Provider Orientation and Education 2018

Doing the right things for the right reasons

January 2018

Welcome To Provider Orientation and Education for 2018

Aetna Better Health of Virginia

Commonwealth Coordinated Care Plus (CCC Plus)
Dual Eligible Special Needs Plan (D-SNP)

Agenda

- About Aetna Better Health of Virginia
  - Values and Behaviors
  - Plans Offered by AHB of Virginia
- Family Access to Medical Insurance Security (FAMIS)
- Commonwealth Coordinated Care Plus (CCC Plus)
- Dual Eligible Special Needs Plan (D-SNP)
- Defining the Dual Eligible Population
- How to Identify our Medicare Advantage members
- Covered Services and Benefits
- Referrals, Prior Authorization, Medical Management, and Appeals
- SNP Model of Care (MOC)
- Claim Submission & Claim Management
- Enrollee-Beneficiary Protections
- Online Provider Portal (Resources-Tools)

About Aetna Better Health of Virginia

History of Aetna Medicaid

Aetna Values and Behaviors

Aetna Better Health of Virginia Service Area

Plans offered by Aetna Better Health of Virginia

- FAMIS and Medallion
- CCC Plus
- D-SNP

About Aetna Better Health of Virginia – Aetna Medicaid

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 three (3) million members through Medicaid managed care plans in sixteen (16) states: Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nevada, New York, New Jersey, Ohio, Pennsylvania, Texas, Virginia, and West Virginia. We also serve ABD, dual eligible members (and other programs) in thirteen (13) of those states. Aetna Medicaid (Aetna Better Health of Virginia) was also recently awarded new contracts to serve Virginia Medicaid's LTSS program.

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.

About Aetna Better Health of Virginia - Values & Behaviors

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About Aetna Better Health of Virginia – Service Area

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

About Aetna Better Health of Virginia – Service Area (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

About Aetna Better Health of Virginia – Plans Offered

At Aetna Better Health of Virginia, we believe in improving every life we touch as good stewards to those we serve.

We have been serving the Medicaid population in Virginia since 1996, and we are excited to be expanding our plan offerings in 2018 to include a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP).

In 2018, we will offer managed care services and programs to individuals and families who qualify for Medicaid, FAMIS (Family Access to Medical Insurance Security), CCC Plus (Commonwealth Coordinated Care Plus), and D-SNP (Medicare Advantage Dual Eligible Special Needs Plans).

About Aetna Better Health of Virginia – FAMIS & Medallion

Aetna Better Health of Virginia is a managed care organization duly licensed in accordance with the laws of the Commonwealth of Virginia. We offer coverage for the Medicaid/FAMIS programs

We contract with doctors, hospitals, drug stores and other medical providers to give care to our Aetna Better Health of Virginia members. As a contracted provider, you make up Aetna Better Health' provider network and are called participating providers. All Aetna Better Health of Virginia members are directed to use participating providers whenever possible.

Aetna Better Health of Virginia has a quality improvement program to make sure our services meet high standards of quality and safety. Our QI program is reviewed and updated each year.

Aetna Better Health of Virginia wants to ensure our members receive: the right kind of care, easy access to quality medical and behavior health care, help with any chronic conditions or illnesses, and support when they need it most.

We value high member satisfaction with their doctors and with us.

About Aetna Better Health of Virginia – CCC Plus

The CCC Plus program is a new statewide Medicaid managed long term services and support program that will serve approximately 214,000 individuals with complex care needs, through an integrated deliver model, across the full continuum of care. Aetna Better Health of Virginia was approved by DMAS to provide care coordination and health care services for the program.

CCC Plus will launch regionally. Start dates for eligible members are:

Tidewater – August 1, 2017

Central – September 1, 2017

Charlottesville/Western – October 1, 2017

Roanoke/Alleghany – November 1, 2017

Southwest – November 1, 2017

Northern/Winchester; December 1, 2017

Members transitioning from Medallion 3.0 that are in the Aged, Blind and Disabled (ABD) program will start January 1, 2018. Members currently in the Commonwealth Coordinated Care program will also transition to CCC Plus January 1, 2018.

About Aetna Better Health of Virginia – CCC Plus

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.

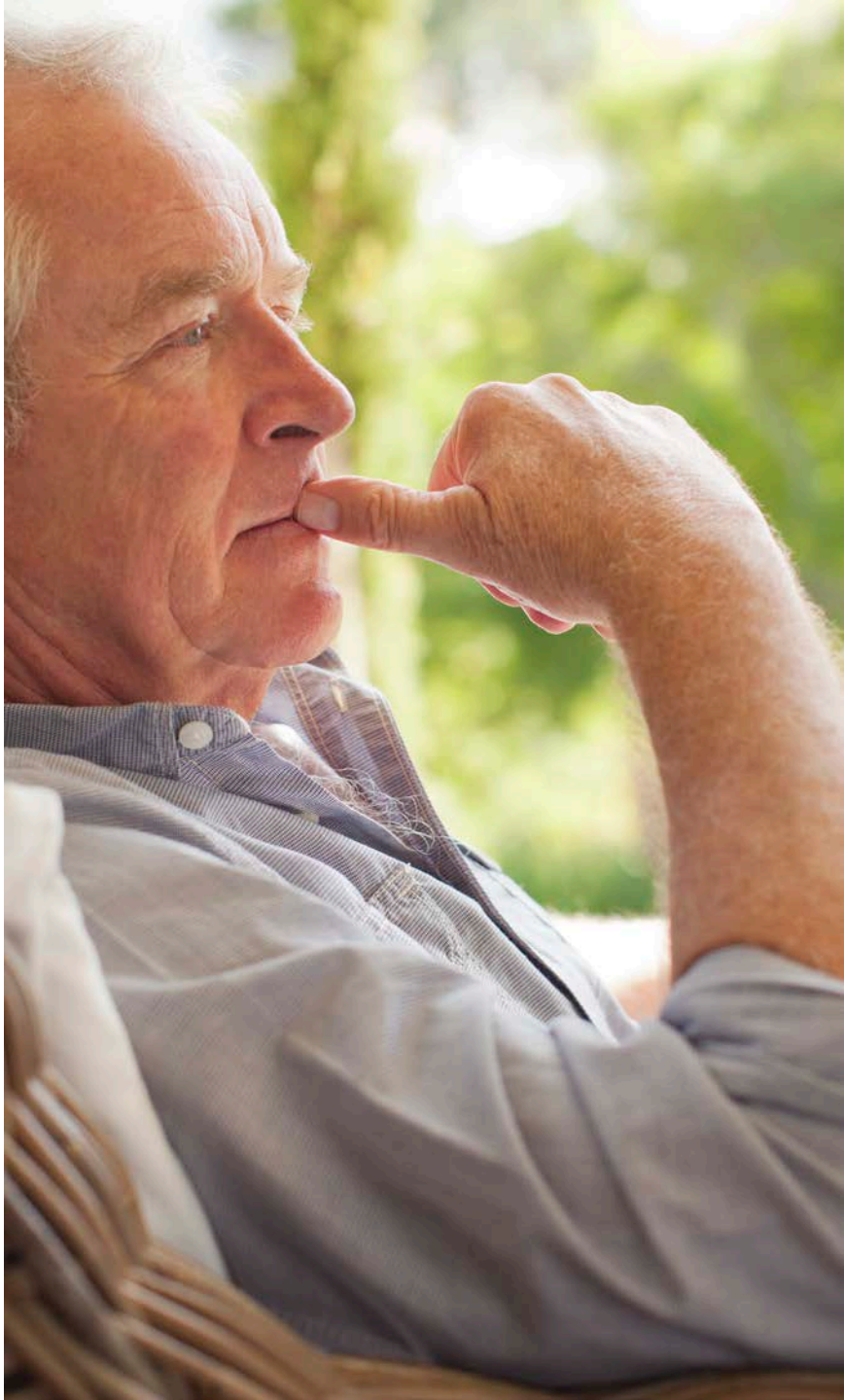
Ref: DMAS http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Ref: Aetna Provider Manual

Who is Eligible to be a CCC Plus Member

- Individuals age 65 and older
- Adult or child with a disability
- Residents in a nursing facility (NF)
- Individuals who receive 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]
- Individuals who receive 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

For additional information please visit the DMAS site:
http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx



About Aetna Better Health of Virginia – Medicare Advantage

- Aetna Better Health of Virginia's Medicare Advantage Special Needs Plan (HMO SNP) is available to people who have Medicare and who receive Medicaid assistance from the Commonwealth Coordinated Care Plus (Medicaid).
- Aetna Better Health of Virginia is committed to serving the needs of all dual eligible individuals, and through our Special Needs Plan we offer our members additional benefits and services not covered under Medicare.
- To ensure our success in the dual eligible products, we will change the way that we operate, and how we govern planning and performance management.
- Our future-state operating model and model of care will be designed to leverage best practices and internal capabilities and expertise
    - Utilize common core operations/functions and limit replication in markets or segments unless required by state
    - Utilize common policies and processes and adapt to meet state or market specific requirements
    - Where possible, utilize common platforms to help in care management and ease procedures for claim coordination and claims management.

D-SNPs and Aetna Better Health of Virginia HMO-SNP

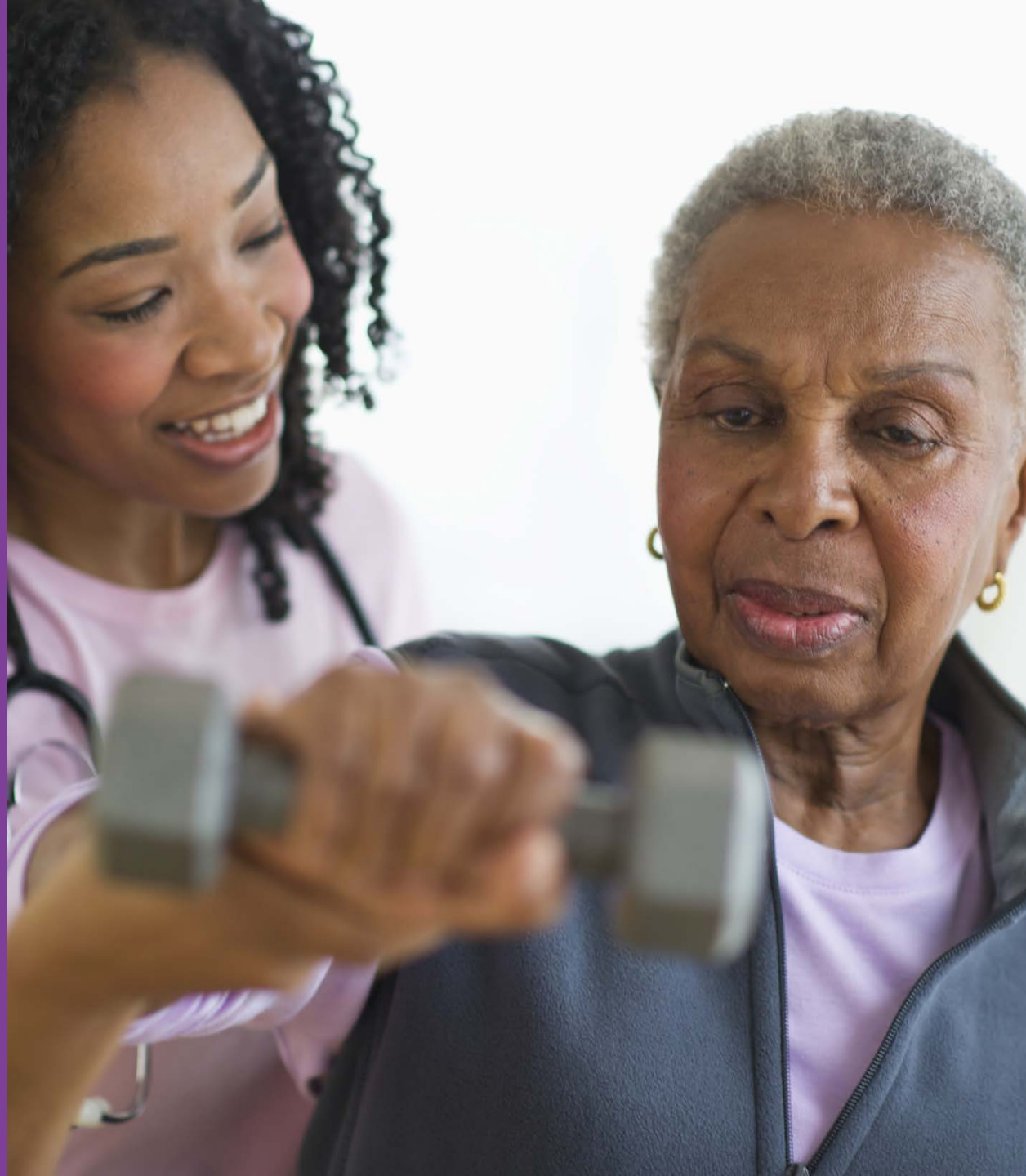
Dual SNP (D-SNP)

- A dual special needs plan is a type of Medicare Advantage plan.
- It's for people who qualify for both Medicare and Medicaid (duals), who have a specific health condition and/or are a resident of a long-term care facility.
- It combines the benefits of Medicare parts A, B and D.

Aetna Better Health of Virginia HMO-SNP

- Our dual special needs plan for Virginia
- Also known as HMO-SNP
- Per our contract with CMS and the state, we will use the official title of Aetna Better Health of Virginia HMO-SNP in all content

Aetna will emerge as an industry leader in serving dual populations by developing best-in-class operating and clinical models, collaborating with members, providers, and community based organizations in pursuit of quality solutions that address the continuum of our members' health care needs.



Defining the Dual Eligible Population

Identifying the Dual Eligible Population

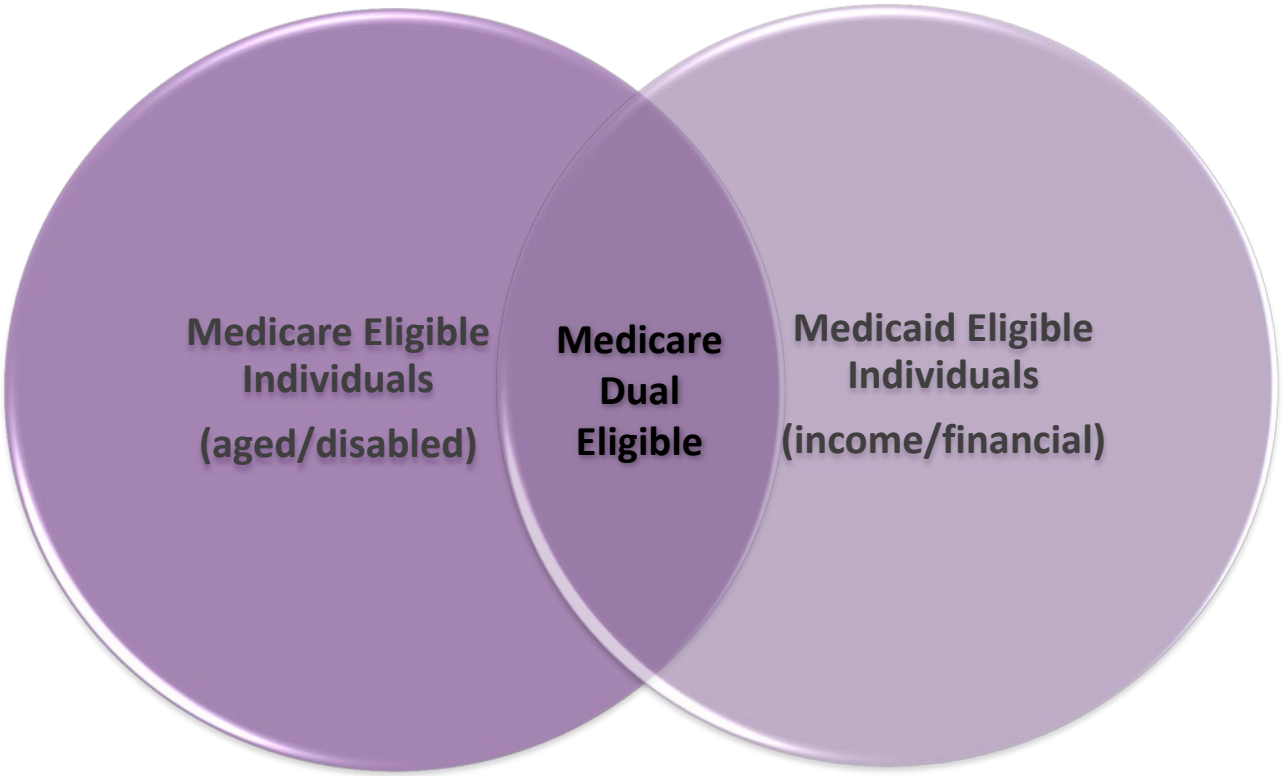
Eligibility for Medicare Advantage

Eligibility for Dual Eligible Special Needs Plans

Eligibility for Commonwealth Coordinated Care Plus (CCC Plus)

Benefits of Patients Joining a Special Needs Plan

Defining Dual Eligible Population



Dual Eligible Beneficiaries:

Approximately 11.4 million individuals (2015)

15% of Medicaid enrollment

20% of Medicare enrollment

Dual eligible individuals are often in poorer health and require more care compared with other Medicare and Medicaid beneficiaries

Defining Dual Eligible Population – Medicare Advantage

In general, an individual is eligible to elect an MA plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B;

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;

5. The individual or his/her legal representative completes an enrollment request and includes all information required;

6. The individual is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment request; and

7. The individual makes a valid enrollment request that is received by the plan during a valid election period.

Defining Dual Eligible Population – Special Needs Plan

MA Special Needs Plans (SNP) must limit enrollment to individuals who meet specified eligibility requirements. Dual Eligible SNPs (D-SNPs) enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX).

Before processing an enrollment into a dual eligible SNP (D-SNP), the SNP must confirm eligibility, including both MA eligibility and Medicaid eligibility. Acceptable proof of Medicaid eligibility may include:

- a current Medicaid card,
- a letter from the state agency that confirms entitlement to Medical Assistance,
- or verification through a systems query to a State eligibility data system.

Defining Dual Eligible Population – CCC Plus

In Virginia, DMAS has sole responsibility for determining the eligibility of an individual.

In general, CCC Plus includes Medicaid members who:

Receive Medicare benefits and full Medicaid benefits (dual eligible), including members enrolled in Commonwealth Coordinated Care (CCC).

Receive Medicaid long term services and supports (LTSS) in a facility or through one of the home and community-based (HCBS) waivers, except Alzheimer's Assisted Living waiver.

Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, will enroll for their non-waiver services only. At this time, their DD waiver services will continue to be covered through Medicaid fee-for-service.

Are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals currently enrolled in the Medallion 3.0 program.

Defining Dual Eligible Population – Excluded Populations

Limited Coverage Groups

Governor's Access Plan (GAP)

Family Planning

Qualified Medicare Beneficiaries only

Special Low-Income Medicare Beneficiaries

Health Insurance Premium Payment (HIPP)

Qualified Disabled Working Individuals

Qualifying Individuals

Other Programs

Members of Medicaid Medallion and FAMIS managed care

PACE (Program of All –Inclusive Care for the Elderly)

Money Follows the Person (MFP)

Alzheimer's Assisted Living Waiver (AAL)

Specialized Settings

Intermediate Care Facilities for Individuals with Intellectual Disability

Veterans Nursing Facilities

Psychiatric Residential Treatment

Level C

State facilities: Piedmont, Catawba and Hancock

Special Conditions

Hospice and End Stage Renal Disease

(CCC Plus enrolled individuals who elect hospice or have ESRD will remain CCC Plus enrolled)

Defining Dual Eligible Population – Benefits of Joining

What's The Benefit of Joining a D-SNP?

- Medicare & Medicaid were never meant to work together, creating gaps and overlaps in care. However, if an individual is enrolled in CCC Plus and also qualifies for Medicare, he/she can enroll in a D-SNP and have all health care needs and benefits coordinated.
- Qualified beneficiaries can enroll in the same health plan for their Medicare and Medicaid benefits. This will enhance and simplify the coordination of benefits and reduce enrollee administrative burden.
- If an individual is enrolled in a D-SNP, they will not have premiums or co-pays for doctor or specialist visits (However, they may have some co-pays for prescription drugs).
- D-SNPs often provide coverage for additional services not covered by Medicare or Medicaid.
- D-SNPs offer more focused care to ensure beneficiaries receive the help they need to manage their health.

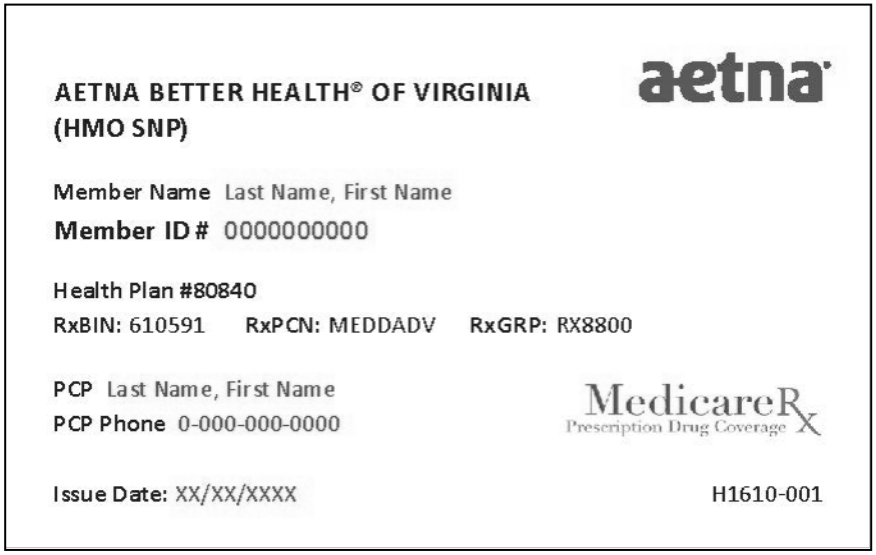
Identifying our D-SNP Members

Information on the Aetna Better Health of Virginia member ID card can help you file claims more efficiently and accurately

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

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

Providers should remind patients to bring their Aetna Better Health of Virginia ID card to the pharmacy when they have a prescription filled



AETNA BETTER HEALTH® OF VIRGINIA
(HMO SNP)

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Member Name Last Name, First Name
Member ID # 0000000000

Health Plan #80840
RxBIN: 610591 RxPCN: MEDDADV RxGRP: RX8800

PCP Last Name, First Name
PCP Phone 0-000-000-0000

MedicareRx
Prescription Drug Coverage

Issue Date: XX/XX/XXXX

H1610-001

Important information

Member Services:	1-855-463-0933 (TTY 711)
24-Hour Nurse Line:	1-855-463-0933 (TTY 711)
Behavioral Health:	1-855-463-0933 (TTY 711)
Pharmacy Help Desk:	1-866-328-7517 (TTY 711)
Website:	www.aetnabetterhealth.com/virginia

Submit claims to:
Aetna Better Health of Virginia
P.O. Box 63518
Phoenix, AZ 85082-3518
Claim Inquiry: 1-855-463-0933 (TTY 771)

This card does not guarantee coverage.

Covered Services and Benefits

4 Parts of Medicare

DSNP Covered Services

DNSP Value Added Benefits

CCC Plus Carved Out Services

CCC Plus Added Benefits

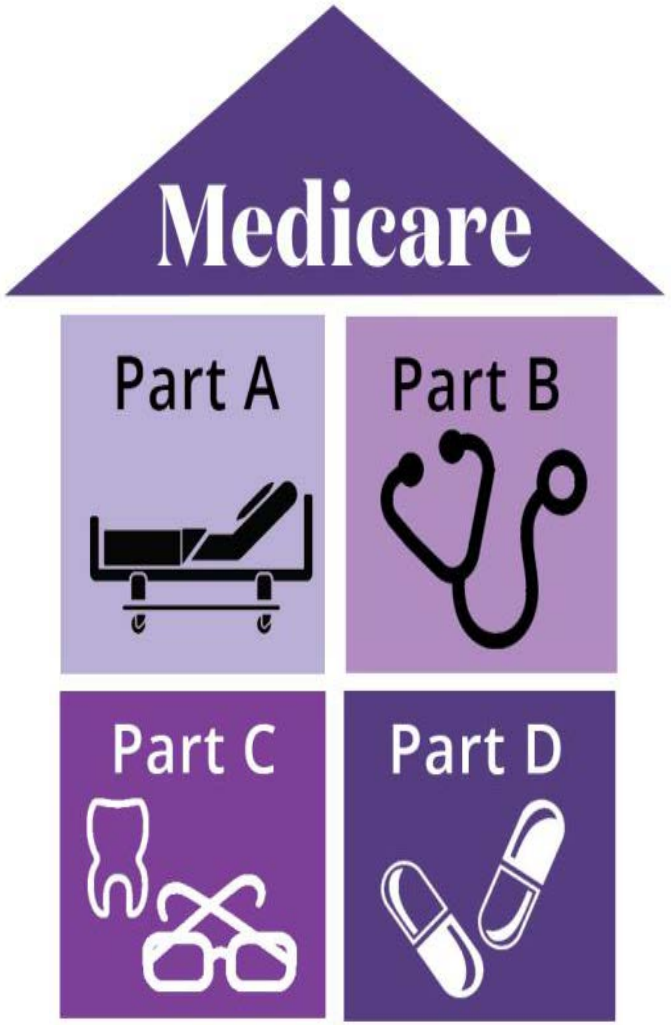
Additional Benefits

Covered Services & Benefits – The 4 parts of Medicare

Medicare coverage includes four parts.

- Part A – hospital insurance for care in a hospital or facility
- Part B – medical insurance that covers medically necessary services like doctor's visits
- Part C – private insurance plans that cover Medicare benefits, which may include drug coverage and may also offer services *not* typically covered by Medicare. These are known as Medicare Advantage plans.
- Part D – prescription drug coverage

Parts A and B are often referred to as "original" Medicare.



Covered Services & Benefits – DSNP Covered Services

In Virginia, Medicaid eligibility categories include the following:

- QMB Plus;
- SLMB Plus;
- Other Full-Benefit Dual Eligible (FBDE)

Because the eligibility categories only include full benefit dual eligible (FBDE) individuals, all enrollees in Aetna Better Health of Virginia's D-SNP have no responsibility for Medicare cost sharing for any Medicare covered services. Restated, ANY Medicare cost sharing that is applied to a claim is covered under the members Medicaid plan.

Benefit	DSNP	Medicaid Cross-Over?	Member Responsibility
Inpatient	As Filed	YES	$0 Copay
SNF	As Filed	YES	$0 Copay
PCP	As Filed	YES	$0 Copay
Specialist	As Filed	YES	$0 Copay
Ambulatory Surgery	As Filed	YES	$0 Copay
Outpatient Hospital	As Filed	YES	$0 Copay
DME	As Filed	YES	$0 Copay
Diagnostic Imaging	As Filed	YES	$0 Copay

Covered Services & Benefits – DSNP Value Added Benefits

- HEARING: 1 routine exam - every 2 years, 1 fitting/evaluation for hearing aid- every two years. Hearing aids $1000 every three years
- DENTAL: Maximum Plan Benefit Coverage amount of $500 per year, Preventive exams and cleanings 2x year, 1 set of x-rays 1x a year, fluoride 1x a year. Comprehensive- Fillings, extractions, root canals, crown endo, perio and oral surgery
- VISION: $200 allowance per year (Contacts only)
- TRANSPORTATION: 30 roundtrip/ 60 one-way trips to plan-approved locations. Appointments for dental, vision, hearing, and behavioral health services. Visits to pharmacies to pick up prescription drugs within a 50 mile limit. Trips to Silver Sneakers and smoking cessation classes. Plus trips for podiatry services
- SMOKING CESSATION: up to 50 counseling sessions / year; nicotine patches, gum, lozenges, some Rx meds w/o prior authorization
- SILVER SNEAKERS: Fitness program designed specifically for older adults
- OVER-THE-COUNTER (OTC) BENEFITS: $50 each month of OTC medication mailed directly to where you live. OTC medication is limited to approved items. You can order your monthly OTC Medications three ways. By Mail, By Phone or by internet. You can order online at Aetnava.otchs.com

Covered Services & Benefits – CCC Plus Carved Out

Services for CCC Plus enrolled individuals that are paid for through fee-for-service.

- Dental Services (Smiles for Children)
- School Health Services
- Preadmission Screening
- Developmental Disabilities (DD) Waivers- Carve out includes waiver services, related transportation, case management and support coordination. Also includes waiver services covered through EPSDT for DD Waiver enrolled individuals.

DD Waiver services covered through EPSDT includes: Private duty nursing, Skilled nursing, Personal care, Assistive Technology, Center-based Crisis, Community-based Crisis.

Non-waiver services are covered under CCC Plus program.

Covered Services & Benefits – CCC Plus Additional Benefits

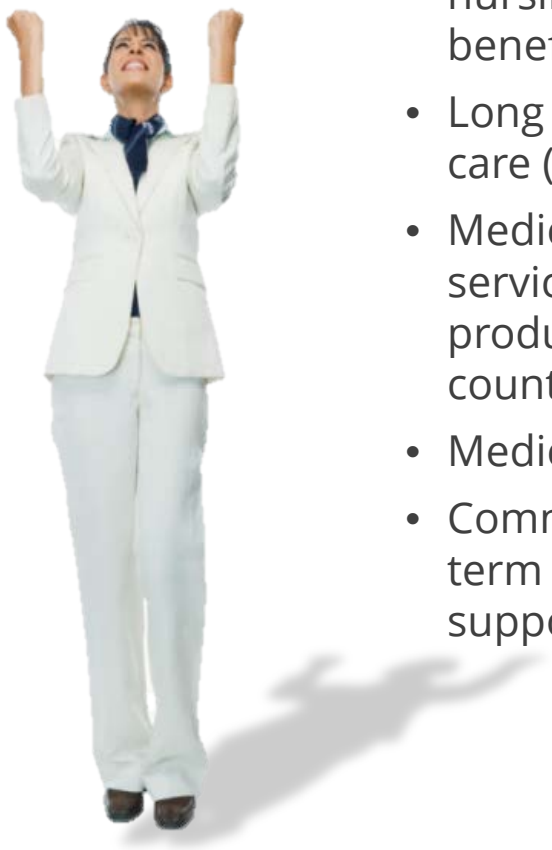
Member will also receive:

- Person centered, individualize support plan
- Same standard Medicaid services provided
- Care coordinator for each member
- Team of health care professionals working together
- Assistance connecting to housing, food and community resources
- **Hearing-** Exam and one hearing aide per year, unlimited visits for hearing aid fittings (Limited to $500 annually)
- **Dental-** Exam and cleaning twice per year, annual set of bitewing x-rays, fillings, extractions, root canals or dentures. Limited to $525 annually
- **Vision-** Exam and $100 toward eyewear per year

Medicare and Medicaid Benefits Combined

Medicare

- Inpatient hospital and
- Outpatient care (medical and psychiatric)
- Primary physician and specialists services
- Skilled nursing
- Home health care
- Prescription drugs
- Durable medical equipment



Medicaid CCC Plus

- Hospital and skilled nursing when Medicare benefits are exhausted
- Long term nursing facility care (custodial)
- Medicare non-covered services (i.e. incontinence products, over-the-counter medicines, etc.)
- Medicare copayments
- Community based long term services and supports

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Coordination with Medicare and Medicaid

Medicare Covers:	Medicaid Covers:	CCC Plus Covers:
Hospital care Physician & ancillary services Skilled nursing facility (SNF) care Home health care Prescription drugs Durable medical equipment	Medicare Cost Sharing Hospital and SNF (when Medicare benefits are exhausted) Nursing facility(custodial) HCBS waiver services Community behavioral health and substance use disorder services Medicare non-covered services, like OTC drugs, some DME and supplies, etc.	Medicaid services Medicare coinsurance and deductibles Coordination with the members Medicare health plan Dual Special Needs Plan (DSNP) contracts facilitate care coordination across the full delivery system Option to choose the same health plan for Medicare and Medicaid

Covered Services & Benefits – Pharmacy Coverage

CVS Caremark administers covered DMAS Preferred Drug List (PDL) Prescriptions

- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications.
- We may deny a claim if the referring physician fails to provide their NPI number, and or if referring physician is not credentialed through us.
- The following documents are available online:
  - Preferred Drug List (PDL)
  - Over-the-Counter Drug List
  - Prior Authorization Form
  - Mail Order Form

Covered Services & Benefits – CCC Plus Program Advantages

- Improve quality of care for the individual
- Offers a network of high quality providers
- More flexible- may include additional benefits
- Care coordinators help individuals navigate the health care system
- Aetna Better Health of Virginia provides comprehensive health coverage
- Local providers, Aetna Better Health and health care agencies collaborate

Prior Authorizations, Medical Management, Quality Management and Appeals

Medical Prior Authorization

Prior Authorization Decision Timeframes

Medical Management

Quality Management – HEDIS, HOS, and CAHPS

Contracted Provider Dispute Process

Provider submitted Appeals (on behalf of)

Medical Prior Authorization

You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:

- Secure Web Portal (Only for In-Network Providers)
- Fax
- Phone

Please submit the following with each authorization request:

- Member Information, e.g., correct and legible spelling of name, ID number, date of birth, etc.
- Diagnosis Code(s)
- Treatment or Procedure Codes
- Anticipated start and end dates of service(s) if known
- All supporting relevant clinical documentation to support the medical necessity
- Include an office/department contact name, telephone and fax number

Prior Authorization Decision Timeframes

Service Authorization Decision Timeframes	Turnaround Times
Physical Health	
Inpatient (Standard or Expedited)	1 Business Day or as expeditiously as the member's condition requires
Outpatient/EPSDT Outpatient (Standard)	3 Business Days
Outpatient (Expedited)	No later than 72 hours from receipt of request; or, as expeditiously as the member's condition requires
LTSS to include -HCBS/LSH/EPSDT/etc. (Standard)	5 Business Days
LTSS to include -HCBS/LSH/EPSDT/etc. (Expedited)	No later than 72 hours from receipt of request; or, as expeditiously as the member's condition requires
Behavioral Health	
Standard UM Review (to include outpatient and CMHS)	3 Business Days
Initial and Concurrent Inpatient	1 Business Day
Expedited Urgent – Pre-service Inpatient	3 Hours
Expedited Urgent reviews for other urgent services	24 Hours
Outpatient Drug	
Outpatient Drug Authorization	Telephone or other telecommunication device within 24 hours of a request for authorization

Possible Extensions: Fourteen (14) additional calendar days

Medical Management

Concurrent Review (Inpatient)

Provides a way to evaluate, during a member's stay in an acute care or non-acute facility, the medical necessity of the admission and the appropriateness of the services provided.

- Admissions are reviewed for medical necessity and continuing services are reviewed for the appropriate use of inpatient medical resources. Concurrent review activities identify occurrences of over- or -underutilization and physician practice patterns, identify ways to improve the member's inpatient care outcomes, and monitor the cost-effectiveness of the services by:
- Determining whether an admission and subsequent stay are medically necessary
- Confirming that the setting, level of care, and services are medically appropriate and cost-effective throughout the member's stay
- Confirming the member receives appropriate, efficient, and timely services
- Screening for potential quality, risk, or utilization issues
- Documenting authorizations, review updates, clinical consultations, and decisions accurately and in a timely manner
- Confirming that discharge planning is begun early in the stay and actively participating in the process

Utilization and Concurrent Care Review

Identifying alternative care options (e.g., skilled nursing facility, home health, rehabilitation unit, hospice care) and making recommendations to the discharge planner or treating physician

Identifying and referring members who could benefit from Aetna Better Health's care management program or a community health program

Identifying potential clinical issues based on established criteria and presenting them to the chief medical officer or designated medical director for discussion with the member's primary care or treating provider/practitioner

Confirming that the facility complied with Aetna Better Health's notification requirements

Identifying other payers (e.g., coordination of benefits, third party liability, Medicare liability) responsible for covering the member's care

Identifying high-cost cases for reinsurance notification

Services subject to concurrent review are those provided in acute facilities, behavioral health facilities, rehabilitation facilities and skilled nursing facilities.

Quality Management – HEDIS, HOS, and CAHPS

HEDIS

Aetna Better Health's performance is measured annually based on HEDIS® and other performance indicators that are mandated by the state regulator, CMS, or specified in contract agreements. We will begin reporting HEDIS in 2019.

CAHPS and HOS

Aetna Better Health assesses member experience through administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The Medicare Health Outcomes Survey (HOS) survey collects information about consumer-reported experiences with health care.

CAHPS and HOS will be reported beginning in 2019. Aetna Better Health uses a formal process to evaluate potential areas for improvement identified from member surveys or other sources (such as member complaints, grievances/appeals or quality improvement projects). Aetna Better Health prioritizes identified issues, addresses concerns, implements interventions and reassesses issues to determine change in satisfaction. The formal process includes appropriate member and practitioner/provider communications and reporting to QMUM, QMOC and the board of directors via committee minutes.

Contracted Provider Dispute Process

To promote a quicker resolution process the Provider Relations manager or their designee reviews the content of the request, regardless of terminology used by the provider, and completes the triage process to determine the appropriate classification for processing. The provider may be asked to complete and submit the Dispute Form with any appropriate supporting documentation to Aetna Better Health of Virginia's manager of Provider Relations. The Dispute Form is accessible on Aetna Better Health of Virginia's website, via fax or by mail.

The Provider Relations manager assigns the Dispute Form to a Provider Relations representative to research, analyze, and review. In the event of a claim dispute, it is delegated to Claims Inquiry Claims Research (CICR) to research, analyze, and review. Aetna Better Health of Virginia will notify the provider of its decision by phone, email, or fax or by surface mail.

Provider Submitted Appeals

A provider may file an appeal on behalf of a member, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us in writing, within sixty (60) calendar days from the postmark on the Aetna Better Health Notice of Action. All verbal appeals must be followed up in writing. All written appeals should be sent to the following:

Aetna Better Health of Virginia
Attn: Appeals and Grievance Dept.
9881 Mayland Dr
Richmond, VA 23233

An acknowledgement letter will be sent within three (3) business days summarizing the appeal and will include instruction on how to:

- Revise the appeal within the timeframe specified in the acknowledgement letter
- Withdraw an appeal at any time until Appeal Committee review

Additional information is located in the Provider Manual.

SNP Model of Care (MOC)

Model of Care (MOC)

Chronic Care Improvement Program (CCIP)

Quality Improvement Program (QIP)

Interdisciplinary Care Team (ICT)

Model of Care

The 8 Goals of the Model of Care are:

- Increase access to Care
- Improve Quality Services
- Create affordability of services
- Integrate and Coordinate Care
- Improve health outcomes
- Encourage appropriate use of services
- Improve use of preventative health services
- Provide seamless transitions

The initial Health Risk Assessment (HRA)is completed with the member within 1st 90 days and then annually- this tool identifies member needs and prioritized care needs and services

The Individualized Care Plan(ICP) developed and is maintained for each member. The ICP is a summary of health needs, personal goals and service options.

Model of Care – CCIP and QIP

QIP-Quality Improvement Plan -

Ensures that appropriate services are being delivered to SNP beneficiaries. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates beneficiaries' unique healthcare needs.

CCIP – Chronic Condition Improvement Plan-

Goals are to promote effective management of chronic disease, slow disease progression, reduce complications, improve care and health outcomes for members, address potential health disparities and produce best practices.

Model of Care – Interdisciplinary Care Team

1. Unique team of health care professionals, member, family and caregivers for the member including members Primary Care Physician (PCP), can include Pharmacist, Behavioral Health provider, Social Worker

2. Varies depending on member needs

3. Primary Care Physician role in ICT:

- Communicate with ICT
- Collaborate with Aetna Care team on member ICP
- Review and respond to patient specific communication
- Remind member of importance of HRA and ICP and encourage member to work with care coordination team.

Claim Submission and Claim Management

Clearinghouse & Clean Claims

Claim Submission

National Provider Identification (NPI)

National Drug Code (NDC)

Clearinghouse & Clean Claims

- We accept both paper and electronic claims
- Change Healthcare (Emdeon) is preferred clearinghouse: 1-877-469-3263 or by visiting http://www.changehealthcare.com.
  - EDI claims received directly from Change Healthcare (Emdeon)
  - Processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate enrollee enrollment
    - Facilitate daily upload to Aetna Better Health system
- We process clean claims according to the following timeframes:
  - 95% of all clean claims adjudicated within 30 days of receipt
  - 100% of all claims adjudicated within 60 days of receipt
- A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Important- Providers are prohibited from balance billing Aetna Better Health of Virginia enrollees for costs of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Payments that providers receive are, in whole or in part, from federal funds. (Except Part D Pharmacy Copay’s)

Claim Submission

Aetna Better Health encourages participating providers to electronically submit claims through Change Healthcare, aka Emdeon.

You can submit claims via Change Healthcare at http://www.changehealthcare.com.

Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare standards and protocol.

Please use the following Provider ID and Submitter ID when submitting claims to Aetna Better Health:

- **PAYER ID# 128VA**

Paper Claims should be submitted to us at:

Aetna Better Health

Attn: Claims Department

P.O. Box 63518

Phoenix, AZ 85082-3518

Claim Submission

Please note that we follow the CMS and Virginia's standard billing practices (required diagnosis codes, procedure code (CPT, HCPCS), and associated modifiers).

We also follow the CMS Virginia's timely filing requirements along with the claim dispute processes and timeframes.

Common Barriers

- 5010 Requirements (Rendering NPI and pay-to NPI; Both are required)
- NDC Codes Missing or Incomplete
- Lack of Prior Authorization

Resubmissions

- Electronic and paper resubmitted claims are accepted, however, we prefer electronic claims. Resubmitted claims must be labeled appropriately.
- Our Provider Services staff and Manager are available for any escalated issue and/or concerns.

Claim Submission

- Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

  - How to fill out a CMS 1500 Form:
    - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
  - Sample CMS 1500 Form:
    - http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf
  - How to fill out a CMS UB-04/1450 Form:
    - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

National Provider Identification (NPI)

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.

National Drug Code (NDC)

- An NDC is a unique 11-digit, three-segment number assigned to drugs by the Food and Drug Administration (FDA). The Deficit Reduction Act of 2005 (DRA) requires Medicaid agencies to collect NDC numbers on pharmaceuticals.

- Primary Care Providers, Specialty Care Providers, Outpatient Hospital Departments, Federally Qualified Health Centers, Rural Health Centers, and all other outpatient providers administering drugs to patients are required to submit NDC codes.

- NDC codes have an assigned HCPCS code. It is important that claims be submitted with the most accurate information when billing for injectable medications that are administered in the office during an enrollee's visit.

Please refer to the Quick Reference guide located in your Provider Orientation Kit for further information regarding NDC.

Beneficiary Protections

Americans with Disabilities Act

Olmstead Decision

Continuity of Care

Enrollee Rights and Responsibilities

Medical Records Standard

Cultural Competency

Fraud, Waste, and Abuse

Abuse, Neglect, Exploitation, & Misappropriation

Provider Appointment Standards

Critical Incident Reporting

Beneficiary Protections – Americans with Disabilities Act

The Americans with Disabilities Act (ADA) gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

- Our providers are obligated to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities ((e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible)
- Offer waiting room and exam room furniture must meet needs the needs of all enrollees, including those with physical and non-physical disabilities.
- Be accessible along public transportation routes and/or provides enough parking.
- Have clear signage and "way" finding (e.g., color and symbol signage) throughout doctors offices/facilities.

Resources:

- http://www.ada.gov/reg3a.html

Olmstead Decision

On June 22, 1999, the United States Supreme Court held in Olmstead vs. L.C. that unjustified institutional segregation of persons with disabilities is discrimination and a violation of Title II of the Americans with Disabilities Act.[1]

The U.S. Supreme Court held that public entities must provide community-based services to persons with disabilities when: [2]

- Community-based services are appropriate;
- Affected persons do not oppose community-based treatment; and
- Community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Resources:

- http://www.worksupport.com/resources/printView.cfm/376

[1]Source: U.S. Dept. of Justice, Civil Rights Division Web site
[2]Source: U.S. Dept. of Justice, Civil Rights Division

Beneficiary Protections – Continuity of Care

- During the continuity of care period of ninety (90) days, Aetna Better Health of Virginia will pay existing providers.
- Aetna Better Health of Virginia will go out of the network to provide a service for a member if we don’t have a provider currently in network.
- Individuals in a Nursing Facility (NF) at the time of enrollment will not be moved even if the NF does not choose to participate with Aetna Better Health of Virginia. The NF will be paid as an out of network provider based on continuity of care.

Beneficiary Protections – Enrollee Rights & Responsibilities

It is our policy not to discriminate against enrollees based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of enrollee rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating enrollees with respect and dignity.

In the event that we are made aware of an issue with an enrollee not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

For a complete list of enrollee's right and responsibilities, please review the Provider Manual.

Beneficiary Protections – Medical Records Standards

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

- A period of ten (10) years from the end of the contract with Aetna Better Health of Virginia;
- The date ODM or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Additional Information:

- Providers must maintain enrollee records in either a paper or electronic format also com.
- Providers must also comply with HIPAA security and confidentiality of records standards

Our standards for medical records have been adopted from NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.

Beneficiary Protections – 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.

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

Beneficiary Protections – Fraud, Waste, & Abuse

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

Beneficiary Protections – Abuse, Neglect, Exploitation & Misappropriation of an Enrollee's Property

Aetna Better Health's policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

Neglect means intentional or unintentional failure to fulfill a caregiver's obligation or duty to an elderly person. "Self neglect" can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

Abuse constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Aggravating circumstances- (such as cruelty, recklessness and malice, causing injury to others) are often considered by the courts in imposing more severe sentences

Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

Financial exploitation is when someone uses coercion, harassment or deception to misuse or steal a person's money or property.

Mandated Reporters: Professionals we service vulnerable populations, children, disables persons and senior citizens are required to report when financial, physical, sexual or other types of abuse have been observed or suspected or when there is evidence of neglect.

Reporting Abuse and Neglect

Suspected or Known Child Abuse or Neglect

Report immediately to the local Department of Social Services in the county or city where the child resides or where the abuse or neglect is believed to have occurred or to the Virginia Department of Social Services' toll-free child abuse and neglect hotline:

In Virginia: **1-800-552-7096**

Out-of-state: **1-804-786-8536**

Hearing-impaired: **1-800-828-1120**

Suspected or Known Abuse of Aged or Incapacitated Adults

In accordance with Section 63.2-1606 of the Code of Virginia, providers must report immediately to the local adult protective services office or to the Virginia Department of Social Services' toll-free Adult Protective Services hotline at: **1-888-832-3858.**

What should be reported?

- Names, birth dates (or approximate age), race, gender etc)
- Addresses for all victims and perpetrators including current location
- Information about family members or care takers if available
- Specific information about the abusive incident or circumstances contributing to risk of harm (when the incident occurred, the extent of the injuries, how the member says it happened and any other pertinent information)

Aetna Better Health's Compliance Hotline

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Virginia at: **1-800-279-1878.**

Beneficiary Protections – Provider Appointment Standards

Provider Type	Emergency Appointment	Urgent Care Appointment	Routine Care
Primary Care	Same Day	Within two (2) calendar days	Within six (6) weeks of enrollee request
Specialty Care	Immediate	Within two (2) calendar days	Within six (6) weeks of enrollee request

Provider Type	Screening Visit	Initial Visit for Newborns	Preventive Pediatric Visit
EPSDT	Available no more than two (2) weeks after the initial request	During newborn physical exam	According to the American Academy of Pediatricians periodicity schedule up to age twenty-one (21)

Beneficiary Protections – Provider Appointment Standards

Provider Type	Emergency	Initial Prenatal Care- First Trimester	Initial Prenatal Care- Second Trimester	Initial Prenatal Care- Third- Trimester
OB/GYN	Immediate	Within three (3) weeks of first request	Within seven (7) calendar days of first request	Within three (3) calendar days of first request

Provider Type	Initial Prenatal Care- High Risk	Routine Care	Urgent Care	Postpartum Care
OB/GYN Cont.	Within three (3) calendar days of identification of high risk	Within six (6) weeks of enrollee requests	Within two (2) calendar days	Within six (6) weeks of enrollee request

Beneficiary Protections – Provider Appointment Standards

Provider Type	Emergency	Urgent	Routine	Non-Life Threatening Emergency
Behavioral Health	Immediate treatment for potentially suicidal individual	Within two (2) calendar days	Within seven (7) calendar days of first request	Within six (6) hours

Our waiting time standards require that enrollees, on average, should not wait at a PCP's office for more than sixty (60) minutes (1 hour) for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating an enrollee with a difficult medical need, the waiting time may be expanded. The above access and appointment standards are provider contractual requirements. Our Provider Services Department monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Beneficiary Protections – Critical Incident Reporting

Monitoring, tracking and investigating critical incidents are essential to ensuring the health and welfare of our enrollees.

Critical Incident Reporting

Aetna Better Health is contractually obligated to immediately report critical incidents to the Department.

Critical incidents include, but are not limited to the following:

- Unexpected death of an enrollee or Severe injury sustained by an enrollee
- Suspected physical, mental or sexual abuse and/or neglect of an enrollee
- Seclusion, Neglect, Deprivation, Restraint of an enrollee
- Theft or financial exploitation of an enrollee
- Medication error involving an enrollee
- Inappropriate/unprofessional conduct by a provider involving an enrollee
- Illegal Activity by the Enrollee - Fraudulent activities on the part of the enrollee
- Enrollee arrested, charged, or convicted of a crime
- Illegal Activity by the Provider - Enrollee is the Victim - Fraudulent activities on the part of the Provider
- Provider arrested, charged, or convicted of a crime.
- Staff Falsification of Credentials or Records

Provider Resources (Tool-Contacts-Portal)

Provider Services

Online Provider Resources – Provider Portal

Additional Information & Requirements

Questions and Answers

Provider Resources – Provider Services Department

- Contact (Phone/Email) : 1-855-652-8249 or Aetnabetterhealth-VAProviderRelations@aetna.com
- Provider Services Manager:
  - Responsible for Provider Services Representatives
  - Responsible for training Provider Services Reps in all areas (i.e., provider questions, provider complaints, provider responsibilities, claim submission, prior authorization requirements and enrollee eligibility).
- Provider Services Representatives:
  - Educate network providers on our policy and procedures & claim submission.
  - Inform providers of changes through face-to-face visits, provider forums, webinars
  - Provide written or electronic communication including the Provider Manual, Periodic Provider Newsletters, and fax/email blasts.
- If you're interested in participating in our EFT program and/or would like electronic 835 remits, please email us at the above email address for additional information

Provider Resources – Provider Portal

In addition to the telephone numbers and addresses, 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 in our Provider Manual.

To gain access to the Secure Web Portal please fill out the form located on our website under Provider Portal. You can fax it to 844-230-8829. One of our Provider Relations Representatives will follow up with you with the sign in information.

Provider Resources – Add'l Information & Requirements

- Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with the Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).
- Accommodating enrollees with special needs, which includes but is not limited to: offering extend office hours to include night and weekend appointments, promoting practices offering extended hours, and offering flexible appointment scheduling systems
- Ensuring that hours of operation are convenient to, and do not discriminate against, enrollees. This includes offering hours of operation that are no less than those for non-enrollees, commercially insured or public fee-for-service individuals (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals) All services are available 24 hours a day, 7 days a week when medically necessary

Provider Resources – Questions and Answers

Question and/or Concern:	Where to Obtain Answer:
Eligibility	Secure Web Portal or Contact Member Services Department
Medical Prior Authorization	Secure Web Portal, Contact Medical Management Department at 1-855-652-8249, or Fax to 1-855-661-1828
Pharmacy Prior Authorization	Contact CVS Caremark at 1-855-652-8249 or Fax to 1-855-799-2553
Claims Inquiry Claims Research (CICR)	1-855-652-8249
Member Services (includes language line)	1-855-652-8249
Provider Services	Call 1-855-652-8249, email us (Aetnabetterhealth-VAProviderRelations@aetna.com) or Fax your questions to 1-855-652-8249
Benefits	Secure Web Portal or Contact Member Services Department