Provider Newsletter

Fall 2026

Aetna Medicare HIDE (HMO D-SNP)

Contents

Quarterly News

Availity Portal

The Availity Portal offers secure online access to and the ability to manage business transactions through a single, easy to use site. Availity features include buy are not limited to:

- Claim Submission and Status
- Eligibility and Benefits Search
- Authorization Request
- Case Management Link
- Grievance Submission
- Panel Roster

If your organization isn't registered with Availity, get started today at availity.com/provider-portal-registration

You have the power to fight the flu! Vaccinate!

The CDC has proposed the following strategy: mask up, lather up, and sleeve up. We are encouraging our members to: 1) wear a mask in crowded, indoor spaces; 2) wash their hands with soap and water or an alcohol-based sanitizer; and 3) get their annual flu vaccine. The best time to get vaccinated is during September or October, but vaccination after October can still provide protection during the peak of flu season.

For the 2026 flu season, available formulations of quadrivalent vaccine in the United States include several inactivated influenza vaccines (IIVs), one live attenuated influenza vaccine (LAIV), and one recombinant vaccine. Vaccination is recommended for all adults in the absence of contraindications. The choice of formulation depends upon several factors which include age, comorbidities and risk of adverse reactions.

For a full summary of the recommendations from the Advisory Committee on Immunization Practices (ACIP), please refer to the following link: https://www.cdc.gov/vaccines/acip/recommendations.html

2027 Provider Materials

As we are ending 2026, please keep an eye out for updated provider material. The material will include an updated provider manual, scope of benefits, frequently asked questions, and a quick reference guide. It's important to review these materials annually as plan details and benefits may change. You may call provider services 1-855-676-5772 for details on where to find materials once available.

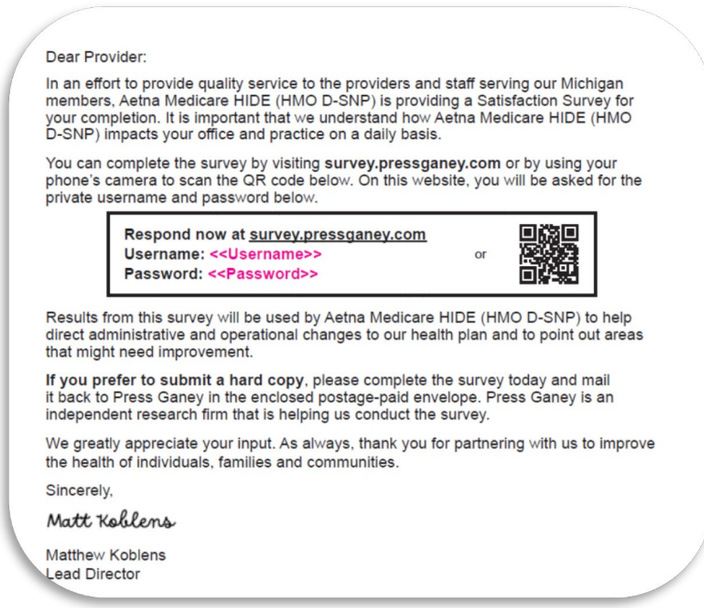
9372350-03-01
Fall Newsletter
September-26

Your Voice Matters—Join Our Quality & Provider Advisory Committee

We would love to hear from you and be a partner to improve our member health and experience. If you are interested joining our monthly Quality Management/Utilization Management/Provider Advisory Committee, please contact Provider Services at COEProviderServices@AETNA.com to learn more or sign up.

Provider Satisfaction Surveys

In an effort to better serve our network, Aetna Medicare HIDE will be sending provider satisfaction surveys to selected network providers. Not all providers will receive a survey. If you do receive a survey in the mail, we ask that you please take the time to complete it so that we can continue to improve our services.



Dear Provider:

In an effort to provide quality service to the providers and staff serving our Michigan members, Aetna Medicare HIDE (HMO D-SNP) is providing a Satisfaction Survey for your completion. It is important that we understand how Aetna Medicare HIDE (HMO D-SNP) impacts your office and practice on a daily basis.

You can complete the survey by visiting **survey.pressganey.com** or by using your phone's camera to scan the QR code below. On this website, you will be asked for the private username and password below.

Respond now at survey.pressganey.com
Username: <<Username>>
Password: <<Password>>
or

Results from this survey will be used by Aetna Medicare HIDE (HMO D-SNP) to help direct administrative and operational changes to our health plan and to point out areas that might need improvement.

If you prefer to submit a hard copy, please complete the survey today and mail it back to Press Ganey in the enclosed postage-paid envelope. Press Ganey is an independent research firm that is helping us conduct the survey.

We greatly appreciate your input. As always, thank you for partnering with us to improve the health of individuals, families and communities.

Sincerely,

Matt Koblens

Matthew Koblens
Lead Director

Member Resources

Balance Billing

Providers may not bill members for any Medicare or Medicaid covered services. Members are not responsible for Medicare cost sharing under CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays included as part of Medicare Advantage benefit plans.

Help Your Patients Get the Most from Their Aetna Medicare HIDE (HMO D-SNP) Health Plan

Aetna Medicare HIDE members have access to valuable supplemental benefits that typically expire on **December 31st.** Please remind your patients to use these benefits before the end of the year, as most unused allowances do not roll over. Members should review their plan documents for details.

Key Benefits Include:

- **Extra Benefits Card & OTC Wallet** – Monthly allowances for healthy foods, utilities, and approved OTC health products like allergy meds and first aid supplies. Funds expire at the end of each month and do not roll over. Questions? Call 1-855-676-5772 (TTY: 711) or visit CVS.com/Aetna
- **SilverSneakers®** Membership – Free access to fitness centers, classes, and online resources. Includes one Home or Steps kit per year. Learn more at SilverSneakers.com or call 1-855-364-0974 (TTY: 711)
- **Non-Emergency Transportation** – Up to 30 round trips or 60 one-way trips to approved health-related locations. Schedule at least **3 days in advance**
- **Dental Services** – One exam, cleaning, x-rays, and fluoride treatment every six months.

Krames Online

We believe our patients' well-being comes first—always. We understand that during clinical encounters, not every question can be addressed in the moment. To support you and your patients beyond the visit, Krames Online provides 24/7 access to trusted health education resources.

With more than 4,000 topics covering health conditions and medications, Krames Online empowers you to confidently guide patients and their families to reliable answers for both common and complex questions. Providers can easily encourage patients to use the search function to continue learning at their own pace; while continuing to support patients with Limited English Proficiency (LEP), patient education materials are available in Spanish (alternative languages if exist). These resources help ensure patients fully understand their care, treatment options, and self-management instructions. Providers are encouraged to offer these translated materials as part of routine care to promote equitable access, informed decision-making, and improved health outcomes.

This resource reflects our commitment to supporting your care delivery—ensuring patients receive the information they need, the answers they deserve, and the tools that reinforce informed, high-quality care.

October: Breast Cancer Awareness Month

What is breast self-awareness?

Breast self-awareness refers to a patient's

understanding of how their breasts normally look and feel. Because breast tissue naturally changes throughout different stages of life, it is important that patients become familiar with what is normal for them. Encouraging breast self-awareness helps patients identify changes earlier and know when to contact their healthcare provider for evaluation.

Why focus on breast self-awareness?

Current recommendations from leading organizations—including the American Cancer Society and the American College of Obstetricians and Gynecologists—emphasize breast self-awareness rather than teaching structured breast self-exams (BSEs). Evidence has not shown that routine BSEs reduce breast cancer mortality.

Breast self-awareness differs from BSEs in that it does not require a specific technique or schedule. Instead, it promotes general awareness so patients can recognize small or early changes and report them promptly.

Reassure patients that it is normal to feel concerned but remind them that most breast lumps are benign. Timely evaluation can help determine whether further imaging or testing is warranted.

You may advise your patients to review the health sheet (also available in Spanish): Aetna.kramesonline.com/Search/3,S,82318

Second Opinions

Aetna Medicare HIDE provides a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. If the health plan is unable to provide a necessary and covered service to a member in-network, services must be adequately and timely covered out of network for as long as the health plan is unable to provide them. The health plan will coordinate payment with the out of network provider and ensure the cost to the member is not greater than it would be if the service were provided in network.

Provider Resources

Help us reduce health disparities

Patients with disabilities often face barriers to receiving timely healthcare. Updated accessibility information helps ensure equitable access to preventive care, treatment, and follow-up services. Keeping this information current helps patients find providers who can meet their specific needs before scheduling an appointment.

You may also tell us about your office's accessibility features:

- Accessible examination tables
- Accessible scales
- Accessible restrooms
- Bariatric examination tables
- Bariatric scales
- Elevators in a multistory building
- Handicapped parking
- Lifts
- Signs in braille
- Video access to offsite interpreter
- Wheelchair ramps

We have records that show missing or unknown demographic details surrounding race and/or ethnicity

Including race and ethnicity in a provider record is important for health equity because it helps identify disparities and improve healthcare outcomes. By identifying these disparities, we can develop culturally appropriate education programs and community outreach initiatives. Our health plan needs to ensure marginalized groups receive screenings and follow-up care. To do so, we need to make sure our members are comfortable with their health care. Without race and/or ethnicity data these patterns remain hidden, and systemic inequities persist.

How you can combat health inequities

Update your provider demographic info. This initiative helps us ensure that providers comply with keeping their information current. The best way to do so is to get in touch with us.

Keep your information current

Keeping your details up to date in our directories helps members find the right information about you and your practice. This also helps ensure that you receive timely payment, communications, reminders and more.

Updating your provider data info

You can update your provider information, including:

- New service locations for an existing contracted TIN

- Race/Ethnicity, Languages spoken, Interpreting services
- Change of name, address, phone number, fax and office hours
- Specialty, hospital affiliations, board certifications and other details

Submitting through Availity (Non-LTSS)

Need to update information? The best way to do so is to follow these:

1. Log in to Availity: Access the Availity portal
2. Access Payer Spaces: Select 'Payer Spaces' in the top navigation, then select the Aetna logo.
3. Use Provider Data Management (PDM):
   a. Select 'Provider Data Management' from the menu to manage your provider roster.
   b. Select your business profile
   c. Choose Manage Type 1 Providers to add a new provider or update existing NPI information.
4. Submit changes: Follow the prompts to add the new provider's NPI, address, and specialization, then click 'Save.'

For LTSS providers, please submit your demographic and provider information updates to: COEProviderServices@AETNA.com

After you send us your materials and information, we'll process the change or contact you for more details. Need to update your participation in our network? Call us at 1- 855-676-5772.

Cultural Competency Training

When we think of culture, we might first think of race or ethnicity. But culture means much more than that. It's a major factor in how people respond to health services. And it affects their approach to coping with illness, getting care and working toward recovery. Patient satisfaction and positive health outcomes are linked to good communication between members and providers. Each segment of our population requires special sensitivities and strategies to embrace cultural differences.

Culturally competent providers:

- Effectively communicate with patients
- Understand their individual concerns
- Ensure patients understand their care plans

Complete the training

You'll want to complete a short training about cultural competency. Take these quick steps:

1. Complete this 7-minute video training about How Effective Healthcare Communication Contributes to Health Equity
2. Then, email us to confirm you've completed the training. Once we receive your email, we can give you credit for completing the training on this topic.

Model of Care Training

Aetna® providers who care for D-SNP members must take compliance training each year. The Centers for Medicare & Medicaid Services (CMS) requires it.

This training is mandatory. All network providers and their employees who serve members of Coventry or Aetna D-SNP plans must complete the training.

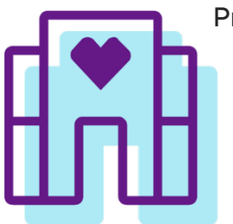
* Training must be done:

- When a new provider or employee is hired, and
- Each calendar year (but no later than December 31)

You don't have to send us an attestation of training completion. But you could be audited by us or CMS so be sure to keep a record of completion.

You can access the course online. Here is a direct link to the Model of Care Training

Appointment Availability Standards & Timeframes



Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

Visit our website to review the appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Use Disorder (MH/ SUD) providers.

Operational Resources

We want to support our health care providers as we work together to reach health care goals. We offer a

variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. This section includes just some of the resources. Additional tools and resources can be found on your provider manual.

For more information, contact our provider service department at 1-855-676-5772 or our provider website.

Delivery System Supports

Aetna Medicare HIDE wants to support our health care providers as we work together to reach health care goals. We offer a variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. Additional tools and resources can be found in your provider manual. You can access our trainings on our website.

Reminder: Required Prior Authorization Form

To help us process requests efficiently and ensure members receive timely access to care, please remember to use the Prior Authorization Form available on our website when submitting requests. The form must be fully completed, including the urgency designation (Standard or Expedited). Providing complete and accurate information allows our team to correctly prioritize incoming requests and avoid delays in review. Thank you for your partnership and commitment to supporting high quality, timely care for our shared members.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through Availity
- Fax the Prior Authorization Request Form to 1-844-241-2495. Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing
- Through our toll-free number at 1 -855-676-5772

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Availity, or call us at 1-855-676-5772.

If response for non-emergency prior authorization is not received within 15 days, please contact us at 1-855-676-5772.

When requesting prior authorization, please provide the following:

- 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
- DOS

Important Note:

- Emergency services do not require prior authorization; however, notification is required the same day.
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed, and authorizations are not a guarantee of payment.
- If providers do not receive outreach or response to non-emergency authorizations, please reach out to provider services at 1-855-676-5772.
- For post stabilization services, hospitals may request prior authorization by calling 1-855-676-5772.

Decision and Notification Requirements

Decision	Decision/notification timeframe
Urgent pre-service approval/denial	Within seventy-two (72) hours of receipt of request
Non-urgent pre-service approval/denial	Within five (5) calendar days of receipt of request
Post-service approval/denial	Within thirty (30) calendar days of receipt of request

Due to the federal and state guidelines, the turnaround time (TAT) for non-urgent pre-service decisions (5 days). It is critical that you submit complete and accurate information upfront to support your authorization request. This includes the designated point of contact, all required medical documentation, and relevant medical history. Missing or incomplete details can delay the review process and impact timely access to care for members. Ensuring thorough submissions helps us meet regulatory requirements and deliver prompt decisions within the timeframe.

We use the MCG criteria to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCGs are updated regularly as each new version is published. UM Criteria is electronically available to practitioners and copies of individual guidelines are

available for review upon request.

You can request a copy of the Medical Necessity Criteria. Call us at 1-855-676-5772 or visit our website.

Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

- We make UM decisions by looking at members' benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don't reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at call 1-855-676-5772. Language translation for members is provided for free by calling call 1-855-676-5772. Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.