AETNA BETTER HEALTH® OF VIRGINIA

Commonwealth Coordinated Care Plus (CCC Plus)

aetna®

CMHRS Authorization Requests

- All CMHRS Service Authorization Requests should be faxed to: **866-669-2454**
- Turn around time is **72 hours** from date of receipt
- If pended and we contact you for additional information we need to receive that within **48 hours**
- Striving to provide person-centered evaluation of service requests and improve collaboration with community-based providers
- use of standardized pdf forms **beginning 4/23/18** – posted on the DMAS website and will be available on our provider portal

Credentialing

Barriers to Implementation:

- Backlog of credentialing applications for CMHRS

Solutions:

- National Credentialing Team is engaged to assist with the credentialing backlog
- Additional resources from other states are assisting
- Quadrupled the size of the credentialing team
- Loading providers as Non-Par at the beginning of the credentialing process so that claims will be approved
- Voluntarily extended the continuity of care period to 5/31/18

Credentialing

For all CMHRS providers, we are currently accepting applications

To join our network, contact us and we will send you a contracting packet

Email: **AetnaBetterHealth-VAProviderRelations@aetna.com**

Phone: **1-800-279-1878**, **option 6**

If you are an ARTS provider

- First, review the DMAS website and ensure you have obtained the necessary ARTS documentation and qualification
- Then, contact us at **NetworkDevelopment-VAContact@aetna.com** to request a network participation packet

Claims

Barriers to Implementation:

- Issues with transition authorizations being received and/or loaded correctly from the MTR file
- Quarterly rate schedule update that eliminated a modifier for TDT that resulted in rejected claims
- Approximately 900 claims had to be reprocessed for the not having a modifier

Solutions:

- Proactively reached out to providers and have worked to validate and load transition of care authorizations from Magellan
- Initiated a pre-check query to address claims not being paid due to an authorization not being on file as a short-term fix
- IT updated operating procedures as a long-term solution

Community Service Board Services and Value-Based Provider Programming

Addiction and Recovery Treatment Service- ARTS

- Opportunity to combine services in a value based environment
- Aetna Medicaid collaboration with service providers to create appropriate set of metrics that bring value and allow savings to be shared
- Combine best practices of both CSB and Aetna Medicaid to bring about best alignment for member care management

Pay for Quality	Program related to quality metrics for providers who do not immediately qualify for our other VBS programs and rewards providers for achieving better performance on a broad spectrum -e.g. Healthcare Effectiveness Data and Information Set and utilization metrics for their Aetna member panel.
Patient-Centered Medical Home (PCMH)	Program for providers whose patients (our members) are best served by a medical home or who have complex substance abuse needs and require an integrated behavioral health/physical health home. PCMHs/IHHs help to address the complex health needs of the entire community through a highly coordinated system of care including comprehensive primary care, specialty care, acute care, behavioral health integration, and community.
Shared Savings/Shared Risk	Includes opportunity for providers to earn incentives based on the costs of the services they provide compared to a benchmark. Providers must qualify to earn shared savings incentives by achieving clinical quality outcomes objectives. These arrangements are for those practices serving a larger portion of our Medicaid members and who possess the skills and infrastructure necessary to manage the population and financial risk.