2020 Important Information for Practitioners and Providers

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

It is important that we communicate effectively with our practitioners and providers. The following is important information you need to know in order to provide the best care to our members. Please refer to your provider manual located on our provider website for additional information.

How to reach us:

<table>
<thead>
<tr>
<th>Aetna Better Health of West Virginia</th>
<th>Toll-free</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>Provider Services (claims Inquiry and Claims Research)</td>
<td>1-888-348-2922</td>
<td>1-866-669-2454</td>
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<tr>
<td>Member Services</td>
<td>1-888-348-2922</td>
<td>1-866-366-7088</td>
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<td>Prior Authorization</td>
<td>1-888-348-2922</td>
<td>1-866-810-8476</td>
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<tr>
<td>Provider Relations</td>
<td>1-888-348-2922</td>
<td>1-866-810-8476</td>
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<tr>
<td>Behavioral Health Services</td>
<td>1-888-348-2922</td>
<td>1-866-388-1752</td>
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<tr>
<td>Appeals</td>
<td>1-888-348-2922</td>
<td>1-866-261-0581</td>
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<tr>
<td>Integrated Care Management</td>
<td>1-888-348-2922</td>
<td>1-866-261-0581</td>
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1. Utilization Management

Utilization Management (UM) is a system for reviewing eligibility for benefits for the care that has been or will be provided to patients. The UM department is composed of Prior Authorization and Concurrent Review.

To support utilization management decisions, we use nationally recognized, and/or community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Medical necessity is based upon clinical standards and guidelines as well as clinical judgment. All clinical standards and guidelines used in the UM program have been reviewed and approved by practicing, participating physicians in our network. You can receive a copy of our clinical criteria and guidelines by calling your network management/provider relations representative.

The medical director makes all final decisions regarding the denial of coverage when the services are reviewed via our UM program. The provider is advised that the decision is a payment decision and not a denial of care. The responsibility for treatment remains with the attending physicians. The medical director is available to discuss denials with attending physicians and other providers during the decision process. Notification includes the criteria used, the clinical reason(s) for the adverse decision, peer-to-peer rights, and a contact person’s name, address and telephone number.

The policy on payment for services helps ensure that the UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.
UM decisions are based only on appropriateness of care and service and the existence of coverage

- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

How to contact Utilization management
UM staff is available to discuss specific cases or UM questions by phone weekdays, 8:30 am – 5:00 pm, by calling 1-844-835-4930; TTY 711. UM Staff is available on holidays and weekends by voice mail and fax. The ability to receive faxed information is available 24 hours per day, 7 days per week at 1-866-366-7008. When initiating or returning calls regarding UM issues, staff will identify themselves by name, title and organization name. Members who need language assistance can call member services at the number on the back of their ID card.

2. Evidence based guidelines
Aetna Better Health uses evidence-based clinical practice guidelines and Preventive Health Guidelines. The guidelines consider the needs of enrollees, opportunities for improvement identified through our QM Program, and feedback from participating practitioners and providers. Guidelines are updated as appropriate, but at least every two years. Aetna Better Health participates with West Virginia Medicaid to develop, adopt and distribute clinical practice and preventive health guidelines. The Clinical Practice Guidelines and Preventive Health Guidelines are located on our provider website. Click on Practice Guidelines.

3. Access Standards
Aetna Better Health requires participating practitioners and providers to comply with the following appointment access standards:

<table>
<thead>
<tr>
<th>PCP Appointments</th>
<th>Standard</th>
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<tbody>
<tr>
<td>Regular/routine care appointment</td>
<td>Within calendar 21 days</td>
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<tr>
<td>Urgent care appointment</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergency care appointment</td>
<td>Seen immediately or referred to ER facility</td>
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<tr>
<td>After-hours care</td>
<td>24 hours day/ 7 days per week</td>
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<table>
<thead>
<tr>
<th>Specialty Care Appointments</th>
<th>Standard</th>
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<tbody>
<tr>
<td>New patient initial visit</td>
<td>Within 90 calendar days</td>
</tr>
<tr>
<td>Existing patient follow up visit</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Urgent care appointment</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergency care appointment</td>
<td>Seen immediately or referred to ER facility</td>
</tr>
<tr>
<td>Maternity Appointments</td>
<td>Standard</td>
</tr>
<tr>
<td>--------------------------------</td>
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<tr>
<td>Initial prenatal visit</td>
<td>Within 14 days of pregnancy confirmation</td>
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<tr>
<th>Behavioral Health Care Appointments</th>
<th>Standard</th>
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<tr>
<td>Initial visit for routine care</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Urgent care appointment</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Care for a non-life threatening emergency</td>
<td>Within 6 hours</td>
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<tr>
<td>Follow-up routine care</td>
<td>Within 60 calendar days</td>
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4. **Members have rights and responsibilities**

Members have a right to participate in decisions about their health care. Practitioners should discuss the plan of care with each member and are encouraged to consider member input in the proposed treatment plan. Members can accept or refuse medical or surgical treatment and choose a different provider. They also have the right to learn about other treatment options and different courses of care no matter how much they cost and/or if Aetna Better Health will pay for it.

Members have many rights and responsibilities. You’ll find the complete member rights and responsibilities statement in the Provider Manual and on our [provider website](#). Click on Resources, then Member Rights.

5. **Population Health Management and Integrated Care Management Programs**

The Aetna Medicaid Population Health Management (PHM) strategy is a personalized approach that emphasizes empowering members to achieve health goals by recognizing and elevating the individual’s expertise and central role in their own health. Our PHM programs meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals. Members are stratified to high risk, medium or rising risk, or low risk level, as indicated by their known risk factors.

Aetna Better Health of West Virginia implements a population-based approach to specific chronic diseases or conditions. All Aetna Better Health members with identified conditions are auto enrolled in the Chronic Condition program based on claims date. The chronic conditions managed include diabetes, COPD, asthma, CAD, depression, and heart failure. Our goal is to assist our members and their caregivers to better understand their conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Members who do not wish to participate can call member services to dis-enroll from the program.

Members with complex healthcare needs often need extra help understanding their choices and benefits. They may need support to navigate the community resources and services available. Our Integrated Care Management (ICM) Program is a collaborative process which involves the member, their caregivers, their providers, and a nurse Case Manager from Aetna Better Health. In addition to helping members who have special medical needs, we have care management programs for high-risk pregnancy, pregnant
women with substance use disorder and their babies (NAS), and Opioid Management. Members can be referred to the ICM Program from a variety of sources including our medical management programs, discharge planners, members, caregivers, and practitioners. Please call us at 1-888-348-2922 or Fax us at 844-330-1001 to refer your patients to our Integrated Care Management Program.

6. Pharmaceutical Management
The pharmacy benefit for outpatient prescriptions is carved out to the state. The health plan continues to manage medications administered in provider/practitioner offices and inpatient facilities. For questions about member benefits related to prescription medications, contact DXC Technologies at 1-888-483-0797. For questions regarding in-office or inpatient medications contact us at 1-888-348-2922. You can visit our provider website and click on Pharmacy for the latest information regarding pharmaceutical management procedures.

7. Family Planning
Our members have direct access for family planning services without a referral and may also seek family planning services at the practitioner or 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

For members 15-44 years of age, the medical record should include documentation of a discussion regarding family planning which may include assessments of sexual activity, contraception, STD screening, and/or counseling OR documentation that the member saw a family planning practitioner.

Aetna Better Health of West Virginia encourages providers and practitioners to notify the health plan of newly diagnosed pregnancies within seven (7) days.

8. Members have direct access to women’s health specialists
We provide 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. Women’s health specialists include obstetricians, gynecologists, nurse practitioner and certified nurse midwives. 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 us from requesting or requiring notification from the practitioner for data collection purposes.
9. Advanced Directives
We maintain written policies and procedures related to advance directives that describe the provision of health care when a 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 of West Virginia’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.

10. Continuity and Coordination of Care
Continuity and Coordination of Care Research indicates that health outcomes are far better when primary care practitioners, specialists, and behavioral health practitioners work in partnership to meet an individual’s healthcare needs. We expect this collaboration will positively impact the overall health and wellbeing of our members.

Aetna Better Health has identified that continuity and coordination of care for our members is an area where we have room for improvement. Therefore, we encourage our behavioral health practitioners and specialists to keep Primary Care Providers informed about member treatment, including hospitalizations, assessments, or recommended treatment plans.

Our members may self-refer or directly access services without referral from their PCP. Therefore, we encourage primary care practitioners to discuss specialty and behavioral care with their members, to help coordinate needed services.

11. Second Opinions
Aetna Better Health of West Virginia 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 practitioner within our network. Practitioners should refer the member to another network practitioner within an applicable specialty for the second opinion. Members will incur no expenses other than standard co-pays for a second and third opinion provided by a participating practitioner, as applicable under the member Certificate of Coverage. Out-of-network services must receive prior authorization and are approved only when an in-network practitioner or provider cannot perform the service. The member will incur no more cost for an out-of-network second opinion than they would if the service was obtained in-network.

12. Out of Network Services
If Aetna Better Health is unable to provide necessary medical services, covered under the contract, within the network of contracted practitioners and providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network practitioners/providers, for as long as the plan is unable to provide the services. The member will not incur any additional cost for seeking these services from an out-of-network practitioner or provider. For Medically Necessary covered emergency services, Aetna Better Health will cover a member’s out of network hospital fees until member records, clinical

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information and care can be transferred to a network hospital, or until such time as the member is no longer enrolled with Aetna Better Health of WV, whichever is shorter.

13. Hours of Operation Parity
We utilize accessibility and availability standards based on requirements from NCQA, State and Federal regulations. The Access Standards are communicated to practitioners, providers and members via the Aetna Better Health website and the Provider Manual. Federal law requires that participating practitioners and providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the practitioner or provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid fee-for-service members. Practitioners and providers that do not meet Aetna Better Health of West Virginia’s access standards are provided recommendations for improvements in order to meet the set standards.

14. Medical Record Documentation Requirements
All practitioners and providers are required to follow Aetna Better Health’s established medical record documentation standards, which are recognized by agencies that accredit and regulate Aetna Better Health. On an annual basis, Aetna Better Health performs a statewide medical record documentation audit to ensure compliance with current standards.

Click here to review our Medical Record Documentation Standards.

For results of our most recent medical record documentation audit, go to the provider website and click on Document Library, then Provider News.

15. Member Satisfaction Surveys
Aetna Better Health of West Virginia performs an annual survey to assess member satisfaction using the NCQA HEDIS CAHPS 5.0H Membership Satisfaction Survey. A workgroup analyzes survey results and prioritizes opportunities for improvement. To view the results of our most recent member satisfaction activities, go to the provider website and click on Document Library, then Provider News.

The following ideas may enhance your time with Aetna Better Health members and help to improve their healthcare experiences:

➢ Be an active listener
➢ Ask the member to repeat in their own words what instructions were given to them
➢ Rephrase instructions in simpler terms if needed
➢ Clarify words that may have multiple meanings to the member
➢ Limit use of medical jargon
➢ Be aware of situations where there may be cultural or language barriers

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16. Reporting suspected Fraud and Abuse

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

Practitioners and providers can report suspected fraud or abuse to Aetna Better Health of West Virginia in the following ways:

- Write us:
  Aetna Better Health of West Virginia
  Attn: Compliance Department
  500 Virginia Street, East, Suite 400
  Charleston, WV 25301

- Call Aetna Better Health’s Fraud, Waste and Abuse toll-free number at 1-844-405-2016

For more information on Fraud, Waste and Abuse refer to the Medicare Learning Booklet on Preventing, Detecting, and Reporting Fraud, Waste and Abuse.