and experienced fraud, waste, and abuse investigators work collaboratively to conduct investigations identified through various sources.

The SIU reviews medical claims on a prospective and retrospective basis using sophisticated data mining technology tools to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU also may request supporting documentation or schedule an on-site audit to investigate previously paid claims. The investigation does not mean that a provider is practicing fraud. In many cases, the SIU finds the provider billing practice was in error. In all cases, the SIU will work with the appropriate Provider Relations Representative to communicate what is believed an inappropriate billing practice.

If a Provider or member is suspected of fraud, waste or abuse, an investigation begins, an audit is performed, and the member or Provider is referred to our Program Integrity Committee for review. When appropriate and an investigation and audit is warranted, those cases are reported to external entities, i.e., including but not limited to the Department of Medicare and Medicaid Services, the Virginia Department of Health and Human Services Office of Inspector General. Reports include the name and ID number of the party involved, the source of the complaint, the provider type, nature of the complaint, approximate dollar amount involved, and the legal and administrative status of the case.

Our credentialing process for contracted providers includes a verification that the provider is eligible to participate. We specifically check the Excluded Provider Database on the HHS OIG Web site to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid, or SCHIP. This information is also requested on the credentialing and re-credentialing application.

Aetna Better Health contract provisions with participating providers specifically state, that they shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. The provider hereby certifies that no such excluded person currently is employed by or under contract with them or with any “downstream” entity with which they contract relating to the furnishing of these services to Medicaid members.

Our Credentialing Verification Center conducts ongoing monitoring of the HHS OIG and State Professional Registration boards internet sites. Any information found pertaining to participating Aetna Better Health providers are referred for review by the credentialing committee to ensure compliance.

Our delegated credentialing entities are required to verify that the providers with whom they contract are eligible to participate, including checking the HHS OIG Web site to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid, or CHIP. Part of our ongoing evaluation of the delegated entities is confirmation of ongoing monitoring of state and federal web sites to identify current sanctions or complaints.

As required by the Deficit Reduction Act of 2005, it is Aetna Better Health’s policy to provide detailed information to Aetna Better Health employees, vendors or other subcontractors, and other persons acting on behalf of Aetna Better Health, about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, “False Claims Acts”). The False Claims Acts assist the Federal and State Government in preventing and detecting fraud, waste, and abuse in Federal health care programs, such as Medicare and Medicaid.

Chapter 15 – Commonwealth Coordinated Care Plus (CCC Plus)

What is Commonwealth Coordinated Care Plus?

The Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid managed care program through the Department of Medical Assistance Services (DMAS). Aetna Better Health was approved by DMAS to provide care coordination and health care services. Our goal is to help members improve their quality of care and quality of life.

How CCC Plus Works

Aetna Better Health contracts with doctors, specialists, hospitals, pharmacies, providers of long term services and supports, and other providers. These providers make up our provider network. Members will also have a Care Coordinator who will work closely with the member and the member’s providers to understand and meet their needs. The Care Coordinator will also provide the member with information about their covered services and the choices that are available to them.

What are the Advantages of CCC Plus

CCC Plus provides person-centered supports and coordination to meet the member’s individual needs. Some of the advantages of CCC Plus include:

- Members will have a care team, which may include doctors, nurses, counselors, or other health professionals who are there to help the member receive the care they need.
- Members will have a Care Coordinator who will work with the member and their providers to make certain they receive the care they need.
- Members will be able to direct their own care with help from their care team and Care Coordinator.
- The care team and Care Coordinator will work with the member to come up with a care plan specifically designed to meet their health and/or long term support needs. The care team will be in charge of coordinating the services the member needs. This means, for example:
 - The care team will make certain the members doctors know about all medicines the member takes so they can reduce any side effects.
 - The care team will make certain the members test results are shared with all doctors and other providers working with the member so they can be kept informed of the members health status and needs.
- Treatment choices that include preventive, rehabilitative, and community-based care.
- An on-call nurse or other licensed staff is available 24 hours per day, 7 days per week to answer member questions.

Care Coordinator

Members will have a dedicated Care Coordinator who will be able to help the member understand our covered services and how to access these services when needed. Their Care Coordinator will also work with the member's doctor and other health care professionals (such as nurses and physical therapists), to provide a health risk assessment, and develop a care plan that considers the needs and preferences of the member.

How a Care Coordinator Can Help

The member's Care Coordinator serves as a single point of contact for the member and will assess, arrange, and monitor all care services provided by other care providers. The Care Coordinator will work closely with the member to manage their care.

Care Coordinator can:

- Provide the member assistance with appointment scheduling
- Answer questions about getting any of the services the member may need. For example: behavioral health services, transportation, and long-term services and supports (LTSS)
 - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.
- Help with arranging transportation for member appointments when necessary.
- Answer questions the member may have about their daily health care and living needs including these services:
 - Skilled nursing care
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Home health care
 - Personal care services
 - Behavioral health services
 - Services to treat addiction
 - Other services

What is a Health Risk Assessment

Within the first few weeks after the member enrolls with Aetna Better Health, their Care Coordinator will meet with them to ask questions about their health, needs, and choices. The Care Coordinator will talk with the member about any medical, behavioral, physical, and social service needs that they may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). A HRA is a complete assessment of the member's medical, behavioral, social, emotional, and functional status. The HRA is generally completed by the member's Care Coordinator within the first 30 to 60 days of their enrollment with us depending upon the type of services that they require. This health risk assessment will enable the member's Care Coordinator to understand their needs and help them receive the care they need.

What is a Care Plan

A care plan includes the types of health services that are needed for a member and how to obtain them. The care plan is developed based on the member's health risk assessment. After health risk assessment is complete, the care team

will meet with the member to discuss health and/or long term services and supports they may need and want as well as their goals and preferences. Together, the member and their care team will make a personalized care plan, specific to their needs.

Benefits

Members have a variety of health care benefits and services available to them. Most services are through Aetna Better Health, however many are offered through DMAS or a DMAS Contractor. This section will describe the following:

- Services provided through Aetna Better Health.
- Services covered by DMAS or a DMAS Contractor.
- Services that are not covered through Aetna Better Health or DMAS.

Services Provided Through Aetna Better Health

Services you receive through Aetna Better Health or through DMAS will not require the member to pay any costs other than their “patient pay” towards long term services and supports.

General areas of covered services under Aetna Better Health include:

- Regular medical care, including office visits with a PCP, referrals to specialists, exams, etc.
- Preventive care, including regular check-ups, screenings, and well-baby/child visits.
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, and community based, medication assisted treatment, peer services, and case management. Services may require authorization.
- Adult day health Care services
- Behavioral health services, including inpatient and outpatient individual, family, and group psychotherapy services are covered. *(Community Mental Health Rehabilitation Services are covered through Magellan, the DMAS Behavioral Health Services Administrator, until December 31, 2017)*
- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources.
- Clinic services, including renal dialysis.
- CCC Plus Home and Community Based Waiver services, (formerly known as the EDCD and Technology Assisted Waivers), including: adult day health care, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services.
- Colorectal cancer screening.
- Court ordered services.
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies.
- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21.
- Early Intervention services for children from birth to age 3.
- Electroconvulsive therapy (ECT).
- Emergency custody orders (ECO).
- Emergency services including emergency transportation services (ambulance, etc.).
- Emergency and post stabilization services.
- End stage renal disease services.
- Eye examinations.
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. Member is free to choose their method for family planning

including through providers who are in/out of Aetna Better Health's network. Aetna Better Health does not require the member to obtain a service authorization or a PCP referral for family planning services.

- Glucose test strips.
- Hearing (audiology) services.
- Home health services.
- Hospice services.
- Hospital care – inpatient/outpatient.
- Human Immunodeficiency Virus (HIV) testing and treatment counseling.
- Immunizations.
- Inpatient psychiatric hospital services.
- Laboratory, Radiology and Anesthesia Services.
- Lead investigations.
- Mammograms.
- Maternity care - includes: pregnancy care, doctors/certified nurse-midwife services.
- Nursing facility - includes skilled, specialized care, long stay hospital, and custodial care.
- Nurse Midwife Services through a Certified Nurse Midwife provider.
- Organ transplants.
- Orthotics, including braces, splints, and supports - for children under 21, or adults through an intensive rehabilitation program.
- Outpatient hospital services.
- Pap smears.
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver).
- Physician's services or Provider Relations, including doctor's office visits.
- Physical, occupational, and speech therapies.
- Podiatry services (foot care).
- Prenatal and maternal services.
- Prescription drugs.
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver).
- Prostate specific antigen (PSA) and digital rectal exams.
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses).
- Psychiatric or psychological services.
- Radiology services.
- Reconstructive breast surgery.
- Renal (kidney) dialysis services.
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology, and audiology services).
- Second opinion services from a qualified health care provider within the network or we will arrange for the member to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet the member's individual needs.
- Surgery services when medically necessary and approved by Aetna Better Health.
- Telemedicine services.
- Temporary detention orders (TDO).
- Tobacco Cessation Services for pregnant women, children, and adolescents under age 21.
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). Aetna Better Health will also provide transportation to/from most "carved-out" and enhanced services.
- Vision services.
- Well Visits.

- Abortion services- coverage is only available in cases where there would be a substantial danger to the life of the mother.

Extra Benefits that Aetna Better Health provided that are NOT covered by Medicaid

<u>Value-Added Services</u>	<u>Additional Detail</u>
Aetna Better Health members have access to services that are not generally covered through Medicaid fee-for-service. These are known as “enhanced benefits”. Aetna Better Living: enriching members’ lives by providing the following enhanced benefits:	
Adult dental: Available to members 21 and older (no prior authorization required)	Exam and cleaning twice per year, annual set of bitewing X-rays, fillings, extractions, root canal or dentures (limited to \$525 annually)
Adult vision: Available to members 21 and older (no prior authorization required)	Exam and \$100 toward eyewear per year
Adult hearing: Available to members 21 and older (with prior authorization)	Exam and one hearing aid per year, unlimited visits for hearing aid fittings (limited to \$500 annually)
Personal care attendant: Available (with prior authorization) to high-risk members in a nursing facility	24 hours a day and seven days a week
Diabetes care: Available to members 21 and older (with prior authorization)	One pair of therapeutic shoes or two shoe inserts per year (limited to \$150 annually)
Medication Adherence Program for Chronic Illness: Available to members with chronic illness (no prior authorization is required)	Assists members with medications and help to ensure they are taking them as prescribed
Wellness rewards: Available to all members 21 and older (no prior authorization required)	Reloadable incentive card: \$15 for diabetic dilated eye exam, \$25 for wellness exam (to include HbA1c labs and LCL-C screening), \$15 woman’s mammography, \$15 cervical cancer screening, \$25 initial colonoscopy, \$15 flu shot, and \$25 prostate cancer screening
Value-Added Services	Additional Detail
Home-delivered meals: Available to members 21 and older with prior authorization	Members (post-discharge from inpatient stay) can receive two meals per day, tailored to their dietary needs and delivered to their home or community based setting for up to seven days
Weight management: Available to all members with prior authorization	12-week program and six-nutritionist-counseling visits—provided through certified nutritionists
Memory care: Available to members diagnosed with dementia or Alzheimer’s disease (requires prior authorization)	Two-door alarms and six window locks

Regional Wellness Centers: Available to all members	Regional Wellness Centers will be established in every region we serve. These centers will function as a one-stop-shop where members, caregivers, providers, community organizations and other stakeholders can use our meeting spaces, computers and Internet, or access our community resources database.
Community Health Workers: Available to all members (no prior authorization required)	Community Health Workers will be deployed throughout the community in each region to link members to: safe housing, local food markets, job opportunities and training, access to health care services, community based resources, transportation, recreational activities and other services. This assistance is available to all members.
Expanded Respite: Available to all members receiving respite services with Prior Authorization	10 additional respite hours per month
Housing Solutions	<p>No Place Like Home Grants to facilitate the transition from a nursing facility to a private residence. These grants provide for services including a home environmental assessment, home modifications, rent, and utility payment, hoarding intervention, cleaning services, handyman services, and pest control.</p> <p>No Place Like Home Rental Assistance for members transitioning from a nursing facility into a private residence.</p> <p>Members transitioning from a nursing facility into the community can access Aetna Better Communities benefits up to \$5,000 per member. Benefits are funded through \$200,000 in annual grants to Virginia 501(c)(3) non-profits.</p>
On-Demand Transportation (no Prior Authorization required)	Dramatically improves service, quality, and accessibility, offering our members real-time status and location updates through a phone application. Members, Care Coordinators and Discharge Planners can order via phone or through the mobile application. We also offer free rides to the pharmacy directly following a doctor's appointment. There is no limit to rides for covered services: available to all members receiving transportation through managed care; no PA required.
Free Cell Phone: Available to members 18 and older (no Prior Authorization required)	Free cell phone with 350 minutes per month, free unlimited texting and free calls to member services

Services covered by DMAS or a DMAS Contractor

Carved-Out Services

The Department of Medical Assistance Services provides the below coverage to members. Providers must bill fee-for-service Medicaid (or a DMAS Contractor) for these services.

- Community Mental Health Rehabilitation Services (CMHRS) are currently provided through Magellan, the DMAS Behavioral Health Services Administrator. Beginning on and after January 1, 2018, Aetna Better Health will provide coverage for CMHRS.

CMHRS are listed below:

- Mental Health Case Management
 - Therapeutic Day Treatment (TDT) for Children
 - Day Treatment/ Partial Hospitalization for Adults
 - Crisis Intervention and Stabilization
 - Intensive Community Treatment
 - Mental Health Skill-building Services (MHSS)
 - Intensive In-Home
 - Psychosocial Rehab
 - Level A and B Group Home
 - Treatment Foster Care Case Management
 - Behavioral Therapy
 - Mental Health Peer Supports
- Dental Services are provided through the *Smiles For Children* program. DMAS has contracted with DentaQuest to coordinate the delivery of all Medicaid dental services. The name of the program is *Smiles For Children*. *Smiles for Children* provides coverage for the following populations and services:
 - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
 - For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
 - For adults age 21 and over, *Smiles For Children* coverage is only available for limited medically necessary oral surgery services. Routine dental services are not covered for adults other than as described above for pregnant women.
 - Adult dental: Available to members 21 and older (no prior authorization required)—exam and cleaning twice per year, annual set of bitewing X-rays, fillings, extractions, root canal or dentures (limited to \$525 annually)
 - Developmental Disability (DD) Waiver Services, including Case Management for DD Waiver Services, are covered through DBHDS. The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services.
 - School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's *Individualized Education Program (IEP)*. While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.

Services That Will End a Member's CCC Plus Enrollment

If a member is receiving any of the services below, their enrollment with Aetna Better Health will end.

- PACE (Program of All Inclusive Care for the Elderly).
- Medicaid Money Follows the Person (MFP) Program.
- Alzheimer's Assisted Living Waiver.
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21).
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.

Services that are not covered through Aetna Better Health or DMAS

The following services are not covered by Medicaid or Aetna Better Health. If a member is receiving any of the following non-covered services, the member will be responsible for the cost of these services.

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by Aetna Better Health)
- Medical care other than emergency services, urgent services, , or family planning services, received from providers outside of the network unless authorized by Aetna Better Health
- Personal care services (except through some home and community-based service waivers or under EPSDT)
- Prescription drugs covered under Medicare Part D, including the Medicare copayment.
- Private duty nursing (except through some home and community-based service waivers or under EPSDT)
- Weight loss clinic programs unless authorized
- Care outside of the United States

Hospice

There are four levels of hospice care: 1) routine home care where most hospice care is provided; 2) continuous home care which is furnished during a period of crisis and primarily consists of nursing care; 3) inpatient respite care which is short-term care and intended to relieve family members or others caring for the individual; and 4) general inpatient care which is short term and intended for pain control or acute or chronic symptom management which cannot be provided in other settings. Please contact the member's Case manager to discuss these services in greater detail.

Hospice Claims

The only claims payable during a hospice election period by Aetna Better Health would be additional benefits covered under Aetna Better Health that would not normally be covered under the covered services. All other claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to hospice services or not.

Aetna Better health is not responsible to cover services when a member is in a Hospice Election Period. Aetna Better health will continue to cover only value added services outside of standard coverage. All claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to Hospice services or not.

The below grid describe our business practices related to hospice notification/billing room and board, etc.:

Frequently Ask Question	Aetna Better Health
How do I submit a hospice notification?	The provider would be required to submit an order along with supporting documentation.
What is the notification process for a higher hospice level of care?	The provider would be required to submit an order along with supporting documentation.
What is the notification timeline?	Requests are received and entered same day. Notification of determination will be verbally communicated to the requesting provider within one business day.
What is the notification process after hours or on weekends?	Call us at: 855-652-8249 and press the prompt for Preauthorization and the member will be connected with an afterhours nurse to process requests.
What is the appeal process?	<p>Pre-Service: The member or the member's representative can call or write us to file an appeal within 60 days of receiving a Notice of Adverse Benefit Denial (NABD).</p> <p>Call us at: 855-652-8249 or write to us:</p> <p>Aetna Better Health of Virginia Attn: Appeal Department PO Box 818070 Cleveland, OH 44181</p> <p>Fax: 1-866-669-2459</p> <p>Post-Service: To dispute a claim denial, the provider should follow the instructions and ensure filing within 60 days of the date listed on the remittance advice. The filing should be mailed to the address printed on the remittance advice.</p>
What are the authorization contacts? What is the escalation contact?	Call us at: 855-652-8249 and press the prompt for Preauthorization and the member will be connected with a representative. Escalation Contact: Stephanie Hargan at: 959-299-6312 .
Will health plans provide 95% of room and board payment to Nursing Facilities when a patient elects hospice?	Hospice services provided in a nursing facility will be paid 95% of the RUG-IV Grouper 48 adjusted rate for claims with dates of service on or after July 1, 2017
Electronic Funds Transfer	Providers are offered EFT when they are contracted with us. Providers who are not currently receiving electronic payments and wish to do so can contact Provider Relations.

Hospice Billing Codes	Revenue Codes: 0651 - Routine Home Care, 0652 - Continuous Home Care, 0655 - Inpatient Respite Care, 0656 - General Inpatient Care, 0658 - Nursing Facility (billed in conjunction with either revenue code 0651 or 0652; claims must also contain one revenue code 0022), 0551 - Skilled Nursing Visit (billed in conjunction w/procedure code G0299), 0561 - Medical Social Service Visit (billed in conjunction w/procedure code G0155). For nursing facility residents, HIPPS code (RUG code in the 1st 3-digits and assessment code or modifier in the last 2-digits).
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Hospice Billing Instructions and Covered Services and Limitations - reimbursement services as per the wage rule and reimbursement of revenue code 0658	0658 - Nursing Facility: A resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Hospice providers are reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care. We also have the discretion to negotiate an alternative payment method with Hospice providers for nursing home room and board services.
Are physician visits covered? How is physician billing handled?	Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected are waived except for services provided by the individual's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (There is an exception for children under the age of 21 who are allowed to receive concurrent medical care, meaning they may continue to receive curative treatment while being enrolled in hospice - see Concurrent Care for Children requirement (§2302 of the Patient Protection and Affordable Care Act). HOW IS BILLING HANDLED - The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed.
Can hospice bill Medicare and Medicaid?	Yes, Hospice can bill Medicare and Medicaid for individuals who are eligible.
Where do I submit my claims?	We prefer that provider submit claims electronically. Our EDI Payor ID (Claim) # is 128VA. If electronic submission is not possible, providers may submit paper claims to: Aetna Better Health of Virginia P.O. Box 63518 Phoenix, AZ 85082-3518
What are the documentation requirements?	See Hospice Manual, Chapter IV starting on page 2 through page 10. Correct. Documentation requirements are noted within this Chapter.
What constitutes a clean claim?	A "clean" claim is defined as a one that does not require the payer to investigate or develop on a prepayment basis. Clean claims must be filed in the timely filing period.
What will your payment turnaround times be?	Payment turnaround time is 14 days from receipt of a clean claim. Aetna generates two check runs a week, on Wednesday and Friday.
What are the staffing requirements?	The hospice provider shall design and implement a staffing plan that reflects the types of services offered and shall provide qualified staff in sufficient numbers to meet the assessed needs of all patients, including those patients residing in the provider's hospice facility, if applicable. (12VAC5-391-210(B))
How will Care Coordination interface with hospice?	The patient's plan of care is developed, reviewed, and updated using a coordinated interdisciplinary team approach with the participation of each core service, as well as any other disciplines providing services.
How do I check Medicaid eligibility/certification periods?	For eligibility verification, call Aetna Better Health Member Services at 855-652-8249 , visit our provider portal at aetnabetterhealth-virginia-aetna.com , or check the web portal.

Early and Periodic Screening, Diagnostic, and Treatment Services

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep a child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

Aetna Better Health provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by Aetna Better Health. For any services not covered by Aetna Better Health, the member can get these through the Medicaid fee-for-service program.

Early Intervention Services

Early intervention includes services such as speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to help families support their child's learning and development during everyday activities and routines. Services are generally provided in the member's home.

For more information, the member should call their Aetna Better Health Care Coordinator.

Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in the member's home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations.

Some Behavioral Health services are covered through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). The member's Care Coordinator will work closely with the BHSA to coordinate the services, including those that are provided through the BHSA.

Addiction and Recovery Treatment Services (ARTS)

Aetna Better Health offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options are also available if the member is dealing with using prescription or non-prescription drugs. Other options that are helpful include peer services (someone who has experience similar issues and in recovery), as well as case management services.

How to Access Long-Term Services and Supports (LTSS)

Aetna Better Health provides coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can provide assistance that helps the member live in their own home or other setting of their choice and improves their quality life. Examples services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community based waiver), but also in nursing facilities.

Commonwealth Coordinated Care Plus Waiver

Some Members may qualify for home and community based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver is meant to allow a Member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, the member may choose how to receive personal assistance services. Members have the option to receive services through an agency (known as agency directed) or may choose to serve as the employer for a personal assistance attendant (known as self-directed.)

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or self-directed)
- Respite care (agency or self-directed)
- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for Members transitioning to the community from a nursing facility or longstay hospital
- Assistive technology
- Environmental modifications

Self-Directed Care

Self-directed care refers to personal care and respite care services provided under the CCC Plus Waiver. These are services in which the member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. The member will receive financial management support in the role as the employer to assist with enrolling the providers, conducting provider background checks, and paying providers.

The member's Care Coordinator will also monitor the member's care as long as they are receiving CCC Plus Waiver services to make sure the care provided is meeting the member's daily needs.

Nursing Facility Services

If a member is determined to meet the coverage criteria for nursing facility care, and choose to receive long-term services and supports in a nursing facility, Aetna Better Health will provide coverage for nursing facility care. If the member has Medicare, Aetna Better Health will provide coverage for nursing facility care after the member has exhausted their Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If a member is interested in moving out of the nursing facility into the community, please have them contact their Care Coordinator.

Screening for Long Term Services and Supports

Before a member can receive long-term services and supports (LTSS) the member must be screened by a community based or hospital screening team. A screening is used to determine if a member meets the level of care criteria for LTSS.

Freedom of Choice

If a member has been approved to receive long-term services and supports, they member has the right to receive care in

the setting of their choice:

- In the member's home, or
- In another place in the community, or
- In a nursing facility.

Members can choose the doctors and health professionals of their choice from the Aetna Better Health network. If they prefer to receive services in their home under the CCC Plus Waiver, for example, the member can choose to directly hire their own personal care attendant(s), known as self-directed care. Another option the member has, is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal assistance workers on the member's behalf, known as agency direction. The member will also have the option to receive services in a nursing facility from our network of nursing facility providers.

Developmental Disability Waiver

If a member is enrolled in one of the DD waivers, the member will be enrolled in CCC Plus for their non-waiver services. The DD waivers include:

- The Building Independence (BI) Waiver,
- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

DD Waiver services, DD and ID targeted case management services, and transportation to/from DD waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21.

If a member has a developmental disability and needs DD waiver services, the member will need to have a diagnostic and functional eligibility assessment completed by their local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in the member's person-centered individualized service plan.

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in the member's community. For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at: <http://www.mylifemycommunityvirginia.org/> or call 1-844-603-9248. A Care Coordinator will work closely with the member and the member's DD or ID case manager to help them get all of their covered services.

Non-Emergency Transportation Services

Non-Emergency Transportation Services Covered by Aetna Better Health

Non-Emergency transportation services are covered by Aetna Better Health for covered services, carved out services, and enhanced benefits. Exception: If the member is enrolled in a DD Waiver, Aetna Better Health provides coverage for their transportation to/from the member's non-waiver services.

Transportation may be provided if the member has no other means of transportation and need to go to a physician or a health care facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at **855-652-8249**. If the member is having problems getting transportation to their appointments, call our Member Services at: **855-652-8249**.

In case of a life-threatening emergency, call 911.

Transportation to medical appointments is a covered benefit and members must call 3 working days before their visit or we will not be able to guarantee a ride. We must preauthorize the service. Members may ask for medical transportation for eye, dental, behavioral health and medical visits. Transportation is not covered for picking up prescriptions and refills at a pharmacy when drugs can be delivered or mailed. Transportation is covered if the pharmacy does not have delivery or will not mail the prescription or the prescription cannot be filled at the medical facility. **Normally the prescription should be filled initially on the return trip from the medical appointment.** Transportation may be in the form of a public or private vehicle. This transportation must be used only when the member visit is for care that is covered and the member does not have their own transportation.

Transportation to and From DD Waiver Services

If a member is enrolled in a DD Waiver, Aetna Better Health provides coverage for transportation to and from non-waiver services. (Call the number above for transportation to non-waiver services.)

Transportation to a member's DD Waiver services is covered by the DMAS Transportation Contractor. Members can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at: http://www.dmas.virginia.gov/Content_pgs/trn-info.aspx or by calling the Transportation Contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6:00 AM to 8:00 PM. The DMAS Transportation Contractor is available 24 hours a day, 7 days a week to schedule urgent reservations, at: **866-386-8331** or TTY **866-288-3133** or 711 to reach a relay operator.

If a member has problems getting transportation to their DD waiver services, the member may call their DD or ID Waiver case manager or the DMAS Transportation Contractor at the number above. Members may also call their Care Coordinator. Care Coordinator's will work closely with the member and the member's DD or ID Waiver case manager to help get the services that they need.

Copayments

CCC Plus members

There are no copayments for services covered through the CCC Plus Program. This includes services that are covered through Aetna Better Health or services that are carved-out of the CCC Plus contract. The services provided through Aetna Better Health or through DMAS will not require a member to pay any costs other than their patient pay towards long-term services and supports.

CCC Plus does not allow providers to charge members for covered services. Aetna Better Health pays providers directly. This is true even if we pay the provider less than the provider charges for a service.

If a member receives services that aren't covered by our plan or covered through DMAS, the member must pay the full cost. If a member is not certain wants to know if we will pay for any medical service or care, please have them contact Member Services.

Member Patient Pay Towards Long Term Services and Supports

Members may have a *patient pay* responsibility towards the cost of nursing facility care and home and community based waiver services. A patient pay is required to be calculated for all members who get nursing facility or home and community based waiver services. When a member's income exceeds a certain amount, the member must contribute toward the cost of their long-term services and supports. If a member has a patient pay amount, they will receive notice from their local Department of Social Services (DSS) with their patient pay responsibility. DMAS also shares patient pay amounts with Aetna Better Health if the member is required to pay towards the cost of their long-term services and supports.

Medicare Members and Part D Drugs

If a member has Medicare, members will receive prescription medicines from Medicare Part D; not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

Member Eligibility and Enrollment

Members eligible for the CCC Plus Program when they have full Medicaid benefits, and meet one of the following categories:

- 65 and older,
- An adult or child with a disability,
- Reside in a nursing facility (NF),
- Receiving services through the CCC Plus home and community based services waiver [formerly referred to as the Technology Assisted and Elderly or Disabled with Consumer Direction (EDCD) Waivers],
- Receiving services through any of the three waivers serving people with developmental disabilities (Building Independence, Family & Individual Supports, and Community Living Waivers), also known as the DD Waivers.

CCC Plus Enrollment

Eligible individuals must enroll in the CCC Plus program. DMAS and the CCC Plus Helpline manage the enrollment for the CCC Plus program. To participate in CCC Plus, the member must be eligible for Medicaid.

Reasons a member would not be eligible to participate in CCC Plus program:

- Lost Medicaid eligibility.
- Member does not meet one of the eligible categories listed above.
- Enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- Enrolled in the Medicaid Health Insurance Premium Payment (HIPP) program.
- Enrolled in PACE (Program of All-Inclusive Care for the Elderly).
- Enrolled in the Medicaid Money Follows the Person (MFP) Program.
- Enrolled in the Alzheimer's Assisted Living Waiver.
- Member resides in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- Member is receiving care in a Psychiatric Residential Treatment Level C Facility (children under age 21).
- Member resides in a Veteran's Nursing Facility.
- Member resides in one of these State long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.

Service Areas

Aetna Better Health's service area includes the entire Commonwealth of Virginia—all 95 counties and 38 independent cities.



Counties:

Accomack	Charles City	Goochland
Albemarle	Charlotte	Grayson
Alleghany	Chesterfield	Greene
Amelia	Clarke	Greensville
Amherst	Craig	Halifax
Appomattox	Culpeper	Hanover
Arlington	Cumberland	Henrico
Augusta	Dickenson	Henry
Bath	Dinwiddie	Highland
Bedford	Essex	Isle of Wight
Bland	Fairfax	James City
Botetourt	Fauquier	King and Queen
Brunswick	Floyd	King George
Buchanan	Fluvanna	King William
Buckingham	Franklin	Lancaster
Campbell	Frederick	Lee
Caroline	Giles	Loudoun
Carroll	Gloucester	Louisa
Lunenburg	Pittsylvania	Smyth
Madison	Powhatan	Southampton
Mathews	Prince Edward	Spotsylvania
Mecklenburg	Prince George	Stafford
Middlesex	Prince William	Surry
Montgomery	Pulaski	Sussex
Nelson	Rappahannock	Tazewell
New Kent	Richmond	Warren
Northampton	Roanoke	Washington
Northumberland	Rockbridge	Westmoreland
Nottoway	Rockingham	Wise
Orange	Russell	Wythe

Page	Scott	York
Patrick	Shenandoah	

Cities:

Alexandria	Galax	Poquoson
Bristol	Hampton	Portsmouth
Buena Vista	Harrisonburg	Radford
Charlottesville	Hopewell	Richmond
Chesapeake	Lexington	Roanoke
Colonial Heights	Lynchburg	Salem
Covington	Manassas	Staunton
Danville	Manassas Park	Suffolk
Emporia	Martinsville	Virginia Beach
Fairfax	Newport News	Waynesboro
Falls Church	Norfolk	Williamsburg
Franklin	Norton	Winchester
Fredericksburg	Petersburg	Poquoson

The below grid outlines enrollment dates by region*:

Date	Region
August 1, 2017	Tidewater; including CCC opt-outs
September 1, 2017	Central; including CCC opt-outs
October 1, 2017	Charlottesville/Western; including CCC opt-outs
November 1, 2017	Southwest and Roanoke/Alleghany; including CCC opt-outs
December 1, 2017	Northern/Winchester; including CCC opt-outs
January 2018	CCC Demonstration (Transition plan determined with CMS) Aged, Blind and Disabled (ABD) (Transitioning from Medallion 3.0)

*Dates and regions are subject from DMAS.

Coverage for Newborns Born to Moms Covered Under CCC Plus

Members who have a baby will need to report the birth as quickly as possible in order for the baby to be enrolled in Medicaid. Members can do this by:

- Calling the Cover Virginia Call Center at **855- 242-8282** to report the birth over the phone, or
- Contacting your local Department of Social Services to report the birth.

Medicaid Eligibility

Medicaid eligibility is determined by the member’s local Department of Social Services (DSS). If a member has questions please have them contact them directly. For more information visit Cover Virginia at www.coverva.org, or call **855-242-8282** or TDD: **888-221-1590**.

Choosing or Changing Health Plan


Members receive a notice from DMAS that included their initial health plan assignments. With that notice, DMAS included a comparison chart of health plans in the member’s area for them to choose. Members either choose Aetna Better Health of another Managed Care Organization, or DMAS may have assigned them to a health plan based on their history with their managed care plan.

Identification Cards (ID)

Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled. An ID card will be mailed to each new member when a PCP is selected or assigned.

We encourage members to keep their identification card with them at all times.

Example of CCC Plus ID Card (non-dual members)

<p>AETNA BETTER HEALTH® OF VIRGINIA Commonwealth Coordinated Care Plus</p> <p style="text-align: right;">aetna</p> <p>Name <i>Last Name, First Name</i> Medicaid/Member ID # 0000000000 DOB <i>00/00/0000</i> Sex <i>X</i> PCP <i>Last Name, First Name</i> PCP Phone <i>0-000-000-0000</i> Effective Date <i>00/00/0000</i></p> <hr/> <p>RxBIN: 610591 RxPCN: ADV RxGRP: RX8837 Pharmacist Use Only: 1-866-386-7882</p> <p style="text-align: right;">CVS caremark</p> <p style="text-align: center;"> <small>Plus Commonwealth Coordinated Care Plus Health Services</small></p> <p>www.aetnabetterhealth.com/virginia</p> <p><small>THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEVANDUAL</small></p>	<p>In case of an emergency go to the nearest emergency room or call 911.</p> <p>Important numbers for members Member Services: 1-855-652-8249 (TTY 711) Transportation: 1-855-652-8249 Behavioral Health and Substance Use Hotline: 1-855-652-8249 24 Hour Nurse Line: 1-855-652-8249 Smiles for Children: 1-888-912-3456</p> <p>Important numbers for providers Eligibility/Preauthorization: 1-855-652-8249 Radiology Preauthorization: 1-855-652-8249</p> <p>Submit claims to: Aetna Better Health of Virginia P.O. Box 63518 Phoenix, AZ 85082-3518 EDI Payer: 128VA</p> <p>Submit appeals to: Aetna Better Health of Virginia 9881 Mayland Drive Richmond, VA 23233</p> <p style="text-align: right;"><small>MEVANDUAL</small></p>
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Example of CCC Plus ID Card (dual members)

<p>AETNA BETTER HEALTH® OF VIRGINIA Commonwealth Coordinated Care Plus</p> <p style="text-align: right;">aetna</p> <p>Name <i>Last Name, First Name</i> Medicaid/Member ID # 0000000000 DOB <i>00/00/0000</i> Sex <i>X</i> PCP NO ELECTION REQUIRED PCP Phone Effective Date <i>00/00/0000</i></p> <hr/> <p>RxBIN: 610591 RxPCN: ADV RxGRP: RX8837 Pharmacist Use Only: 1-866-386-7882</p> <p style="text-align: right;">CVS caremark</p> <p style="text-align: center;"> <small>Plus Commonwealth Coordinated Care Plus Health Services</small></p> <p>www.aetnabetterhealth.com/virginia</p> <p><small>THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEVADUAL</small></p>	<p>In case of an emergency go to the nearest emergency room or call 911.</p> <p>Important numbers for members Member Services: 1-855-652-8249 (TTY 711) Transportation: 1-855-652-8249 Behavioral Health and Substance Use Hotline: 1-855-652-8249 24 Hour Nurse Line: 1-855-652-8249 Smiles for Children: 1-888-912-3456</p> <p>Important numbers for providers Eligibility/Preauthorization: 1-855-652-8249 Radiology Preauthorization: 1-855-652-8249</p> <p>Submit claims to: Aetna Better Health of Virginia P.O. Box 63518 Phoenix, AZ 85082-3518 EDI Payer: 128VA</p> <p>Submit appeals to: Aetna Better Health of Virginia 9881 Mayland Drive Richmond, VA 23233</p> <p style="text-align: right;"><small>MEVADUAL</small></p>
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Member Rights

It is the policy of Aetna Better Health to treat members with respect. We also care about keeping a high level of confidentiality with respect for a member's dignity and privacy. . It is also our policy that we make certain that our members are free to exercise his/her rights and that by exercising those rights, it does not adversely affect the way we and or our providers treat our members.

Members have the right to:

- Receive timely access to care and services;
- Take part in decisions about their health care, including their right to choose their providers from Aetna Better Health network providers and their right to refuse treatment;
- Choose to receive long term services and supports in their home or community or in a nursing facility;
- Confidentiality and privacy about their medical records and when they receive treatment;
- Receive information and to discuss available treatment options and alternatives presented in a manner and language they understand;
- Get information in a language they understand – members can receive oral translation services free of charge;
- Receive reasonable accommodations to ensure they can effectively access and communicate with providers,

- including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services;
- Receive information necessary for them to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of their medical records and ask that the records be amended or corrected;
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to the member or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience;
- Get care without regard to disability, gender, gender identity, sexual preference, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be informed of where, when and how to obtain the services they need from Aetna Better Health, including how they can receive benefits from out-of-network providers if the services are not available in Aetna Better Health's network.
- Complain about Aetna Better Health to the State. The member can call the CCC Plus Helpline at **844-374-9159** or TDD **800-817-6608** to make a complaint about us.
- Appoint someone to speak for them about their care and treatment and to represent them in an Appeal;
- Make advance directives and plans about their care in the instance that they are not able to make their own health care decisions.
- Change their CCC Plus health plan once a year for any reason during open enrollment or change their MCO after open enrollment for an approved reason. Call the CCC Plus Helpline at **844-374-9159** or TDD **800-817-6608** or visit the website at <https://cccplusva.com> for more information.
- Appeal any adverse benefit determination (decision) by Aetna Better Health that the member disagrees with that relates to coverage or payment of services.
- File a complaint about any concerns the member may have with our customer service, the services they received, or the care and treatment they have received from one of our network providers.
- To receive information from us about our plan, their covered services, providers in our network, and about their rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this Section of the handbook.)

Right to be Safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If a member is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, a member should call their local department of social services or the Virginia Department of Social Services' 24-hour, toll-free hotline at: **888-832-3858**. Members can make this call anonymously; they do not have to provide their name and the call is free.

Trained local workers may be provided to assist and help the member receive the types of services they need to assure that they are safe.

Right to Confidentiality

Aetna Better Health will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse.

Aetna Better Health staff will ask questions to confirm the member's identity before we discuss or provide any information regarding their health information.

We understand the importance of keeping personal and health information secure and private. Both Aetna Better Health and the member's doctors make sure that all member records are kept safe and private. We limit access to

personal information to those who need it. We maintain safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies. If needed, we may use and share personal information for “treatment”, “payment” and “health care operations”. We limit the amount of information that we share about members as required by law. For example, HIV/AIDS, substance abuse and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

Right to Privacy

We are required by law to provide members with the Notice of Privacy Practices. This notice is included in the member’s member packet and in our member newsletter. This notice informs members of their rights about the privacy of their personal information and how we may use and share personal information. Changes to this notice will apply to the information that we already have about the member as well as any information that we may receive or create in the future. Members may request a copy at any time by calling Member Services at **855-652-8249** or by going to our website at www.aetnabetterhealth.com/virginia.

In doctor offices, member’s medical record will be labeled with their identification and stored in a safe location in the office where other people cannot it. If the doctor office uses a computer to store medical information, there should be a special password to safeguard member medical records.

Member medical record cannot be sent to anyone else without their written permission, unless required by law. When a member asks their doctor’s office to transfer records, they will give the member a release form to sign. It’s the doctor’s office responsibility to do this service for our members.

We will assist the member:

- To provide quick transfer of records to other in or out-of-network providers for the medical management of their health
- When the member changes primary care providers, to assure that their medical records or copies of medical records are made available to their new primary care provider.

If a member would like a copy of their medical or personal records, they may send us a written request. The member may also call Member Services at **855-652-8249** (TTY/TDD: **711** or 800-828-1120) and ask for a form that they or their representative can fill out and send back to us. Members have a right to review their requested medical records and ask they be changed or corrected.

Follow Non-Discrimination Policies

Members cannot be treated differently because of their race, color, national origin, disability, age, religion, gender, gender identity, sexual preference, marital status physical or mental disability, pregnancy, childbirth, sexual orientation, health status, or medical conditions.

If you think that a member has not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at **800-368-1019**. TTY users should call **800-537-7697**. You can also visit <http://www.hhs.gov/ocr> for more information.

Aetna Better Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Member Responsibilities

As a Member, they also have some responsibilities. These include:

- Present their Aetna Better Health Membership card whenever they seek medical care.
- Provide complete and accurate information to the best of their ability on their health and medical history.
- Participate in their care team meetings, develop an understanding of their health condition, and provide input in developing mutually agreed upon treatment goals to the best of their ability.
- Keep their appointments. If they must cancel, call as soon as they can.
- Receive all of their covered services from Aetna Better Health's network.
- Obtain authorization from Aetna Better Health prior to receiving services that require a service authorization review.
- Call Aetna Better Health whenever they have a question regarding their Membership or if they need assistance toll-free at one of the numbers below.
- Tell Aetna Better Health when they plan to be out of town so we can help them arrange their services.
- Use the emergency room only for real emergencies.
- Call their PCP when they need medical care, even if it is after hours.
- Tell Aetna Better Health when they believe there is a need to change their plan of care.
- Tell us if they have problems with any health care staff. Call Member Services at one of the numbers below.
- Call Member Services at one of the phone numbers below about any of the following:
 - If they have any changes to their name, their address, or their phone number. Report these also to their case worker at their local Department of Social Services.
 - If they have any changes in any other health insurance coverage, such as from their employer, their spouse's employer, or workers' compensation.
 - If they have any liability claims, such as claims from an automobile accident.
 - If they are admitted to a nursing facility or hospital.
 - If they get care in an out-of-area or out-of-network hospital or emergency room.
 - If their caregiver or anyone responsible for their changes.
 - If they are part of a clinical research study.

In addition, Aetna Better Health complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

Overpayment

Network providers may voluntarily disclose overpayments or improper payments of funds directly to Aetna Better Health. We ask that the provider return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified. Please send the refund check along with an explanation to Aetna Better Health, at the address below.

Aetna Better Health of Virginia
 Attn: Finance Provider Refund Check Dept.
 4500 E. Cotton Center Blvd.
 Phoenix, AZ 85040

In the event Aetna Better Health determines an overpayment based on an internal audit, we will send a letter to the provider explaining the overpayment, the name of the member the overpayment was made on and any other pertinent information to help the provider locate the overpayment in their system. In the letter, we will outline the timeframe in which we require the overpayment funds to be sent back to us along with information if the provider disputes the request.

CCC Plus Access and availability standards

The tables below indicate appointment wait time standards for primary and specialty care; standards for acceptable wait time in the office when a member has arrived for a scheduled appointment, and acceptable after-hour appointment standards.

Physician type	Appointment type	Availability standard
All Provider Types	Emergency	Appointments for emergency services shall be made available immediately upon the Member's request.
	Urgent Care	All urgent care and symptomatic office visits shall be available within no more than twenty-four (24) hours of the Member's request; however, as quickly as the symptoms demand. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting.
	Routine	Appointments for routine, primary care services shall be made within thirty (30) calendar days of the Member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days, or for routine specialty services like dermatology, allergy care, etc.
Prenatal	First (1st) Trimester	Fourteen (14) calendar days of request
	Initial Second (2nd) Trimester	Seven (7) calendar days of request
	3 rd Trimester	Within five (5) business days of request.
	High Risk	Within three (3) business days of identification of high risk or immediately if emergency exists.

Notes:

- Primary Care Provider (PCP) is defined as Family Practice, Internal Medicine, Pediatrics, and General Practice, Nurse Practitioners, Obstetricians/Gynecologists, Pediatricians, and Specialists who perform primary care functions.
- High Volume Specialists are determined by the Health Plan through annual High Volume Specialist Reports. OB/GYN Providers and Oncologists are considered mandatory High Volume/High Impact Specialist providers and will be added to the annual High Volume Specialist listing.
- When developing the network, Aetna Better Health takes into account the linguistic and cultural preferences of health plan membership. Member access to more than one PCP that is multi-lingual and culturally diverse is required for Medicaid.
- Selection of Ancillary Provider access as determined by the State.

Providers must be available to members 24 hours a day, 7 days a week. When the provider is unavailable, arrangements must be made for another primary care physician to cover services.

Providers must offer hours of operation to members of Aetna's Virginia Medicaid managed care program ("Virginia Medicaid members") that are no less (in number or scope) than the hours of operation offered to other non-Medicaid patients, or if a provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to members of the Commonwealth of Virginia's Medicaid Fee for Service Program. Provider agrees to provide covered services to Virginia Medicaid members on a twenty-four (24) hour per day, seven (7) day per week basis.

Further, provider agrees to meet Virginia state standards for timely access to care and services, taking into account the urgency of need for services.

Regional Wellness Centers

About Regional Wellness Center (RWC)

Aetna Better Health has established Aetna Better Living Regional Wellness Centers, in the State of Virginia, where members, caregivers, providers, and community organizations can meet face-to-face with care coordinators, case managers, provider relations staff, community health workers, peer supports, employment and workforce specialists, and community resource team members.

The Regional Wellness Centers are a centralized point for member events and education, provider training, member and caregiver drop-in, health fairs, volunteerism, and many other supports for the community, including Integrated Care Team meetings in order to develop and execute individual member care plans.

Additionally, community health workers will link members to safe housing, local food markets, job opportunities, and training, access to health care services, community-based resources, transportation, recreational activities, and other services and supports, such as expanded respite for caregivers.

Our Wellness Centers will be available to all members, with no limits, as well as caregivers, providers, and community organizations.

Our goal is to offer our members “A seamless, one-stop system of services and supports”.

Regional Wellness Staff & Assistance

Our staff in the Aetna Better Living Regional Wellness Centers includes community health workers (CHWs), who live in the local area and will help us to identify members who have gaps in care and need to see their provider. At least one dedicated regional team is located in each region, with a Regional Wellness Center Manager to coordinate staff that live in and operate within the region.

Staff within our Regional Wellness Center may include:

- Regional Wellness Center Manager
- Peer Support Specialists
- Community Health Workers (CHWs)
- Housing Specialists
- Workforce Specialists
- Recovery and Resiliency Specialists
- Practice Transformation Consultants (for BH Health Homes)

Staff will be available to assist members with:

- Employment through our Workforce Specialist and other staff, including helping members write resumes;
- Providing interview coaching and linking members to employers;
- Hosting GED classes and support groups for children and families affected by deportation and children of divorced parents;
- Offering educational workshops on health and wellness related topics including healthy cooking, nutrition, parenting, self-esteem for teens, and more;
- Connecting members to services and social supports through our extensive database of all available community services and support;
- Support for mental health and substance use issues through our Peer Support Specialists with similar life experiences who can relate to our members and offer practical suggestions;

- Scheduling transportation and health and life coaching in the Regional Wellness Center;
- Housing through our Housing Specialist and other staff who link members to resources for accessible housing, utility assistance, and other resources including home modifications.
- Offering health and life coaching.
- Supporting caregivers with peer groups and workshops

Enhanced Services & Incentives

Aligning with our holistic approach to wellness for each Commonwealth member, we are offering Aetna Better Care enhanced services and incentives, including adult dental, vision, and hearing benefits; diabetic foot care; wellness rewards; a medication adherence program for chronic illness; home-delivered meals; weight management; and memory care devices.

We also sponsor Family Day for foster families in which we provide education on child safety. Homelessness is a problem in the Virginia Beach area, along with mental health and substance abuse issues.

Homelessness is a serious obstacle to healthy living. To improve a person’s health, we assist people in obtaining stable and safe housing. Aetna is proud to collaborate with Virginia Supportive Housing (VSH), the Commonwealth’s largest supportive housing organization, in their effort to eliminate homelessness. We coordinate care in homeless shelters using our peer supports and Community health workers. In addition, we sponsor a SUITS & SHOES program to assist men and women going to job interviews with clothes to wear to an interview after completing the GED program.

If identified, we offer extensive education using local CHWs to identify families at risk, establish relationships, and connect them with the local team, FISOC staff, peer supports, BH and Social workers to identify the root causes of violent behavior and develop individualized solutions which include but are not limited to, help with housing, employment, nutrition, and finding the local food bank

Transition Support

To facilitate a successful transition from the nursing facility to the member’s home, we offer our members with *No Place Like Home Grants and Rental Assistance* that include home environmental assessments, home modifications, utilities, and rent payments for the initial months, hoarding interventions, cleaning and handyman services, and pest control.

Regional Wellness Center Facility

The Wellness Centers will make available free of charge conference rooms and meeting space for community events as well as private areas for members and families who wish to meet with our Case Managers.

We will also have training areas for providers, who can also meet in person with provider relations staff if assistance is required for billing questions or issues. In addition, we will make wireless internet and printers available free of charge as well.

Eligibility

Our wellness centers are available to all members, with no limits, as well as to caregivers, providers, and community organizations. All members can use our wellness centers regardless of condition/need to visit wellness center.

Note: Physician services will not be offered at regional wellness centers; services offered will not replace health care services provided by PCP and other specialists.

Services for Caregivers

We offer the following Caregiver services at our Regional Wellness Centers:

- Provide workshops on topics such as, “How to Take Care of Yourself While Caring for Others”
- Use of meeting space, computers and internet Services for Providers/Community Based Organizations

- Assistance with billing, claims resolution, and other questions

Provider Education

Aetna Better Health will offer training sessions for providers at our regional wellness centers where our Case Managers will educate them on the ways in which to better help I/DD members overcome their fears and anxieties associated with treatment and care. These sessions will enable providers to eliminate members' need for sedation or restraint, as well as to reduce their fear, resistance, and avoidance. Through a gradual, step-by-step process, (in collaboration with their family members or support system), providers receive hands-on training that enable them to move from practice to treatment, thus making routine care a success.

Medicare Advantage D-SNP Information

Definition of D-SNP - Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Medicaid (Title XIX). D-SNPs offer the opportunity for more integrated and/or coordinated care by employing policies and procedures that better integrate member materials, enrollment, communications, grievance and appeals, and quality improvement programs.

Who is eligible for DSNP - In general, an individual is eligible to elect (enroll in) a D-SNP when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he or she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan;
2. The individual has not been medically determined to have ESRD prior to completing the enrollment request;
3. The individual permanently resides in the service area of the MA plan;
4. The individual is a U.S. citizen or lawfully present in the United States; and,
5. The individual is eligible for coverage under Virginia Medicaid.

Approved Populations. Aetna Better Health of Virginia offers their D-SNP to beneficiaries that meet the following requirement:

Entitled to benefits under Medicare Part A, B and D, and receiving full Medicaid benefits including:

- Qualified Medicare Beneficiary Plus (QMB+),
- Special Low Income Medicare Beneficiary Plus (SLMB+), and
- Other Full-Benefit Dual Eligible (FBDE).

Excluded Populations. Aetna Better Health of Virginia is prohibited from enrolling those that meet one of the following criteria:

- Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries such as:
- Qualified Medicare Beneficiaries (QMBs);
- Special Low Income Medicare Beneficiaries (SLMBs);

- Qualified Disabled Working Individuals (QDWIs);
- Qualifying Individuals (Qis);
- Individuals residing outside of the MA D-SNP approved service areas; or
- Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

When does the D-SNP program become available - Effective January 1, 2018, Aetna Better Health of Virginia will offer our Medicare Advantage Dual Special Needs Program (D-SNP).

Enrollment Periods for the D-SNP Program - New members will be eligible to enroll during Medicare's annual open enrollment period (Annual Election Period, or AEP) from October 15 through December 7 of every year. In addition, individuals receiving assistance from Virginia Medicaid may enroll on the first of any month starting in January 2018, through a Special Election Period (SEP) outside of the annual election period. For any additional questions regarding our upcoming D-SNP program, please feel free to reach out to us at 1-855-463-0933.

*Referenced from www.dmas.com

Monitoring and Oversight Activity

HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the organization that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

Providers agree to make available, for the purposes specified in the preceding paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS or their designee may require.

Providers further agree to maintain and make records available for oversight activity for a minimum of ten (10) years.

All maintained records must be sufficient to enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract.

Providers must comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

For records subject to review, CMS will provide notification to the MA organization that a direct request for information has been initiated. When applicable, we will work with all First Tier and/or Downstream Entities to collect the requested documentation.