2025 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. If your practice phone number or address changes, be sure to let us know by calling Provider Relations at **1-888-348-2922**.

We strive to keep our online Provider Directory up to date. Please take a moment to review your information on our website and contact your provider relations representative immediately if any updates are needed.

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.

Topics included in this notice:

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AETNA BETTER HEALTH OF WEST VIRGINIA

1. How to reach us:

Aetna Better Health of West Virginia	Toll-free	Fax
Provider Services (claims inquiry and claims research)	1-888-348-2922	
Member Services	1-888-348-2922	1-866-669-2454
Prior Authorization	1-888-835-4930	
Provider Relations	1-888-348-2922	1-866-810-8476
Behavioral Health Services	1-888-348-2922	
Appeals	1-888-348-2922	1-888-388-1752
Integrated Care Management	1-888-348-2922	1-866-261-0581

2. Provider Portal

Aetna Better Health of WV is now using Availity for our provider portal. If you are already using Availity, simply choose *Aetna Better Health All Plan* from your drop-down list of payers. If you are not registered, go to our Provider Website, select the *Resources* tab, and click on *Provider Portal*. On the Availity portal you will be able to submit prior authorization requests; submit grievances and appeals; check claim status; check eligibility and benefits, etc.

PCP offices can access member panel rosters and review gaps in care for members. For more information on Availity, refer to the Provider Portal page of the provider website.

We encourage PCP offices to regularly check their member panel roster on Availity and reach out to members who haven't recently been seen to schedule an appointment.

3. 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 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. 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.

4. 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. The Clinical Practice Guidelines and Preventive Health Guidelines are located on our provider website. Click on *Resources*, and then *Clinical guidelines and policy bulletins*.

AETNA BETTER HEALTH OF WEST VIRGINIA

5. Appointment Access Standards and Hours of Operation Parity

We utilize accessibility and availability standards based on requirements from NCQA, State and Federal regulations. Aetna Better Health requires participating practitioners and providers to comply with the following appointment access standards:

PCP Appointments	Standard
Regular/routine care appointment	Within 21 calendar days
EPSDT Service	Scheduled in accordance with EPSDT guidelines and periodicity schedule within 30 days
Urgent care appointment	Within 48 hours
Emergency care appointment	Seen immediately or referred to ER facility
After-hours care	24 hours day/ 7 days per week

Specialty Care Appointments	Standard
New patient initial visit	Within 90 calendar days
Existing patient follow up visit	Within 30 calendar days
Urgent care appointment	Within 48 hours
Emergency care appointment	Seen immediately or referred to ER facility

Maternity Appointments	Standard
Initial prenatal visit	Within 14 calendar days of pregnancy confirmation

Behavioral Health Care Appointments	Standard
Initial visit for routine care	Within 10 business days
Routine/Follow-Up (non-urgent, asymptomatic conditions)	Within 60 calendar days
Emergency care	Immediately, or referred to ER
Urgent care (no immediate danger to self or others and/or if the situation is not addressed within 48 hours, it may escalate)	Within 48 hours
Non-life threatening emergency (no immediate danger to self or others and/or if the situation is not addressed within 6 hours, it may escalate.)	Within 6 hours
Discharge Follow-up Visit	Within 7 calendar days of discharge

The Access Standards are communicated to practitioners, and providers via the Aetna Better Health website and the Provider Manual. Members are notified about access standards in the

Member Handbook and on the Aetna Better Health website. 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/CHIP members. If the practitioner or provider serves only Medicaid and/or CHIP recipients, hours offered to managed care members must be comparable to those for Medicaid and CHIP 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.

6. Health Equity

All providers are strongly encouraged to learn more about health equity. Patient satisfaction and positive health outcomes are directly related to good communication, in a culturally competent manner, between a member and their provider. It's incumbent on practitioners to make sure patients understand their care regimen. Each segment of our population requires special sensitivities and strategies to embrace individual differences. Aetna Better Health offers a variety of trainings and resources for practitioners on topics including:

- Cultural Competency
- LGBTQ+
- Trauma-informed Care
- Health Literacy
- Combating Implicit Bias and Stereotypes

See the Training and Health Equity sections of the provider website for details on these trainings and other resources.

7. Social Determinants of Health Resources

Social Determinants of Health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Aetna Better Health connects members with resources and services they need to address issues that may negatively impact their health.

WV211 is a free resource that can connect members with services to assist them with things like paying bills, locating healthy food, and finding affordable housing. Members can visit www.wv211.org to get started or call us at **1-888-348-2922 (**TTY**: 711)** for assistance with SDoH resources.

Members can also call, text or chat for help by dialing **211**. The service is available 24 hours a day, 7 days a week. The 211 service is free and confidential.

8. Members have rights and responsibilities

All members have certain rights and responsibilities. You'll find those rights and responsibilities listed in the Provider Manual and on our member website. Click on *Members* then *Rights and responsibilities*.

9. HEDIS

HEDIS is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. The HEDIS Section on the provider website is full of information designed with you and your practice in mind. It includes key information related to HEDIS such as measure requirements, coding information, and best practices. You can read our condition-specific *HEDIS News You can Use* newsletters, download the latest HEDIS Toolkit for Provider Offices or sign up for monthly HEDIS webinars. Go to the provider website and click on *Resources* then click on *HEDIS*.

10. Population Health Management and Integrated Care Management Programs

The Aetna Better Health 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. Aetna Better Health members with identified conditions are outreached and offered enrollment into the Chronic Condition program. 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 clinical 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, 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. Call us at **1-888-348-2922** or Fax us at 844-330-1001 to refer your patients to our Integrated Care Management Program.

11. Pharmaceutical Management

The pharmacy benefit for outpatient prescriptions is carved out to West Virginia fee-for-service Medicaid. Aetna Better Health manages medical pharmaceuticals which include medications administered in provider/practitioner offices, hospitals and inpatient facilities, ambulatory care centers, and in member homes when given by a health care professional. Members do not have copayments for medical pharmaceuticals.

Our medical pharmaceutical management procedures follow the same utilization management processes as requests for medical services using clinical criteria sets specific to medical pharmaceuticals. You can get a copy of the criteria for a medical pharmaceutical by giving us a call.

Our medical pharmaceutical management procedures do not include the development of an open or closed formulary or preferred drug list; however, in order to promote evidence-based and clinically appropriate drug use, the clinical criteria may include processes for pharmaceutical classes, preferred pharmaceuticals, considerations for limiting access to drugs in certain classes, quantity level limits, therapeutic interchange, step-therapies, or other management methods.

The criteria does not include a tiered formulary system that would impact the cost to an enrollee, generic substitution, automatic substitutions, or incentives that apply to the use of certain pharmaceuticals.

For medical pharmaceuticals which are also available in point-of-sale form, Aetna Better Health staff are required to follow the West Virginia Bureau for Medical Services (BMS) Preferred Drug List (PDL). Aetna Better Health is not responsible for the development of the Department PDL but utilizes it for decision-making in these instances. The WV BMS PDL can be found at this link: https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/Preferred-Drug-List.aspx

While we do not maintain a formulary or PDL, you may request an exception based on the clinical criteria for a medical pharmaceutical by indicating the exception request along with you original prior auth request or by contacting our Utilization Management department at **844-835-4930**. The exception must be based on medical necessity, and you need to submit clinical documentation which may include evidence of an adverse reaction to a preferred medication, or other clinical rationale to support the exception request. An Aetna Better

Health pharmacist and/or medical director will review your exception request. Members have a right to appeal a denial of an exception request.

For general questions regarding medical pharmaceuticals contact us at **844-835-4930.** You can also visit our **provider website** for the latest information regarding pharmaceutical management procedures . Go to the *Working with us* tab, and then click on *Pharmacy*.

For questions about member benefits related to outpatient prescription medications, contact Gainwell Technologies at **1-888-483-0797**.

12. 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).

It is the policy of Aetna Better Health that family planning services include medical history and physical examinations (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling. These specific services include but are not limited to:

- Comprehensive family planning examination
- Contraceptive medical visits
- Family planning education and counseling by a practitioner/provider
- Contraceptive medications, including Long-Acting Reversible Contraception (LARCs)
- Birth control methods ordered at a family planning visit
- Supplies and associated medical and laboratory examinations, including oral and barrier method contraceptives
- Treatment of complications resulting from contraceptive use, including emergency department treatment

The following are important components of a comprehensive family planning exam:

- Assessing a member's risk for unintended pregnancy, poor pregnancy outcome, or need for family support services
- Age-appropriateness of information provided to members and the need for confidentiality of information
- Pregnancy diagnosis and counseling, including:
    - Referral to a participating obstetrical practitioner/provider for early entry into prenatal care, for members diagnosed as pregnant who wish to continue the pregnancy

   - Information on all legal options available for members diagnosed with unintended pregnancies and, if they desire, referral for appropriate obstetrical and gynecological service
   - Information about the availability of contraceptive methods for non-pregnant members
- Education, including:
   - Reasons why family planning is important to maintain individual and family health
   - Basic information regarding reproductive anatomy
   - Risk factors and complications of various contraceptive methods
   - Information on the transmission, diagnosis and treatment of sexually-transmitted diseases
   - Education about acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV)
   - Procedures of self-breast examination

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.

13. 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 practitioners 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.

14. Advance 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 (whether statutory or as recognized by the courts of the State) relating to the provisions of health care when the individual is incapacitated.

The PCP is responsible for documenting in member's medical record whether or not a member has executed an advance directive and communicating the member's request to accept or refuse treatment to attending staff in hospitals or other facilities. See your provider manual for more information on advance directives.

15. 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 always an opportunity 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 patients, to help coordinate needed services.

16. 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.

17. 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 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.

18. 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 a regular basis, Aetna Better Health performs a statewide medical record documentation audit to ensure compliance with current standards.

To view our Medical Record Documentation Standards go to the Provider website. From the *Resources* tab, click on *Materials and forms* then *Administration*.

19. Member Satisfaction Surveys

Aetna Better Health of West Virginia performs an annual survey to assess member satisfaction using the NCQA HEDIS CAHPS 5.1H 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 *Working with us* , then *Medical management.* Scroll down to *Quality management*.

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

20. Reporting suspected Fraud, Waste and Abuse

Participating practitioners and providers are required to report to Aetna Better Health 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 and/or CHIP program.

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

- Call Aetna Better Health's Fraud, Waste and Abuse toll-free number: **1-844-405-2016**
- Report it online using the Fraud, waste and abuse reporting form on our website: aetnabetterhealth.com. From any page of the website, scroll to the bottom and click on *Fraud, waste and abuse*
- Write us:

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

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