



Frequently Asked Questions – Aetna Georgia Dual Eligible Special Needs Plans (D-SNPs)

What is a D-SNP?

A D-SNP, or Dual Eligible Special Needs Plan, is a type of Medicare Advantage plan that limits enrollment to people who are dually eligible for Medicare and Medicaid (also known as “dual eligibles”). D-SNPs include features and benefits that enable us to effectively care for the dual eligible population.

Is a D-SNP a Medicaid plan?

No, a D-SNP is a Medicare Advantage plan. However, all members enrolled in a D-SNP are eligible for both Medicare and Medicaid.

Eligibility: Who can join an Aetna D-SNP?

Your patient can join our plan if they live in the plan service area and:

- Have Medicare Part A and Part B
- Are in one of the following Medicaid eligibility categories:
 - Qualified Medicare Beneficiary (QMB)
 - Qualified Medicare Beneficiary plus full Medicaid benefits (QMB+)
 - Special Low Income Medicare Beneficiary plus full Medicaid benefits (SLMB+)
 - Full Benefit Dual Eligibles (FBDE)

QMB and SLMB are Medicare Savings Programs (MSP) categories. You can learn more about the MSP at the following [link](#).

How do I confirm my patient is enrolled in an Aetna D-SNP?

Ask them for their Medicaid and Aetna ID card at every visit. You should also check your patient’s Aetna eligibility. You can do this through the secure [provider portal](#). If the tool is unavailable, just call Aetna provider services at **1-800-624-0756 (TTY: 711)** or the number located on your patient’s ID card.

Am I required to see D-SNP members?

If you are an Aetna Medicare provider and your practice is open to new patients, you are required to see D-SNP members. Check your participation status using our [provider search tool](#).

Proprietary

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What happens if one of my patients loses their Medicaid eligibility?

We will continue to cover their Medicare benefits for a grace period of up to six (6) months. If your patient does not regain their Medicaid eligibility, they may be responsible for their copay, coinsurance, or deductible. If at the end of the grace period, your patient has not regained their Medicaid eligibility, or enrolled in a different plan, we must disenroll them from this plan. If this happens, your patient will be placed back in Original Medicare.

Will my patients have Aetna D-SNP and Aetna Medicaid?

Your patients in the D-SNP plan are not required to be enrolled in a sponsored Aetna Medicaid plan. As such, they may or may not be enrolled in our Medicaid plan. If they are enrolled in a sponsored Aetna Medicaid plan, Aetna will coordinate benefits for both plans.

What are some of the benefits of my patient being enrolled in this plan?

This plan offers supplemental benefits and services that are not typically available with Original Medicare at no extra cost to the member. These include:

- Transportation to medical appointments
- Prescription drugs
- A SilverSneakers® fitness membership
- A personal care manager and interdisciplinary care team
- An allowance for preventative and comprehensive dental care
- Vision benefits for contacts and glasses
- Hearing aids
- An allowance for over-the-counter items
- An allowance to pay for groceries and utilities.

Where can I find Medicaid benefits and services that may be available to my patient?

You can speak to a member of our care team at **1-800-241-9379 (TTY:711)**. A care manager can help coordinate any Medicaid benefits and services available to your patient.

If you choose not to call, you can find a publicly posted list of services at the following link.

[Additional Medicaid FAQs | Georgia Medicaid](#)

What are Long Term Services and Supports (LTSS)?

LTSS are Medicaid programs. Medicaid LTSS refers to the range of services provided to individuals who need assistance with daily living activities for an extended period, due to age, illness, or disability. These services can be delivered in various settings, including in-home, community-based settings, or in facilities like nursing homes. In Medicaid, LTSS refers to the services and supports that help Medicaid enrollees with:

- Functional limitations/chronic illnesses
- Performing routine activities of daily living (ADLs) like bathing, grooming, dressing, meal preparation, eating and medication assistance
- [Long Term Services and Supports | Georgia Medicaid](#)

How will the interdisciplinary care team (ICT) compliment the care I provide to my patient?

The ICT works with you to help your D-SNP patients receive the most appropriate, highest quality of care. This includes:

Assisting with supplemental benefits such as transportation, dental and vision care

- Assisting with discharge planning and care transitions
- Helping members understand their medications.
- Connecting members with programs to help with utility bills, safe housing, healthy foods and more
- Accessing and coordinating care with their Medicaid benefits
- Developing an Individualized Care Plan (ICP) based on the results of their comprehensive Health Risk Assessment (HRA) and input from their medical provider(s)
- Coordinating visits to providers

What if we need to obtain prior authorization for services?

Federal rules dictate that Medicaid is the payer of last resort. As such, prior authorizations will begin with Aetna® D-SNP. You can call **1-866-409-1221 (TTY: 711)** for questions about utilization management. The process for providers participating with Aetna through their affiliation with an IPA may differ. Please refer to your IPA guidelines.

Who should providers bill first for services rendered to Georgia D-SNP members – Medicare or Medicaid?

Federal rules dictate that Medicaid is the payer of last resort. As such, you'll bill Aetna D-SNP first. If you're an Aetna IPA, follow your IPA instructions.

Aetna will send you the provider remittance advice form. When it comes, bill the state for your patient's Medicaid for any coinsurance/deductible amounts. This is typically referred to as crossover claims. The actual payment level depends on the state payment policies. If you are a Medicare provider who chooses not to submit a claim to Medicaid, or the state does not pay you any additional funds, the payment you receive from us would be payment in full. The state may require SLMB+ D-SNP members to pay a copay. Refer to the remittance advice form you receive from your crossover claim for details.

You don't have to become a Medicaid provider, but you do need to register in order to submit a crossover claim. If you haven't already enrolled with Medicaid, [start your enrollment and find instructions to submit crossover claims](#). This applies to Medicaid providers who see patients managed by the State of Georgia, not a Managed Care Organization (MCO). For MCO members, contact the carrier for enrollment instructions.

How do I submit claims and encounters for D-SNP members?

Claims can be submitted electronically using payer ID 60054.

What vendor(s) can I use to send claims?

You can see a complete list of participating vendors at the following [link](#).

Can I submit paper claims?

If permitted under your participation agreement you may submit paper claims per standard process for all Aetna Medicare Advantage plans. Paper claims should be mailed to:

Aetna Medicare
PO Box 981106
El Paso, TX 79998-1106

Can I bill D-SNP members for Medicare cost-sharing or any unpaid balances?

No. Consistent with federal requirements providers may not bill D-SNP patients when the state Medicaid program is responsible for covering the patient's portion. D-SNP members cannot be billed for Medicare cost-sharing amounts, including copays, coinsurance, or deductibles. This is known as the prohibition against balance billing. If Medicare and Medicaid do not cover the full amount, providers must accept the Medicaid payment as payment in full. Billing the member directly for any remaining balance is not allowed under federal and state regulations.

I am an Aetna Medicare network provider, and I understand I have to bill the state for the member's cost-share portion, but I don't want to become a Medicaid provider.

What are my options?

Effective 1/1/23, state Medicaid agencies may accept providers and suppliers enrolled in Medicare for purposes of processing Medicare cost-sharing claims. * You must otherwise meet all federal Medicaid enrollment requirements. Even if you're a provider or supplier of a type recognized as eligible to enroll in the Colorado Medicaid program or are located out of state. This change means you may not have to become part of the Medicaid provider network or see Medicaid patients in order to submit crossover claims. If you choose not to register with Medicaid, the state isn't required to process your cost-share claims. In other words, our payment to you would be payment in full.

*FOR PROCESSING MEDICARE COST-SHARING CLAIMS: 42 CFR § 455.410(d) Enrollment and screening of providers.

Are there any situations when I won't have to submit a claim elsewhere to receive the full payment?

Once the patient has met their Maximum Out of Pocket (MOOP), we'll pay 100% of Medicare A&B covered services for the remainder of the calendar year. At that point, you won't bill secondary payors or your patient for plan covered Medicare A&B covered services. The Explanation of Payment (EOP) or provider remittance advice you receive from us will inform you once MOOP has been met.

Where can I get my patient's health information?

You may request a patient's information by calling Aetna's Provider Service line at **1-800-624-0756** or by downloading your patients' HRA and ICP through our secure [provider portal](#).

What if my patient needs language assistance?

Aetna providers interpreter services for members with limited English proficiency. For interpreter services, call **1-800-525-3148 (TTY: 711)**.

How can I contact Aetna?

You can reach us at **1-844-826-5291 (TTY: 711)**. We are available between 8 AM through 8 PM ET, 7 days a week.

Aetna Provider Home Page	Provider Homepage
Aetna Provider Manual	Provider Manuals
Secure Provider Portal (remittance advice forms, claims, etc.)	Availity Log In
Patient Care Team email box	CRDSNP@Aetna.com
Prior Authorization	See the medical exception and precertification section of the provider manuals for: - Medical exceptions for coverage of drugs on the Formulary Exclusions List or the Step Therapy List - Requesting a prior authorization - Exceptions to quantity limit
Appeals	Disagree with a claim's decision? Write to the PO box listed on the EOB statement or the denial letter related to the issue being disputed. Please include the reason(s) for the disagreement. Learn more about our appeals process.
Medicare Advantage resources for providers including reference guides and FAQs	Medicare Resources for Providers
OfficeLink updates on plans, procedures, drug lists, Medicare, and state-specific information	OfficeLink Updates Newsletter Archive Aetna
Forms for health care professionals including VCC, appeals and disputes, phone, and address changes, and more	Forms and Applications for Health care Professionals
Educational Webinars and demos	Educational Webinars