A Provider Manual for

Aetna Medicare Assure Value (HMO D-SNP) &
Aetna Medicare Better Health (HMO D-SNP)
2025-2026

aetna®

Contents

Welcome to Your Provider Manual

This provider manual is for providers of patients belonging to an Aetna Medicare Advantage Dual Eligible Special Needs Plan (HMO D-SNP). These plans are available to Virginia residents who have Medicare and either receive Medicaid assistance from Commonwealth Coordinated Care Plus (Medicaid) or enrolled in a Medicare Savings Program in the state of Virginia.

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. Our members receive coordinated Medicare and Medicaid covered services.

This provider manual applies to the following plans:

	Aetna Medicare Better Health (HMO D-SNP)	Aetna Medicare Assure Value (HMO D-SNP)
Contract (PBP)	H1610(001)	H1610(003)
Eligibility	Live in the plan's service area, which includes statewide coverage in Virginia	Live in the plan's service area, which includes statewide coverage in Virginia
	Have Medicare Part A & B	Have Medicare Part A & B
	Be in a Medicare Savings Program (MSP) or qualify for State Medicaid benefits	Be in a Medicare Savings Program (MSP) or qualify for State Medicaid benefits
	Be enrolled in Commonwealth Coordinated Care Plus (CCC Plus) through Aetna Better Health of Virginia®	
Qualifying Medicare Savings Programs	Qualified Medicare Beneficiary Plus (QMB Plus)	Qualified Medicare Beneficiary (QMB)
	Specified Low-Income Medicare Beneficiary Plus (SLMB Plus)	
	Full Benefit Dual Eligible (FBDE)	

Your Provider Resource

You've told us what's important to you. And we listened. Through your feedback, we continually update this manual to make it easier for you to work with us.

This manual applies to any health care provider, including physicians, health care professionals, hospitals, facilities and ancillary providers. Please read this manual carefully. Your agreement requires you to comply with Aetna policies and procedures including those contained in this manual.

Visit **aetnabetterhealth.com/virginia-hmosnp/** or our provider portal to find additional policies, procedures, and information. You'll find programs we offer that could benefit your Aetna patients. And of course, you'll find our contact information, so you can reach us whenever you need to. Visit **Availity.com** for electronic tools that save you time, and information on how to get your claims paid faster, your pre-authorization requests processed promptly, and your administrative burdens lessened. We want you to find what you need, quickly and efficiently.

Have questions? Contact us via **AetnaBetterHealth.com** — we're here to help.

Creating a diverse, equitable and safe workplace

We are an equal opportunity employer. We believe in and promote a diverse, equitable and safe workplace environment. We count on you to do the same in your hiring practices and workplace policies.

A word about compliance

The policies and information stated in this manual should align with the terms of your agreement with us. If they don't, the terms of your agreement override this manual.

You're responsible for complying with all applicable laws and regulations. We may issue notifications regarding legal requirements as laws or regulations change. However, you're responsible for compliance regardless of whether we've issued a notification.

State or federal laws, regulations or guidance may include requirements that this manual doesn't mention. In that event, those requirements apply to you and/or to us. If those requirements are not consistent with (or are more stringent than) our policies and procedures, they may override the policies and procedures in this manual.

A Note About this Manual

While this manual contains basic information about Aetna Better Health and the Department of Medical Assistance Services (DMAS), providers are required to fully understand and apply DMAS requirements when administering covered services. Please refer to **www.dmas.virginia.gov** for further information on DMAS. You can also access the DMAS Provider Manual **here**.

Here to help you

This manual is for you — physicians, hospital medical and facility staff, and providers who participate in our network and care for our members. It aims to:

- Help you understand our processes and procedures
- Serve as a resource for answering your questions about our products, programs or doing business with us

You'll find almost everything you need to do business with us. Please visit our **website** to find other policies and procedures that are not documented in this manual.

Changes and updates

When things change, we'll let you know. You are required to provide us with your email address so we can contact you with important information, such as updates about our members and group health plans.

Likewise, we update this manual annually and as needed. When we make changes that affect you, such as to clinical policies, procedures, plan names or ID cards, we'll let you know. If your office hasn't heard from us or your

contact information has changed, you must let us know.

Our newsletter is published quarterly — April 1, July 1, October 1 and January 1. It can include changes to policies that may affect your practice or facility

Learn more

- Read Updates on our **website** in the Providers section.
- Revie Provider data demographics in this document.

New to the Aetna® network?

We have tools and resources to help you work with us.

- **Aetna Provider Manual:** this handbook contains information on Aetna benefits and products. It includes information important to patient care such as primary care physician (PCP) selection, referral requirements and precertification instructions..
- **Provider portal:** you'll notice the term **provider portal** used throughout this manual. You can perform most electronic transactions through this website. That includes submitting professional and institutional claims, checking patient benefits and eligibility, requesting precertifications, making edits to existing authorizations and submitting clinical information. You must register to use the website. Just go to **Availity.com**, select **Register** and then follow the instructions.
- **Orientation:** on our provider site, you can **sign up for a orientation** and learn how to work with us.

Note: The term "precertification" (used here and throughout the office manual) refers to the utilization review process used to determine if a requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage.

Provider Data Demographics

Federal provider directory regulations require Aetna® and providers to work together to maintain accurate provider directory lists. It is required by law for you and Aetna to keep your information current and to confirm its accuracy every ninety (90) days. However, Aetna may require confirmation upon request as well

Updating your data helps patients find you.

We include provider data information in our directories to help patients find care. Being in our directories allows new patients to find out if you are accepting new patients, where you're located, and how to reach you. In addition, by making sure we have your current information, we can send you timely communications and reminders. Remember to notify us of your data changes in accordance with state, federal, and contractual requirements, and guidelines. Failure to do so will result in corrective action in accordance with applicable law.
Continue reading to learn how to update your information.

Medicare and Medicaid providers

Go to **Availity.com** to update your information. (If you can't use Availity.com, submit a Request Changes to Provider Data Submission Form.) Here are some examples of what you can update:

- Accepting new patients' status
- Service location additions or removals for an existing contracted tax identification number
- Appointment phone number
- Email address
- Fax number
- Gender
- Hospital affiliations
- Languages spoken.
- Name
- Office hours
- Panel status
- Specialty
- Street address

Provider roster requirements

This section outlines the standards and requirements for any Delegated Credentialing provider group or other provider groups approved by us to submit a roster of providers or provider updates to us, so we can upload the information into our systems.

A Delegated Credentialing Entity or Delegate is a hospital, group practice, credentials verification organization (CVO) or other entity that we have given the authority to perform specific provider credentialing functions. When credentialing responsibilities are delegated to you, you are known as the Delegated Entity.

Roster data quality

The information contained on rosters directly impacts our provider directories and other systems (for example, claim payment systems) and must be maintained, completed and accurate in accordance with applicable law.
We reserve the right to analyze and score each roster received and will return poor-quality rosters for correction and resubmission to us.

Continued submission of poor-quality roster information may result in:

- A request for corrective action
- Omission of providers from the search tool
- Our refusal to accept any further rosters from your group.
- A requirement for your group to maintain demographic data through other means (such as through Availity)
- Termination of Delegated Entity status

Provider roster submission requirements to get a roster template, email us at COEProviderServices@Aetna.com and put "Roster template request" in the subject line.

Delegates or other groups who are approved by us to submit rosters are required to:

- Submit a complete and accurate roster in Excel or similar columnar format. (Word and PDF files are not acceptable.)
- Include all necessary roster fields on submissions. (For examples, see the "Roster fields" section.)
- All providers must submit information monthly and quarterly, as described in the bullets. (If you already submit information more frequently, please continue to do so. If you want to start submitting more frequently, please do so.) Minimum required submissions:
  - A monthly roster with adds, changes and deletions
  - A quarterly full roster that includes all providers
- Contact each provider in your network at least once a quarter to validate that their demographic information is correct.

Roster fields

The roster shall contain separated fields for each element. This includes but is not limited to the following elements:

- **Provider information:** Date of Birth, Degree, Ethnicity, Gender, First Name, Last Name, Middle Initial, Role (Primary care provider, specialist, or both), and practice name
- Licenses and identification numbers
- Board certification (board name, effective date, and expiration date)
- Controlled dangerous expiration date
- State license number
- State license state of issue
- Tax ID number
- Tax ID owner name
- U.S. Drug Enforcement Administration (DEA) registration number
- U.S. Drug Enforcement Administration (DEA)
- **Billing Information**: City, state, and ZIP code
- Credentialing date (most recent)
- Credentialing date (original)
- Medicare expiration date
- Medicare expiration date registration number expiration date
- U.S. Drug Enforcement Administration (DEA) state of issue
- Service contact information
- Service location appointment phone number
- Service location: email, fax number, street address, suite number, city, state, and zip code
- **Provider affiliation information:** Primary location (Y or N), services provided, Accepting new patients (Y or N), accessible to persons with disabilities (Y or N), ages treated, genders treated, languages spoken by staff, office hours, specialty, directory print (Y or N)
- Medicare number
- National Provider Identifier (NPI) number
- National Provider Identifier (NPI) type
- State license effective date and expiration date

Helpful Links

Here are the websites to use to access related content and information.

Website	Link
Aetna® Better Health Plan Site	**www.aetnabetterhealth.com/virginia-hmosnp/**
Find a Network Provider	**www.aetnabetterhealth.com/virginia-hmosnp/find- provider**
Availity	**www.Availity.com**
The Aetna provider portal	**www.aetnabetterhealth.com/virginia-hmosnp/providers/portal**
Aetna Fraud, Waste or Abuse	**www.aetnabetterhealth.com/virginia-hmosnp/fraud- abuse**
VA Quit Line	**www.vdh.virginia.gov/tobacco-free-living/quit-now- virginia/**
DentaQuest (Dental)	**www.dentaquest.com/state-plans/regions/virginia/**
LifeScan/OneTouch® (Order Code: 123AET200)	**www.onetouch.orderpoints.com**
ModivCare (Transportation)	**www.modivcare.com/offerings/nemt/**
NationsHearing (Hearing)	**www.NationsHearing.com/Aetna**
SilverSneakers®	**www.SilverSneakers.com**
VSP (Vision)	**www.vsp.com/eye-doctor**
DMAS Provider Medicaid Information	**www.dmas.virginia.gov**
Provider Medicaid Enrollment	**www.virginiamedicaid.dmas.virginia.gov**
Drug formularies	**www.aetnabetterhealth.com/virginia- hmosnp/formulary**
Adult and Child Abuse & Neglect Hotline	**www.dss.virginia.gov/family/cps/index.cgi**

Key contacts

Here are the numbers to call for questions or requests on behalf of your patients.

Department	Contact information
Provider Contact Center • Claim inquiries and questions • Member eligibility and benefits • Patient management • Precertification	1-855-463-0933 (TTY: 711)
Aetna Credentialing Customer Service	1-855-463-0933 (TTY: 711)
24-hour Nurse Line	1-855-463-0933 (TTY: 711)
DentaQuest (Dental)	1-800-508-6782
LifeScan/OneTouch® (Order Code: 123AET200)	1-877-764-5390
ModivCare (Transportation)*	1-844-452-9375
NationsHearing (Hearing)	1-877-225-0137
Behavioral health	1-855-463-0933 (TTY: 711)
SilverSneakers®	1-888-423-4632
VSP (Vision)	1-800-877-7195
BRCA Genetic Testing program (genetic testing for breast and ovarian cancers)	1-877-794-8720 (TTY: 711)
CVS Caremark® Mail Service Pharmacy	• Phone: 1-855-463-0933 (TTY: 711) Fax: 1-800-378-0323 •

Department	Contact information
Complaints, Grievances, and Disputes **Note:** The information is also available on our **provider portal** on Availity.	1-855-463-0933 (TTY: 711) Fax: 1-855-883-9555 Email: **COEGandA@aetna.com** Address: PO Box 818070 Cleveland, OH 44181 **Note:** When you call, have the EOB statement and the original claim handy.
Coverage Decisions and Appeals for Part D Prescription Drugs	1-855-463-0933 (TTY: 711) Fax: 1-877-270-0148 Address: 4500 E Cotton Center Blvd Phoenix, AZ 85040
Payment Requests for Medical Coverage	Fax: 1-855-259-2087 Address: 7400 W Campus Rd New Albany, OH 43054
Payment Requests for Prescription Drugs	Address: PO Box 52446 Phoenix, AZ 85072-2446
Enhanced clinical review program	CareCore National (doing business as “eviCore healthcare”) 1-800-420-3471 Medsolutions (doing business as “eviCore healthcare”) 1-888-693-3211 National Imaging Associates (NIA) **1-866-842-1542**

Infertility program	1-800-575-5999 (TTY: 711)
National Medical Excellence Program® (transplants)	1-877-212-8811 (TTY: 711)

Electronic solutions

From the time a member schedules an appointment through the claim payment, we're committed to making it easy for your office or practice to work with us electronically. Take advantage of our suite of electronic transactions and increase your office's efficiency. Below are key features and benefits of our electronic transactions.

Note: If you perform transactions through a vendor other than our **provider portal** on Availity®, functionality may vary.

Eligibility and benefits inquiry

Our Eligibility and Benefits Inquiry transaction enables you to request patient eligibility status quickly and easily. It can help you:

- Verify member eligibility and demographics
- Find detailed financial information, including deductible, copayment and coinsurance for individual and family levels

Authorization adds, inquiries and updates

Our Authorization Add and Authorization Inquiry transactions are quick, easy ways to request or check the status of an authorization. Benefits include:

- The ability to access all Aetna® benefits plans 24 hours a day, 7 days a week
- The ability to confirm whether a valid authorization is present or not and to check the status of previously submitted requests (for pended requests, we will respond with a detailed status, so you see our progress in processing your request)
- The ability to make updates to an authorization before the date of service through our provider portal on Availity

Complete an Authorization Inquiry transaction and click on the Update link in the upper right corner of the response. From there you can:

- Change an admitting or attending provider, facility, or vendor and create a new request once a decision has been made
- Add up to five new diagnosis codes or a note in the comments field (there is space for 264 characters), and create a new request once a decision has been made
- Update or change admission details prior to service, such as changing the admit date or adding a discharge (once the service has begun, changes to the existing dates and procedures cannot be made)
- Add, update or cancel up to five procedure codes and the associated details (for Medicare members, submit a new request)
- Make additional changes such as adding an end date to an initial request, as long as the request isn't more than 180 days from the date of service (once the service has begun, do not change existing dates and procedures)
- Submit clinical information in support of pending and new authorization requests and open concurrent review cases (create a new request once a decision has been made and, once a decision has been made, do not cancel or void procedures and services)

Providers can upload supporting information (such as medical records or additional information forms) through our provider portal on Availity using the Authorization Submission or Authorization Inquiry transaction. Users can upload up to six electronic files at a time, with a size of 32MB per file, by clicking the Add Files button. We accept the following file types:

- Microsoft® Word (.doc, .docx)
- Microsoft® Excel® (.xls, .xlsx)

- Adobe® PDF (.pdf)
- Images (.gif, .jpg, .jpeg, .png, .tiff)
- Rich text format (.rtf)

The files are uploaded securely, so you don't need to password-protect them. By uploading clinical information electronically, you no longer need to fax or mail requested information to us.

Referral add and inquiry

Referral Add and Referral Inquiry transactions are quick, easy ways to request or check the status of a referral. You can:

- Request referral authorization
- Inquire about the status of a referral
- Use for any Aetna® plans that require a referral

Claim submissions

You can submit all claims electronically and get reimbursed faster than submitting paper claims. In doing so, you can:

- Receive an automatic acknowledgement for all submitted claims
- Submit coordination of benefits (COB) claims electronically

Dental Claims

Providers may use standard dental claim form, 837D, in addition to the CMS 1500 form. The 837D form can include applicable CDT codes as opposed to CPT codes with **medical ICD-10 diagnosis code**
All dental claims inextricably linked to other medically covered services which are submitted to Aetna on a dental claim form must meet the following requirements:

- ICD-10 diagnosis code must be included in the Box 34A of the 837D Dental Claim form.
- Modifier KX, must be located at the beginning of Box 30, to indicate the dental service is medically necessary and appropriately documented in the patient's medical record.

Please see the **CMS site**'s notification on '**Dental and Oral Health Services'** for further details.

Please note: Regular routine dental services should be submitted through DentaQuest. Please contact **DentaQuest**, **1-800-508-6782**, for any claims submission questions relating to routine non-medical dental services.

On our **provider portal**, you can submit professional and institutional claims at no charge, including COB claims and corrected and voided claims. If we pend your claim for additional information from you, you can upload your supporting documents electronically through our **provider portal**. Log in and complete a Claim Status Inquiry transaction. Then, upload your documents through the Send Attachments link. Users can upload up to five 32MB documents at a time by clicking the Attach button. We accept these file types:

- Microsoft Word (.doc, .docx)
- Microsoft Excel (.xls, .xlsx, .csv)
- Adobe PDF (.pdf)
- Images (.gif, .jpg, .jpeg, .png, .tiff)
- Web pages (.json, .xml)

Be sure to include an electronic copy of your Explanation of Benefits (EOB) statement or Explanation of Provider Payment (EPP) as one of your documents. The EOB statement contains a code we use to route your documentation to the correct area for handling. You can find EOBs on Availity's Remittance Viewer.
Documents are uploaded securely, so you don't need to password-protect them. By uploading information

electronically, you no longer need to fax or mail requested information to us. Allow us a reasonable amount of time to review your documentation and claim.

Claim disputes and appeals

For claims, submit your electronic appeal, reconsideration, and rework requests by any of the ways below. (Both use the same time frame requirements.) A claim must be in Finalized status before you can dispute it.
To dispute a claim, go to "Claim Status transaction" and select the claim you want. If it is in Finalized status, there will be a Dispute Claim button. Click it and upload any supporting documentation. Then, click Submit. On our **provider portal**, to initiate a claim dispute — in Claim Status Response, just click on the Dispute Claim button

Rules for electronic submission

You can submit claims electronically using:

- The Health Insurance Portability and Accountability Act (HIPAA) ASC X12N 837 format for professional claims and the ASC X12N 837 format for institutional claims
- An industry standard successor format, unless your state requires another format

We ask that you use electronic real-time, HIPAA- compliant transactions for:

- Authorization (also called precertification)
- Claims Status Inquiry
- Eligibility and Benefits Inquiry
- Referrals

Electronic payment methods

We prefer providers to receive payments by electronic funds transfer (EFT) and accept an electronic remittance. Providers who do not enroll to receive direct deposit payments may receive virtual credit card (VCC) payments. Visit **our website** for more information and to access our portal — where you can do enrollments and make changes.
EFT allows you to get your payments up to a week faster than waiting for checks to arrive in the mail. This option also allows you to:

- Save paper and manage your business effectively with a convenient audit trail
- Sign up to receive emails when payments have been transmitted to your bank

When you receive EFT payments, we will assign each payment a unique trace number. If you are not enrolled to receive electronic remittance advice (ERA), you can retrieve electronic copies of our Explanation of Benefit (EOB) statements from our **provider portal**. Use the same trace number to view or download EOB statements.
If you do not enroll in EFT, we may enroll you to receive payments by virtual credit card (VCC). VCC payments work in the same way as processing credit card payments without having the
card present. Processing payments is a simple two- step process:

1. First, you will receive an Explanation of Payment (EOP) printed with a 16-digit card number.
2. Then you can manually enter the number and the full amount of the payment into your credit/debit point of sale (POS) terminal before the card's expiration date.

You will receive your funds in the same time frame as you get other credit card payments today. We do not charge a fee to enroll in or to accept VCC payments. You will just pay your standard merchant fees, like any other credit card payment you process through your POS terminal. You may choose to disenroll from VCC, but you must enroll in EFT first and agree to process any outstanding VCC payments.

Online claims Explanation of Benefits (EOB) statements

Through our **provider portal**, you can save more paper by accessing your EOB statements online. You can also:

- Access all available EOB statements online, 7 days a week, within 24 hours of claims processing
- View, download and save as a PDF, or print EOB statements

Use the Remittance Viewer tool on our provider portal to get Explanation of Benefits (EOB) statements. You can search for EOB statements using the:

- Check or electronic finance transaction (EFT) trace number
- National Provider Identifier (NPI)
- Payer name
- Tax ID

Electronic remittance advice (ERA)

Our ERA transaction provides EOB statement information electronically. This allows you to:

- Automate your posting processes
- Receive separate ERAs for the same tax ID number for all associated billing addresses and National Provider Identifiers (NPIs)
- Enroll in EFT alone
- Enroll in ERA alone
- Enroll in both EFT and ERA

When you receive both ERA and EFT, your trace number will be the same for both your ERA file and your EFT. Visit **our website** for more information and to access our portal — where you can do enrollments and make changes.

Capitated providers

If you're paid on a capitated basis, you need to provide us with member encounter data. To ask for more information on submitting encounters, visit our website and select the **Contact Aetna** link.

Working through clearinghouse vendors: transactions by vendor

Learn more about our various claim submission methods and connectivity options on our **website.**

Our Products

Aetna® Journey Handbook

The Journey Handbook is an easy-to use tool that puts basic product information at your fingertips. It provides clear, concise information about our plans including:

- PCP selection and referral requirements
- Precertification instructions
- Laboratory and radiology services

You can go online to access the Handbook

Joining Our Network

How to apply

Join the Medicare Network

If you are already participating with the Medicare Advantage program there is no need to sign up as you will automatically be placed in our system. If you are interested in applying for participation in our Medicare network, please visit the Medicare website at **www.aetnabetterhealth.com/virginia- hmosnp/providers/hmo-snp-pr/** and complete the Provider online request form. If you would like to speak to a representative, please contact **1-855-463- 0933.**

Join the Medicaid Network

If you would like more information about joining the Virginia Medicaid network call the Virginia Department of Medical Assistance Services (DMAS) **at 1-888-829- 5373**.

Credentialing (and recredentialing)

You must be credentialed in order to initially participate in our network. Thereafter, to continue to participate, you must be recredentialed every three years, unless otherwise required by state regulations, federal regulations, or accrediting agency standards. All credentialing and recredentialing activities are performed by a National Committee for Quality Assurance (NCQA)-certified credentialing verification organization. When using the Council for Affordable Quality Healthcare (CAQH), ProviderSource, Medversant, or any other approved credentialing application vendor, remember that you must designate Aetna® as an authorized health plan to access your credentialing application.

Facilities

During the credentialing process for facilities, we review to determine if the facility is in good standing with both state and federal regulatory bodies and if it is accredited by an Aetna–recognized accrediting entity. If it is not accredited by an Aetna–recognized accrediting entity, we check to see if a Centers for Medicare & Medicaid Services (CMS) survey, a state survey, or other onsite quality assessment was conducted.

Health care professionals

During the credentialing process for health care professionals, we review the provider's qualifications, practice and performance history. PCP selection and referral requirements:

- Precertification instructions
- Laboratory and radiology services
- In most states, for individual health care professionals, we use CAQH ProView to get your credentialing application.

How to check your status

Call Aetna Credentialing Customer Service at **1-855-463-0933 (TTY: 711)**

Questions?

Please contact any of the organizations below.

- CAQH ProView Help Desk: **1-888-599-1771**
- One Health Port and Medversant Help Desk: **1-888-973-4797**

Radiology accreditation

We require accreditation to be eligible for reimbursement for the technical component of advanced diagnostic imaging procedures.

Accreditation can be from:

- The American College of Radiology (ACR)
- The Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC), and/or RadSite

The following types of providers require this accreditation:

- Independent diagnostic testing facilities
- Freestanding imaging centers
- Office-based imaging facilities
- Physicians
- Nonphysician practitioners
- Suppliers of advanced diagnostic imaging procedures

For these purposes, advanced diagnostic imaging procedures exclude X-ray, ultrasound, fluoroscopy and mammography. Included are:

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Computed tomography (CT)
- Echocardiograms
- Nuclear medicine imaging, such as positron emission tomography (PET)
- Single photon emission computed tomography (SPECT)

Note: Providers not accredited by the ACR, IAC, TJC and/or RadSite will not be eligible for payment for advanced diagnostic imaging services. The accreditation process can take 9 to 12 months.

Provider identification numbers

To comply with HIPAA regulations, providers who are required to have an NPI should include their NPIs on HIPAA standard transactions. The HIPAA standard transactions are:

- Claims
- Eligibility and benefits inquiry
- Claims status inquiry
- Precertification add
- Referral add

In addition to an NPI, claims must also include the billing provider's tax identification number (TIN).

Share your National Provider Identifier (NPI)

If you're a provider who's required to have an NPI, make sure you share NPIs with us. In addition, share your NPI with other providers who may need it to conduct electronic claims, referrals or precertification requests.

Aetna provider identification number (PIN)

Physicians, hospitals and health care professionals contracted with us also have an Aetna-assigned PIN, which is used in our internal systems and in certain transactions on our **provider portal**. You should use your NPI in electronic transactions for purposes of identifying yourself as a provider. However, you can use your PIN or TIN to identify yourself when contacting us by other methods.

Primary care provider (PCP) responsibilities

PCPs will arrange the overall care and covered services for members according to their plan. This includes urgently needed or emergency services.

We have standards for member access to primary care services. Each PCP is required to have appointment availability within these time frames:

- Urgent Care: within 24 hours
- Non-Urgent Care: within 72 hours
- Preventative Care: within 28 calendar days

In addition, all participating PCPs must have a reliable 24/7 answering service or machine with a notification system for call-backs. A recorded message or answering service that refers members to emergency rooms is not acceptable. State requirements supersede these accessibility standards and are located in the Regional Office Manual Supplements.

Specialty care provider responsibilities

We have standards for member access to specialty care services. Each specialty care provider is required to have appointments available with these time frames:

- Urgent Care: within 24 hours
- Non-Urgent Care: within 4 weeks or as soon as medically indicated
- Preventative Care: within 28 calendar days

In addition, all participating specialty care providers must have a reliable 24/7 answering service or machine with a notification system for call-backs. A recorded message or answering service that refers members to emergency rooms is not acceptable. State requirements supersede these accessibility standards and are located in the Regional Office Manual Supplements.

Accessibility standards and participation criteria

Provider Type	Emergent	Urgent	Non-Urgent	Preventative & Routine	Wait Time in Office Standard
Primary Care Provider(PCP)	Immediate	Within 24 hours	Within 72 hours	Within 28 days	No more than 45 minutes,
Specialty Referral	Immediate	Within 24 hours of referral	Within 4weeks or shorter as medically indicated	Within 28 days	No more than 45 minutes
Dental Care	Within 48 hours	Within 3 days of referral	Within 30 days of referral		No more than 45 minutes
Mental Health / Substance Abuse (MH/SA)	Immediate	Within 24 hours	Within 10 days of the request	Within 10 days of the request	No more than 45 minutes

Lab and Radiology Services	Immediate	Within 48 hours		3 weeks for routine appointments	No more than 45 minutes
OB/GYN	Immediate		3 weeks of a positive of a positive pregnancy test 3 days of high-risk identification 7 days of request in first and second trimester 3 days of first request in third trimester		No more than 45 minutes
Pediatric	Immediate		Within 3 months of enrollment		

Physician-requested member transfer

Some cases may require a participating physician to ask an Aetna® member to leave their practice when repeated problems prevent an effective physician– patient relationship. Such requests can't be based solely on:

- The filing of a grievance, appeal, a request for external review or other action related to coverage by the patient
- High usage of resources by the patient
- Any reason that's not permitted under applicable law

You are required to take the following actions when requesting to end a specific physician–patient relationship:

- The Provider must send a letter informing the member of the termination and the reason(s) for the termination. The letter must be provided to the member at least thirty (30) days prior to the removal.
- The Provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
- Upon request, the Provider will provide resources or recommendations to the member to help locate another participating Provider and offer to transfer records to the new Provider upon receipt of a signed patient authorization.

In the case of a PCP, Aetna will work with the member to inform him/her on how to select another Primary Care Provider (PCP).

Medical clinical policy bulletins

Aetna Clinical Policy Bulletins (CPBs) are internally developed policies that we use as a guide for determining health care coverage for our members. Our CPBs are written on selected clinical issues, especially addressing new medical technologies such as devices, drugs, procedures and techniques. The CPBs are used as a tool to be interpreted in conjunction with the member's specific benefits plan and after discussions with the treating physician. Our benefits plans generally exclude from coverage medical technologies that are considered experimental and investigational, cosmetic and/or not medically necessary.
CPBs are continually reviewed and updated to reflect current information.
We review new medical technologies and new technology applications regularly. We determine whether and how such technologies will be considered
medically necessary and/or not experimental/ investigational under our benefits plans.
Our process of assessing technologies begins with a complete review of the peer-reviewed medical literature and other recognized references concerning the safety and effectiveness of the technology. This evaluation involves analyzing the results of studies published in peer-reviewed medical journals.
We consider the position statements and clinical practice guidelines of medical associations and government agencies, including the Agency for Healthcare Research and Quality (AHRQ). When applicable, we consider the regulatory status of a drug or device, including:

- Review by the U.S. Food and Drug Administration (FDA)
- Centers for Medicare & Medicaid Services (CMS) coverage policies

We develop our CPBs from a review of relevant information regarding a particular technology. CPBs are published on our website for public reference.
Note: Under most plans, the term **"medically necessary"** refers to health care services that a physician provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These services adhere to the following generally accepted standards of medical practice:

- They are clinically appropriate
- They are not primarily for the convenience of the patient, physician or other health care provider
- They are not more costly than an alternative or sequence of services which are at least as likely to produce equivalent results

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature. These standards are generally recognized by the relevant medical community or otherwise consistent with the standards above.

Compliance

Nondiscrimination

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of a number of factors. These include:

- Race
- Ethnicity
- Gender
- Creed
- Ancestry
- Lawful occupation
- Age
- Religion
- Marital status
- Sex
- Sexual orientation
- Gender identity
- Mental or physical disability
- Medical history
- Medicare or Medicaid beneficiary
- Color
- National origin
- Place of residence
- Health status
- Claims experience
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Genetic information
- Source of payment for services
- Status as private purchasers of a plan or as participants in publicly financed programs of health care services
- Cost or extent of Provider Services required

All participating physicians should have a documented policy regarding nondiscrimination.
All participating physicians or health care professionals may also have accommodation obligations under the federal Americans with Disabilities Act. The Act requires that they provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

There are additional requirements for physicians or health care professionals that are covered entities under the Section 1557 Nondiscrimination in Health Programs and Activities Final Rule.
They are required to provide access to medical services, including diagnostic services, to an individual with a disability. Participating physicians or health care professionals may use different types of accessible medical diagnostic equipment. Or ensure they have enough staff to help transfer the patient, as may be needed, to comply.

Members rights and responsibilities

We want you to have a good relationship with our members and vice versa. That's why we advise our members of their **rights and responsibilities** as they relate to their selection and interactions with providers.

Advance directives and the Patient Self- Determination Act (PSDA)

The PSDA is a federal law designed to raise public awareness of advance directives. An advance directive is a written statement, completed in advance of a serious illness, about how one would want medical decisions to be made for themselves if he or she is incapable of making them. The two most common forms of advance directives are the Living Will and the Durable Power of Attorney for Health Care.
The Centers for Medicare & Medicaid Services (CMS) strongly urges all practitioners to include documentation in the medical record regarding whether a Medicare member has completed an advance directive. This is also an Aetna® medical record documentation requirement.
The patient should complete the Advance Directive Notification Form. We recommend that each patient return this form to their PCP so that it may be placed in their medical file.
We encourage you to discuss advance directives with your patients.
Note: The PSDA impacts all Aetna members over the age of 18.

Informed consent

All participating physicians and other health care professionals should:

- Understand and comply with applicable legal requirements regarding patient informed consent
- Adhere to the policies of the medical community in which they practice and/or hospitals where they have admitting privileges in general, it's the participating physician's duty to:
    - Give patients adequate information
    - Be reasonably sure the patient understands this information before treating them

Transparency: Physician-member communications policy

Our contracts do not prevent participating providers from disclosing rate or payment information when required by law, such as federal law associated with "Price Transparency." They also do not contain clauses that "gag" or prevent Aetna or payers from disclosing price and quality information, or other data or information, in violation of applicable law.

We encourage providers to discuss issues openly with their patients and include language in our contracts to promote open physician–member communication.

The objective is to give our members the comfort of knowing their physicians and other health care professionals have the right and the obligation to speak freely with them.

Providers should discuss with their patients:

- Pertinent details regarding the diagnosis of their conditions
- The nature and purpose of any recommended procedure
- The potential risks and benefits of any recommended procedure
- The potential risks and benefits of any recommended treatment
- Any reasonable alternatives to such recommended treatment

Verifying member eligibilityand benefit

The following are ways to identify whether a patient is an Aetna® plan member.

Digital ID cards

Twenty-four hours after the plan effective date, members can access and view their digital ID cards on their **Member Website**and on the Aetna Health℠ mobile app. Members can easily print replacement ID cards from their Aetna member website. Digital ID cards are identical to plastic ID cards. Providers can also view an electronic version of the member's physical ID card. ID cards allow you to easily see all the information you need and verify the patient's eligibility at the same time. You can view your Aetna patient's ID card right from our **website**.

Member ID cards

Members should receive an ID card within four weeks of enrollment. At each visit, your office should ask to see the member's ID card and collect the appropriate copayment, as applicable. Note: *Some members will have digital ID cards. These members may present their mobile device or a printed copy when getting care.*

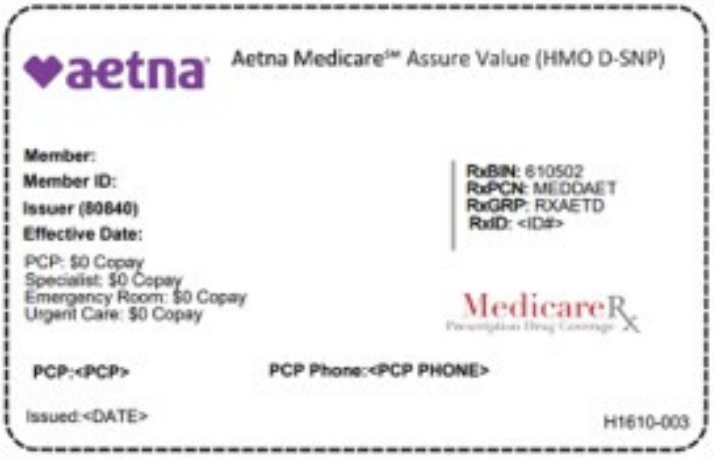
Members can access and print some of the information that appears on their ID card via the Instant Eligibility feature on their Aetna member website, including:

- Member ID number
- Member name
- Group number
- Member Services telephone number(s)
- Claims address

See the following example cards:

Aetna Medicare Better Health (HMO D-SNP)

Aetna Medicare Assure Value (HMO D-SNP)



Providers can access and print member ID cards from through **Availity.com**.

- To access the electronic image of the card, the user must first submit an eligibility request for a member.
- When a successful eligibility response is returned, a tab which contains an image of an ID card will display on the screen.
- The user can click the image to view a copy of the actual member ID card.

A paper or digital version of the member's information should be accepted in lieu of an actual member ID card. **No ID card?** Use the Eligibility and Benefits Inquiry transaction. It's available on our **Provider Portal**. Enter the patient's full name and date of birth to easily find patient coverage and detailed benefits information. It's accurate and provides greater detail than the ID card.

Verifying benefits

Use the Eligibility and Benefits Inquiry transaction to obtain member-specific plan details. Check eligibility prior to a patient's visit since coverage could have expired or been suspended. Depending on plan details, transaction fields may include:

- Copay, deductible and coinsurance
- Exclusions and limitations
- Visits used and visits remaining
- Referral and precertification requirements

Here are some tips to help you complete a transaction.

- Search using the patient's full first and last names and date of birth if you don't have the member ID number.
- Select "Benefit Type" to jump to a specific benefit.
- Under the "Eligibility" link, access your rosters for HMO capitation.

Verifying Your Network Participation

To verify your network participation, you can use any of the options below:

- Review your contract.
- Call the Provider Contact Center.
- You can also find network participation in Availity as you're viewing eligibility.

Precertification

Precertification occurs before inpatient admissions and select ambulatory procedures and services. Use our online tools to help you determine if precertification is required for a particular procedure. Then, submit precertification requests for those services.

- **Precertification Code Search tool** — allows you to enter up to five Current Procedural Terminology (CPT®*) codes at a time to determine whether a medical precertification is required for your patient.
- **Online Precertification transaction** — allows you to add a precertification request for those services that require it and inquire to see if a precertification has been approved.

You can submit a precertification by electronic data interchange (EDI), through our **Provider Portal** or by phone, using the number on the member's ID card.

Based on historical experience, we may sometimes allow particular providers to follow a streamlined precertification process for certain services.

Visit our website to learn more about **Precertification.**

Emergencies

Medical emergencies

If an Aetna® member requires emergency care, they're covered 24 hours a day, 7 days a week, anywhere in the

world. In the event of a medical emergency, we advise our members to follow the guidelines below when accessing emergency care. This is regardless of whether they are in or out of an Aetna service area.

- Call 911 or go to the nearest emergency facility. If a delay would not be detrimental to the patient's health, call the primary care physician.
- After assessing and stabilizing the patient's condition, the emergency facility should contact the primary care physician so they can assist the treating physician by supplying information about the patient's medical history.
- If the member is admitted to an inpatient facility, the patient, a family member or friend acting on behalf of the patient should notify the primary care physician or Aetna as soon as possible.
- All follow-up care should be coordinated by the primary care physician, where applicable (medical only).

An "emergency medical condition" involves acute symptoms that are severe enough that someone with an average knowledge of health could expect that the absence of medical attention would result in serious harm. For pregnant women, the health of both the woman and her unborn child must be taken into consideration. State mandates may apply.
Depending on the benefits plan, members traveling outside their service area or students who are away at school are covered for emergency and urgently needed care.
Claims submitted to us by the provider that supplied care must appear to meet the standards for emergency or urgent care. Otherwise, we may need to review the records from the emergency visit. In this situation we will send a request to the treating facility for the records of the visit and notify the member of the request. If the member wishes, they may provide us with additional information regarding the circumstances of the visit.

Follow-up care after emergencies

The primary care physician should coordinate all follow-up care. In all cases, the primary care physician must record all information regarding the emergency visit in the patient's chart. We require precertification before we cover any out-of-network follow-up care, either inside or outside the Aetna® service area. You can obtain precertification electronically or by calling the number on your patient's member ID card. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.
Note: State regulations and contractual provisions

After assessing and stabilizing the patient's condition, the emergency facility should contact the primary care physician so they can assist the treating physician by supplying information about the patient's medical history. If the member is admitted to an inpatient facility, the patient, a family member or friend acting on behalf of the patient should notify the primary care physician or Aetna as soon as possible. All follow-up care should be coordinated by the primary care physician, where applicable (medical only).
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Note: State regulations and contractual provisions regarding emergency admissions may, in some cases, overrule the procedures described in this manual.

Claims & Billing

Member billing

Billing members for noncovered services — consent requirements

All of our member plans include certain exclusions. Common exclusions include services that are considered experimental and/or investigational (see **Medical Clinical Policy Bulletins** for examples). Of course, services that are not medically necessary are also generally excluded.

Balance billing

Balance billing members is prohibited under the plan. In no event should a Provider bill a member (or a person acting on behalf of a member) for payments that are the obligation of Aetna or a covered service under this plan. This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna and must indemnify the member for payment of any fees that are the legal obligation of Aetna for services furnished by Providers that have been authorized by Aetna to service such members, as long as the member follows Aetna rules for accessing services described in the approved member Evidence of Coverage (EOC) and or their member Handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services.
- Agreeing that when referring a member to another Provider for a non-covered service, Provider must make certain that the member is aware of his or her obligation to pay in full for such non-covered services.

Billing Aetna® members who were not with Aetna

When services were provided you may bill or charge individuals who were not our members at the time that you provided services.

Claims information

Go to our **Claim Information** page to find all our claims, payment and reimbursement tools and guidelines.
Aetna requires clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.
Aetna requires that clean claims be submitted within 120 days from the date of service. Aetna will consider a claim for resubmission only if it is re-billed in its entirety.

Clean claims

We know it's important to you that your office gets paid promptly. To reduce payment delays, have your office submit "clean claims." A clean claim is a claim that is received in a timely manner and includes all the information we need to process it for payment. Unless otherwise required by law or regulation, clean claims include all of the following:

- Detailed and descriptive medical and patient data
- A corresponding referral (whether in paper or electronic format), if required for the applicable claim
- All the data elements of the UB-04 or CMS- 1500 (or successor standard) forms (including but not limited to member identification number, National Provider Identifier (NPI), date(s) of service, and a complete and accurate breakdown of services)

In addition, a clean claim:

- Doesn't involve coordination of benefits
- Has no defect or error (including any new procedures with
- Has no defect or error (including any new procedures no CPT* codes, experimental procedures or

other circumstances not contemplated at the time of execution of your agreement) that prevents timely adjudication

Claims Payment Time Frames

Aetna processes clean claims according to the following time frames:

- 90% of clean claims will be adjudicated within 30 days of receipt
- 99% of clean paper claims will be adjudicated within 90 days of receipt

If applicable, providers paid on a capitation basis will be paid according to the time period specified in your provider agreement with Aetna. Providers have a maximum of 120 days from the date of service for initial submission of a claim.

How do I submit Claims?

Using the member's ID number from the plan ID card, you'll only need to submit one claim. Your claims will automatically process first through Medicare benefits and then through Medicaid benefits. You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to submit a secondary claim to Aetna.

There are three avenues to submitting claims:

- We encourage participating providers to electronically submit claims through ECHO Health, Inc. Use submitter ID **#128VA** when submitting claims to Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP).
- When using Availity, providers must select Aetna Better Health and NJ-VA MAP D- SNP as the Payor due to Aetna's claims administration system for this plan.
- For paper claims submissions, please use submitter ID **#128VA** when submitting claims to Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP). Paper claims should be sent to the following address:

Aetna Medicare Better Health (HMO D-SNP)
Or Aetna Medicare Assure Value (HMO D-SNP)
PO Box 982980
El Paso, TX 79998-2967

Claims submission tips

To ensure accurate and timely claims payment:

- Review rejection reports from your vendor
- Correct and resubmit rejected claims electronically through your vendor
- Ensure the member and patient names and ID numbers are correct
- Ensure procedure and diagnosis codes are valid

Disagree with a claim decision?

Initiate a claim dispute by using any of the ways below.

Online

If you are registered for our Provider Portal, submit a Claim Status Inquiry transaction. If the claim is eligible to dispute, you'll see a Dispute Claim button. (Read more about how dispute a claim online in the "Electronic solutions" section.)

Mail

If your practice management or hospital information system requires a claims address for submission of electronic claims, or if your office does not have electronic capabilities, the claims address is:
Aetna Medicare Better Health (HMO D-SNP)
Payer ID#128VA
PO BOX 982980
El Paso, TX 79998

Resubmitted claims should be clearly marked *"Resubmission"* on the envelope.

Coordination of benefits

Coordination of benefits (COB) establishes the order in which benefits are paid and the amount by which the secondary plan may reduce its benefits. COB ensures that the combined payments of all plans do not add up to more than the covered health care expenses. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.
We coordinate benefits as allowed by state or federal law following the National Associations of Insurance Commissioners (NAIC) guidelines. If there is no applicable law, then we coordinate according to the member's plan.
We use 100% Allowable (Standard Allowable Calculation) method to calculate COB:

- This is the method used under most state laws.
- The benefits paid by both plans will equal no more than the total allowable expense.
- An allowable expense is defined as any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom the claim is made

Medicare and Medicaid dual eligibles

If the primary plan benefit is equal to or more than the Aetna benefit, then Aetna will not pay a benefit.
If the primary plan benefit is less than the Aetna benefit, then Aetna will pay the difference between the primary plan's benefit and the Aetna benefit.
Medicare and Medicaid "dual eligibles" are individuals who are entitled to both Medicare Part A and/or Part B and are enrolled in the Medicare Savings Program or Medicaid.
If a dual eligible enrolls in the Aetna plan, then the provider must bill Aetna as the primary payer and the state Medicaid plan as the secondary payer. If you have questions about who pays first, or you need to update your other insurance information, call Provider Services. Please have the member ID number to your other insurers so your bills are paid correctly and on time.
Note: State mandates take precedence over Aetna standards.

The National Advantage™ Program

The National Advantage Program provides medical cost management on covered services that are not provided within the network.
The National Advantage Program could apply on your claims when your broad network rate is not applicable to a specific plan such as a narrow or nonnetwork plan (such as a custom, performance, accountable care organization, or indemnity plan).
The hierarchy of rates is:

1. Your contracted rates for the product
2. The National Advantage Program rate, if specified, or the non-gated plan rate, if the National Advantage Program rate is not specified.

While most plans that participate in the National Advantage Program include the National Advantage Program logo on the members' ID cards, National Advantage Program rates may still be applicable.
Under the National Advantage Program, providers may only bill for copayment, coinsurance, or a deductible.

Coding

As changes to coding are published by nationally recognized coding entities, we will update our internal systems and practices, as appropriate. Updates may include assignment/reassignment of codes to service groupings and/or other updates that are consistent with Aetna policies and applicable law. Until any updates are complete, services may be subject to the standards and coding set for the prior period.

Claims payment policy

The rates and compensation under your agreement are subject to Aetna's coding/claim edit policies.

Rebundling

We rebundle claims to the primary procedure codes for those services considered part of, incidental to, or inclusive of the primary procedure. Rebundling allows for other adjustments such as inappropriate billing or

coding. Examples of these include:

- Duplicative procedures or claim submissions
- Mutually exclusive procedures
- Gender and procedure mismatches
- Age and procedure mismatches

The software packages that we use includes rebundling logic. This logic is based on Medicare and/or other industry standards.

Diagnosis-related group (DRG)

A diagnosis-related group (DRG) is the most widely used strategy for classifying acute care hospital patients and measuring the case mix. The most common principal diagnosis is the condition primarily responsible for the admission of the patient to the hospital for care.

Our payment policies are designed to help us pay providers based on the code that most accurately describes the procedure that was performed.

A DRG interim bill

An interim bill (also known as a split bill) allows a hospital to submit a claim for a portion of the patient's hospital stay.

We will reimburse the first interim bill from a facility with a DRG payment methodology, based on the admitting information, and will reimburse the balance when we receive the final bill. Visit **Availity.com** to learn more about billing.

Overpayment recovery

For the plan, overpayment notifications are typically sent within 60 days of the payment issue date. Time frames are subject to change in order to comply with regulatory or legislative requirements.

procedures and practices (e.g., DRG assignment), which may be updated from time to time, and which may consider actual services performed and the setting in which they are provided.

Audits

Hospital bill audit

The purpose of a hospital bill audit is to review the itemized bill against the claim and the medical record. This audit is used on claims where we pay a percentage of billed dollars (charges). In addition, the audits identify items that may not have been ordered by the physician or were not supported in the medical record. The audits exclude outpatient hospital claims paying a percent of billed dollars (charges).

Diagnosis-related group (DRG) audit

DRG audits ensure diagnosis and procedures codes are assigned accurately through medical record audits. A detailed narrative and proposed DRG revisions are presented to the provider for acceptance.
A DRG short-stay audit is a post-service, post- payment review of Medicare risk inpatient claims paid under a DRG methodology to validate that the provider appropriately billed and received payment for the setting of care in which the patient was treated.

Implant audit

Implant audits ensure providers are complying with the contract cost limitation language on implants and high cost drug reimbursement. This audit focuses on claims that bill with revenue codes 274–279. Implant audits occur through review of implant log/invoice and Medication Administration Record. A detailed narrative is sent to the provider with the audit findings.

Prepay review

We may review our members' medical records before certain claims are processed. This review includes, but is not limited to, itemized bills or more specific detail
for claims contracted on a percentage-of-charges basis. The review may result in payment being denied for duplicate charges, errors in billing or categorization of capital equipment.

Medical Records

Record keeping - Participating practitioner medical record criteria

Aetna® health plans have established medical record criteria and documentation standards. Their intent is to facilitate communication and coordination of care and promote effective patient care. These criteria provide a guideline for organizing and documenting diagnostic procedures and treatments.
We expect all participating practitioners to comply with these documentation standards, as well as state laws and regulations that require biennial medical record audits.

Records maintenance and access

You need to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. You are required to keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

Member record access

We have the right to access confidential medical records of Aetna® members for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing utilization management functions. We may request medical records as a part of our participation in the Healthcare Effectiveness Data and Information Set (HEDIS®).
HIPAA privacy regulations allow for sharing of protected health information (PHI) for the purpose of making decisions around treatment, payment or health plan operations.

Privacy practices

Protecting our members' health information is one of our top priorities. Our members expect and rely on us

to protect their protected health information (PHI). In turn, we expect our participating physicians, facilities, and office staff to safeguard our member's PHI, and treat it with the same care and consideration. Our references to PHI include information that relates to:

- A patient's physical or mental health or condition
- The provision of health care to the patient
- Payment for the provision of health care to the patient Our references to PHI do not include:
- Publicly available information
- Information that is available or reported in a summarized or aggregate fashion but does not identify the patient

We use PHI internally or share it with our affiliates when it is necessary or appropriate to do so. For example, in connection with a patient's care or treatment, the operation of our health plans, or other related activities. In these circumstances, we may disclose PHI to:

- Health care professionals
- Payers, including:

-Health care provider organizations
-Self-funded health plans
-Others who may be financially responsible for payment for the services or benefits patients receive under their plans)

- Other insurers, third-party administrators, vendors, consultants, government authorities and their respective agents

The ways in which we use PHI include:

- Auditing and anti-fraud activities
- Coverage reviews
- Claims Payments
- Compliances with legal and regulatory requirements
- Coordination of care and benefits

- Data and information systems management
- Disease and case management
- Due diligence activities in connection with the purchase or sale of some, or all, of our business.
- Early detection
- Formulary management
- Health claims analysis and reporting
- Health services research
- Litigation proceedings
- Performance measurement and outcome assessments
- Preventive health
- Quality assessment and improvement activities
- Transfer of policies or contracts to and from other insurers, HMOs, and third-party administrators or sale of some or all of our business
- Underwriting activities
- Utilization reviews and management insurers, HMOs, and third-party administrators or sale of some or all of our business

Like Aetna, providers are covered entities under HIPAA. They are required to keep PHI confidential, and to adhere to their obligations under the HIPAA Privacy Rule. All health care professionals and employed staff who have access to member records or confidential member information should be made aware of their legal, ethical, and moral obligations regarding member confidentiality.
The federal Department of Health and Human Services provides helpful information. This includes but is not limited to information on the obligations of Covered Entities.

aetna®

Referrals

Referral policies

The plan doesn't require you to get a referral from your PCP to see a specialist.
In benefits plans that require the issuance of referrals for specialist care, the primary care physician is responsible for coordinating their patients' health care. If it's necessary for the patient to see a specialist, other than for direct-access services or emergency care, the primary care physician must issue a referral prior to the patient's visit to the specialist. The referral must be for covered benefits under the plan.
To confirm covered benefits, you can submit an inquiry through the Eligibility and Benefits Inquiry transaction or call the number on your patient's member ID card. Referrals should not be retroactive.
In addition to the requirement that primary care physicians review every referral issued by their practice, we recommend that the initial consultative referral be authorized for one visit, except when the patient is either known to have a predicted need for more visits or involved in an ongoing process of care.
This encourages communication from the specialist to the primary care physician.
After an initial consultation, additional referrals from the primary care physician are required if the specialist:

- Wishes to provide additional services not originally requested on the referral
- Refers their patient to a second specialist
- Requires visits that will exceed the number of visits initially authorized by the primary care physician
- Will need an extension beyond the referral expiration date

We require specialists to communicate with the primary physician in a timely fashion. After receiving the consultation report from the specialist, the primary care physician can consider the appropriate course of treatment (for example, referrals for additional services and/or follow-up care, if needed).Referrals may be authorized for consultation and treatment (C&T) using CPT** code "99499."
Specialists will be reimbursed for any associated covered procedure performed in an office setting, in accordance with current claims processing guidelines.
Referrals do not permit specialists to refer members to another specialist for care. If this is necessary, patients must get a referral from their primary care physician to see another specialist. Referral is not a guarantee of payment. Payment is subject to eligibility on the date of service, plan benefits, limitations and exclusions, pre- existing condition limitations, and patient liability under the plan.
No plans require a referral for emergency services. Some plans do not require the issuance of a referral. In those plans, a patient may self-refer to either participating or nonparticipating physicians or other health care professionals. The patient is responsible for paying any applicable copayment, deductible and/or coinsurance for self-referred benefits.
We may terminate our agreement if you refer members to nonparticipating providers without one of the following:

- Sound clinical reasons
- Our advance approval
- Emergency services
- The member's request for referral to an out-of- network provider after notice and informed consent of the patient has been documented in writing

Referral processes

Referrals can be made through Availity or by calling Provider Services. Referrals are not required by the plan, but may be required by individual specialist providers.

Utilization and Care Management

Overview

Our Care Management model integrates available programs and services. This includes case management, disease management and specialty areas such as behavioral health. Our role is to help coordinate health care and

to encourage members to be informed participants in health care decision- making.
Our care management activities for hospitalized members include:

- Focused discharge planning to help with the member's transition to the next level of care
- Targeted, concurrent review of the member's hospital course of treatment to evaluate the appropriate level of coverage* for medical services

Utilization management and standards

We use utilization review to promote adherence to accepted medical treatment standards. Additionally, utilization review encourages participating physicians to minimize unnecessary medical costs consistent with sound medical judgment. We expect participating providers to adhere to the following requirements:

- Participate, as requested, and collaborate with Aetna utilization review, care management and quality improvement programs and with all other related programs (as modified from time to time) and decisions with respect to all members.
- Regularly interact and cooperate with Aetna clinicians.
- Abide by Aetna participation criteria and procedures, including site visits and medical chart reviews, and submit to these processes biannually, annually, or otherwise, when applicable.
- Cooperate to help us review and transition members hospitalized in a nonparticipating facility to a participating facility.
- Obtain advance authorization from Aetna prior to any nonemergency admission. In addition, when a member requires an emergency hospital admission, notify us, according to our rules, policies and procedures in effect.
- To the extent medically appropriate and required by the plan's terms, refer or admit members only to participating providers for covered services. Provide these providers with complete information on treatment procedures and diagnostic tests performed prior to the referral or admission.
- Abide by CMS's Medicare Outpatient Observation Notice (MOON) requirement provided to members and related to observation services.

You may have an Aetna patient who requires services under an Aetna specialty program. If they do, we expect accepted medical treatment standards. Additionally, utilization review encourages participating physicians to minimize unnecessary medical costs consistent with sound medical judgment. We expect participating providers to adhere to the following requirements:

- Participate, as requested, and collaborate with Aetna utilization review, care management and quality improvement programs and with all other related programs (as modified from time to time) and decisions with respect to all members.
- Regularly interact and cooperate with Aetna clinicians.
- Abide by Aetna participation criteria and procedures, including site visits and medical chart reviews, and submit to these processes biannually, annually, or otherwise, when applicable.
- Cooperate to help us review and transition members hospitalized in a nonparticipating facility to a participating facility.
- Obtain advance authorization from Aetna prior to any nonemergency admission. In addition, when a member requires an emergency hospital admission, notify us, according to our rules, policies and procedures in effect.
- To the extent medically appropriate and required by the plan's terms, refer or admit members only to participating providers for covered services. Provide these providers with complete information on treatment procedures and diagnostic tests performed prior to the referral or admission.
- Abide by CMS's Medicare Outpatient Observation Notice (MOON) requirement provided to members and related to observation services.

Note: For these purposes, coverage means either of the following:

- The determination of whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefits plan
- The determination of where a provider is required to comply with our utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement you to work with us to transfer the member's care to a specialty program provider.

How to contact us about utilization management issues

- Our staff, including medical directors, are available to receive provider and member inquiries about utilization management issues. You can call us during and after business hours via toll-free phone numbers.
- Health care providers may contact us during normal business hours (8 AM to 8 PM, 7 days a week) by calling the toll-free precertification number on the member ID card.
- When only a Member Services number is on the card, you'll be directed to the Precertification Unit through a phone prompt or a Member Services representative.
- Members and providers may access staff on weekends, holidays, and after business hours through the same toll-free phone numbers.

plan members if they do not get precertification.

Utilization review policies

Summaries of utilization review policies, including precertification, concurrent review, discharge planning and retrospective review are located on our public website to determine:

- Whether or not the particular service or treatment is a covered benefit under the member's benefits plan
- When a provider is required to comply with Aetna® utilization management programs
- Whether or not the particular service or treatment is payable under the terms of the provider agreement

How do we determine coverage?

Aetna medical directors make all coverage denial decisions that involve clinical issues. Only Aetna medical directors and licensed dentists, oral and maxillofacial surgeons, psychiatrists, psychologists, board-certified behavior analysts-doctoral (BCBA-D) and pharmacists make denial decisions for reasons related to medical necessity. (Licensed dentists, pharmacists and psychologists review coverage requests as permitted by state regulations.) Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state. Patient Management staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review. Staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition:

- State-mandated use of particular criteria and guidelines
- MCGTM guidelines (Seattle, WA: MCG Health, LLC)
- Clinical Policy Bulletins (CPBs) or Pharmacy Clinical Criteria — Clinical Policy Bulletins (PCPBs) (based on peer-reviewed, published medical literature)
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and the Medicare Benefit Policy Manual
- National Comprehensive Cancer Network (NCCN) Guidelines
- Level of Care Assessment Tool (LOCAT)
- Applied Behavior Analysis (ABA) Medical Necessity Guide
- The American Society of Addiction Medicine (ASAM) Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition.

This content is copyrighted. Contact the American Society of Addiction Medicine at **ASAMcriteria@asam.org** for information on how to purchase it. Participating physicians may ask for a hard copy of the criteria that were used to make a determination by contacting our Provider Contact Center at **1-855-463-0933 (TTY: 711)** We base decisions on the appropriateness of care and service. We review coverage requests to determine if the requested service is a covered benefit under the terms of the member's plan and is being delivered consistent with established guidelines. Aetna offers providers an opportunity to present additional information and discuss their cases with a peer-to- peer reviewer as part of the utilization review coverage determination process. The timing of the review incorporates state, federal, CMS and NCQA requirements. If we deny a request for coverage, the member (or a physician acting on the member's behalf) may appeal this decision through the complaint and appeal process. Depending on the specific circumstance, appeals may be made, as applicable to:

- A government agency
- The plan sponsor
- An external utilization review organization that uses independent physician reviewers

Admissions protocol

In the case of referred care, the admitting physician must electronically submit or contact us for preadmission precertification.* In the case of self-referred care, the member must contact Aetna®. Our precertification staff also takes calls from hospital admissions personnel. However, if the preadmission information isn't complete, we contact the admitting physician for clarification. If the admission is precertified for surgical cases, we assign a recommended length of stay (RLOS). This determines when a review will start. For other cases, we give specific guidelines with the admission precertification. The RLOS determination is primarily based on Milliman Care Guidelines®.

Notify us of hospital admissions within one business day

We need notice of all inpatient admissions, including those through the emergency department, within one business day of the admission. If a patient is unable to provide coverage information, you must contact us as soon as you become aware of their Aetna coverage. You must also explain any extenuating situation. You may contact us by phone (call the number on the patient's member ID card) or through electronic data interchange (EDI) through our **Provider Portal.**

All-products precertification list Precertification

The process of collecting information before inpatient admissions and certain ambulatory procedures and services.

The process includes:

- Confirmation of member eligibility
- Assessment of medical necessity
- Communicating a coverage decision to the treating practitioner and/or member before the procedure, service or supply
- Identifying members for pre-service discharge planning
- Identifying and registering members for covered Aetna specialty programs, such as case management and disease management, behavioral health, the National Medical Excellence Program and the Aetna Maternity Program

If we need to review the applicable medical records, we may provide you with, and you need to agree to accept, a precertification reference pending or tracking number. The reference number is not an approval. You will be notified once a coverage decision is made. Medical records may be submitted using our provider portal.

Note: The term "precertification" refers to the utilization review process used to determine whether the requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage. Precertification may be the member's responsibility in certain plan types that offer out-of-network benefits. Per Medicare laws, rules and regulations, there is no penalty to Medicare Advantage

Member Programs and Resources

We offer many programs that some of your Aetna® patients may benefit from. If they qualify, there's no extra charge for them to join. We review our members' records to see who might be a good candidate for some of these programs. If we feel a member would benefit from joining, we reach out to them directly. We inform them about the program and invite them to participate. These programs are not a substitute for regular visits to a physician. They are meant to support the member's physician. Through some of these programs, we work directly with the member. If that is the case, we apprise the physician of the member's health status as appropriate.

If you feel any of your Aetna patients would benefit from one of these programs, let us know by calling the Provider Contact Center. Your Aetna patients can also contact us about these programs by calling the number on their member ID cards.

Member programs

Care management

Our care management programs are designed to help members achieve their optimal health.

Program areas include:

- Disease management
- Case management
- End of life
- Transplant
- Women's health and maternity
- Integrated clinical programs for behavioral health, disability and pharmacy, as well as wellness programs

Disease management

Our disease management program is designed to help your patients work with their doctors. The goal is to effectively manage ongoing health conditions and improve outcomes.

Participants have access to nurse care managers, who are available to provide education and support.

Participants may also have access to some or all of the following:

- One-on-one work with an Aetna nurse, who acts as their "personal health coach"
- Personalized information about their current health conditions and issues
- Educational information about multiple aspects of their medical condition(s), treatment options and medications
- Support in making lifestyle changes to achieve and maintain optimal health

Our disease management programs are included. For additional information or to refer your patients, call the Member Services number on the member's ID card.

Aetna® members have access to a disease management program. It includes diabetes, coronary artery disease, cerebrovascular disease and stroke, and congestive heart failure. The program offers information and tools to help these members better control their conditions. For more information or to refer members, call the Member Services number on the Aetna member ID card.

Fitness programs for Aetna

Aetna offer fitness benefits through a program called SilverSneakers® which is administered by Tivity Health. Medicare Members and providers can contact Member Services to determine if the fitness benefit is available and which program option is offered.

Member resources

24-hour Nurse Line

The 24-hour Nurse Line puts members in touch with registered nurses 24 hours a day, 7 days a week. The nurses can provide information on thousands of health issues, medical procedures and treatment options. They can also offer members suggestions for communicating more effectively with their doctors.

You can reach us at **1-855-463-0933 (TTY: 711)**, 24 hours a day, 7 days a week

Behavioral health

Check out information on the **Behavioral Health** page. There, you'll find:

- Information on behavioral health treatments
- Information on substance abuse treatments
- Peer to Peer and Family to Family Recovery help
- Information on other Behavioral Health programs

Behavioral health Appointment Availability standards

Service	Emergency Services	Non-Life Threatening Emergency	Urgent – No Immediate Danger	Preventative & Routine Care	Wait Time in Office Standard
Time Frame	Immediately	Within 6 hours	Within 48 hours	Initial visit: Within 10 business days of the original request	No more than 45 minutes

Additionally, behavioral health providers are contractually required to offer:

Service	Follow-up BH Medication Mgt.	Follow up BH Therapy	Next Follow-up BH Therapy
Time Frame	Within 3 months of first appointment	Within 10 business days of first appointment	Within 30 business days of first appointment

Screening for coexisting behavioral health and substance use disorders

Do you have Medicare-Medicaid Dual-eligibility Special Needs Program (D-SNP) members? Our behavioral health clinical team works with **D-SNP** members to identify those who may have a behavioral health and/or substance use disorder diagnosis.

These members will receive:

- An initial screening for coexisting mental health and substance use disorders using evidenced based screening tools
- A individualized care plan (if the screening shows the co-existing conditions)
- A behavioral health care manager who, as a part of the care team, will help maintain continuity of care

How to make a referral

Help make sure these members get the quality care they need. Refer them to **Aetna D-SNP**. Resources:

- Aetna emotional well-being resources
- U.S. Centers for Medicare & Medicaid Services Roadmap to Behavioral Health
- U.S. Substance Abuse and Mental Health Services Administration

Pharmacy Management & Drug Formulary

Overview of the Pharmacy Plan Drug List (formulary)

Providers should prescribe medications according to the applicable drug formulary(ies). We may modify the drug formulary(ies) from time to time.

Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP) Prescription Drug Plans

You can find the Medicare prescription drug formularies at the following links:
www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/snp-prescriptions

Requirements for Part B drugs

Under Medicare Advantage plans, some medically administered Part B drugs, like injectables or biologics, may have

special requirements or coverage limits. One of these special requirements or coverage limits is known as step therapy, in which we require a trial of a preferred drug to treat a medical condition before covering another non-preferred drug. See the Aetna Part B step therapy list.

How your patients can learn more

To learn more, encourage members to visit our Aetna member website. Once logged in, instruct them to select **Pharmacy** at the top of the page.

Treating complex diseases and chronic conditions

Some specialty medications and infusion therapies are available only through limited distribution networks. CVS Specialty® works hard to monitor the FDA pipeline. It is part of our effort to get access to new specialty therapies quickly. If CVS Specialty gets a prescription order for a therapy we don't have access to, our team responds without delay. We return the referral/prescription back to the sending source advising them who can service (if known).

Ordering through CVS Specialty is easy

- E-prescribe: NCPDP ID# 1466033
- Fax: 1-800-323-2445
- Phone: 1-800-237-2767 (TTY: 711)

Physicians can enroll for ePrescribe by visiting the CVS Specialty website. Prefer to fax? Print and complete an enrollment form.

Electronic Prescribing

Physicians use e-prescribing technology to input prescriptions through an electronic medical record (EMR) using a tablet, smartphone or desktop computer. Physicians can send orders electronically to the patient's pharmacy, eliminating the need for patients to physically take the prescription to their pharmacy. Electronic prescribing also helps:

- Reduce paperwork and result in faster, more accurate information
- Simplify the prescribing process for physicians and patients
- Reduce medication errors resulting from unreadable handwritten prescriptions

The CVS Health® Payer Solutions tries to integrate our pharmacy information with our clinical support tools. Our goal is to make insightful connections that can help us identify and act on opportunities to help improve member health.

Learn more about e-prescribing products and services.

Precertification

Most members with Aetna pharmacy benefits may have a plan that includes precertification. These drugs require an extra coverage review before they are covered. Precertification is based on current medical findings, FDA-approved manufacturer labeling information and guidelines, and cost and manufacturer rebate arrangements. Visit our website to determine which medications may require precertification.

If you have questions, call our Provider services phone number **1-855-463-0933**

Step Therapy

Some members may have a plan that includes step therapy. With step therapy, certain drugs are not covered unless members try one or more preferred alternatives first. Step therapy is based on:

- Current medical findings
- U.S. Department of Food and Drug Administration (FDA)-approved manufacturer labeling information
- FDA guidelines
- Cost and manufacturer rebate arrangements

If it is medically necessary, a member can get coverage of a step therapy drug without trying a preferred alternative first. In this case, a physician, patient or a person appointed to manage the patient's care must request coverage for a step therapy drug as a medical exception. The drugs requiring step therapy are subject to change. You'll find current step therapy requirements on our website. If you have questions, call our Provider services phone number **1-855-463-0933**

Quantity limits

We also limit coverage on the quantity of certain drugs. Quantity limits are established using medical guidelines and FDA-approved recommendations from drug manufacturers. The quantity limits include the following:

- Dose efficiency edits: limits coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing.
- Maximum daily dose: a message is sent to the pharmacy if a prescription is less than the minimum, or higher than the maximum, allowed dose.
- Quantity limits over time: limits coverage of prescriptions to a specific number of units in a defined amount of time.

You, your patient or the person appointed to manage the patient's care may request a medical exception for coverage of amounts over the allowed quantity. Contact **Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP)** to request an exception.

Medical exception and precertification

You can ask for a medical exception for coverage of drugs on the Formulary Exclusions List or the Step Therapy List or request prior authorization or exceptions to quantity limits. Physicians, patients or a person appointed to manage the patient's care can contact the Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP) Precertification Unit. To contact us, see the options below

	Phone	Fax	Online
Medicare Part B	**1-855-463-0933** (Follow the Prompts)	**1-877-270-0148**.	aetna.com/health-care-professionals/medicare/part-b-drug-um.html#criteria
Medicare Part D	**1-855-463-0933** (Follow the Prompts)	**1-877-270-0148**.	

Prescribing providers can download the drug specific prior authorization form or general pharmacy prior authorization forms from the health plan website. To support the timely review of the prior authorization request, prescribers are asked to supply the following information:

- Member's name, date of birth, and identification number
- Prescribing practitioner's/provider's name, and telephone and fax numbers
- Medication name, strength, frequency, quantity, and duration
- Diagnosis for which medication is prescribed
- Other medications tried for the same indication
- Medical records to support the necessity for the authorization (e.g. non-formulary drug, age limit, QLL, or ST override, generic override, or vacation overrid

Transition-of-coverage (TOC) policy

CMS requires Part D plan sponsors, like Aetna®, to have an appropriate TOC process. Members who are taking Part D drugs that are not on the plan's formulary or that are subject to utilization management requirements can get a transition supply of their drug in certain circumstances. This gives members the opportunity to work with their doctors to complete a successful transition and avoid disruption in their respective treatments.

Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP) has established a TOC process in accordance with CMS requirements that applies to new members as well as current members who remain enrolled in their Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP) from one plan year to the next.

The following is a summary of the key features of Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP)'s TOC process.

Newly enrolled members who are taking a Part D drug that is not on the formulary, or is subject to a utilization management requirement or limitation (such as step therapy, pre-authorization or a quantity limit), are entitled to receive a maximum of a 30-day supply of the Part D drug within the first 90 days of their enrollment. (The period of time in which they are entitled to receive the transition supply is called their "transition period.")

Existing members who renew their Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP) coverage and are taking a Part D drug that is removed from the formulary, or is subject to a new utilization requirement or limitation at the beginning of the new plan year, are entitled to receive a maximum 30-day supply during their transition period. For existing members who renew their Aetna Medicare Better Health (HMO D-SNP) & Aetna Medicare Assure Value (HMO D-SNP) coverage from one year to the next, their transition period is the first 90 days of the new plan year.

Whether an individual is a new or renewing member, if the member's initial prescription is for less than the full transition amount (30 days), the member can get multiple fills up to the 30-day supply. If a member lives in a long-term care facility and is entitled to a transition supply, Aetna will cover a 31-day supply (unless the prescription is for fewer days).

Members may also be entitled to receive a transition fill outside of their transition period in certain circumstances.

We send a TOC notice to members via first-class mail within 3 business days from the date the transition fill claim is processed. The letter:

- Notifies members that the transition fill was a temporary supply
- Describes the options available to the member if the drug for which they received the transition fill is not on the formulary or is subject to a utilization management requirement or restriction (including changing to a therapeutic alternative, or seeking an exception or prior authorization, as appropriate)
- Describes the procedures for requesting an exception or prior authorization
- Encourages members to work with their respective doctors to achieve a successful transition so they can continue to receive coverage for the drugs they need A duplicate copy of the notice is sent to the prescribing physician.

To contact us, call Aetna at **1-855-463-0933** or fax the prescription drug coverage determination form to **1-877-270-0148**.

Performance programs

We use practitioner and provider performance data to help improve the quality of service and clinical care our members receive, if certain thresholds are met. Accrediting agencies require that you let us use your performance data for this purpose.

Quality, accreditation, review and reporting activities

We expect providers to cooperate with any of our quality activities, or any review of Aetna®, a payer or a plan by:

- The National Committee for Quality Assurance (NCQA)
- The Utilization Review Accreditation Commission (URAC) or other applicable accrediting organizations
- A state or federal agency with authority over Aetna and/ or a plan, as applicable

We expect our network providers to comply with our reporting requirements. These include Healthcare Effectiveness Data Information Set (HEDIS) and similar data collection and reporting requirements.

Patient-centered medical home (PCMH)

PCP practices can participate as a PCMH in two ways:

- Direct contract via an amendment to a physician or group agreement
- Via the Aetna external PCMH recognition program
- Each arrangement has its unique parts, but they all generally include these two requirements:
- NCQA or other accepted organization's PCMH recognition, preferably Level 3 with a fully implemented electronic medical record (EMR) process
- Adherence to the seven principles of PCMH (as promoted by the PCPCC)

These two requirements cover many terms and standards, such as:

- Case management
- Enhanced access for patients
- ePrescribing
- Measures tracking
- Patient registries

Our PCMH Recognition programs are designed to:

- Meet the triple aim of improved efficiencies, clinical outcomes and patient satisfaction
- Help establish a sufficient amount of PCMH sites to enable us to offer the advantages of a benefits plan featuring PCMHs to plan sponsors. Under this type of plan, members would choose a PCMH PCP practice for their primary care services

A direct contract is available in all markets to all providers that include PCPs and is executed via a signed amendment to the provider's current participation agreement. The external PCMH recognition program is only available in markets that Aetna decides to implement.

Clinical Medical Management

Model of Care

Aetna Special Needs Plan (HMO SNP) is available to people who have Medicare and who are enrolled in a Medicare Savings Program or receive Medicaid. Aetna is committed to serving the needs of all dual eligible individuals, and through our Special Needs Plan we offer our members additional benefits and services not covered under Medicare. To ensure our member's care, Aetna operates, coordinates and manages performance. Our model of care is designed to leverage best practices and internal capabilities and expertise to utilize common core operations/functions and limit replication in markets or segments unless required by state. The eight (8) Goals of the Model of Care are:

- Increase access to Care
- Improve Quality Services
- Create affordability of services
- Integrate and Coordinate Care
- Improve health outcomes
- Encourage appropriate use of services

- Improve use of preventative health services
- Provide seamless transitions
- The initial Health Risk Assessment (HRA)is completed with the member within 1st 90 days and then annually- this tool identifies member needs and prioritized care needs and services The Individualized Care Plan(ICP) developed and is maintained for each member. The ICP is a summary of health needs, personal goals and service options.

Clinical practice and preventive service guidelines

Evidence-based clinical practice and preventive services guidelines from nationally recognized sources promote consistent application of evidence-based treatment methodologies. This helps to provide the right care at the right time. For this reason, we make these guidelines available to our network providers to help improve health care

These guidelines are provided for informational purposes only. They aren't meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines don't dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case. Evidence-based guidelines can be found on various nationally recognized sources. Here are links to some of those sources.

Clinical practice guidelines

- American College of Cardiology and American Heart Association
- American College of Obstetricians and Gynecologists
- Agency for Healthcare Research and Quality
- American Diabetes Association
- American Psychiatric Association
- Journal of the American College of Cardiology
- National Heart, Lung and Blood Institute

Behavioral health clinical practice guidelines

- American Academy of Pediatrics (AAP)
- Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
- American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder
- American Psychiatric Association (APA) Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder
- American Psychiatric Association (APA) Guideline for the Treatment of Patients with Substance Use Disorders
- Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain Preventive services guidelines
- Centers for Disease Control and Prevention Immunization Schedules
- U.S. Preventive Services Task Force

Case management

According to the Case Management Society of America's website, "Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes. "Case management is a standard component of most Aetna® medical plans.
The foundation of the case management program is evidence-based medical literature and clinical practice guidelines. There are both automated and manual processes to identify members for case management through a variety of methods.

Case managers coordinate care and services for complex case management members who require the extensive use of resources as a result of a critical event or diagnosis. Case managers assist these members with navigating the health care system in order to facilitate the appropriate delivery of care and services.
Case management screening occurs before member outreach in order to determine member eligibility and the appropriateness of case management service We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card.
Once we decide that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan that's specific to the member's situation and needs.
Clinical care management staff, in coordination with the attending practitioner, member, or the member's representative, develop an individualized case management plan based upon an assessment of the member's situation and needs. The case management plan includes documentation of prioritized goals, which are specific, measurable, and time-bound, and reflective of issues that the member assessment identifies.
Targeting the case manager's activities helps to identify issues, remove barriers to care, and facilitate the achievement of the member's health goals.
There is regular review, monitoring and evaluation of the progress in meeting case management plan goals and objectives for each member active in case management. Case closure occurs once there is resolution of all member issues and barriers and/or the member meets case closure criteria.

Coordination of Care

Importance of collaboration

We monitor and try to improve coordination and collaboration between treating providers of care. Results from our annual Physician Practice surveys have shown that physicians continue to be concerned that they do not regularly receive reports about their patients' ongoing evaluation and care from other practitioners and facilities. These include medical specialists, behavioral health practitioners, skilled nursing facilities, home health agencies, surgical centers or hospitals. The increased focus on patient safety in the medical community also highlights the critical nature of improving collaboration between treatment providers.

Sharing patient information

Increased treatment compliance and improved outcomes have been attributed, in part, to collaboration between providers. In addition, the quality of communication is rated as an important factor considered by primary care physicians when choosing a specialist to whom they can refer their patients.
To this end, we strongly encourage you to send progress notes and discharge summaries to your patients' other treating practitioners

Accessing communication forms

You can access these forms on our provider website.
We appreciate your efforts to close the communication gap between specialists, facilities and primary care physicians and promote improved patient care and safety.

Transition of care

Transition of care provides a temporary bridge for members at the time of plan enrollment or renewal. Members in an active course of covered treatment that meets clinical coverage criteria/guidelines with a treating provider may be eligible for transition of care coverage consideration. The treating provider must fall under one of these categories:

- Is not a contracted provider in the member's plan
- Is not a practitioner designated for inclusion within a tiered network (Aetna® Performance Network) or Aexcel® specialty categories when a specific practitioner or provider network is applicable to the member's plan
- Is not included within a plan sponsor-specific network

Additionally, the treating provider must be an individual practitioner (for example, a specialist, physical therapist, or speech therapist) or home care agency in order to be eligible for the transition of care process

Transition of care does not apply to nonparticipating durable medical equipment (DME) vendors or pharmacy vendors. Transition of care does not apply to nonparticipating facilities, with the exception of facilities in which:

- The Aetna contract has terminated (for reasons other than quality issues)
- A treating participating practitioner temporarily has privileges only at the nonparticipating facility
- An "active course of treatment" is defined as a program of planned services that:*
- Starts on the date a physician or other health care professional first renders a service to correct or treat the diagnosed condition
- Covers a defined number of services or period of treatment
- Includes a qualifying situation (for example, a surgical follow-up)

The four steps for requesting transition of care

1. The member asks for a Transition Coverage Request Form from Member Services or their employer. The member completes the form with help, as needed, from the nonparticipating treating physician.
2. The member or nonparticipating treating physician faxes the completed form to the Aetna fax number on the form.
3. We review the information. When necessary, an Aetna Medical Director evaluates the treatment program. The director may also contact the treating physician or health care professional.
4. We send a letter about the coverage decision to the member and the nonparticipating treating physician or health care professional. If coverage is approved, the letter also includes the length of time the transition benefits apply. We also send a letter to the member's primary care physician, as applicable.

Complaints and appeals

We have a formal complaint and appeal policy for physicians, health care professionals and facilities. Physician, health care professional and facility appeals involve payment decisions (claims). A provider may also appeal pre-service or concurrent medical- necessity decisions. However, those appeals will be handled through the Member Appeal Process.

Note: The process may vary due to state-specific requirements. For more information on complaints or appeals, contact your local Aetna office.

Claim Resubmission (Corrected Claim)

A claim that is resubmitted to Aetna via the same process of a new day claim (via provider's claims tool, Aetna's claims portal, or mailed) but the claim itself has been corrected in some way and the claim is designated as 'Corrected' via Bill Type code. Paper claims should also have the word 'RESUBMISSION' written across the top of the claim. Note: Claim resubmissions are mailed to the following address:

Aetna Medicare Better Health (HMO D-SNP)
Or Aetna Medicare Assure Value (HMO D-SNP)
PO Box 982980
El Paso, TX 79998-2967

Claim Reconsiderations for PAR providers (Dispute)

A claim for a PAR provider in which the provider is not correcting the claim in anyway but disagrees with the original claim outcome and wishes to challenge the payment or denial of a claim. This requires the provider to fill out the PAR Provider Dispute Form. Alternatively, a PAR provider can also submit a Reconsideration via the secure web portal for better convenience. This requires the provider to request access to the portal.

Claim Reconsiderations for NON-PAR providers (Appeal)

A claim for a non-contracted provider in which the provider is not correcting the claim in anyway, but disagrees with the original claim outcome and wishes to challenge the payment or denial of a claim. This requires the provider to fill out the NON-PAR Provider Appeal Form.

You may submit an appeal for a claim denied based on error or absence of fact, except for timely filing. Federal regulations 42 CFR 42 § 422.504(9) requires us to protect Aetna® members from financial liability, therefore, appeals must include a signed **Waiver of Liability (WOL) Form.**

Medicare

Aetna® Medicare Advantage plans

Below is a summary of how our Aetna HMO-DSNP plans work with primary care physician (PCP) selection, referrals and out-of-network benefits.
Members may select a participating PCP; if the member doesn't select a PCP, one will be auto assigned.
The plan doesn't require you to get a referral from a PCP to see a specialist. But the specialist may still ask you for one. Members are required to receive all covered services — with the exception of emergent or urgently needed services and out-of-area renal dialysis — through network providers. Members may change the auto-assignment by contacting Aetna.
Services received outside of the Aetna participating provider network are not covered — except for emergency, out-of-area urgent care, or out-of-area renal dialysis
Aetna contracts with the Centers for Medicare & Medicaid Services (CMS) to offer the HMO-DSNP, dual-eligible plans. As such, we're considered a Medicare Advantage organization (MAO).
Go the dual eligible **plan page** for specific plan information.

Home assessment program

As part of our ongoing quality improvement efforts, we periodically offer in-home health assessments to our Aetna Medicare Advantage members. It's possible your patients may be asked to participate in this no-additional cost, comprehensive assessment. It is voluntary, performed in the patient's home by a licensed provider, and allows you access to information about your patient's home condition and environment. If one of your patients is selected to participate in this program, a summary of the completed assessment will be mailed to you.
We'll use information from the assessment to identify care management programs which may benefit the member. If you have questions about the home assessment program, call our Provider Contact Center at **1-855-463-0933 (TTY: 711)**.

Quality improvement program

An annual Chronic Care Improvement Program (CCIP) is implemented in accordance with CMS requirements. It is designed and conducted to coordinate care, promote quality and help improve member satisfaction.
The goal of the CCIP is to promote effective management of chronic disease and improve health outcomes and quality of care. Programs are available to support your patients and to help them make healthy lifestyle choices. Effective management of chronic disease can achieve positive outcomes. Examples of documented outcomes include slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency room (ER) encounters and inpatient stays, improving the member's quality of life, and providing cost savings for the member.

Prescription drugs

We administer prescription drug coverage as part of the HMO_DSNP plans.
Quantity limits, step therapy and precertification requirements apply to certain prescription drugs. **Formulary:** the Aetna HMO-DSNP prescription drug formularies can be found **here.**

Note: All formularies applicable to Dual-eligible plans are reviewed and approved by CMS.

Transition-of-coverage (TOC) policy

The Centers for Medicare & Medicaid Services (CMS) require Part D Plan Sponsors, like Aetna Medicare, to have a Transition of Coverage (TOC) process. The following applies to members who are taking Part D drugs that are not on the plan's formulary or that are subject to new utilization management requirements. These members can get a transition supply of their drug in certain circumstances. This gives them the opportunity to work with their doctor to complete a successful transition and avoid disruption in their treatment.
Aetna Medicare® has established a TOC process in accordance with CMS requirements that applies to new members as well as current members who remain enrolled in their Aetna plan from one plan year to the next. The following is a summary of the key features of Aetna Medicare's TOC process.
Newly enrolled members who are taking a drug that is not on the Aetna formulary or is subject to a utilization management requirement or limitation (such as step therapy, pre-authorization or a quantity limit), are entitled to receive a maximum of a 30-day supply of the drug within the first 90 days of their enrollment. (The period of time in which they are entitled to receive the transition supply is called their "transition period.")
Existing members who renew their Aetna Medicare coverage and are taking a Part D drug that is removed from the formulary or is subject to a new utilization requirement or limitation at the beginning of the new plan year, are entitled to receive a maximum 30-day supply during their transition period. For existing members who renew their Aetna Medicare coverage from one year to the next, their transition period is the first 90 days of the new plan year.
Whether an individual is a new or renewing member, if the member's initial prescription is for less than the full transition amount (30 days), the member can get multiple fills up to the 30-day supply. If a member lives in a long-term care facility and is entitled to a transition supply, Aetna will cover a maximum fill of 31-day supply (unless the prescription is for fewer days).
Members may also be entitled to receive a transition fill outside of their transition period in certain circumstances.
We send a TOC notice to members via first-class mail within 3 business days from the date the transition fill claim is processed. The letter:

- Notifies members that the transition fill was a temporary supply

- Describes the options available to the member if the drug for which they received the transition fill is not on the formulary or is subject to a utilization management requirement or restriction (including changing to a therapeutic alternative, or seeking an exception or prior authorization, as appropriate)
- Describes the procedures for requesting an exception or prior authorization
- Encourages members to work with their respective doctors to achieve a successful transition so they can continue to receive coverage for the drugs they need
- A duplicate copy of the notice is sent to the prescribing physician.

Additional prescription drug plan information

Days supply:

Generally, a 1-month prescription may be filled for up to a 30-day supply. A member may obtain up to a 100supply of maintenance medications from either a participating retail pharmacy or through a participating mail-order vendor.

Mail-order drug option:

A member may obtain up to 100-day supply of maintenance medications from our preferred CVS Caremark Mail Service Pharmacy.

Specialty pharmacies fill high-cost specialty medications that require special handling. Although specialty pharmacies may deliver covered medications through the mail, they are not considered "mail-order pharmacies." to antibiotics and some other drugs.

Part D drug rules

Here are three general rules that apply to Part D drug prescription coverage:

Medicare Part D cannot provide coverage opportunity to work with their doctors to complete a successful transition and avoid disruption in their respective treatments.

1. Medicare Part D cannot provide coverage for a drug that would be covered under Medicare Part A or Part B.
2. Medicare Part D cannot provide coverage for a drug that is purchased and/or consumed outside the United States and its territories.
3. Medicare Part D usually cannot provide coverage for "off-label use." Generally, coverage for "off-label use" is allowed under Medicare Part D only when the use is supported by the following reference books:

- The American Hospital Formulary Service Drug Information
- The DRUGDEX Information System
- The United States Pharmacopeia-Drug Information (USP DI) or its successor
-

Also, by law, the following categories of drugs are not covered by Medicare Part D unless enhanced drug coverage is included or offered under a particular Medicare Part D plan or benefit:

- Nonprescription drugs (also called over-the- counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs used for the treatment of anorexia, weight loss or weight gain
- Outpatient drugs that the manufacturer is selling, only if the associated tests or monitoring services are also purchased from the manufacturer

The amount a member with Medicare Part D coverage pays when filling prescriptions for these drugs does not count towards the plan deductible, initial coverage limit or qualifying for the Catastrophic Coverage Stage. Also, those eligible for the Low-Income Subsidy will not pay the plan cost-share in place of their subsidized cost-sharing.

Note: Most injectable medications and oral drugs not covered under Medicare Part B will be considered Medicare Part D drugs, but coverage will be determined by the formulary. Precertification is required for Medicare Part B situational drugs. If you have questions regarding whether a medication is covered under Medicare Part B versus Medicare Part D, contact Aetna® at **1-855-463-0933 (TTY: 711)** for assistance.

Home infusion

The following provisions only apply to providers who dispense home infusion drugs that are covered under HMO-DSNP members:

- The provider will be paid clean claims within 30 days, and the provider will be reimbursed at the rates agreed to by the provider and Aetna.
- Updates to prescription drug pricing used for payment will occur no less frequently than once every seven days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the home infusion drug.
- The provider will submit claims for home infusion drugs whenever the Medicare member's ID card is presented (or is on file), unless the Medicare member expressly requests otherwise.
- The provider must submit claims for home infusion drugs by means of a point-of-service claims adjudication system.
- The provider must provide Medicare members with access to the negotiated prices.
- The provider must apply the correct cost-sharing amount to the member, as indicated by Aetna®.
- The provider must inform the Medicare member of any difference between the price of the home infusion drug being dispensed and the price of the lowest-priced generic version, unless the home infusion drug being dispensed is the lowest-priced generic version.
- Before dispensing, the provider must ensure that the professional services and ancillary supplies necessary for home infusion drugs are in place.

The provider must provide delivery of home infusion drugs within 24 hours of Medicare member's discharge from an acute setting, unless prescribed later. The provider must submit claims for equipment, supplies and professional services associated with dispensed home infusion drugs for members.

Additional Aetna Medicare Advantage information

As outlined in Medicare laws, rules and regulations, physicians and health care professionals (and their employees, independent contractors and subcontractors) contracted with an Aetna Medicare Advantage organization ("contracted providers") must comply with various requirements. Refer to your Aetna contract for further information regarding these Medicare contractual requirements. What follows is a general summary of some Medicare requirements that apply to contracted providers.

Physician-member communications policy

Our contracts with participating providers do not contain "gag clauses." Nothing about the contract prevents the physicians or other health care professionals from discussing issues openly with their patients. We include language in our contracts to promote open physician- member communication.

Our objective is to give members the comfort of knowing that their physicians and other health care professionals have the right and the obligation to speak freely with them.

We encourage providers to discuss with their patients:

- Pertinent details regarding the diagnosis of their conditions
- The nature and purpose of any recommended procedure
- The potential risks and benefits of any recommended procedure or treatment
- Any reasonable alternatives to such recommended treatment

Demographic data quarterly attestation

We require Aetna–contracted Medicare Advantage providers to validate their demographic information quarterly as noted in our provider agreement and/or provider newsletters. Availity® will send a notification each quarter for your review and attestation. As an Aetna Medicare Advantage provider, you are obligated to comply with this validation.

If you move your office, or change other demographic information, such as your email address or phone number, go to the Provider Data Maintenance function on Availity to update your profile within seven days of the change. Do not wait for the quarterly attestation process, and do not call or fax the information to Aetna. We will get the update from the vendor and process

it accordingly.
It's important that you complete the validation and attestation requests from Availity within the allotted time frame. To do so, login to the provider portal and complete the attestation of your demographic information. We take this requirement very seriously and will act against providers who refuse to cooperate. Ultimately, this action can include termination of your participation in our Aetna Medicare Advantage networks.
The U.S. Centers for Medicare and Medicaid Services (CMS) is also encouraging health plans and providers to use the National Plan and Provider Enumeration System (NPPES) as a resource to improve data accuracy. We join CMS in reminding providers to review, update, and certify that their data is current in the **National Plan & Provider Enumeration System (NPPES)**. Accurate provider directories help Medicare beneficiaries identify and locate providers and make health plan choices.

Medicare Outpatient Observation Notice (MOON) requirement

All participating hospitals and critical access hospitals (CAHs) must adhere to the provisions of the MOON Notice Act developed by CMS. Under this act, hospitals and CAHs must deliver a MOON to any member, including Medicare Advantage members, who receives observation services as an outpatient for more than 24 hours. The MOON must be provided to members no later than 36 hours after services begin. Go to **CMS.gov/medicare/medicare-general- information/ bni/index** to find the notice and the accompanying instructions.

Medicare Medical Loss Ratio (MLR) requirements

Congress, under the Affordable Care Act, amended the MA program provisions in the Social Security Act to require MAOs to achieve an 85% MLR, beginning with contract year 2014. CMS issued regulations to implement these MLR requirements that include maintenance and access to records obligations.
These new requirements apply to any provider who:

- Is contracted with an MAO to participate in their Medicare network
- Retains medical/drug cost data that the MAO uses to calculate Medicare MLRs for which the MAO does not have independent access

Under these new regulations, MAOs "are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs." This requirement exists for 10 years from the date that such calculations were reported to CMS. Additionally, the MAO "must require any third-party vendor supplying drug or medical cost contracting and claim adjudication services" to provide the MAO with "all underlying data associated with MLR reporting … regardless of current contractual limitations." If this MA regulation is applicable to a participating provider, the provider is required to do both of the following:

- Ensure that they are retaining such data for the requisite time period (11 years from the **CMS MLR reporting date**, not the termination of the CMS contract, as referenced in existing MA regulations).
- Preserve the MAO's and government's ability to obtain data and records, as necessary, to satisfy any government information request during the 11-year period.

Advance Directives

Our contracted providers must document in a prominent place in an MA plan member's medical record whether the member has executed an advance directive. Refer
to the Member Rights and Responsibilities policy for more information on advance directives.

MA Organization Determination (OD) process

Medicare beneficiaries enrolled in MA plans are entitled to request an OD, which is a decision or determination concerning the rights of the member with regard to services covered by Medicare and/or Aetna®, and any decision/determination concerning the following items:

- Reimbursement for coverage of emergency, urgently needed services or post-stabilization care.
- Payment for any other health services furnished by a provider or supplier other than the organization that the member believes are Medicare covered. Or, if not covered by Original Medicare, should have been furnished, arranged for or reimbursed by the organization.

- Denial of coverage of an item or service the member has not received but believes should be covered.
- Discontinuation of coverage of a service, if the member disagrees with the determination that the coverage is no longer medically necessary.
-

Members can request an expedited or standard organization determination decision. We will review and process the request in accordance with the CMS requirements and time frames. If the member's request is denied, the member may exercise his or her appeal rights.

Obligation to respond to requests for records

We are required to ask our network providers to give us clinical documentation to help make coverage decisions for pharmacy or medical services. Under our contract with you, you're obligated to provide this information to us promptly upon request. Our clinical staff will contact your office by phone or fax when we need documentation.

The timelines for making coverage decisions are short and highly regulated, so it is critical that you provide us with the requested clinical information on a timely basis. If you don't, it adversely impacts your patients' access to care and results in unnecessary coverage denials. Please make sure your staff knows they must respond quickly to medical record requests. Failure to respond may impact your future participation status.

Ban of Advance Beneficiary Notice of Noncoverage (ABN)

Provider organizations should be aware that an ABN is not a valid form of denial notification for members.

ABNs, sometimes referred to as "waivers," are used in the Original Medicare program. CMS prohibits use of ABNs for members enrolled in a Medicare Advantage plan. Therefore, ABNs cannot be used for patients enrolled in Aetna® Medicare Advantage plans.

As a provider who has elected to participate in the Medicare program, you should understand which services are covered by Original Medicare and which are not. Aetna HMO-DSNP plans are required to cover everything that Original Medicare covers and in some instances may provide coverage that is more generous or otherwise goes beyond what is covered under Original Medicare.

As an Aetna contracted provider, you are expected to understand what is covered under Aetna HMO-DSNP plans. CMS mandates that providers who are contracted with a plan, such as Aetna, are not permitted to hold a members financially responsible for payment of a service not covered under the member's plan unless that member has received a pre-service OD notice of denial from Aetna before such services are rendered.

If the member does not have a pre-service OD notice of denial from Aetna on file, you must hold the member harmless for the noncovered services. You cannot charge the member any amount beyond the normal cost-sharing amounts (such as copayments, coinsurance and/or deductibles).

Providers and members can initiate pre-service ODs. You must go through this process to determine if the requested or ordered service is covered prior to a member receiving it, or prior to scheduling a service such as a lab test, diagnostic test or procedure. The procedure to request a pre-service OD is similar to the procedure to request a prior authorization. Call the number on the member's ID card and ask for a
pre-service OD to determine if the service will be covered for the member.

Once we make a determination, the member will be notified of the decision. You will only be able to charge the member for the service if the member has already received the decision from us before you render the services in question to the member and the member has signed a Waiver of Liability.

Coverage determinations and exceptions process Coverage determinations

Beneficiaries enrolled in the HMO-DSNP plan have the right to request a coverage determination concerning the prescription drug coverage they're entitled to receive under their plan, including:

- Basic prescription drug coverage and supplemental benefits
- The amount, including cost sharing, if any, that the member is required to pay for a drug

An adverse coverage determination constitutes any unfavorable decision made by or on behalf of Aetna® regarding coverage or payment for prescription drug benefits a member believes they are entitled to receive.

The following actions are considered coverage determinations:

- A decision not to provide or pay for a prescription drug that the member believes should be covered by the plan. (This includes a decision not to pay because the drug is not on the plan's formulary, is determined to not be medically necessary, is furnished by an out-of-network pharmacy, or we determine is otherwise excluded under section 1862(a) of the Social Security Act, if applied to Medicare Part D.)
- The failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the member.
- A decision concerning an exceptions request
- for a plan's tiered cost-sharing structure.
- A decision concerning an exceptions request involving a nonformulary drug.
- A decision on the amount of cost sharing for a drug.

We have both standard and expedited procedures in place for making coverage determinations.

Exceptions process

The exceptions process can be initiated for:

- Requests for exceptions involving a nonformulary drug
- Requests for exceptions to a plan's tiered cost- sharing structure

A decision by a plan sponsor concerning an exceptions request constitutes a coverage determination. Therefore, all of the applicable coverage determination requirements and time frames apply. The member, their appointed representative or the prescribing physician can submit an exceptions request either orally or in writing, via phone or fax.

- Phone: 1-855-463-0933 (TTY: 711)
- Fax: 1-877-270-0148
- Website: **https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/claims**

Medicare coverage determinations and exception requests have a strict turnaround time for completion. It is critical that you send your requests to the correct areas of Aetna so we may handle them appropriately for our members. Send all Medicare prescription drug requests via phone or fax.

- Phone: 1-855-463-0933 (TTY: 711)
- Fax: 1-877-270-0148
- Website: **https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/claims**

A complete description of our coverage determination and exceptions process, and how to contact us if you are assisting a member with this process, is available on our Aetna plan websites. Medicare beneficiaries enrolled in the HMODSNP plans members are entitled to specific CMS-mandated appeal and grievance rights. We have departments dedicated to processing all member appeals and grievances related to Medicare coverage.

Appeals and grievances are processed in accordance with the standard and expedited requirements and time frames established by CMS. Following an adverse organization determination or coverage determination, Members have the right to appeal any decision about the plan's failure to pay or provide coverage for what the member believes are covered benefits, drugs and services (including non-Medicare covered benefits). Members can appeal for coverage of medical benefits, services and drugs covered through the medical benefit.

We may ask for the cooperation and/or participation of contracted providers in our internal and external review of procedures relating to the processing of Medicare member appeals and grievances. If necessary, contracted providers should:

- Instruct the member to contact us for their appeal rights
- Inform the member of their right to receive, upon request, a detailed written notice from us regarding coverage for services
- We have both standard and expedited procedures in place for making coverage determinations.
- Promptly respond to any plan requests for information needed to review an appeal or assist with grievance resolution

Members should be directed to contact Member Services using the phone number listed on their Aetna® member ID card. In

addition, notices sent due to an adverse organization or coverage determination provide contact information and instructions for filing an appeal.
When a member appeals a denied service, drug or other benefit they believe they are entitled to, we may need clinical records from you. We require you to handle all requests for clinical records as promptly as possible.
There are expedited instances when we have less than 24 hours to respond to an appeal and your clinical information is imperative to making an accurate and timely decision.
Please note that CMS-mandated time frames do not stop due to weekends, holidays, or any other time when your office may be closed.

Confidentiality and accuracy of member records

Contracted providers must safeguard the privacy and confidentiality of, and ensure the accuracy of, any information that identifies an plan member. Original medical records must be released only in accordance with federal and state laws, court orders or subpoenas. Specifically, our contracted providers must:

- Maintain accurate medical records and other health information
- Help ensure timely access by members to their medical records and other health information
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and member information
- Provide staff with periodic training in member information confidentiality

Refer to the **Privacy Practices section** on page 33 for further information.

Coverage of renal dialysis services for Medicare members who are temporarily out- of-area

An Aetna plan member may be temporarily out of the service area for up to six months plans must pay for renal dialysis services obtained by an plan member while the member is temporarily out of their service area. These services can be from a contracted or noncontracted Medicare-certified physician or health care professional.

Direct access to in-network women's health specialists

Plan members have direct access to mammography screening services at a contracted radiology facility. They also have direct access to in-network women's health specialists for routine and preventive services.

Direct-access immunizations

Without a referral, members may receive influenza, hepatitis B and pneumococcal vaccines from any network provider. There is no cost to the member if any of these vaccinations are the only service provided at that visit.

Health-risk assessment

We offer all members the opportunity to complete a health-risk assessment within 90 days of their enrollment in a plan. The information obtained through the assessment is sent to the member's primary care physician if we have one on file.

Receipt of federal funds, compliance with federal laws, and prohibition on discrimination

Payments received by contracted providers from MAOs for services rendered to plan members include federal funds. Therefore, a contracted providers are subject to all laws applicable to recipients of federal funds. These include, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.

- The anti-kickback statute (section 1128B(b) of the Social Security Act)
- Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164

In addition, our contracted providers must comply with all applicable Medicare laws, rules and regulations.
And, as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any MA plan member on the basis of health status.

Provider terminations

When a provider's participation in the Aetna Medicare network is terminated, CMS requires that we make a good-faith effort to provide members with a written notice of the termination. This notice must be at least 30 calendar days prior to the termination effective date to all plan members who are patients seen on a regular basis by the provider.
However, note that when a PCP is terminated from the Aetna Medicare network, all members who are patients of that PCP must be notified of the PCP's termination at least 30 days prior to the termination effective date. If you choose to terminate your Aetna Agreement with us, on the other hand, your contract stipulates that you must give us advance notice. For example, 90–120 days prior to terminating (or based on your contractual language).
Aetna shall provide physicians a 60-day written notice before terminating a physician contract without cause, unless a greater timeframe is specified in the physician's contract.

Financial liability for payment for services

In no event should a contracted provider bill a plan member (or a person acting on behalf of a plan member) for payment of fees that are the legal obligation of the plan.
Note: CMS issued a memo to MAOs dated September 17, 2008, ("CMS Guidance") providing guidance regarding balance billing by providers of certain individuals enrolled in both Medicare Advantage plans and a State Medicaid plan ("Dual Eligible beneficiaries"). More specifically, this CMS Guidance states that providers are prohibited from balance billing Dual-Eligible beneficiaries who are classified as Qualified Medicare Beneficiaries (QMB) for Medicare Parts A and B cost-sharing amounts. The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or MA plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as a "private pay patient" in order to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment.
Providers participating in Aetna Medicare networks are required to provide covered services to Aetna Medicare Dual-Eligible beneficiaries enrolled in Aetna Medicare Advantage plans ("Dual-Eligible members") and comply with all of the requirements set forth in this CMS Guidance. Participating providers must accept Aetna payment as payment in full or bill Medicaid for the Dual Eligible member's copayment.

Medicare Compliance Program requirements
CMS requires that Aetna first tier, downstream and related entities (FDRs) fulfill Medicare Compliance Program requirements. If you are contracted to provide health care and/or administrative services for any of our Medicare plans, you are an FDR.

We describe all of CMS compliance program requirements in our First Tier, Downstream and Related Entities (FDR) Medicare Compliance Program Guide (FDR Guide). Be sure to review the **FDR Guide** and make sure you are complying to all of the requirements.

Standards of Conduct and Compliance policies

Your organization should distribute Standards of Conduct and Compliance Policies that explain your:

- Commitment to comply with federal and state laws
- Ethical behavior requirements
- Compliance program operations

Your policies should be distributed within 90 days of hire, when revised, and annually thereafter.

Exclusion list screening

Your organization should not employ or contract with an individual or entity that is excluded from participating in federally funded health care programs. Prior to contracting and monthly thereafter, you must screen employees and downstream entities against the following lists:

- Office of Inspector General (OIG) List of Excluded Individuals and Entities
- General Services Administration (GSA) System for Award Management (SAM)

If an excluded individual or entity is identified, you must notify us and immediately remove them from working on our Medicare business. This individual or entity should not bill for Medicare-covered services, and Aetna® cannot pay such claims.

The Patient Protection and Affordable Care Act (PPACA), implemented in 2010

We refer to PPACA as the Affordable Care Act (ACA). As part of the ACA, Congress enacted a broad new law — ACA Section 1557 — that generally prohibits most health insurers, including Aetna, from discriminating on the basis of race, color, national origin, sex, disability or age. A central element of the ACA Section 1557 rules is a requirement that covered entities, including health care providers such as hospitals or doctors, provide special aids to persons with communication disabilities, such as the deaf and hard of hearing, so they can equally access and benefit from their services. Sections of the ACA 1557 portion were repealed in the summer of 2020 with an effective date of 8/18/20. Aetna expects providers to comply with ACA Section 1557. Sections of the ACA 1557 portion were repealed in the summer of 2020, with an effective date of August 8, 2020.

The "effective communication" baseline rule As an Aetna Provider, you are obligated to do both of the following:

- Ensure all communications with the deaf and hard of hearing are as effective as those with other persons.
- Provide appropriate auxiliary supports and services to the deaf and hard of hearing, whenever necessary, to afford them an equal opportunity to benefit from their services.
- Ensure the ability to assist members in a variety of languages, per federal law requirements.

When deciding whether a particular aid should be provided, keep in mind that the general goal is to ensure all communications with individuals who are deaf or hard of hearing are effective.

Individuals qualifying for auxiliary supports and services

Individuals qualify for auxiliary supports and services if either of the following apply:

- They are deaf or hard of hearing.
- They are in one of the classes of people covered by the regulations.

The term "deaf" includes individuals who do not hear well enough to rely on their hearing to process speech and language. The term "hard-of-hearing" includes individuals with conditions that affect the frequency or intensity of their hearing. A deaf or hard-of-hearing person would be covered by ACA Section 1557 if they are substantially limited in hearing or substantially limited in some other major life activity because of hearing loss. An individual may be considered deaf or hard of hearing even if their hearing loss is eased by the use of a hearing aid or cochlear implant.

Auxiliary support and service options

The regulations include a long, but non exhaustive list of auxiliary supports and services that may be provided in a particular instance. The list includes (among other possibilities):

- Qualified interpreters, who can provide services in person and on-site or remotely through technology, such as video remote interpreting (VRI)
- Use of written materials and exchange of written notes
- Voice-, text- and video-based telecommunications products, such as video relay service (VRS)
- Text telephones, called "teletypewriters" (TTYs)

There are many other options, though all must be provided free of charge to people who are deaf or hard of hearing. Any special technology such as VRI or VRS must meet technical and operational standards and users must be properly trained. The appropriate aid to use will depend on the individual with the disability, the type of communication and the context. When deciding which aid to provide, primary consideration should be given to the person with a disability who is requesting the service. Aids should also be provided in a timely manner and in such a way that protects the privacy and independence of the

aetna®

individual.

Persons qualified to act as interpreters

Interpreters used by covered entities (whether interpreting in-person or via VRI) should be qualified. A qualified interpreter may use one of several methodologies, but must:

- Adhere to generally accepted interpreter ethics principles, including client confidentiality
- Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology

You must not require a person who is deaf or hard of hearing to bring someone with him or her to interpret, nor should you rely on an adult companion or child to interpret, unless:

- There is an emergency involving an imminent threat to the safety or welfare of the individual or the public and no other interpreter is available.
- The person requests interpretation from their companion and reliance on the companion is determined to be appropriate.

For more from the Office of Civil Rights on effective communications for persons who are hard of hearing, go to the U.S. Department of Health and Human Services website.

Oversight of your subcontractors

If your subcontractors provide health care and/or administrative services for Aetna®, they are a downstream entity. You must ensure that your downstream entities abide by all laws, rules and regulations. This includes ensuring your:

- Contractual Agreements contain all CMS- required provisions
- Downstream Entities comply with applicable Medicare requirements, including operational and compliance program requirements

What may happen if you don't comply

If our FDRs fail to meet these CMS Medicare compliance program requirements, it may lead to:

- Development of a corrective action plan
- Retraining
- Termination of your contract and relationship with Aetna

Making sure you maintain documentation

You are required to maintain evidence of your compliance with the requirements for 10 years. Aetna or CMS may request that you provide documentation of your compliance with these requirements.

Report concerns or questions

If you identify noncompliance or fraud, waste and abuse, you must report it to us by using the mechanisms outlined in our **Code of Conduct**. We prohibit retaliation for good-faith reporting of concerns.
If you have questions about the requirements that apply to FDRs or if you have difficulty finding our **FDR Guide,** call our Provider Contact Center.

Medicare Access and CHIP Reauthorization Act (MACRA) reimbursement policy

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015.
MACRA created the Quality Payment Program (QPP), which repeals the Sustainable Growth Rate (SGR) formula. It changes the way Medicare rewards physicians for value versus volume over time. Our MACRA reimbursement policy applies to both of the payment tracks below:

- **Advanced Alternative Payment Model (AAPM):** our value-based contracting reimbursement programs are known as "CPC+" or "Medicare Collaboration Premier" or "Medicare Collaboration Enhanced." They offer providers CMS-

approved options to qualify for this track as an Other Payer AAPM as long as the AAPM criteria are met within your specific contract terms. However, our provider reimbursements do not adjust to include reciprocal AAPM bonuses. AAPM bonuses are based on CMS Fee-For-Service membership, not your Aetna®–specific membership.

- **Merit-Based Incentive Payment System (MIPS):** our provider reimbursements do not adjust to include performance-based incentive payments made under traditional Medicare as the result of MACRA. Incentive payments are based on CMS Fee-For-Service membership, not your Aetna-specific membership.

Temporary move out of the service area

CMS defines a temporary move as an absence from the service area (where the member is enrolled in a plan) of six months or less.

A plan member is covered while temporarily out of the service area for emergent, urgent and out-of-area dialysis services. If a member permanently moves out of the plan service area or is absent for more than six months, the plan must disenroll the member.

Members travelling can get services from providers in our network for the service area they're visiting. Plan coverage rules still apply. For example, they may need referrals for some services. Our network isn't in all locations, so it is important members check for participating providers in the area they're visiting.

Urgently needed services

Urgently needed services are covered services provided to a member that are both of the following:

- Non-preventive or non-routine
- Needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition

Urgently needed services include conditions that cannot be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Physicians and other health care professionals and marketing MAOs and their contracted providers must adhere to all applicable Medicare laws, rules and regulations relating to marketing. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting an MAO or a particular MA plan, informing Medicare beneficiaries that they may enroll or remain enrolled in an MA plan offered by an MAO, explaining the benefits of enrollment in an MA plan or rules that apply to members, or explaining how Medicare services are covered under an MAO plan.

Regulations prevent MAOs from conducting sales activities in health care settings except in common areas. MAOs are prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive health care services. MAOs are permitted to schedule appointments with beneficiaries residing in long-term care facilities, only if the beneficiary requests it.

Physicians and other health care professionals may discuss, in response to an individual patient's inquiry, the various benefits of MA plans. They shall remain neutral when assisting Medicare beneficiaries with enrollment decisions. Physicians are encouraged to display plan materials for all plans in which they participate.

For additional information, physicians and health care professionals can also refer their patients to: **1-855- 463-0933 (TTY: 711)**

- The State Health Insurance Assistance program
- The specific MAO marketing representatives
- The CMS website at **Medicare.gov**

Physicians and other health care professionals cannot accept MA plan enrollment forms.

We follow the federal anti-kickback statute and CMS marketing requirements associated with Medicare marketing activities conducted by providers and related to Aetna Medicare plans. Payments that we make to providers for covered items and/or services will:

- Be fair market value
- Be consistent with an arm's length transaction
- Be for bona fide (genuine) and necessary services
- Comply with relevant laws and requirements, including the federal anti-kickback statute

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to Medicare marketing

activities conducted by providers, refer to Chapter 3 of the Medicare Managed Care Manual, and the **Medicare Communications and Marketing Guidelines** contained therein, which can be found on the CMS website.

Annual notice of change

Medicare plan benefits are subject to change annually. Members are provided with written notice regarding the annual changes by the date specified by CMS. Providers can access the member website for information on the individual plans and benefits that will be available within their service area for the following calendar year.

Services received under private contract

As specified by Medicare laws, rules and regulations, physicians may "opt out" of participating in the Medicare program and enter into private contracts with Medicare beneficiaries. If a physician chooses to opt out of Medicare due to private contracting, no payment can be made to that physician directly or on a capitated basis for Medicare-covered services. The physician cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others.
The MAO is not allowed to make payment for services rendered to MA members to any physician or health care professional who has opted out of Medicare due to private contracting, unless the beneficiary was provided with urgent or emergent care.

Claims and billing requirements

Physicians and other health care professionals must use the current revision of the International Classification of Diseases, Clinical Modification (ICD- 10-CM) codes and adhere to all conventions and guidelines specified in the ICD-10-CM Official Guidelines for Coding and Reporting. Complete, accurately use both the CMS Healthcare Common Procedure Coding System (HCPCS Level II) and the required procedural codes of the American Medical Association's (AMA's) Current Procedural Terminology (CPT), current edition.
Hospitals and physicians using the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSMV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System.

- The ICD-10 CM codes must be to the highest level of specificity: A code is invalid if it does not contain the full number of required characters detailed in the tabular list. Valid codes may contain three to seven characters.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all status codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.
Care outside of the United States
If the member sees an out-of-network provider for urgent/emergency care outside of the United States and he/she has made payment to the provider, the member should submit their claims to Aetna® along with documentation of any payments made to the provider.

Submitting Medicare claims and encounter data for risk adjustment

Risk adjustment is used to fairly and accurately adjust payments made to MAOs by CMS based on the health status and demographic characteristics of an enrollee. CMS requires MAOs to submit diagnosis data regarding physician, inpatient and outpatient hospital encounters on a quarterly basis, at minimum. CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs. Providers are required to submit accurate, complete and truthful risk-adjustment data to the MAO. Failure to submit complete and accurate risk-adjustment data to CMS may affect payments made to the MAO and payments made by the MAO to the physician or health care professional organizations delegated for claims processing.

Risk adjustment medical record validation

CMS conducts medical record reviews to validate the accuracy of the risk-adjustment data submitted by the MAO. Medical

records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to the MAO. In addition, Medicare Advantage regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported by Aetna to CMS, as required by CMS.
Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. CMS may adjust payments to the MAO based on the outcome of the medical record review.

Centers for Medicare & Medicaid Services (CMS) physician incentive plan: general requirements

Aetna® Medicare Advantage regulations require that MAOs and their participating providers meet certain CMS monitoring and disclosure requirements that apply to "physician incentive plans." As outlined in 42 C.F.R § 422.208(a), a "physician incentive plan" means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any MA plan enrollee.
The physician incentive plan requirements apply to an MAO and any of its first-tier and downstream provider arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Provider downstream arrangements may include an intermediate first-tier entity.
CMS imposes the following requirements on MAOs and their participating providers regarding physician incentive plan arrangements:

- MAOs and their participating providers cannot make
- a specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
- If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the MAO or participating provider must ensure that all physicians and physician groups at substantial financial risk (as described in 42 C.F.R §422.208(a) & (d)) have either aggregate or per-patient stop-loss protection (as described in 42 C.F.R §422.208(f)). In addition, MAOs and participating providers must conduct periodic Aetna
- MA member surveys in accordance with MA regulations.
- For all physician incentive plans, the MAO must provide CMS with assurances that applicable physician incentive plan requirements are met, as well as provide information concerning physician incentive plans, as requested. To meet this CMS requirement, any participating provider with a physician incentive plan arrangement must annually provide Aetna with the following information for each physician incentive plan arrangement:
  - Whether referral services are covered by the physician incentive plan
  - The type of physician incentive plan arrangement (that is, withhold, bonus, capitation)
  - The percent of total income at risk for referrals
  - The patient panel size
  - The amount and type of stop-loss protection

We will disclose any physician incentive plan arrangements maintained by participating providers, if required to do so, under applicable laws and regulations.

CMS physician incentive plan: substantial financial risk

As more fully described in 42 C.F.R. § 422.208 (a) and (d), substantial financial risk occurs when risk is based on the use or costs of referral services and that risk exceeds a risk threshold of 25% of potential payments. (Payments based on other factors, such as quality of care furnished, are not considered in this determination.) Refer to 42 C.F.R. §422.208 for additional information.

CMS physician incentive plan: stop-loss protection requirements

In addition, as more fully described in 42 C.F.R. §422.208(f), MAOs and their participating providers must ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

- Aggregate stop-loss protection must cover 90% of the costs of referral services that exceed 25% of potential

payments.

- For per-patient stop-loss protection, if the stop- loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel. It may be a combined policy or consist of separate policies for professional services and institutional
- services. In determining patient panel size, the patients may be pooled, as described in 42 C.F.R. § 422.208(g).

Stop-loss protection must cover 90% of the costs of referral services that exceed the per- patient deductible limit. The per-patient stop- loss deductible limits are set forth in 42 C.F.R. §422.208(f).
Participating providers with physician incentive plan arrangements must maintain, at their sole expense, any stop-loss coverage they are required to maintain under applicable laws and regulations. They must also provide evidence of such coverage to us upon request.

Aetna® Medicare Advantage organization (MAO) obligations

The MAO is prohibited from restricting a physician or health care professional from advising his or her patients about:

- Their health status
- Their treatment options
- The risks and benefits of their treatment options
- The opportunity to refuse treatment and/or express preferences about future treatment decisions

CMS: Medicare Communications and Marketing Guidelines (MCMG)

In February 2022, CMS released new guidelines: Medicare Communications and Marketing Guidelines (MCMG). Review the Activities with Healthcare Providers or in the Healthcare Setting for complete details.
Provider-initiated activities are those conducted by a health care professional at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship.

Permissible activities

- Distributing unaltered, printed materials created by CMS
- Providing the names of plans with which they participate
- Answering questions or discussing the merits of a plan or plans, including cost sharing and benefits information (these discussions may occur in areas where care is delivered)
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP), plan marketing representatives, their state Medicaid or Social Security office, or Medicare via **Medicare.gov** or **1-800-Medicare (1-800-633-42273**)
- Referring patients to plan marketing materials available in common areas
- Providing information and help applying for the low-income subsidy (LIS)

What contracted providers may do

- Make communication materials available, including in areas where care is delivered
- Make plan marketing materials and enrollment forms available outside of the areas where care is delivered (such as common entryways or conference rooms)

Distributing or making plan marketing materials available is allowed as long as the provider does this for all plans in which they participate. Providers must remain neutral when helping beneficiaries with enrollment decisions.

Ambulance services

Ambulance services, including fixed-wing and rotary- wing ambulance services, are covered only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Note that air ambulance services are covered only if the member's medical condition is such that

transportation by ground ambulance is not appropriate. The member must be transported to the nearest hospital with appropriate facilities.
Non-emergency, scheduled, and repetitive ambulance services may be covered if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a physician certification statement dated no earlier than 60 days before the date the service is furnished indicating that these services are medically necessary.
Non-Ambulance Transportation services are covered through ModivCare. This sub-contractor provides non-ambulance, non-emergent transportation services.

Rights and Responsibilities for Aetna® Plan Members

We inform our Aetna plan members that they have the following rights and responsibilities.

Rights Information

- Get information about our plan. This includes information about how we're doing financially, and how our plan compares to other health plans.
- Get information about our network providers, including our network pharmacies.
- Get information in a way that works for them. Our plan includes:
- Free language interpreter services available to answer questions from non-English-speaking members.
- Information in Braille, large print, and in other accessible formats.
- Information that is accessible and appropriate for people who are eligible for Medicare because of disability.
- Get an explanation about any prescription drugs and medical care or service not covered by our plan.
- Receive in writing: Why we will not pay for or approve a prescription drug or medical care or service
- How they can file an appeal to ask us to change this decision even if they obtain the prescription drug or medical care or service from a pharmacy or provider not in the Aetna network
- Receive an explanation about any utilization management requirements, such as step therapy or prior authorization, which may apply to their plan.
- Make a complaint if they have concerns or problems related to their coverage.
- Be treated fairly (that is, not retaliated against) if they make a complaint.
- Get a summary of information about the appeals made by members and the plan's performance ratings, including how it's been rated by plan members and how it compares to other Medicare health plans.
- Call Aetna Member Services to get more information about their rights, and protections, plus ask questions and share concerns.
- Get free help and information from their State Health Insurance Assistance Program (SHIP).
- Visit Medicare.gov to view or download the publication. It's available at **Medicare.gov/publications**.
- Call **1-800-Medicare (1-800-633-4227**) 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

-Call the Office for Civil Rights at **1-800-368- 1019** if they think we've treated them unfairly or not respected their rights. TTY users should call **1-800-537-7697.**

Access to care

- Choose a network health care provider.
- Go to a women's health specialist in our plan (such as a gynecologist) without a referral.
- Get timely access to providers. "Timely access" means getting services within a reasonable amount of time.
- Get their prescriptions filled within a reasonable amount of time at any network pharmacy.
- Call Member Services if they have a disability and need help in order to access to care

Freedom to make decisions

- Get full information from their health care providers when they go for medical care. This includes knowing about all of the treatment options that are recommended for their condition, no matter the cost or whether they're covered by our plan.
- Participate fully in decisions about their health care. Their health care providers must explain things in a way that they can understand. Their rights include knowing about all of the treatment options that are recommended for their condition, no matter the cost or whether they're covered by our plan.
- Know about the different medication therapy management programs they may join.
- Be told about any risks involved in their care.
- Be told beforehand if any planned medical care or treatment is part of a research experiment. They must be given the choice to refuse experimental treatments.

- Refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This includes the right to stop taking their medication.
- Receive a detailed explanation if they think a health care provider has denied care they believe they were entitled to receive or should continue to receive. In these cases, they must request an initial decision, called an "organization determination."
- Ask someone such as a family member or friend to help them with decisions about their health care. They may fill out a form to give someone the legal authority to make medical decisions for them.
- Give their doctors written instructions about how they want them to handle their medical care. This includes "Advanced Directives," a "Living Will," and a "Power of Attorney for Health Care," if they become unable to make decisions for themself. They can contact Aetna® Member Services to ask for the forms.

Personal rights

- Be treated with dignity, respect and fairness at all times. We must obey laws that protect them from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health status, ethnicity, creed, age, claims experience, medical history, genetic information, evidence of insurability, geographic location within the service area or national origin. Receive privacy of their medical records and personal health information according to federal and state laws that protect the privacy of their medical records and personal health information. There are exceptions allowed or required by law, such as the release of health information to government agencies that are checking on quality of care.
- Receive a written notice called a "Notice of Privacy Practice" that tells them about privacy of their medical records and personal health information rights and explains how we protect the privacy of their health information.
- Look at medical records held at the plan, and get a copy of their records.
- Ask us to make additions or corrections to their medical records.
- Know how we've given out their health information and used it for nonroutine purposes.
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Get information from us about our network pharmacies, providers and their qualifications, as well as information about how we pay our doctors. For a list of the providers and pharmacies in the plan's network, they may see the Provider Directory. For more detailed information about our providers or pharmacies, they may visit AetnaMedicare.com or call Aetna Member Services.

Input

Suggest changes in the plan's policies and services, including our Member Rights and Responsibilities policy.

Responsibilities

As a member, they have a responsibility to:

- Exercise their rights
- Learn about their coverage and the rules they must follow to get care as a member.
- Unless it's an emergency, when seeking care, they must let health care providers know that they're enrolled in our plan. They must also present their member ID card to health care providers.
- Give their doctor and other health care providers the information they need to care for them.
- Follow the treatment plans and instructions that they and their doctors agree on.
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals and other offices.
- Tell our plan if they have additional health insurance or drug coverage and use all of their insurance coverage.
- Pay their plan premiums and copayments/coinsurance for their covered services.
- Pay for services that aren't covered.

Communicate

- Ask their doctors and other providers if they have any questions, and have providers explain their treatment in a way that they can understand.
- Tell their doctor or other health care providers that they're enrolled in our plan. Show their member ID card whenever they get their medical care or Part D prescription drugs.
- Let us know if they move.
- Let us know if they have any questions, concerns, problems or suggestions.

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