Provider Newsletter

Spring 2025

Encourage your patients to Complete the CAHPS survey

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an Agency for Healthcare Research and Quality (AHRQ) program. Recently, some of our members were sent CAHPS surveys to complete.

CAHPS surveys ask patients to report on their experiences with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities.

Providers' services to our members are integral to the outcome of the CAHPS survey. Questions ask patients about their experience with getting needed care, tests, or treatment, getting appointments with a specialist, getting urgent and routine appointments, and coordinating care. It also addresses how the patient felt about physicians explaining things in an easy-to-understand manner, listening, demonstrating respect, and spending enough time with the member.

Spread the word

Your support in getting these members to complete the CAHPS survey is critical to identifying how well our members' needs are being met. Encourage your patients to complete the survey if they receive one.

Learn more about CAHPS.

Contents

Be more efficient with Availity: Join our provider portal

Have you joined our Provider Portal, Availity? With Availity, you can more easily support your patients – our members.

Availity has made it easier for you to:

- Submit appeals and grievances.
- Submit prior authorizations and check their status.
- Submit and check up on claims.
- Plus more!

If you are already registered in Availity, you can simply select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

If you are not registered, we recommend that you do so immediately.

Click here to learn more about **Availity Portal Registration**.

Go here to register.

Need help?

For registration assistance, call Availity Client Services at **1-800-282-4548** between 8 AM and 8 PM ET, Monday through Friday.

Clinical practice guidelines

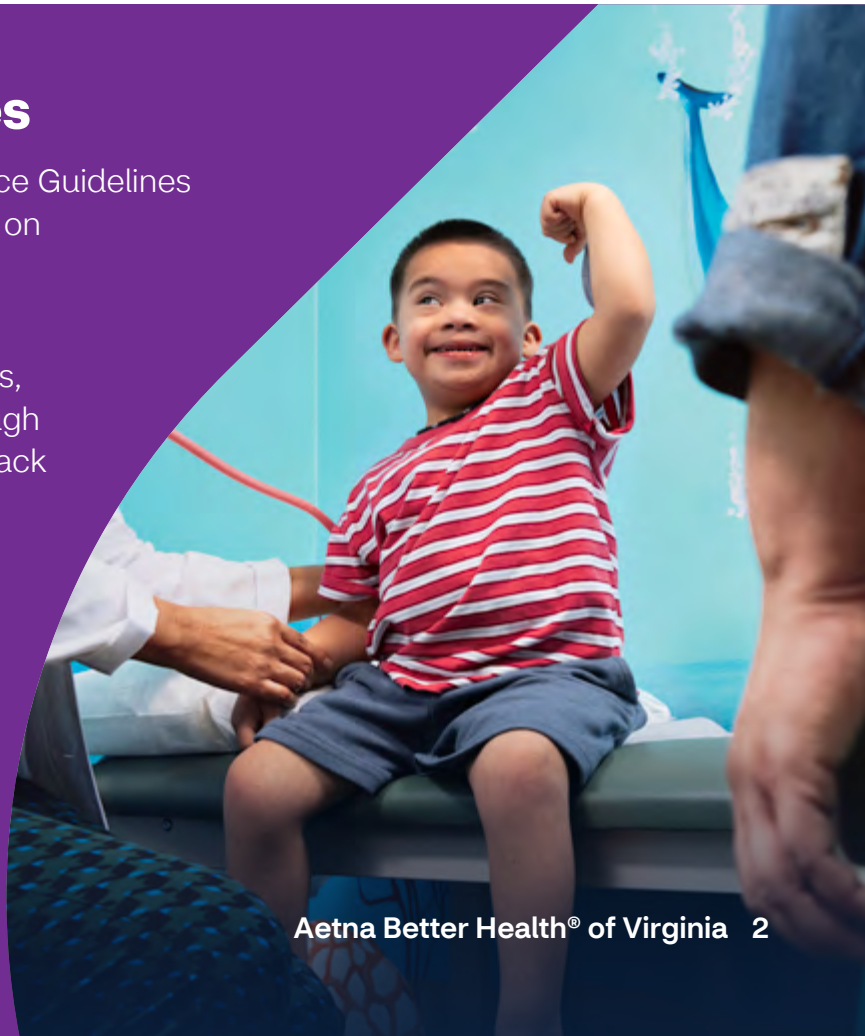
Aetna Better Health of Virginia's Clinical Practice Guidelines and Preventive Services Guidelines are based on nationally recognized recommendations and peer-reviewed medical literature.

The guidelines consider the needs of members, opportunities for improvement identified through our Quality Management program, and feedback from participating providers.

Guidelines are updated as appropriate, but at least every two years.

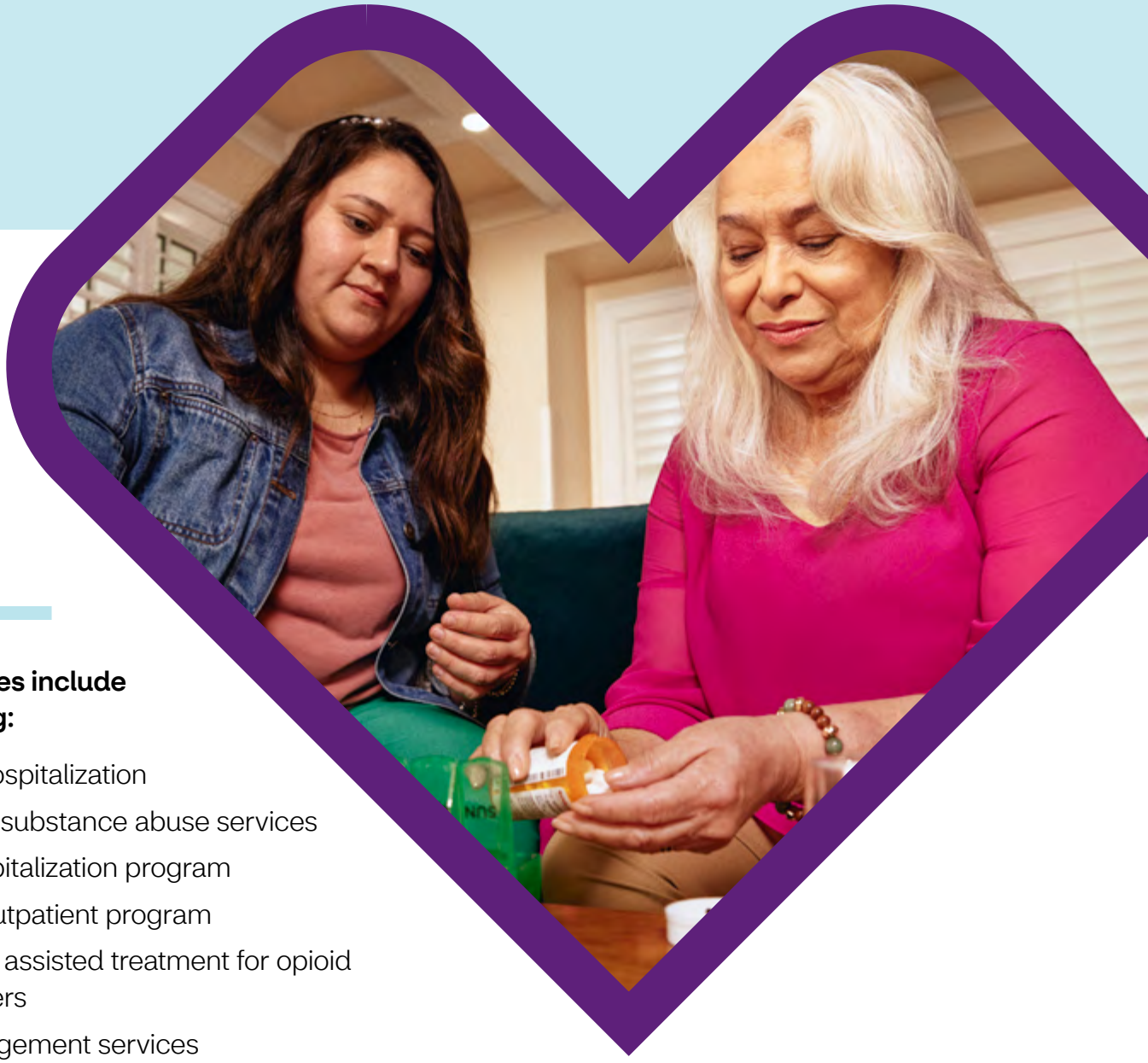
Learn more

More information about our practice guidelines is on our website at **AetnaBetterHealth.com/Virginia/providers**. At the bottom of the page, select *"Clinical practice guidelines."*



Does your patient need help for a substance use disorder?

The Addiction Recovery and Treatment Services (ARTS) benefit offers many services for members seeking help for opioid or other substance use disorders. ARTS benefits cover a wide range of addiction treatment services which are based on American Society of Addiction Medicine criteria.



ARTS services include the following:

- Inpatient hospitalization
- Residential substance abuse services
- Partial hospitalization program
- Intensive outpatient program
- Medication assisted treatment for opioid use disorders
- Care management services
- Peer support services

If you want to learn how our Behavioral Health department can provide support, visit AetnaBetterHealth.com/Virginia.

Help improve communication between treating providers

A recent survey showed that PCPs are concerned because they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.

This breakdown in communication can pose a risk to quality patient care. We know that coordinating care with many providers, facilities, and behavioral health care professionals can be a challenge.

Important clinical and mental health information to be shared should include:

- Diagnosis
- Medication
- Treatment plan

Providing consistent information about patients to other providers can improve the overall communication between providers through continuity and coordination of care.

Talking with your patients' other treating health care professionals helps you give them the best care. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

Integrated care management program

Aetna Better Health of Virginia's Integrated Care Management (ICM) program implements a population-based approach to specific chronic diseases or conditions while engaging the member on an individual basis. All Aetna Better Health of Virginia members with identified conditions are auto-enrolled in the chronic condition program based on claims data. The chronic conditions managed include:

- Diabetes
- COPD
- Asthma
- Coronary artery disease
- Depression
- Congestive heart failure

The primary goal of our ICM program 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 disenroll from the program at any time.

Services we offer:

Services for members with chronic conditions include but are not limited to:

- Coordination of care assistance
- Disease-specific education and support
- Assistance in receiving community-based services

In addition to helping members who have special medical needs, we have care management programs for high-risk pregnancies and opioid management, as well as for pregnant women with substance use disorder and their babies.

Members can be referred to the ICM program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers. We encourage you to refer patients who would benefit from chronic condition management.

Need to refer a patient to Care Management?

Call Member Services at **1-800-279-1878**. We are here to help and look forward to joining you on our members' journey to better health.

Interpreter and translation services is a covered benefit

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the health plan, the provider is financially responsible for associated costs.

For more information, refer to the *"Health Literacy"* section in your Aetna Better Health provider manual. To request interpreter and translation services, call **1-800-279-1878 (TTY: 711)**.

Providers can call interpreters for members

Did you know? Providers are able to call interpreters for members who need them. There are a few options for requesting interpretation services for both members and providers:

In-person

- The interpreter will meet the member at the location (such as the provider's office).
- Requests should be submitted at least three business days ahead of the appointment.

Over the phone

- Requests can be submitted same day.

Video (Zoom)

- Requests should be submitted at least three business days ahead of the appointment.
- Emails of each participant are required.

Scheduled video

- The interpreter service provides the link, and the member must have a cellphone.
- Requests should be submitted at least three business days ahead of the appointment.
- For more information about having an interpreter available for members, call Provider Services at **1-800-279-1878 (TTY: 711)**.

Quality management spotlight

Provider resources for using the medicaid enterprise system

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 more.

Respite Care

Respite services include unskilled (Agency Directed (AD) or Consumer Directed (CD)) and skilled nursing services. AD respite care can be provided at home, in the community by a personal care aide, or at a licensed facility for developmental disabilities. The main goal of respite is to **relieve unpaid primary caregivers due to the physical burden and emotional stress of providing support and care to the waiver individual.** The maximum amount of all types of respite care services an individual may receive is **480 hours** in a state fiscal year (July 1 – June 30).

Provider agencies are responsible for monitoring AD respite hours, and coordination between the Service Facilitator (SF) and agency is necessary when both AD and CD services are used. Authorization from the service contractor is required before care starts, and DMAS reimburses only the initial 480 hours billed per fiscal year.

Once the allotted hours are used, no additional hours will be approved until the next fiscal year. Providers/SFs need to verify the individual continues to meet the criteria to receive respite services, as well as develop a Plan of Care (DMAS-97A/B) and update annually.