Frequently Asked Questions — Aetna® Chronic Condition Special Needs Plans (C-SNPs)

Q: What is a C-SNP?

A: A Chronic Condition Special Needs Plan (C-SNP) is a type of Medicare Advantage plan specifically designed for individuals living with severe or disabling chronic conditions. These plans are tailored to meet the unique healthcare needs of eligible members. You can learn more about C-SNP at the following link.

Q: What states currently offer C-SNP?

A: C-SNP is offered in the following states:

State	Plan Types
Pennsylvania (Greater Pittsburgh and Philadelphia)	– Aetna Medicare Prime Chronic Value (HMO C-SNP) – Aetna Medicare Chronic Care Value (HMO C-SNP) – Aetna Medicare Chronic Care (HMO C-SNP) – Aetna Medicare Prime Chronic Care (HMO C-SNP)
Illinois (Greater Chicagoland)	– Aetna Medicare Prime Chronic Value (HMO C-SNP) – Aetna Medicare Prime Chronic Care (HMO C-SNP)

Q: Eligibility: Who is eligible for an Aetna C-SNP?

A: Medicare beneficiaries may enroll if they live in the plan service area and:

- Have Medicare Parts A and B
- Have one or more of the plan's covered chronic conditions
- Complete a **Pre-Qualification Assessment Tool (PQAT)** as part of the enrollment application to verify the chronic condition
- Have a healthcare provider (e.g. primary care provider or specialist) complete a **Verification of Chronic Condition (VCC) form** within 30 days of enrollment. ***Failure to complete this form may result in disenrollment at the end of the second month.***

Q: What conditions qualify for an Aetna C-SNP?

A: A PCP or specialist will need to verify their patient has at least one of the following conditions:

- Diabetes
- Chronic heart failure
- Cardiac arrhythmias
- Coronary artery disease
- Peripheral artery disease
- Chronic venous thromboembolic disorder

An Aetna C-SNP is only for Medicare members with at least one of these eligible conditions. If we find that a member has enrolled in a C-SNP but does not have one of these conditions, we must disenroll that member.

Q: Am I required to see Aetna® C-SNP members?
A: If you're an Aetna Medicare provider, and your practice is open to new patients, you're required to see C-SNP members. Check your participation status using our **provider search tool**.

Q: How do I confirm my patient is enrolled in an Aetna C-SNP?
A: Ask the patient for their Aetna Medicare ID card at every visit. Providers can verify patient eligibility through the **secure provider portal** or by calling **1-800-624-0756** (TTY: 711).

Q: What are some of the benefits of my patient being enrolled in this plan?
A: This plan offers supplemental benefits and services that are not typically available with Original Medicare at no extra cost to the member. These include:

Benefit	This Plan covers
Coverage beyond Medicare Part A and Part B	✓
$0 copay for PCP visits and certain specialist visits (cardiology, endocrinology, nephrology and pulmonology)	✓
Personal care team	✓
Dental benefits for things like dentures	✓
Vision benefits for contacts and glasses	✓
Hearing aids	✓
An allowance for over-the-counter-items	✓

In Home Support Services and meal delivery following a facility discharge	✓
Help with everyday expenses with a Monthly Extra Supports benefit	✓
Low and $0 copays at in-network pharmacies for covered Part D drugs to help with chronic conditions	✓

Q: How does the **interdisciplinary care team (ICT)** support members enrolled in a C-SNP?

A: An Aetna C-SNP provides each member with a dedicated team of healthcare professionals who collaborate with the member and their providers to create a personalized care plan. This team supports members by:

- Helping members understand and access their C-SNP benefits
- Assisting with scheduling medical and dental appointments
- Connecting members to local and state programs for additional support, such as meal delivery, transportation, and other community resources
- 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
- 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

Q: What if my patient needs language assistance?

A: We offer a language assistance program to support members with limited English proficiency. For interpreter services, call **1-800-525-3148 (TTY: 711)**.

Q: How do I submit claims for payment?

A: Claims should be submitted electronically. If permitted under your participation agreement you may submit paper claims per standard process for all Aetna Medicare Advantage plans.

Q: What number do I use to submit electronic claims?

A: Aetna Medicare plans use payer ID 60054 for claims and encounters.

Q: What vendor(s) can I use to send claims?
A: You can see a complete list of participating vendors at the following link.

Q: Where do I submit paper claims?
A: Paper claims may be submitted at:
Aetna Medicare
PO Box 981106
El Paso, TX 79998-1106

Q: Where can I get my patient's health information?
A: 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.

Q: What if we need to obtain prior authorization for services?
A: Federal rules dictate that Medicaid is the payer of last resort. As such, prior authorizations will begin with Aetna® C-SNP. You can call **1-866-409-1221 (TTY: 711)** for questions about utilization management.

Q: How can I contact Aetna?
A: You can reach us at **1-844-826-5291 (TTY: 711)**. We're available between 8 AM through 8 PM ET, 7 days a week.

Aetna Provider Home Page	https://www.aetna.com/health-care-professionals/medicare.html
Aetna Provider Manual	https://www.aetna.com/health-care-professionals/provider-education-manuals/provider- manuals.html
Secure Provider Poral (remittance advice forms, claims, etc.)	Aetna Member, Provider, Employer, & Agent/Broker Login
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.