Provider Newsletter

Fall 2024

Contents

Aetna Better Health Member Language Profile: Understanding Our Members' Communication Needs

Communication and language barriers are associated with inadequate quality of care and poor clinical outcomes, such as higher hospital readmission rates and reduced medication adherence. People with limited English proficiency or those who experience limited vision or hearing may need an interpreter, and those with vision impairment may need materials presented in alternative formats while receiving care in order to ensure equitable care.

While most our members are primarily English-speaking, approximately 5% of our members primarily speak a language other than English. The largest group among these members are those who primarily speak Spanish—about 3% of our member population.

AetnaBetterHealth.com/Virginia

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Aetna Better Health® of Virginia

2023 Member Language	Grand total (N= 288,079)	% of total Medicaid population
Preferred Language		
English	274,098	95.1%
Spanish	9,249	3.2%
Arabic	712	0.2%
Vietnamese	424	0.1%
Farsi	338	0.1%
Unknown	1759	0.6%

To assist with translation services needs for multiple languages (including ASL) on various formats, including in-person, telephonic, and by video (Zoom), you or the member can call our Interpreter Services line at **1-800-385-4104 (TTY: 711)**. This number is also included on each member's ID card.

Telephonic interpretation can be requested on the same day. All others may need to be requested three business days in advance, and the member will need a cell phone for interpreter service requests via video/Zoom.

For more information, or if you have a request for any other alternative translation assistance needed for one of our members, call Member Services at **1-800-279-1878**.

Community Resources for Our Members in Need

Aetna Better Health of Virginia's Population Health Management (PMH) program shows that health is more than just optimal delivery of clinical care.

It's also about the well-being of the total population within communities, including social determinants of health, such as socio-cultural background, economic factors, and the reduction of barriers pertaining to access to food, safety, and other resources.

Our PHM programs allow us to meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals.

You can refer a member by directing them to call our Member Services department at **1-800-279-1878.**

Or, if you would like to offer direct assistance to members in need, feel free to review our list of community resources on our website here.

Update for Providers:

KED HEDIS® Measure

The KED (Kidney Health Evaluation for Patients with Diabetes) HEDIS measure is for all members aged 18 to 85 with diabetes (type 1 and type 2) who receive a comprehensive kidney health evaluation. This evaluation requires that both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR) be completed during the measurement year.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Important Formulary Information

Visit our Pharmacy page on our website here for important formulary information, such as the formulary and search tool and formulary updates.

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

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.

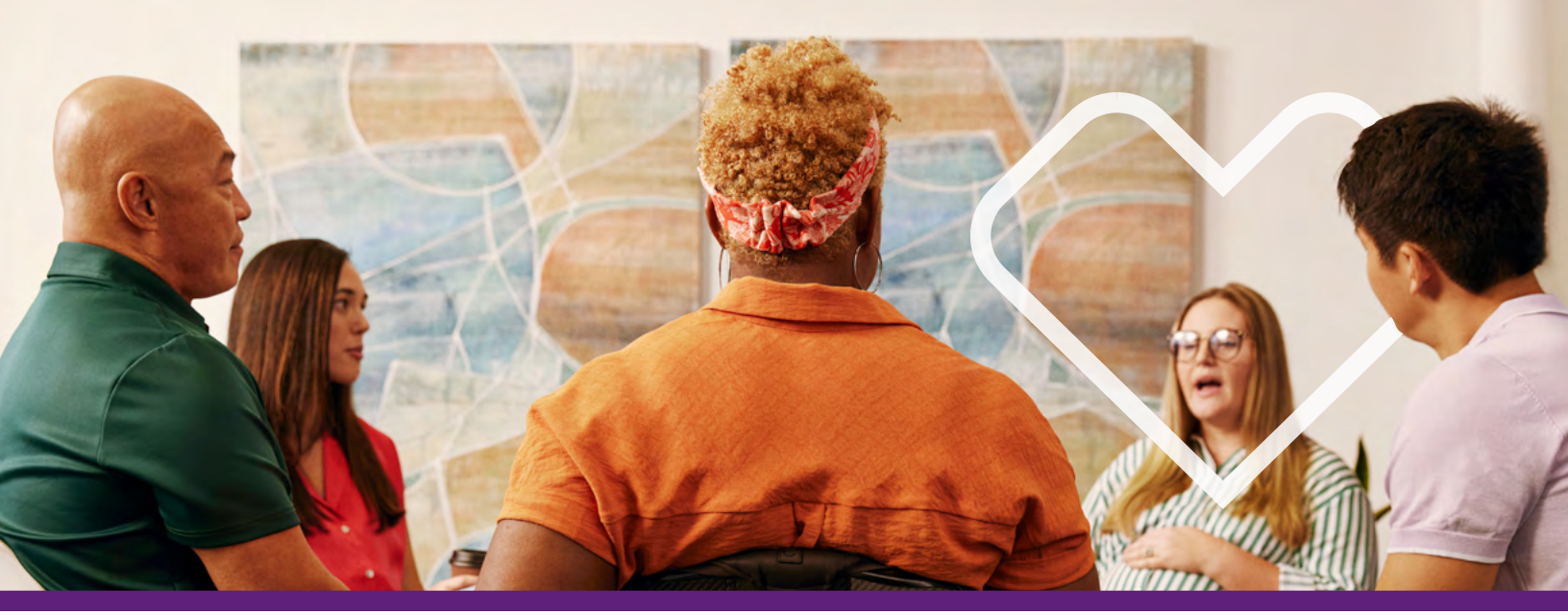
A free copy of individual guidelines pertaining to a specific case is available for review upon request by calling **1-800-279-1878**.

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.

Members can call our member services line at **1-866-316-3784** to be connected with a dental provider.



Social Determinants of Health

What are social determinants of health, and how do they affect patients and their health outcomes?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, and age.

Did you know that you can use ICD-10 codes to document and record SDOH conditions that impact your patients? SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

What are the Z code categories? (Subject to change)

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing

Who can collect SDOH data?

Any member of a person's care team can collect SDOH data during any encounter.

Why collect SDOH data?

- Enhance patient care
- Improve care coordination and referrals
- Support quality measurement
- Data analysis can help improve quality, care coordination, and experience of care

Achieving health equity and putting members on a path to better health our priority. As a participating provider with Aetna Better Health of Virginia, join us in this journey to health equity and understanding how it connects to SDOH, as well as disparities, culture, bias, and best practices in population-sensitive care.

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 (Chapter IV) on December 29, 2023. 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.

Personal Care Split-Shift Service Delivery (Agency and Consumer-Directed)

There are situations where an individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). For example, an individual may need assistance with ADLs in the morning and additional ADL assistance in the evening. A split shift is indicated when there are at least two hours between each shift. When a split shift is desired, the provider/SF must complete two Plans of Care, labeled AM and PM, to indicate each shift of services. The total number of hours on morning and afternoon plans of care combined cannot exceed the number of hours allowed for the individual's level of care without prior approval from the service auth contractor.

For agency-directed services, when a split-shift service is provided and a different aide is working on each shift, the RN/LPN Supervisor must alternate the supervisory visit between both shifts in order to provide supervision to each aide. If weekend or night service is the only time when the services are provided (example: 11:00 PM until 7:00 AM), the RN/LPN must make a supervisory visit at least every other visit during the time the aide is working. If the individual is also receiving services during the day hours, and the aide that is providing the weekend or night services is different than the weekday aide, the RN/LPN can make the supervisory visit during the weekday and discuss the other shifts with the individual and/or family/caregiver.