Provider Newsletter

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Provider Guide: New Menstrual Care Benefit

The OTC Health Solutions® Period Products Stipend

Aetna Better Health of Virginia members will now be able to connect with CVS Pharmacy® each month to receive $20 worth of menstrual products delivered directly to their door. Products in this box and other period-related items will be available as part of the OTC Health Solutions benefit. To learn more now and access the benefit, you can visit here.

Period poverty is a real issue.

Many individuals do not have the ability to purchase supplies (i.e., pads, tampons, cleansing wipes, etc.) to manage their periods each month.

- Sixteen percent of female teens had to buy period products instead of other necessities, like food or clothing.1
- One in five low-income women miss work or school due to lack of access to menstrual care products.2

Without adequate access to menstrual care products, people may use the same product for a long period of time. Or, they use alternatives (such as paper towels or newspaper). This can cause health problems, such as yeast infections, bacterial vaginosis, toxic shock syndrome, and urinary tract infections.

Read on to learn more about this new benefit and what else Aetna Better Health is doing for women's health!

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New Member Menstrual Care Benefit

Aetna Better Health is sending out Period Packs to new eligible members (primarily women aged 10 to 55) enrolling in January through June of 2022.

The Period Pack is a box that members will receive in the mail that will provide a variety of products to manage their period better. The box includes the following items:

- CVS Health Thin Overnight Pads
- CVS Health Thin Pantiliners (Unscented)
- Fragrance-Free Cleansing Cloths
- Gentile Cleansing Wash
- Ultra-Thin Pads with Regular Wings
- Advanced Antibacterial Hand Wash
- Hand Sanitizer

These Period Packs will also be available to current and prospective members at some Cenevia locations as well as community Aetna Better Health events.

Women's Health Resources from Aetna Better Health

Aetna Better Health encourages women to get their yearly well woman exams and screenings. Our members can receive gift cards after they receive these important services.

For example, members can receive a $15 Walmart gift card for completing a mammogram and then another $15 Walmart gift card for completing a Pap smear.

Our members' wellbeing is our priority. So, we encourage every member to reach out to their provider and schedule an appointment. Our Member Services team is available 24 hours a day, 7 days a week at **1-800-279-1878 (TTY: 711)** to assist members in finding a provider if they don't already have one.

How to Support Your Patients with This Benefit

Please mention the OTC Health Solutions Period Stipend to Aetna Better Health patients when they come for their visit. Please refer them to the enroll in the stipend here or to call Member Services at **1-800-279-1878 (TTY: 711)**.

Smiles for Children Program

Calling all dentists!

Please join our program and help save our members!

The Virginia Department of Medical Assistance Services (DMAS) now offers comprehensive dental services for approximately 900,000 adult Medicaid members.

This historic benefit expansion is a response to the needs of our members and a recognition of the importance of oral health in achieving positive overall health outcomes.

To learn more about about the Smiles for Children program, click here.

Fee-For-Service Pause In Claims

This is an important update for fee-for-service Medicaid providers. As the Medicaid Enterprise System is prepared for launch, provider payments will briefly be paused from March 25 until April 4. We have carefully planned to make this transition as seamless as possible.

Medicaid providers can continue to submit claims during this period through electronic and paper transactions. You can continue to use the Medicaid provider portal for direct data entry of your claims through close of business on March 29, when the current portal will cease operations. A new Provider Services Solution (PRSS) portal will launch April 4.

We will hold and process all claims submitted during the transition and make payments beginning on April 15. For example, some providers receive payment each Friday. Because of the transition, payments normally scheduled for Friday, April 1, will instead be made on Friday, April 15. Providers who receive payments once a month will see no impact from this pause.

Once the new system launches, you will continue to submit claims in the same way you do today, with one change: You must assign taxonomy codes to claims starting April 4, 2022. Learn more about the new taxonomy code requirement here.

Please note that access to the current claims entry screens will be through the new PRSS portal beginning April 4, 2022.

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*.

New Implementation Client

On **May 1, 2022**, Aetna Better Health of Virginia will enhance the existing claims editing program to improve the overall accuracy of claim processing. We wanted to share this information in advance so you will be prepared for the upcoming changes. In the past, modifiers (including, but not limited to, modifiers 25, 59, 79, and 24) have been used to override bundling edits inappropriately.

Due to the prevalence of incorrect modifier usage, the Centers for Medicare & Medicaid Services (CMS) adopted the Office of the Inspector General's recommendations and implemented a prepayment review of modifiers using claim details and patient history for support of the modifier override.

Registered nurses with coding credentials will utilize nationally sourced guidelines documented within the Current Procedural Terminology (CPT) manual, the American Medical Association's (AMA) Coding with Modifiers manual, the CMS's Correct Coding Initiatives manual, and the CMS claims processing manuals to review information on the claim and in claim history.

CMS encourages contractors to reexamine their modifier 25 outreach activities and, where applicable, incorporate modifier 25 reviews in their prepayment review strategies. As always, if you disagree with a payment decision, medical records can be submitted for further evaluation.

While these changes require a period of adjustment, Aetna Better Health is committed to assisting you during this adjustment period. Please contact your Health Network Consultant for general inquiries regarding this program.

Learn more here.

Monitoring Metabolic Risks of Antipsychotic Medications

Metabolic changes in patients with schizophrenia who receive antipsychotic agents can contribute to the development of metabolic syndrome and increase the risk for type 2 diabetes mellitus and cardiovascular disease. Some antipsychotic treatments (such as olanzapine/Zyprexa) can cause significant increases in body weight and adiposity (4-10 kg). Increased adiposity has been associated with decreases in insulin sensitivity which may contribute to increases in plasma glucose concentrations and lipid levels[1]. As a result, it is important that metabolic functions and risk factors are systematically monitored.

Consensus guidelines from the American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists and the North American Association of for the Study of Obesity recommend the following[2]:

- At baseline, assess the patient's and/or family history of obesity, diabetes, cardiovascular disease, dyslipidemia, or hypertension.
- Assess and document the patient's BMI at baseline, at four, eight, and 12 weeks, and at least every three months thereafter, or more often as indicated.
- Assess and document the patient's fasting glucose, fasting lipid profile, and blood pressure at baseline and after three months of treatment. If the results are normal after three months of treatment, glucose and blood pressure monitoring is recommended annually. If the lipid profile is normal after three months, follow-up monitoring is recommend at least every five years.

Children and adolescents prescribed concurrent antipsychotics are at high risk for developing metabolic syndome. There is a lack of evidence supporting concurrent use. Because of this, guidelines caution against their use[3]. Additionally, the use of multiple concurrent antipsychotics in children and adolescents is a HEDIS measure for quality of care[4].

References
1 Newcomer, J. W. (2004). Metabolic risk during antipsychotic treatment. ***Clinical Therapeutics, 26***(12), 1936-1946.
2 American Diabetes Association. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. ***Diabetes Care, 27***(2), 596-601.
3 Correll, C. U., Kratochvil, C. J., & March, J. S. (2011). Developments in pediatric psychopharmacology: focus on stimulants, antidepressants, and antipsychotics. ***The Journal of Clinical Psychiatry, 72***(5), 655-670.
4 National Committee for Quality Assurance. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC). Retrieved from, https://www.ncqa.org/hedis/measures/use-of-multiple-concurrent-antipsychotics-in-children-and-adolescents

Keeping Directory Information Up to Date

Help us keep your practice information updated in the directory. Having a correct listing is a prerequisite for proper handling of your claims and is important in ensuring uninterrupted care for our members. The following elements are critical to the accuracy of your listing:

- Street address
- Phone number
- Ability to accept new patients
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory.

Update your directory information by submitting the spot check form online, available at this link: www.medicaid.aetna.com/MWP/myaccount/viewProviderDocuments.

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.

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The timely access standards for 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

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 individual health goals.

Latest Provider Manual

Our provider manual is reviewed annually, at a minimum, and is updated as needed. Your provider manual is your primary information source and an effective guide to your participation with us. It is located on our website for you to download.

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** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus).

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** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus). 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** (Medallion/FAMIS) or **1-855-652-8249** (CCC Plus).

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.

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.

Member Rights and Responsibilities

As a provider to our members, it is important that you know our members rights and responsibilities. To view:

- Medallion and FAMIS
- CCC Plus

Visit **AetnaBetterHealth.com/Virginia/medicaid-rights-responsibilities.html** on our website.

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

Learn More about Our HMO SNP Plan

Interested providers and offices are encouraged to contact Russ Barbour, Director of DSNP, at 804-968-5146.

Aetna Better Health of Virginia (HMO SNP) is a Medicare Special Needs Plan, which means our plan benefits and services are designed for people with special health care needs. Our plan offers additional benefits and services not covered under Medicare, such as dental, hearing aids, and contact lenses.

Aetna Better Health of Virginia (HMO SNP) is available to people who have Medicare and who receive Medicaid assistance from the Commonwealth Coordinated Care Plus (Medicaid).

Additionally, please visit us on the web at **AetnaBetterHealth.com/Virginia-hmosnp**.

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
Medallion/FAMIS	**1-800-279-1878**	**1-877-817-3707**
CCC Plus	**1-855-652-8249**	**1-877-817-3707**

For weekend, after-hours admissions, and urgent/emergent issues after hours, call **1-800-279 1878** (TTY: **711**) for Medallion/FAMIS members and **1-855-652-8249** (TTY: **711**) for CCC Plus members 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.