Provider Newsletter

Contents

Spotlight: Provider Services Solution Portal

Effective **July 1, 2022**, the provider enrollment process is initiated through the Virginia Department of Medical Assistance Services (DMAS) instead of through the health plan. Make sure you're in compliance with the 21st Century Cures Act by enrolling in the Provider Services Solution (PRSS) portal.

Any provider not yet contracted with Aetna Better Health of Virginia will first need to enroll with DMAS using their Provider Portal. DMAS will then alert Aetna Better Health of your request to join our network, and we will reach out to you with a contract package.

Start enrollment through the new PRSS enrollment wizard. Type **virginia.hppcloud.com** in your web browser to get started. Only one enrollment application is necessary in PRSS. The application process allows for selection of multiple MCO plans. Once approved, your PRSS portal online account will be used to revalidate enrollment, make changes to personal or business information, and check member eligibility.

Find helpful training resources.

Questions?

Contact the PRSS Provider Enrollment Helpline at **804-270-5105** or **1-888-829-5373**, or email Provider Enrollment at vamedicaidproviderenrollment@gainwelltechnologies.com.

Aetna Better Health® of Virginia

aetna®

VA-22-10-07

AetnaBetterHealth.com/Virginia

Winter 2022

New Quality Toolkits for Providers

EPSDT Toolkit

Aetna Better Health has compiled an EPSDT Provider Toolkit with easy-to-follow visit assessment guidance for each recommended visit age, as well as color-coded preventative guidelines and helpful links.

View and download the EPSDT Provider Toolkit.

Or, view the toolkit on Availity. Go to ***Payer Spaces***, then select ***Aetna***, then ***Resources***.

Quality Toolkit

Our Quality Management Department created a HEDIS® Quality Toolkit to help providers improve patient care and provide resources to help improve quality measurements, such as CPT codes, care management information, and other provider resources.

View and download the EPSDT Provider Toolkit.

Important HEDIS Reminder

As a reminder, HEDIS MMR season starts at the end of January and goes to the beginning of February.

Our Quality Management Department will send requests to you via fax. We will let you know where to send medical record requests securely to Aetna Better Health. Please be sure update Aetna Better Health with any changes to your contact information. If there are any questions regarding the medical record requested, email QualityManagementPrograms@Aetna.com.

Supplemental Data Reminder

We would also like to remind all providers that the organization would like to collect supplemental data to close gaps in care by **December 30, 2022**. Our Outreach Coordinators will review that information to close any gaps. Please be sure to log in and view your GIC reports in Availity to send needed information. If you do not have access to Availity and would like to have your report emailed securely, please email QualityManagementPrograms@aetna.com.

Please fax any supplemental data (medical records) to **833-401-2089** with the subject "Attention: Quality Management."

New Wellness Rewards for Members

Did you know? Aetna Better Health members can earn rewards for getting important preventive care services.* Below are the available rewards a member may be eligible.

Diabetes Well Visit

Members may receive a $25 incentive for having completed a hemoglobin A1c test, blood pressure check and/or a diabetic eye exam. All services are also based on the provider's recommendation.

Well Woman Exam

Members who complete eligible screenings and exams, which includes: Pap smear, mammogram, chlamydia screening, colorectal cancer screening, and flu vaccine, may receive a $25 incentive. The age requirements for each screening/exam are outlined, however all are also based on the provider's recommendation.

Men's Health (NEW!)

Members who complete eligible screenings deemed medically and age appropriate by the provider may receive a $25 incentive.

Screenings include preventative care services, colorectal cancer screening, prostate exam, and flu vaccine.

Moving On: Transitioning from Pediatrics to Primary Care (NEW!)

This is a new incentive specific to members transitioning from pediatrics to adult primary care. The age requirements are 18 to 20, as this is a transitional time for many young adults who are managing their healthcare independently without the assistance of a parent/guardian.

Members may receive a $50 incentive for having completed various services, which include preventative care services, adult medical screenings, weight management, and recommended vaccinations.

**Members are eligible for one incentive per calendar year per reward type.*

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, please call **1-800-279-1878**.

Does Your Patient Need Community Resources?

In a recent survey, Aetna Better Health of Virginia members expressed a desire for their providers to discuss availability of community resources with them during their appointments.

Housing, food security, income, and transportation are among the social determinants shown to have a significant impact on health outcomes for people with complex needs, who may also need help with chronic disease self-management, behavioral health support, and social connectedness. Many families have been even further impacted by the COVID-19 pandemic. Medical practices are unlikely to be able to meet these needs. Instead, they can identify community resources and refer patients to them.

Did you know? Our website includes a list of available and local community resources that you and our members can use, in order to identify and engage them in services that can address these needs. Visit our full list of community resources here.

Services provided include rent and utility bill assistance, assistance with obtaining food, housing, transportation, jobs, and even legal help. Simply refer a member to the above website address, or you can perform a focused search to build your own list of commonly needed resources that your patients can use. Together, we can improve health outcomes by reducing barriers related to social determinants of health.

Helping Your Patients Access Community Resources with Find Help

Helping your patients find community resources is not always easy. However, finding the help that your patients need can be made a little simpler, thanks to Find Help. Our Find Help platform is a nationwide network of free and reduced-cost social programs that can help those in need connect directly to these services.

Programs are listed in every ZIP code in the United States and can be accessed through the platform. Find Help makes it easy for your patients who need help, along with those who help others, to find resources like food, housing, health care, work, financial assistance, and more.

Your patients can simply search by ZIP code, find the services they need, and find out how to get connected, all with dignity and ease.

Recommend Find Help to your patients today. Simply go to **Aetna-VA.FindHelp.com** to get connected.

12-Months Extended Postpartum Coverage for New Moms

Virginia recently expanded postpartum coverage for new mothers receiving Medicaid services from 60 days to 12 months. Virginia's postpartum Medicaid expansion includes continuous eligibility, regardless of change in income, during the postpartum coverage period.

Additionally, after pregnancy, in addition to typical postpartum care services, Medicaid members are also able to continue to receive other health care services under Medicaid for 12 months.

Change of Hearing Vendor

Starting **January 1, 2023**, the hearing benefit for eligible members will go through NationsHearing. Eligible members are 21 years or older. The current benefit amount of $1,500 per year for hearing aids will stay the same. Members can call NationsHearing at **1-833-427-9922** to learn about their choices and set up their hearing exam.

New Moms Boxes and New Moms Stipend

Starting **January 1st, 2023**, members who are pregnant through one year postpartum are eligible for a $25 per month stipend benefit if they connect regularly with their case manager. They will be able to connect with CVS Pharmacy® each month to receive free products delivered directly to their door.

To receive coverage, members must choose products from the list of approved OTC items, like diapers, creams, disposable underwear, etc. Also starting **January 1st, 2023**, moms who just gave birth will receive a box of necessary items, like lanolin cream, a digital thermometer, baby lotion, etc., for themselves and their babies. **Members will automatically receive this box if they are actively connected with their case manager.**

Our Population Health Management

Aetna Better Health of Virginia's Population Health Management (PMH) program recognizes that health is more than the 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 meet members with the right level of services for each person and enable members to use those services to achieve their health goals.

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, please 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.

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.

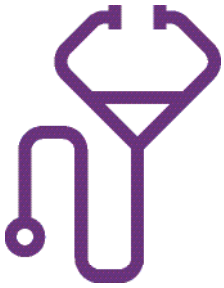
Please review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health member.

Treatment for Acute Bronchitis

Did you know there is a HEDIS measure for **Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis**?

This quality measure looks to determine when an antibiotic was not prescribed, despite an office visit for acute bronchitis/ bronchiolitis. An estimated 80% to 90% of all antibiotic use occurs in the outpatient setting, and 30% to 50% of those antibiotic prescriptions are estimated to be unnecessary.

The Center of Disease Control and Prevention indicates that most acute bronchitis will resolve regardless of whether it is viral or bacterial in nature. Symptoms will typically last no greater than three weeks and may include:



- Cough.
- Chest soreness.
- Fatigue.
- Headache.
- Body aches.
- Sore throat.

Watchful waiting should be considered. Antibiotics will not change the clinical course but may increase the risk of antibiotic resistance.

To learn more, visit the National Committee for Quality Assurance (NCQA) website here.

Insufficient Documentation Errors

An insufficient documentation error can occur when medical documentation submitted with a claim fails to support payment for the services billed. This happens when it cannot be determined that certain allowed service were:

- Actually provided.
- Provided at the level billed.
- Deemed medically necessary.

Some additional examples of insufficient documentation errors may include:

- Progress notes that are incomplete (i.e., no signatures or undated).
- Medical records that have not been authenticated (i.e., no signature or illegible signature).
- No documentation of intent to order services or procedures (i.e., incomplete or no signed order or progress note expressing intent for services to be given).

For more information, please review the Centers for Medicare and Medicaid Services fact sheet on complying with medical documentation requirements.

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?

Please 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.

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 QM Program, and feedback from participating providers.

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

Where to learn more:

More information about our practice guidelines, are on our website at **AetnaBetterHealth.com/Virginia**.

Simply scroll down and select Practice Guidelines on the left-hand menu.

Community Resources for Our Members in Need

Aetna Better Health of Virginia's Population Health Management (PMH) program shows that health is more than the 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.

Availity: Better for Your Faxing Needs

Did you know? You can submit prior authorizations (PA), medical records, or additional information forms for your requests online through Availity.

Register for Availity here.

On Availity, submit a PA or PA inquiry transaction and upload your documentation. Or, view the status to retrieve the event, then upload the documentation. If you did not use Availity for the initial request, you can still use Availity to upload your documentation. Perform a PA inquiry, then follow the status in your Availity PA/referral dashboard to upload your document.

Always include a current form with your initial request. View our forms here under "Provider Forms" and complete it online and save it to your computer to use during your PA request. Download a new form each time you need it so you'll always have the most current one.

Availity also offers free live webinars to show you how it works. For help and training, log in to Availity, then select ***Help & Training*** > ***Get Trained*** and search for ***Authorization Submissions and Follow-Up Training for Aetna Better Health and Mercy Care Providers – Recorded Webinar***.

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.

...continued

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.

Diabetes Care

Did you know that health plans monitor quality measures related diabetic care?

There is an extensive list of quality measures around diabetes care, which includes:

- Poorly controlled A1c >9%.
- Adequate controlled A1c <8%.
- Well controlled A1c <7.

As a health plan, we seek to partner with our members and providers to drive to the very best outcomes possible relating to managing diabetes.

Despite A1c quality measures, we recognize A1c targets have morphed over the years. A simple value has changed into a more individualized approach to treatment targets in diabetes.

The American Diabetes Association recommends an A1c goal of less than 7 % for nonpregnant adults.

The goal can be more aggressive, like 6.5%, if the provider and member feel its clinically appropriate, or less stringent, less than 8%, for members where there is a history of severe hypoglycemia, limited life expectancy, advanced microvascular/macrovascular complications, extensive comorbid conditions, or long-standing diabetes where control was difficult to achieve despite glucose monitoring and multiple antidiabetic drugs, including insulin.

A1c monitoring should be conducted every 6 months for members at goal and more frequently (quarterly) for those not at the predetermined A1c target.

Most people with type 2 diabetes should be started on metformin as well as nonpharmacologic strategies like weight management and physical activity.

Early combination therapy can be considered for those who are unlikely to meet their respective goal with monotherapy especially if the member has a compelling indication like:

- Atherosclerotic cardiovascular disease (coronary heart disease, cerebrovascular disease, or peripheral heart disease).
- Heart failure (EF<45%).
- Chronic kidney disease.

Early introduction of insulin should be considered for members with an A1c greater than 10%, ongoing catabolism, or persistent symptoms of hyperglycemia.

The treatment regimen and member adherence should be re-evaluated every 3-6 months. Adjustments should be made based on patient centered glycemic management, and intensification should not be delayed if members are not meeting their goals.

...continued

Some other elements to evaluate in members with diabetes includes:

- Up-to-date vaccinations.
- Smoking cessation.
- Weight management.
- Glucose monitoring at home.
- Blood pressure (ada goal <140/90).
- Lipid management.
- Kidney function.
- Foot care.

It is also recommended that members have a diabetic eye exam once a year, which consists of a dilated retinal exam to examine for diabetes-related damage to blood vessels in the eye.

Help Stop Fraud!

Fraud, waste, and abuse are widespread in the health care industry and generally result in the increase of health care costs. Aetna Better Health is dedicated to fighting fraud, waste, and abuse through its Fraud Prevention Program. This program is designed to detect and eliminate health care fraud, waste, and abuse.

The most common types of health care fraud, waste, and abuse are:

- Billing for services never provided
- Billing for more expensive services than were actually provided
- Incorrectly stating a diagnosis to get higher payments
- Performing unnecessary services to get higher payments
- Misrepresenting non-covered procedures as medically necessary
- Selling or sharing a member's identification number for the purpose of filing false claims

If you believe you have information relating to health care fraud, waste, and abuse, please contact our Fraud Prevention Department. Our Fraud Prevention Department will review the information and will maintain the highest level of confidentiality as permitted by law.

To report suspected fraud or abuse, contact us:

- Toll-free FWA Hotline is **1-844-317-5825**
- Email **reportfraudabuseVA@aetna.com**

You can help support our mission to reduce and eliminate fraud in the health care industry by following a few simple guidelines:

- Be careful when providing health care information, including a member's identification number.
- Inform your patients to be cautious of "free" medical treatments in which the patient is required to provide them with health care information.
- Aetna Better Health receives bills from providers to pay. This includes doctor visits, inpatient and outpatient services, and equipment and supplies, etc. There will be times when a member receives a letter telling them how we paid for these services. If a member receives a letter, it's important they know to fill it out and return it as soon as possible in the postage paid envelope provided.
- Understand the benefit plan and what types of treatments, drugs, services, etc. are covered.

How to Request Prior Authorization

If a service you are providing our member needs prior authorization, please call:

Program	Phone number	Fax
Prior Authorizations for Legacy M4	**1-800-279-1878**	**866-669-2454**
Prior Authorizations for Legacy Plus	**1-800-279-1878**	**855-661-1828**

For weekend, after-hours admissions, and urgent/emergent issues after hours, call **1-800-279 1878** (TTY: **711**) and follow the prompts for afterhours preauthorization. You will be directed to an on-call nurse that can assist you. You may also request a prior authorization on the Provider Portal. When requesting a prior authorization, please include:

- Member's name and date of birth
- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service

Emergency services do not require prior authorization; however, notification is required the same day. For post stabilization services, hospitals may request prior authorization by calling our Prior Authorization department. All out-of-network services must be authorized. Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

Cultural Competency and Health Equity Training

Culture is a major factor in how people respond to health services. If affects their approach to:

- Coping with illness
- Accessing care
- Taking steps to get well

We ask that all of our providers complete cultural competency training. Patient satisfaction and positive health outcomes are directly related to good communication, in a culturally competent manner, between a member and his or her provider. By completing the attestation form on our website, your records in the Aetna Better Health provider directory will be updated to reflect you have completed this required training.

Learn more about health equity and cultural competency here. Training resources are also available.

As part of our cultural competency program, we also encourage our providers to access information on the Office of Minority Health's web-based A Physician's Guide to Culturally Competent Care. The American Medical Association, American Academy of Family Physicians, and the American College of Physicians endorse this program, which provides up to 9.0 hours of category 1 AMA credits at no cost.

Learn More about Our Medicare Advantage Dual Eligible Special Needs plans (HMO DSNP)

Our Medicare Advantage Dual Eligible Special Needs plans are for people who have both Medicare and Medicaid.

Our plans are designed for people with special health care needs. We offer additional benefits and services not covered under Medicare, such as dental, hearing aids, and eyewear.

To learn more about our HMO DSNP plans, call **1-855-463-0933** or visit us at **AetnaBetterHealth.com/Virginia-hmosnp**.

Provider Appointment Standards

Timely Access		
Timely access standards for hours of operation for PCPs: (General appointment availability — 20 hours per week per practice location)		
Provider type	**Appointment type**	**Availability standard**
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
	Non-life-threatening emergency	Within six hours
Behavioral Health	Urgent care	Within 48 hours
	Initial visit routine care	Within 10 working days
	First trimester	7 calendar days
	Initial second trimester	7 calendar days
Prenatal	Third trimester and high risk	3 working days from date of referral or immediately, if emergency

Member Rights and Responsibilities

As a provider to our members, it is important that you know our members' rights and responsibilities. To view our members' rights and responsibilities, visit our website here.

Thank you for providing our members with the highest quality of care!

Aetna Better Health of Virginia was rated 3 out of 5 in NCQA's Medicaid Health Plan Ratings 2022. The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes clinicians in key clinical areas. NCQA's HEDIS® is the most widely used performance measurement tool in health care. NCQA's website (www.ncqa.org) contains information to help consumers, employers and others make informed health care choices.