Aetna Better Health of Florida

Assisted Living Facility- ALF General Overview

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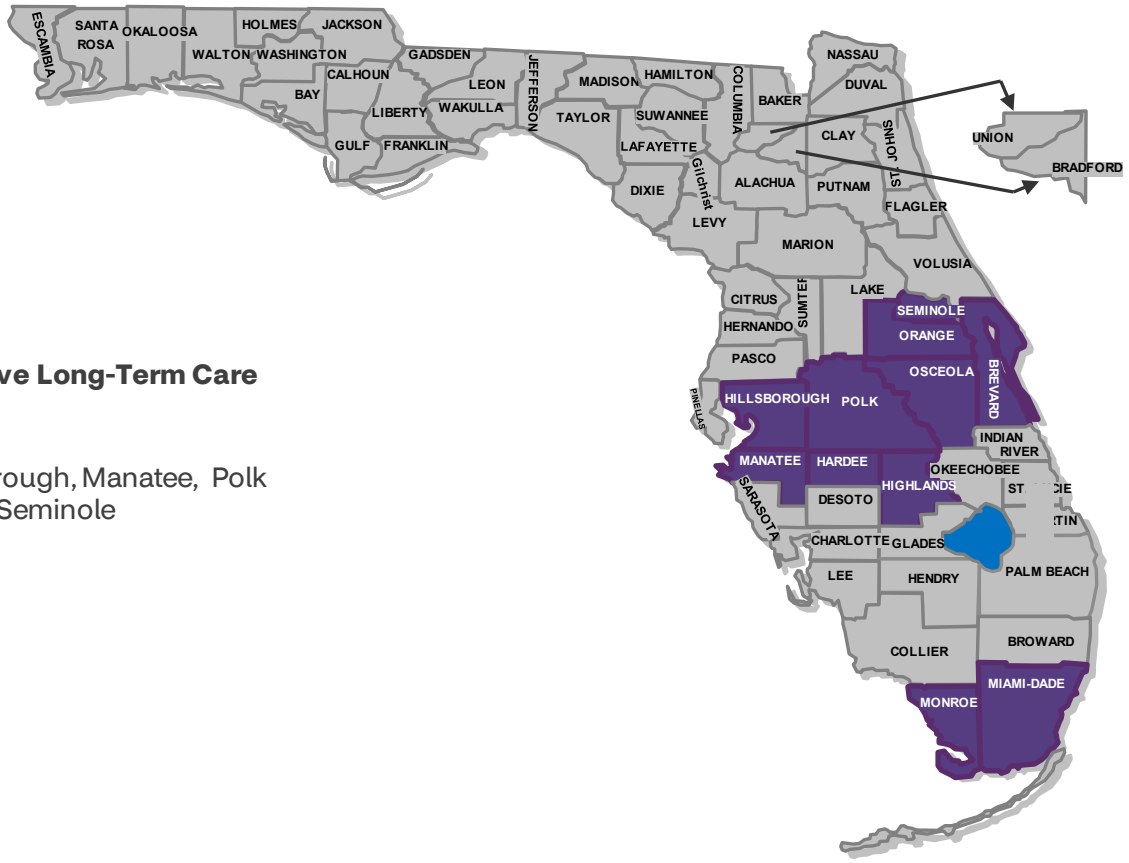
Aetna Better Health of Florida at a Glance



Medicaid (MMA) and Comprehensive Long-Term Care (LTSS)

Region 6: Hardee, Highlands, Hillsborough, Manatee, Polk
Region 7: Brevard, Orange, Osceola, Seminole
Region 11: Miami-Dade, Monroe

Eligibility

All participating and non-participating providers are encouraged to verify member's eligibility status prior to the delivery of covered services. The provider is responsible for verifying a member's current enrollment status before providing care.

Providers will not be reimbursed for services rendered to members who have lost eligibility.

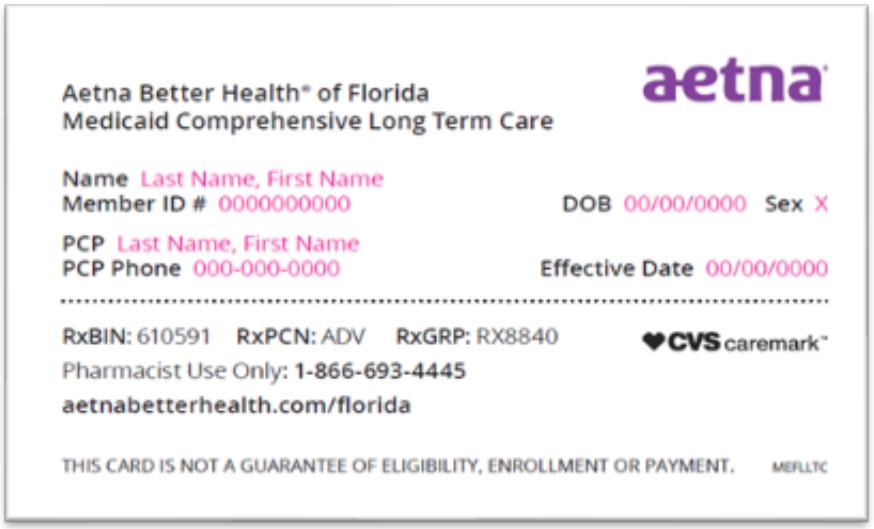
Presentation of an Aetna Better Health of Florida ID card is not a guarantee of eligibility.

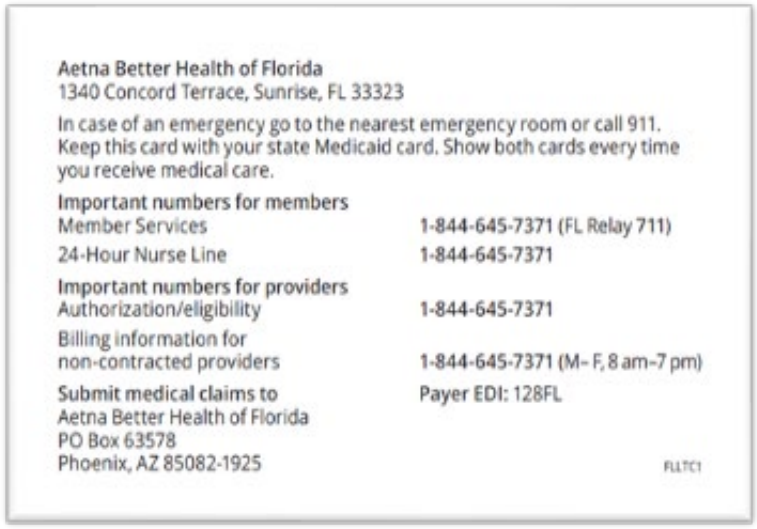
Eligibility can be verified through one of the following:

- Member Services department at 1-844-528-5815
    - To protect member confidentiality, providers will be asked for at least three pieces of identifying information such as the members identification number, date of birth and address before any eligibility information can be released.

- Secure Web Portal: www.aetnabetterhealth.com/florida/providers/provider-portal

Member Identification Card: Comprehensive Long-Term Care





The Member ID# on the Aetna Better Health ID card is the member's existing Medicaid ID number.

Covered Services- LTSS

- Adult Companion Care
- Adult Day Health Care
- Assistive Care Services
- Assisted Living
- Attendant Care
- Behavioral Management
- Caregiver Training
- Care Coordination / Case Management
- Home Accessibility Adaptation Services
- Home Delivered Meals
- Homemaker Services
- Hospice
- Intermittent and Skilled Nursing
- Medical Equipment and Supplies
- Medication Administration
- Medication Management
- Nutritional Assessment / Risk Reduction Services
- Nursing Facility Services
- Personal Care
- Personal Emergency Response Systems (PERS)
- Respite Care
- Occupational Therapy
- Physical Therapy
- Respiratory Therapy
- Speech Therapy
- Transportation Services- Non-emergency

Long-Term Care Prior Authorization

- All services for the Comprehensive Long-Term Care program require a review and approval by the Case Manager.
- Service planning must involve the member and member representative working cooperatively with the member's Case Manager.
- Service authorizations must reflect services specified in the plan of care
- Prior authorization review determinations will be based solely on the information obtained at the time of the review.
- If needed a Medical Director will review service requests for medical necessity before a denial of service authorization occurs.

Translation Services

Interpreter services are available at no cost and offered to our members when necessary, to access covered services including verbal translation and sign language for the hearing impaired.

Please contact our Member Service Department at 1-844-528-5815

For members who are hearing impaired, the health plan will utilize the 711 Telecommunications Relay Service (TRS).

Expanded Offerings- LTSS

- Assisted Living Facility/Adult Family Care Home-Bed Hold Days -thirty (30)-day bed hold for members who live in an ALF or AFCH and are age 18 and older who are admitted to the hospital or nursing home.

- Over-the-Counter Benefit- Over-the-counter products from CVS pharmacy $25.00 limit per household per month on select OTC item. No prior authorization required.

ALF Payments

Assisted Living Facilities are paid through a capitation agreement for Aetna members residing in the facilities.

Members are assigned to the ALF to ensure payments are processed and paid monthly.

- The monthly capitation is run on the 1st Sunday.
- LTSS check are date for the Thursday following the cap run
- Retro Cap Amounts will be reflected on monthly payments (positive or negative balances)
- ALFs must submit the encounter claims for which capitated payments have been received within 30 days of date of service

If you do not receive a payment for an Aetna member, please reach out to your assigned Network Consultant for assistance.

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EFT and ERA Registration

Aetna Better Health provider portal has moved into the Availity system effective January 2021.

Providers will be taken to our health plan website where the EFT and ERA forms are housed when clicking on the EFT and ERA applications.

Why should Providers Register?

- Save time and money with these electronic tools
- Electronic remittance advice (ERA) provides claims payment explanations in HIPM· compliant files.
- Electronic funds transfer (EFT) puts payment right into your account.
- Explanations of Benefits (EOBs) are on our secure provider website. Patient cost estimator is available on our provider portal on Availity.

We highly encourage providers to register for EFT and ERA. Please call our Provider Services Department at 1-844-528-5815 for assistance or your assigned Network Consultant.

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Web Connect Tool

We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health.

Within the next month, ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims, all at no cost to you. Get started TODAY!

You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until 5/31/2021.

You will be able to setup a new account in just seconds. Once you have received your new credentials, you may immediately begin checking eligibility.

Claim submission will be available to you within one business day of setting up your account. Be sure to bookmark the new login page: https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214558

Link: https://physician.connectcenter.changehealthcare.com/#/register/step1/PQCGR5mGCwgELkrDndrXQaA6NIakfqyNVLp3Qt-1Q-sI6IP6mLTz8Qf_jaeJUM9-

Timely Filing Requirements

Providers should submit timely, complete, and accurate claims to the Aetna Better Health of Florida. Untimely claims will be denied when they are submitted past the timely filing deadline. Unless otherwise stated in the provider agreement, the following guidelines apply.

Provider / Claim Type	Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **180 days** after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **365 days** after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within **ninety (90) calendar days** after the final determination of the primary payer. (SMMC Contract) (Section VIII)(E)(1)(h)
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare. (SMMC Contract) (Section VIII)(E)(2)(d)(2)
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within **180 days** from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within **thirty-five (35) days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

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Questions? We've got answers.

Just call our Provider Services Department at 1-844-528-5815 .

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