Fall 2022 Provider Newsletter

What is Availity?

Availity is a single log-in, multi-payer provider portal with self-service tools and provider-initiated transactions in one convenient location. Once registered, providers can simply add the Aetna instances to their registration at any time.

Aetna and Availity

Availity operates Aetna's provider portal for multiple lines of business, including Commercial, Medicaid, Medicare, and DSNP/MMP products. There are now two instances of Availity for Aetna products: "Aetna" instance is for Medicare/Commercial, and the "Aetna Better Health" instance is for Medicaid/DSNP/MMP. Providers will need add both instances to their Availity profile to access our entire population. Availity will eventually replace the Aetna Better Health Medicaid Web Portal.

Uses of Availity

Availity allows providers to verify member eligibility and benefit coverage, submit claims and subsequent disputes, encounters, submit appeals and grievances, and update their rosters. Learn about the additional functions in one of the training options offered by Availity.

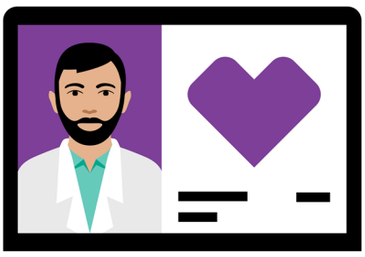
How to receive training?

Did you know that in addition to Availity Client Services, Availity offers a wide range of training sessions for all users via the Availity Essentials Provider Portal? You can simply click on the "Help & Training" dropdown to access both upcoming sessions as well as pre-recorded webinars.

Who can the provider call for assistance?

Call Availity directly at 1-800-AVAILITY (282-4548). Monday through Friday from 8 a.m. to 8:00 p.m. ET (excluding holidays). Availity can also be reached through direct messaging when available. Availity should be contacted for any connectivity or account concerns. Any concerns with an Aetna decision or information on Availity should be directed to the respective provider services.

Quarter 3, 2022



Updating Rosters and Provider Details

One of the functions available within Availity is updating provider demographics and roster information. Due to Availity serving multiple payers, providers can update their profiles on the Provider Data Management (PDM) page and have quarterly updates sent to all participating payers. In the page you can update service locations, location ADA compliance, update contact information, modify NPIs for the business, provide hospital affiliations, and correct provider profiles. You can reach the PDM by clicking on “My Providers” on the main page.

You have the power to fight the flu!

Vaccinate!

The CDC has proposed the following strategy: mask up, lather up, and sleeve up. We are encouraging our members to: 1) wear a mask in crowded, indoor spaces; 2) wash their hands with soap and water or an alcohol-based sanitizer; and 3) get their annual flu vaccine. The best time to get vaccinated is during September or October, but vaccination after October can still provide protection during the peak of flu season.

For the 2022-2023 flu season, available formulations of quadrivalent vaccine in the United States include several inactivated influenza vaccines (IIVs), one live attenuated influenza vaccine (LAIV), and one recombinant vaccine. Vaccination is recommended for all adults in the absence of contraindications. The choice of formulation depends upon several factors which include age, comorbidities and risk of adverse reactions.

For a full summary of the recommendations from the Advisory Committee on Immunization Practices (ACIP), please refer to the following link: https://www.cdc.gov/flu/pdf/professionals/acip/acip-2022-23-summary-of-recommendations.pdf

Reminder: Submitting Expedited (Urgent) Authorization Requests

Aetna’s goal is to always provide a prompt response to the requests submitted and we need your help. As a reminder, an expedited request indicates that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

Submission of all necessary information helps get our members what they need, while in your care. Please see the provider portal for the necessary Prior Auth forms. It is vital that all lines are filled out in their entirety, including CPT codes, diagnosis codes, and your National Provider Identification (NPI). If not, the case could pend for lack of clinical information. The primary reason for denials is lack of clinical information received. Please ensure that you are prepared with appropriate clinical during your submission. Please reach out if you are not sure what needs sent or watch for a fax back from us telling you what will help process your case.

Population Health Management

Aetna Medicare Advantage Dual Eligible Special Needs plans maintains Population Health Management (PHM) programs and activities selected to meet the needs of the member population and target their individual risks. These programs are designed to support delivery of care. Each PHM program includes measurable goals that are used to determine program effectiveness. Aetna continues to work collaboratively with provider networks to ensure that the recommended screenings and services are completed for the served membership. Below are some of the programs we offer to members:

Keeping Members Healthy

Programs are targeted to align with low risk populations. With an emphasis on preventive healthcare and closing gaps in care, members are encouraged to get the screenings that are needed to stay healthy. The PHM program for members is a Flu Vaccination Program that includes educational activities to promote annual flu vaccination.

Managing Members with Emerging Risk

Programs are targeted to align with medium risk populations. Engagement with practitioners focuses on supporting Patient Care Medical Home models to centralize care and patient-driven decision-making. The PHM program for members is a Hepatitis C Program that supports members in completing a prescribed treatment regimen.

Patient Safety and Outcomes Across Settings

Programs are targeted to align with members that experience health services across settings. Engagement with practitioners focuses on communication and collaboration with their patients to share information to prevent duplication and potential for harm. The PHM program for members is Appropriate Use of Acute Care Settings that includes early notification through in-patient alerts.

Managing Multiple Chronic Conditions

Programs are targeted to align with high and intensive risk populations. Engagement with practitioners focuses on maintaining engagement outside of clinic and office visits. The PHM program for members is Life Planning/Advance Directives/Palliative Care that includes providing life planning/advance directive information to members upon enrollment.

Cognitive Impairment Program

This program is targeted towards members and/or their caregivers who are either formally diagnosed with mild to severe cognitive impairments or are identified with positive findings for cognitive impairment. The focus is on member safety (medication, home safety, driving, financial, wandering), supporting a least restrictive residential setting, and working towards an optimal quality of life for the member and the caregiver.

Aetna care managers will work with members and providers to ensure that members receive the right care and services that meet members' needs

Complex Care Management Referral Options
Empowerment through care management

Aetna Medicare Advantage Dual Eligible Special Needs plans offers an evidence-based care management program to help our members improve their health and access the services they need. Care managers typically are nurses or social workers. These professionals create comprehensive care plans that help members meet specific health goals.

All members are assigned their own care manager. The amount of care management a member receives is based upon an individual member's needs. Some of the reasons you may want to ask the health plan to have a care manager contact the member are:

- Does the member frequently use the emergency room instead of visiting your office for ongoing issues?
- Has the member recently had multiple hospitalizations?

- Is the member having difficulty obtaining medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), hypertension, or End Stage Renal Disease (ESRD), yet does not comply with the recommended treatment regimen and would benefit from telemonitoring of these conditions?
- Does the member need help to apply for a state-based long-term care program?
- Does the member live with HIV?
- Is the member pregnant with high-risk conditions?
- Is the member pregnant and over 35 years of age?
- Has the member received a referral to a specialist, but is unsure of the next steps?
- Does the member need information on available community services and resources (e.g. energy assistance, housing assistance)?

What happens to your referral?

After you make a referral, the member's care manager contacts the member. The care manager might also contact the member's caregivers or others as needed.

What will a care manager do?

To help the member learn how to manage their illness and meet their health and other needs, a care manager contacts the member to schedule a time to complete an assessment. The care manager asks the member questions about his or her health and the resources currently being used. Answers to these questions help the care manager determine what kind of assistance the member needs most.

What will a care manager do?

Next, the member and the care manager work together to develop a care plan. The care manager also educates the member on how to obtain what they need. The care manager also may work with the member's health care providers to coordinate these needs. The amount of care management and frequency of contact with the member and others will vary based upon the individual needs of the member.

To make referrals for care management consideration, please call Provider Services at **1--855-463-0933**. A care manager will review and respond to your request within 3-5 business days.

Pharmacy Benefits

Aetna Medicare Advantage Dual Eligible Special Needs plans' (Aetna) List of Covered Drugs ("the Drug List" or the formulary) is a comprehensive list of covered prescription drugs, over-the-counter drugs, and items at participating network pharmacies. The Drug List and network pharmacies are posted on the plan's website at https://www.aetnabetterhealth.com/virginia-hmosnp/. The Drug List is updated monthly throughout the year, and the date of last change is noted on the front cover of the Drug List. Changes to the plan's Drug List is also posted on the plan's website.

Visit https://www.aetnabetterhealth.com/virginia-hmosnp/ for the updated Drug List. For a printed copy of anything on our website, call Member Services toll-free at 1-844-362-0934.

The Drug List has detailed information about prior authorization, quantity limitation, step therapy, or formulary exceptions under "Necessary actions, restrictions, or limits on use." To request prior authorization or formulary exception reviews, call Member Services toll-free at 1-844-362-0934. A Member Services representative will work with you to submit a request for prior authorization or formulary exception.

Types of rules or limits:

- Prior approval (or prior authorization)
- Quantity limits
- Step therapy
- If a medication is not on the Drug List (called Formulary Exception)

Aetna D-SNP's formulary covers most drugs identified by Medicare as Part D drugs, and a member's copay may differ depending upon the tier at which the drug resides. The copay tiers for covered prescription medications are listed below. Copay amounts and coinsurance percentages for each tier vary by Aetna D-SNP plan. Consult your plan's Summary of Benefits or Evidence of Coverage for your applicable copays and coinsurance amounts.

Covered drugs are designated the following coverage tiers.

- Tier 1 drugs are Preferred Generic drugs.
- Tier 2 drugs are Generic drugs.
- Tier 3 drugs are Preferred Brand drugs.
- Tier 4 drugs are Non-Preferred drugs.
- Tier 5 drugs are Specialty drugs.

Long Term Service and Support Announcement

As part of an HMO D-SNP Plan, our members have access to services outside of the typical medical care. These services are called Long Term Service and Supports (LTSS). Our plans allow for the coverage of these services through several vehicles and over a continuum of settings, ranging from institutional care to community based LTSS. We are working in partnership with states, consumers and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life. These services assist members aid members in their personal needs and Activities for Daily Living (ADL) like:

- mobility around their homes
- managing medication
- cooking and healthy food choices
- driving
- money management.

This list is not exhaustive and we'd like to remind providers that these services are available to our members. Providers should also be helping our membership by educating them on their LTSS benefit availability and aiding them in accessing their plan benefits.

In addition to this reminder, Aetna will begin hosting Joint Operating Committee (JOC) meetings, bringing together the Provider Experience Team, LTSS providers and other stakeholders. These meetings are still being organized and will likely be available by 1st Quarter of 2023, but if you'd like to attend, please reach out to the provider experience team.

Please reference your provider manual and our provider website for further details on the LTSS benefits that you should be advising your patients.

Members' Rights and Responsibilities

As a practitioner who ensures high quality care for Aetna Medicare Advantage Dual Eligible Special Needs plans (Aetna) members, you should be aware of the members' rights and responsibilities. Some of the rights members are afforded are as follows:

- A right to receive information about Aetna, our services, our practitioners and providers, and member rights and responsibilities
- A right to be treated with respect and recognition of the member's dignity and right to privacy
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Aetna or the care we provide
- A right to make recommendations regarding Aetna's member rights and responsibilities policy

In addition, our members have the following responsibilities:

- A responsibility to supply information, to the extent possible, that Aetna and our practitioners and providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

For a complete list of member rights and responsibilities visit our website at https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/snp-manual to see our Member Handbook.

New P.O. Box Address and Vendor for Paper Claim and Claim Correspondence

P.O. Box **#63518** Will No Longer Be Valid Starting **December 1st, 2022**.

A key factor in getting claims processed in a timely manner is correct claims submission, and ABH provides multiple options for you to choose from, including the sending of paper claims through the mail.

Aetna will be replacing the current vendor, Change Healthcare (CHC), with Conduent for services related to the receipt and imaging of all paper claim and claim correspondence. The change in vendor requires a change in the P.O. Box number and physical location to which any Aetna Medicaid paper claim and correspondence are currently sent, specifically from **P.O. Box #63518** in **Phoenix, AZ** to **P.O. Box #982974** in **El Paso, TX**.

We are making you aware that the new P.O. box, **#982974,** will be live and reflected electronically anywhere the P.O. box address is currently listed on **December 1st, 2022.** Once the new P.O. Box is live, mail must be sent to the following address:

New P.O. Box

Aetna Better Health of Virginia

P.O. Box 982974

El Paso, TX 79998-2974

Mail will be forwarded from the old P.O. Box to the new P.O. Box for 12 months after **12/1/2022.** To assist us in processing and paying claims efficiently, accurately, and timely, the health plan highly encourages practitioners and providers to submit claims electronically, when possible.

If you have any questions about our claim submission process you can contact our Provider Relations Department at 1-800-279-1878 (Medallion 4.0/FAMIS) or 1-855-652-8249 (CCC Plus).

Electronic Submission of Pharmacy Prior Authorizations

We are committed to making sure our providers receive the best possible information, and the latest technology and tools available. We have partnered with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (ePA) program.

With Electronic Prior Authorization (ePA), you can look forward to:

- Time saving
- Decreasing paperwork, phone calls and faxes for requests for prior authorization
- Quicker Determinations
- Reduces average wait times, resolution often within minutes
- Accommodating & Secure
- HIPAA compliant via electronically submitted requests

Getting started is easy. Choose ways to enroll:

Visit the **CoverMyMeds® website** or call CoverMyMeds® toll-free at **866-452-5017**

Visit the **SureScripts website** or Call SureScripts toll-free at **866-797-3239**

No cost required! Let us help get you started!

- Aetna Better Health Of Virginia (HMO D-SNP), Aetna Medicare Assure Premier (HMO D-SNP), or Aetna Medicare Assure Value (HMO-DSNP)
- PCN: MEDDAET
- Group: RXAETD
- BIN: 610502

Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

- We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don't reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at 1-855-463-0933, 24 hours a day, 7 days a week. Language translation for members is provided for free by calling 1-855-463-0933.

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

The table below indicates appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/SA) providers.

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Primary Care	Immediate	Within 24 hours	Within 28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
Specialist Care	Immediate	Within 24 hours of referral	Within 28 days	No more than 45 minutes, except when the provider is unavailable due to an emergency
OB/GYN	Immediate		Initial Prenatal Care • 1st Trimester: Within 3 weeks • 2nd Trimester: Within 7 calendar days • 3rd Trimester: Within 3 calendar days • High Risk: Within 3 days • Routine Care: Within 3 weeks • Postpartum Care:	No more than 45 minutes, except when the provider is unavailable due to an emergency
Behavioral Health	Immediate	Within 24 hours	Within 10 days of the request	No more than 45 minutes, except when the provider is unavailable due to an emergency

In addition to the standards above, Behavioral Health providers are contractually required to offer:

- Follow-up Behavioral Health Medical Management within 3 months of the first appointment
- Follow-up Behavioral Health Therapy within 10 business days of the first appointment
- Next Follow-up Behavioral Health Therapy within 30 business days of the first appointment