



Provider newsletter

Fall 2026



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Medicaid work requirement - changes effective January 2027

Starting in **January 2027**, a new federal work requirement will require certain adults enrolled in Virginia's Medicaid Expansion to report that they are working, volunteering, participating in a work program, enrolled as a student, or have a certain income to keep their coverage. Providers should be aware that these same adults will also have their coverage reviewed every 6 months instead of every 12 months.

- This new requirement only applies to Medicaid Expansion members ages 19–64 who do not qualify for an exemption.
- It does not apply to children, pregnant or postpartum individuals, adults aged 65 or older, adults with disabilities, or people enrolled in Medicare.
- Certain exemptions will apply, including for individuals with serious medical or mental health conditions, individuals with substance use disorders, parents, guardians, and caregivers of children under 14 or individuals with disabilities, and more.

Federal law is also making changes to retroactive Medicaid coverage beginning January 1, 2027. Coverage before an application date will be more limited, making it important for members to apply, renew, and respond to notices on time.

Members looking for opportunities to meet the requirements can explore statewide resources, including:

- [Virginia Works](#) (job search and training)
- [Serve Virginia](#) (volunteer and service opportunities)
- [Virginia G3](#) (education and credential programs at community colleges)

More information and updates are available on the DMAS website.



Our Community Resource Directory (CRD) is on Availity!

You can use Aetna Better Health of Virginia's Provider Portal, Availity, to access the CRD – a tool for finding resources to support members, like food, housing, mental health support, and more.

With access to the CRD in Availity, you can create referrals for members to address many needs related to social determinants of health. This holistic approach ensures that the care team has multiple touch points with members. That's because the CRD interfaces seamlessly with other platforms, such as our Care Management documentation and reporting systems, as well as our members' Medicaid Web Portal.

Data from the CRD highlights the most commonly requested categories by members and the community organizations that have received the most referrals over time.

Access the CRD in Availity Now

First, navigate to [Availity](#). Then, under **Payer Spaces**, select Aetna Better Health > Applications > Medicaid Community Resource Directory.

New to Availity?

[Learn how to get started.](#)



Improve your practice's HEDIS® performance

Small steps in documentation, coding, and follow-up can make a meaningful difference in HEDIS performance and clinical outcomes.

To support our providers in delivering the highest quality care to our members, we created these guides, which include practical tips to help visits count, as well as to help close gaps in care and support healthier patient outcomes.

[Prenatal/Postpartum Care \(PPC\)](#)

[Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents \(WCC\)](#)

[CMS Core Measure - Depression Screening & Same Day Follow-Up - Age 12 and Older \(CDF\)](#)

The power of patient feedback

Good care is about more than just clinical outcomes. It's also about how patients feel about the care they receive. One of the best ways to understand and improve patient satisfaction is simple: ask them.

Collect feedback, continuously

Use tools, like online surveys or feedback forms, to ask patients directly about their experience. Ask them about wait times, communication, or their overall experience. That feedback helps identify what's working and what needs attention.

Why it matters

- Build trust
- Patients feel heard and valued
- Spot trends
- Uncover recurring issues or strengths
- Drive improvement
- Use feedback to improve service delivery, workflows, and staff training

Tip for action

Start small. Add a short satisfaction question to your discharge process or follow-up calls. Over time, build a system that turns feedback into action.

Community resources for our members in need

Population Health Management programs are available to help support members in their health care journey. We have special programs available for members who are managing conditions or just trying to stay healthy.

[Learn more about these programs.](#)



Important formulary information

Visit our [Pharmacy](#) page on our website for important pharmacy benefit information. You can find information such as:

- The formulary, formulary search tool, and formulary updates
- Prior authorization requirements and coverage rules
- Medication limits, quotas and member cost-sharing
- Pharmacy review processes, including generic substitutions, step therapy and preferred brand alternatives
- How new prescription drugs are added to the formulary and how to request an exception

Review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health member.



Quality management spotlight

Provider resources for using the Medicaid Enterprise System (MES)

Home and community-based services

Aetna Better Health understands that improving members' health outcomes requires increased collaboration between you, the professional who provides care, and us, the health plan that covers that care. Our goal is to support waiver providers with resources and offer best practice recommendations to ensure our community-based members receive the best quality care.

DMAS released an updated CCC Plus Waiver Provider Manual on August 1, 2022. You can access the manual through the [Medicaid Enterprise System \(MES\) portal](#). The website includes valuable information, such as provider enrollment, training, FAQs, memos, bulletins, user guides, and other helpful resources.

DMAS CCC Plus Waiver Provider Manual Spotlight

Background checks

DMAS requires providers to complete an original criminal record clearance from Virginia State Police (VSP) within 30 days of employment for employees that have direct contact with a member. No employee shall be permitted to work in a position that involves direct contact with a member until criminal results has been received, unless such person works under the direct supervision of another employee for whom a satisfactory background check has been completed.

If the individual receiving services is a minor, the RN/PCA must also submit to a search of the VDSS Child Protective (CPS) Central Registry.

List of Excluded Individuals and Entities (LEIE)

DMAS requires providers to validate federal program eligibility for all employees, contractors, and other entities on a monthly basis, utilizing the Health and Human Services Office of the Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) website and immediately report any exclusion information to DMAS. Refer to the Commonwealth Coordinated Care Plus Waiver Provider Manual dated July 17, 2025, Chapter II, pages 6 and 7 for more information.

Utilization Management (UM)

To support UM/prior authorization 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.

UM/prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Virginia policies and procedures. For prior authorization of elective inpatient and outpatient medical services, we use the following medical review criteria.

Criteria sets are reviewed annually for appropriateness to Aetna Better Health of Virginia population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate practitioners and providers in developing, adopting, or reviewing criteria.

The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting practitioners and providers when appropriate.

These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- MCG guidelines
- Aetna Medicaid Pharmacy Guidelines
- Level of Care Utilization System behavioral health services for adults
- American Society of Addiction Medicine substance use services
- Aetna Clinical Policy Bulletins
- Aetna Clinical Policy Council Review

Medical, behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

A free copy of individual guidelines pertaining to a specific case is available for review upon request by calling **1-800-279-1878**.

Need help? [Visit our website](#).

Then, select each section to learn about:

- Member Rights and Responsibilities.
- UM, including how to reach UM staff by phone and after hours, how we make decisions.
- Our affirmative statement about incentives.
- How to obtain UM criteria.
- Clinical Practice and Preventive Guidelines.
- Medical Record Review Standards.
- Our Care Management programs and referrals.
- Available language services and TTY for referrals.

Help your patients use their value-added benefits

Use our guide

Many Medicaid members feel lost when it comes to understanding and using their benefits. So, we created a simple, comprehensive guide to help.

Share the [Value-Added Benefits Member Guide](#) with your patients and let them discover:

- What their benefits are
- If they are eligible
- How and where they can use them

Important information regarding health plan and provider partner responsibilities

Role / Function	Health Plan Responsibilities	Provider Partner Responsibilities
Designated Point of Contact	Assign care management contact(s) and provide contact information. The Contractor must determine which Members should receive Care Management, including identifying: 1. Individuals who meet Department-defined criteria for “Priority Populations”, to include Mandatory High, Mandatory Priority and MCO-Determined Priority Populations, as described in Section 8.4.2, <i>Priority Populations</i>; 2. Other individuals who would benefit from Care Management based on the Contractor’s Assessment of Member need and risk, beyond those identified as Priority Populations, as described in Section 8.4.3, <i>Identifying Other Members Needing Care Management</i>. For Members in Mandatory Priority Populations and MCO-Determined Priority Populations, the Contractor must also determine the appropriate Level of Care Management Intensity (i.e., low, moderate or high).	Assign practice contact(s) and ensure availability for coordination activities and timely response.
Identification & Outreach	Identifying populations and stratifying members based on risk, clinical needs, and social drivers of health.	Support outreach by validating member status, encouraging engagement, and coordinating with the member’s care team as needed.
Referrals to Care Management	Maintain a defined referral intake process and confirm receipt, triage, and assignment. Communicate enrollment status and next steps to the provider partner.	Refer eligible members using the defined process and provide relevant clinical context.
Care Plan Development & Updates	Develop an individualized care plan with the member / caregiver and share relevant care plan components and goals with the provider partner.	Engaging patients in recommended care plans and reinforcing care management interventions.
Documentation & Sharing Information	Maintain documentation of care management activities and communicate relevant updates to provider partners consistent with privacy, consent, and data-sharing requirements.	Accurately document care coordination and follow up activities in the medical record and provide requested clinical information to support coordinated, patient-centered care.
Social Determinants of Health (SDOH) Coordination	Provide SDOH resource navigation and community referrals.	Screen for social risks when appropriate; coordinate referrals and document outcomes.
Gaps in Care Coordination	Communicating care gaps and care management engagement status to provider partners.	Review care gap reports shared by the health plan and take appropriate clinical action within the scope of practice.
Transitions of Care	Coordinate post-discharge outreach, medication reconciliation support, and share discharge-related information with provider partners when available.	Schedule timely follow-up visits, review discharge instructions and reconcile medications as clinically appropriate.

Access and availability standards

We use accessibility/availability standards based on requirements from NCQA, state, and federal regulations. These standards are communicated to providers and members via newsletter, our website, and as part of the provider manual.

Federal law requires that participating 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 provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid fee-for-service members.

Providers who do not meet these access standards are provided recommendations for improvements in order to meet the set standard.

The timely access standards for PCPs, behavioral health providers, and prenatal providers can be reviewed in the chart below.

Provider	Appointment	Availability standard
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
Behavioral Health	Non-life-threatening emergency	Within 6 hours
	Urgent care	Within 24 hours
	Initial visit routine care	Within 5 business days
Prenatal	First trimester	Seven calendar days
	Initial second trimester	Seven calendar days
	Third trimester and high risk	Three working days from date of referral or immediately, if an emergency exists

