2025 Provider Manual

- Medicaid (MMA) Comprehensive Long Term Care (LTC)
- Human Immunodeficiency Virus/Acquired Immunodeficiency
- Syndrome (HIV/AIDS) Specialty Product
- Serious Mental Illness (SMI) Specialty Product

AetnaBetterHealth.com/Florida

ABHFL – 2025.02.01 – Rev 2025.06.09

Table of Contents

Introduction to Aetna Better Health of Florida

Welcome

Welcome to Aetna Better Health of Florida. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Floridians who need us the most. As a Medicaid (MMA), Comprehensive Long Term Care (LTC), HIV/AIDS Specialty Product and Serious Mental Illness (SMI) Specialty Product provider, you play an important role in the delivery of healthcare and support services to our members. The Provider Manual is intended to be used as an orientation tool and guideline for the provision of covered services to members. This manual contains policies, procedures, and general reference information including minimum standards of care which are required of Plan providers. As a Network provider, we hope this information will help you better understand Aetna Better Health of Florida.

Should you or anyone on your staff have any questions about any information contained in this manual or anything else about Aetna Better Health of Florida, please feel free to contact the Provider Relations department. We look forward to working with you and your staff to provide quality managed healthcare service to our members. Our vision is to benefit all stakeholders while considering consumer choice and outcomes, provider qualifications, and Aetna Better Health of Florida's requirements. "Agency" or "AHCA" may be used herein to reference the Florida Agency for Health Care Administration.

Experience and innovation

We have more than 30 years' experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and cost-effective outcomes.

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, case management, and state-of-the-art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.
We work closely and cooperatively with providers to achieve sustainable improvements in service delivery. We are committed to building on the significant improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Meeting the promise of Managed Care

Our state partners chose us because of our expertise in effectively managing integrated health models for Medicaid that provides quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their health, their quality of life, and the social determinants of health that impact their health and wellness. Aetna Better Health of Florida has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

Aetna Better Health of Florida offers Medicaid (MMA), Comprehensive Long Term Care (LTC), HIV/AIDS Specialty Product and Serious Mental Illness (SMI) Specialty Product in the following regions and counties:

- Region D: Hillsborough, Polk, Manatee, Hardee, Highlands.
- Region E: Seminole, Orange, Osceola, Brevard.
- Region I: Miami-Dade, Monroe.

Purpose of this manual

The purpose of this Provider Manual ("Manual") is to ensure that Aetna Better Health of Florida provides your office with our most updated Medicaid (MMA), Comprehensive Long Term Care (LTC), HIV/AIDS Specialty Product and Serious Mental Illness (SMI) Specialty Product business guidelines and requirements necessary to conduct business transactions with Aetna Better Health of Florida.

The manual contains meaningful information that makes it easier for you to work with us more effectively and efficiently. Topics range from how to get claims paid faster to learning how to reduce administrative burdens. We designed the provider manual to give you more time to focus on what's most important to you - improving the health and well-being of your patients.

Periodically, it will become necessary to update this Manual. Updated versions of this Manual are available on our Aetna Better Health of Florida website in our Provider materials and forms page. Significant updates/changes that impact service authorization, claims payment, or grievance and appeals process may also be delivered via fax, mailing or other electronic means with thirty (30) days' advance notice. All updates/changes are recorded on the last page of this manual indicating a description, summary, page number, and the date of the update/change. Please retain updates for future reference and guidance. Additional reference material can be located in our notices and newsletters.

Protocols and guidelines

Provider acknowledges and agrees that (i) all decisions rendered by the Plan its administration of the Agreement, including, but not limited to, all decisions with respect to the determination of whether or not a service is a covered service, are made solely to determine if payment of benefits under applicable member contract is appropriate; and (ii) any and all decisions relating to the necessity of the provision or non-provision of medical services or supplies shall be made solely by the member and provider in accordance with the usual provider patient relationship and provider as applicable, shall have sole responsibility for the medical care and treatment of members under their care. Providers should encourage members under their care to review their member contract concerning benefits, procedures and exclusions or limitations prior to receiving treatment.

Contact Information

Health Plan information

Health Plan line of business
Medicaid (MMA), Comprehensive Long-Term Care (LTC), HIV/AIDS Specialty Plan and Serious Mental Illness (SMI) Specialty Plan

Health Plan address
Aetna Better Health of Florida
261 N University Drive
Plantation, FL 33324

Provider and member services

Member Services Hours of Operation
Monday – Friday
7:30AM –7:00 PM ES

Phone Numbers
Comprehensive Plan
Managed Medicaid (MMA): **1-800-441-5501**
Long Term Care (LTC): **1-844-645-7371**

Fax Numbers
Provider Services Fax: **1-844-235-1340**
Member Services Fax **959-888-4124**
Case Management Fax: **1-844-404-5455**
Grievance & Appeals Fax: **1-860-607-7894**

Deaf or Hearing-Impaired Florida Relay
TTY **711**

Nurse Line – 24 Hours
MMA: **1-800-441-5501 option 5**
LTC: **1-844-645-7371 option 5**

Provider Services Email Address:
FLProviderEngagement@aetna.com

Provider Network and Contract Management Email Address:
FLMedicaidContracting@aetna.com

Behavioral Health Network and Contract Management
BSN (Behavioral Services Network)
833-907-7470
BSN Provider Portal:
https://providers.bsnnet.com/auth/login

Claims

Claims/billing Address
Aetna Better Health of Florida
P.O. Box 982960
El Paso, TX 79998-2960

Claims payer ID
Office Ally: Office Ally | Transform Your Medical Practice
ID for EDI: 128FL
Real Time Payer ID: ABHFL

Claim timely filing – initial & corrected claims
180 days from date of service or date of discharge

Claims inquiry / claims research (CICR)
MMA:**1-800-441-5501 (TTY: 711)**
LTC: **1-844-645-7371 (TTY: 711)**

Contact Information

Provider tools

Availity
Main Webpage: https://availity.com/
Availity Essentials/EDI Clearing house: 1-800-282-4548
Registration: https://availity.com/Essentials-Portal-Registration
Training Resources: 24/7 access to training resources and recorded webinars: https://availity.com/Essentials
Technical Issues Support: 1-800-282-4548
Hours of Operation: M-F 8AM-8PM EST (except holidays)

EFT/ERA Registration
To enroll in EFT/ERA Registration Services (EERS) visit **Aetna Better Health ECHO portal.**

Support Team Phone: 1-888-834-3511 (TTY:711)
Email: allpayer@echohealthinc.com

Prior authorization and case management

Prior Authorization Phone Number Case Management
Comprehensive Plan
Managed Medicaid (MMA): **1-800-441-5501**
Long Term Care (LTC): **1-844-645-7371**

Email: FL_LTC_SAT@aetna.com

Prior Authorization Fax Numbers
Medicaid (general services): **1-860-607-8056**
Obstetrics: **1-860-607-8726**
Pharmacy: **1-855-799-2554**
Behavioral Health: **1-833-365-2474**

Grievance and appeals

By Mail:
Aetna Better Health of Florida PO Box 81040
Cleveland, OH 44181
Email: FLAppealsandGrievances@aetna.com

Phone: MMA: 1-800-4415501 (TTY: 711), LTC: 1-844-645-7371 (TTY:711), FHK: 1-844-528-5815 (TTY: 711)
Fax: 1-860-607-7894

Maternity care

Progeny
ProgenyHealth Phone Number: 1-855-231-4730
Hours of Operation: M-F 8:30AM to 5:00PM ET
Maternity Services email: maternity@progenyhealth.com
**Do not include PHI information*

NICU
ProgenyHealth Phone Number: 1-855-231-4730
Hours of Operation: M-F 8:30AM to 5:00PM ET
NICU Services email: PVAsupport@progenyhealth.com
**Do not include PHI information*
Submissions including PHI send to via sFax to: 1- 866-253-1916

Contact Information

Pharmacy

Pharmacy Helpdesk Number
1-866-693-4445

CVS Mail Order Phone Number
1-855-271-6603

Non-emergency transportation

Phone number: 1-866-799-4463
(selection language, then follow prompts to verify line of business, recipient phone number, and date of birth before speaking with a representative)

Hours of operation during non-holidays:
Reservations must be made M-F, 8:00 a.m. to 5:00 p.m. (EST)

To make a reservation, please call the reservation line at 1-866-799-4463 at least 1 business day in advance but no more than 30 days before your appointment.

Contact after hours or weekends & Ride Assist Help Line: 1-866-799-4464
Use Ride Assist if transportation is late arriving, or to schedule a ride from a facility.

To report fraud & abuse

Fraud & Abuse Hotline
1-855-415-1558 (TTY: 711)

Aetna Better Health of Florida Compliance Hotline
1-888-891-8910

Florida Medicaid Consumer Complaint Hotline Agency for Health Care Administration Medicaid Program Integrity
2727 Mahan Drive, MS #6
Tallahassee, FL 32308
1-888-419-3456
www.ahca.myflorida.com

Aging and Disability Resource Center
1-800-963-5337
www.Elder Affairs.state.fl.us

Aetna Better Health of Florida Special Investigations Unit (SIU)
1-800-338-6361

Florida Attorney General's Office
1-866-966-7226

Florida Department of Children and Families
ACCESS
1-866-762-2237
www.myflfamilies.com

Florida Department of Health (DOH)
1-850-245-4444
www.floridahealth.gov/

To report abuse, neglect or exploitation of elder and disabled adults

Florida Protective Services
1-800-96ABUSE or 1-800-962-2873

The National Domestic Violence Hotline
1-800-799-SAFE (7233)

Administrative Overview

Provider tools

The Plan offers easy access to a variety of functions, web-based tools, and resources on aetnabetterhealth.com/florida. All providers may use this resource to access business activity information such as:

Processes	Tools and materials	Policies and guidelines	Education
Complaints and appeals	Business materials and forms	Clinical guidelines and policy bulletins	Health equity
Prior authorization	Provider manuals	HEDIS	Opioid misuse and addiction resources
Pharmacy prior authorization	Provider Portal	Preferred drug list	Orientation and training
	Notices and newsletters		Webinar trainings

Provider Portal

The Availity Provider Portal (Availity Essentials) is our preferred and trusted source for payer information. It gives you the info, tools and resources you need to support the day-to-day needs of your patients and office. The Provider Portal helps you spend less time on administration so you can focus more on patient care. You get a one-stop portal to quickly perform key functions you do every day. Availity also allows providers to directly communicate with Aetna's clinical and administrative staff through the Contact Us application.

Providers support capabilities offered through Availity include the ability for providers to:

- Claim Submissions
- Claim Status Inquiries
- Payer Space
- Contact Us Messaging
- Appeals & Grievance
- Appeals & Grievance Status
- Panel Rosters
- Specialty Pharmacy Prior Authorization
- Prior Authorization Submission
- Prior Authorization Status
- Eligibility and Benefits
- Reports & PDM

How to get started

If your practice already uses Availity, simply contact your administrator to request a username. If you don't know who your administrator is, call Availity at 1-800-282-4548 for help.

If your practice is new to Availity, you can use the registration link to set up your account: **https://www.availity.com/essentials-portal-registration/**

Provider Relations team is available to address questions regarding the web site and services. You may contact a representative via the **FLProviderEngagement@aetna.com** email.

Translation services

If a language barrier prevents you from communicating effectively with our members, we have translation services available to assist. Our language line provides interpreter services at no cost. Please contact our Member Service Center at **1-800-441-5501** (MMA) **or 1-844-645-7371** (LTC). Inform the Member Service Representative of your need of an interpreter and the language. The connection will be made for you.

For individuals with hearing impairment, we offer a **711** relay. For members who are hearing impaired, the health plan will utilize the **711** Telecommunications Relay Service (TRS). Members should call **711** and a representative will contact Member Service on their behalf.

As a provider of services, you should be aware of members who do not speak English or who have hearing impairments. Under Title VI of the Civil Rights Act and the Federal Rehabilitation Act, interpreter services must be available to ensure effective communication regarding treatment, medical history, or health education. The Plan will arrange and pay for trained professionals when technical, medical or treatment information needs to be discussed with members. Please contact our Member Service department at or **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC). If you need translation services.

Providers must offer the member access to interpreter services, even when the member brings a friend or family member to interpret.

In this event, the member must be offered interpreter services and be informed that the services are available at no charge; the friend or family member should not be used to interpret unless specifically requested by the member, after having been advised of the availability of free interpreter services.

IVR (Integrated Voice Response System)

Access to information such as eligibility, claim status and authorization are available by using our Integrated Voice Response system (IVR) through Member Services and following the appropriate prompts at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC).

Forms and reference documents

Required forms and reference documents can be downloaded and printed from: **AetnaBetterHealth.com/Florida**. The Prior Authorization and Referral Form are available in the Forms section of the Manual.

Designated liaison

Each Provider's office shall designate an office manager or administrator to be the primary contact person for the Provider Engagement department.

Member responsibility

Providers acknowledge and agree that the Plan will have no financial or other liability with respect to a member's failure to pay amounts due the providers for co-payment, co-insurance, or deductible as

required under the member's contract or for non-covered services. Providers may not refuse to provide services to an eligible member solely because the member fails to pay the applicable co-payment at the time services are rendered.

Direct access and cost-sharing

Providers shall, as mandated by State or Federal law, the applicable member contract and this Manual; (i) allow members direct access to certain specialist physicians; (ii) not inhibit members' self-referral for certain services, including mammography screening and influenza vaccinations; and (iii) not impose cost- sharing on any member for influenza or pneumococcal vaccines. To the extent permitted by applicable law and benefit plan design (i.e. open access), members may self- refer without a primary care physician ("PCP") referral for (a) mental and behavioral health services, (b) gynecologists and obstetricians; (c) chiropractors; (d) podiatrists for routine care; (e) dermatologists for five (5) visits per year; and (f) optometrists, if such services are covered for the member, in addition to any other services for which applicable law allows directaccess.

Marketing

Any provider marketing activities or materials for Aetna Better Health of Florida must be approved by us in advance to ensure compliance with CMS and Agency for Health Care Administration (AHCA) guidelines. This mandatory review will include letters announcing affiliation with Aetna Better Health of Florida, plan availability, events, health fairs, etc. Any gifts or promotional items must also follow guidelines promulgated by CMS and AHCA. Contact the Provider Engagement representative for more information at **1-800-441-5501.**

Providers may not make available, accept, or distribute Aetna Better Health of Florida enrollment applications or offer inducements to enroll in a specific plan. Providers shall not offer anything of value to induce a prospective Member to select them as their provider.

Compliance and ethics program

The Plan is dedicated to conducting our business in accordance with the highest standards of ethical conduct. We are committed to conducting business activities with uncompromising integrity and in full compliance with the Federal, State, and local laws governing the health benefits industry. This commitment applies to relationships with shareholders, customers (members, Federal providers, State, and local governments), vendors, competitors, auditors, and all public and government bodies. Most importantly, it applies to Directors, Officers, employees, and representatives. Each employee is responsible for upholding the highest level of ethical standards that exemplify professionalism and promote confidence in the organization.

Provider subcontractor responsibilities

The Plan will be responsible for all work performed under Agency Contract, but may, with the prior written approval of the Agency, enter into subcontracts for the performance of work required under the Agency Contract. All subcontracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106.

Independent contractor relationship

In consideration of monthly premium payments made on behalf of Members, the Plan agrees to arrange for the delivery of health care services in accordance with and subject to the terms and

conditions of the applicable member contract entered between the members, or on the member's behalf, and the Plan.

Provider agrees the Plan, in so arranging for the delivery of health care services and supplies to members, provides such services, or supplies through independently contracted providers.
In accordance with the agreement, provider and the Plan are independent contractors. The Plan shall not be liable for any negligent act or omission committed by a provider or any provider staff or hospital vendor who may from time to time, furnish services or supplies to members. Provider acknowledges and agrees that any decisions made by the Plan concerning appropriateness of setting or whether any service is covered are made solely for purposes of determining whether benefits are due under the applicable member contract, and not for purposes of recommending any medical treatment or non-treatment.

Member Eligibility and Enrollment

To become a member with Aetna Better Health of Florida, a member must first be eligible for the Medicaid (MMA), Comprehensive Long Term Care (LTC), HIV/AIDS Specialty Product and Serious Mental Illness (SMI) Specialty Product. Benefits are predetermined by the State of Florida and not Aetna Better Health of Florida. The Agency for Health Care Administration (AHCA) must approve a member's enrollment with Aetna Better Health of Florida. A member's coverage with us starts on the first day of the month after the member receives approval from AHCA that their enrollment was accepted.

To be eligible for Florida Medicaid, a person must:

- Be a resident of Florida.
- Be a U.S. Citizen.
- Meet specific standards for financial income and resources.

In addition, a person must qualify for the Florida Comprehensive Long Term Care Program by meeting a nursing home level of care need as determined by CARES.

Our members

Our members may include the following groups:

- Temporary Assistance for Needy Families (TANF).
- Supplemental Security Income (SSI) — Aged, Blind and Disabled (ABD) and related groups.
- Institutional Care.
- Hospice.
- Aged / Disabled Adult waiver.
- Individuals who age out of Children's Medical Services and meet the following criteria for the Aged/ Disabled Adult waiver:
  - Received care from Children's Medical Services prior to turning 21.
  - Age 21 and older.
  - Cognitively intact.
  - Medically complex.
  - Technologically dependent.
- Assisted Living waiver.
- Nursing Home Diversion waiver.
- Channeling waiver.
- Low Income Families and Children.
- MEDS (SOBRA) for children born after 9/30/1980 (age 18 – 20).
- MEDS AD (SOBRA) for aged and disabled.
- Protected Medicaid (aged and disabled).
- Full Benefit Dual Eligible (Medicare and Medicaid).
- Individuals enrolled in the Frail / Elderly Program component of United Healthcare HMO.
- Medicaid Pending for Long Term Care Managed Care HCBS waiver services.
- Living with HIV/AIDS.
- One, or a combination of the following conditions: Psychotic disorders, bipolar disorder, major depression, schizo-affective disorder, delusional disorder, obsessive-compulsive disorder.

Open enrollment

Members have the option to change health plans during the initial 90 days after the effective date of enrollment (the member's anniversary date). Thereafter, members can change Health Plans annually during open enrollment, in which they will have a 60-day period to change Health Plans. The Agency will send members a notice of their option to change Health Plans and the associated deadline. Enrollment in a new Health Plan will be effective on the member's anniversary date.

Disenrollment

Member may disenroll from Aetna Better Health of Florida at any time during the first 120 days of enrollment. After the first one hundred and twenty (120) days, the member is "locked in" as an Aetna Better Health of Florida member unless there is a "For Cause" Reason to dis-enroll. The Agency for Health Care Administration (AHCA) will review any relevant documentation submitted by the member regarding the disenrollment request and make a final determination about whether to grant the disenrollment request.

AHCA will send a written correspondence to the member of any disenrollment decision. Members dissatisfied with AHCA's determination may request a Florida Medicaid fair hearing, pursuant to 42 CFR Part 431, Subpart E.

Member identification card

All members receive an identification (ID) card shortly after enrollment. Members must present their ID card to their provider at the time services are rendered. If the member is a recent member who has not yet received a card, he/she must present a copy of the enrollment form. The ID card will list the member's name, member number, primary care physician (PCP) (if applicable), group name and number, the benefit plan type, as well as copayments or coinsurance for office visits, prescriptions, outpatient, and inpatient services. Benefits vary among different products. Therefore, it is important to reference the member ID card for the correct copayment or coinsurance amount. The ID card will also contain important Member Services phone numbers for the Plan and the pharmacy vendor.

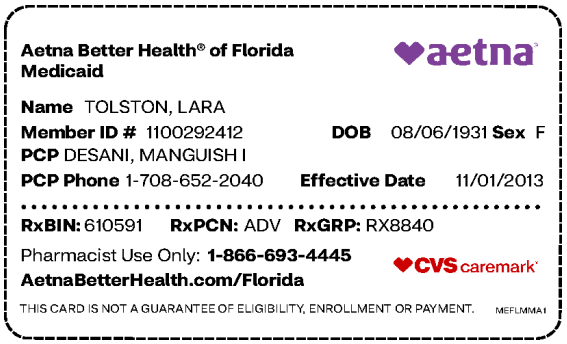
Please note that some members may still carry a Medicaid card for those services not covered under Aetna Better Health of Florida. In addition, some members may have Medicare coverage and will receive a separate Medicare ID card from the Centers of Medicare and Medicaid (CMS). This is often referred to as a red, white, and blue card. If the member has Original Medicare, they will use the Aetna Better Health of Florida ID card instead to receive services. They will NOT use their Medicare card.

The member ID card contains the following information:

Member Name	Claims Address
Member ID Number	Health Plan Name - Aetna Better Health of Florida
Date of Birth of Member	Aetna Better Health of Florida Logo
Member's Gender	Aetna Better Health of Florida's Website
Effective Date of Eligibility	Carrier Group Number

Medicaid Sample ID Card(s)

Medicaid – MMA



Aetna Better Health® of Florida
Medicaid

aetna

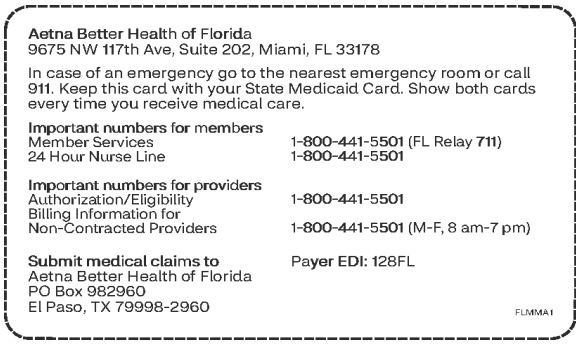
Name TOLSTON, LARA
Member ID # 1100292412 **DOB** 08/06/1931 **Sex** F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 **Effective Date** 11/01/2013

RxBIN: 610591 **RxPCN:** ADV **RxGRP:** RX8840

Pharmacist Use Only: **1-866-693-4445**
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLMMA1



Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

Important numbers for members
Member Services 1-800-441-5501 (FL Relay 711)
24 Hour Nurse Line 1-800-441-5501

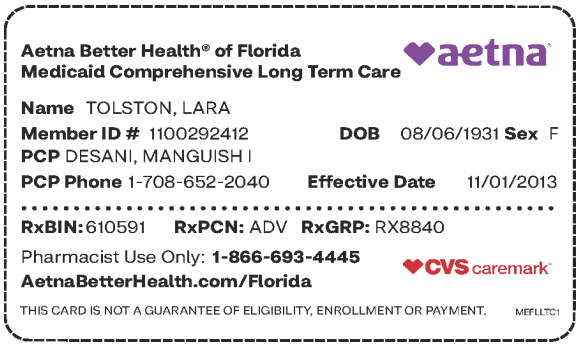
Important numbers for providers
Authorization/Eligibility 1-800-441-5501
Billing Information for Non-Contracted Providers 1-800-441-5501 (M-F, 8 am-7 pm)

Submit medical claims to
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

Payer EDI: 128FL

FLMMA1

Medicaid – Comprehensive Long-Term Care



Aetna Better Health® of Florida
Medicaid Comprehensive Long Term Care

aetna

Name TOLSTON, LARA
Member ID # 1100292412 **DOB** 08/06/1931 **Sex** F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 **Effective Date** 11/01/2013

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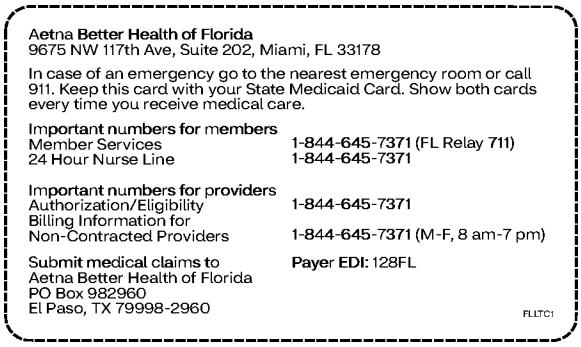

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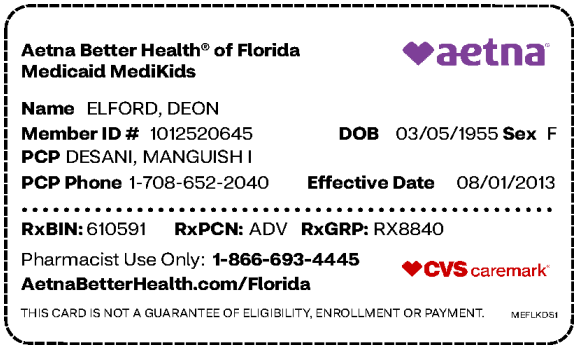
Payer EDI: 128FL

FLLTC1

MediKids



Aetna Better Health® of Florida
Medicaid MediKids

aetna

Name ELFORD, DEON
Member ID # 1012520645 **DOB** 03/05/1955 **Sex** F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 **Effective Date** 08/01/2013

RxBIN: 610591 **RxPCN:** ADV **RxGRP:** RX8840

Pharmacist Use Only: **1-866-693-4445**
AetnaBetterHealth.com/Florida

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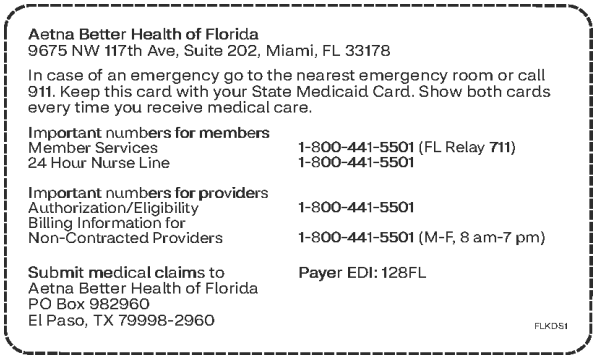
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLKDS1



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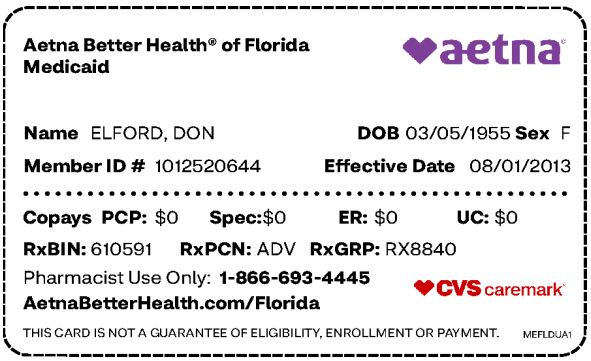
FLKDS1

Dual Eligible



Aetna Better Health® of Florida
Medicaid

aetna

Name ELFORD, DON **DOB** 03/05/1955 **Sex** F
Member ID # 1012520644 **Effective Date** 08/01/2013

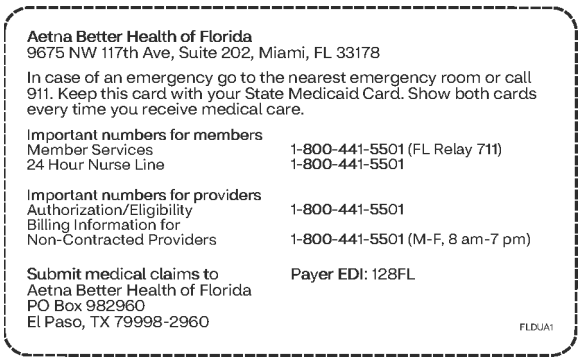
Copays PCP: $0 **Spec:**$0 **ER:** $0 **UC:** $0

RxBIN: 610591 **RxPCN:** ADV **RxGRP:** RX8840

Pharmacist Use Only: **1-866-693-4445**
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLDUA1



Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

Important numbers for members
Member Services 1-800-441-5501 (FL Relay 711)
24 Hour Nurse Line 1-800-441-5501

Important numbers for providers
Authorization/Eligibility 1-800-441-5501
Billing Information for Non-Contracted Providers 1-800-441-5501 (M-F, 8 am-7 pm)

Submit medical claims to
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

Payer EDI: 128FL

FLDUA1

Mixed Services

Medicaid services that are covered in both the LTC and the Managed Medical Assistance programs. When covered by both the member's LTC and MMA plans, such services are the responsibility of the LTC plan.

Mixed services may exceed State Plan limits on those services in accordance with mixed services policy. The Long Term Care benefit includes coverage of the following mixed services:

Assistive care

In accordance with Rule 59G-4.025, F.A.C., an integrated set of 24-hour services only for members residing in adult family care homes.

Attendant nursing care

In accordance with Rule 59G-4.261, F.A.C., for members under the age of 21 years. To provide nursing care of both a supportive and health related nature, specific to the needs of a medically stable, physically handicapped member age 21 and older who requires more individual and continuous care than an intermittent nursing visit. The scope and nature of these services do not otherwise differ from private duty nursing services furnished to persons under the age of 21 years.

Hospice

In accordance with Rule 59G-4.140, F.A.C.

Intermittent skilled nursing

In accordance with Rule 59G-4.130, F.A.C. This service includes the provision of skilled nursing services at intervals of more than one hour apart, and for the length of time necessary to complete the service, for members who do not require continuous nursing care (see attendant nursing care services).

Medical equipment and supplies

In accordance with Rule 59G-4.070, F.A.C. this service includes the provision of medical equipment and supplies specified in the plan of care, including: devices, controls, or appliances that enable the member to increase the ability to perform activities of daily living; devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which he or she lives; items necessary for life support or to address an member's physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State Plan that is necessary to address member needs, including consumable medical supplies, such as adult diapers; and repair of such items or replacement parts.

Personal care

In accordance with Rule 59G-4.215, F.A.C., for members under the age of 21 years. To assist with ADLs and IADLs, including assistance with preparation of meals, and housekeeping chores which are incidental to the care furnished or are essential to the health and welfare of the member. The scope and nature of these services do not otherwise differ from personal care services furnished to persons under the age of 21 years.

Occupational therapy

In accordance with Rule 59G-4.318, F.A.C., for members under the age of 21 years. To provide treatment to restore, improve, or maintain impaired functions (as determined through a multi-disciplinary assessment) to increase or maintain a member's ability to perform tasks required for independent functioning and to improve an member's capability to live safely in the home setting. The scope and nature of these services do not otherwise differ from occupational therapy services furnished to persons under the age of 21 years.

Physical therapy

In accordance with Rule 59G-4.320, F.A.C. To provide treatment to restore, improve, or maintain impaired functions by using of physical, chemical, and other properties of heat, light, electricity, or sound, and by massage and active, resistive, or passive exercise.

Respiratory therapy

In accordance with Rule 59G-4.322, F.A.C., for members under the age of 21 years. This service includes the provision of ventilator support, therapeutic and diagnostic use of medical gasses, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises, and chest physiotherapy. The scope and nature of these services do not otherwise differ from respiratory therapy services furnished to persons under the age of 21 years.

Speech therapy

In accordance with Rule 59G-4.322, F.A.C., for members under the age of 21 years. The provision of services to identify and treat neurological deficiencies related to feeding problems, congenital or trauma- related maxillofacial anomalies, autism, neurological conditions that affect oral motor functions, or when provided to evaluate and treat problems related to oral motor dysfunction. The scope and nature of these services do not otherwise differ from speech therapy services furnished to persons under the age of 21 years.

Transportation

In accordance with Rule 59G-4.330, F.A.C. The provision of transportation to and from the LTC covered services and expanded benefits as described in the LTC plan's contract with AHCA.

Who pays for mixed services?

LTC members will get most mixed services from their LTC plan. The following shows which plan is responsible

Long-term Care Plan pays for:	Managed Medical Assistance Plan pays for:
Assistive care services Case Management Nursing (includes Home Health) Hospice Durable medical equipment and supplies Therapy services Non-emergency transportation to services covered by the LTC plan	Non-emergency transportation to services covered by the MMA plan; All emergency transportation

To find out more about mixed services or other information about the LTC or MMA programs, please visit the Agency's website at: **http://ahca.myflorida.com/SMMC**.

Emergency Services Responsibilities

Aetna Better Health of Florida has an emergency management plan that specifies what actions Aetna Better Health will take to ensure the ongoing provision of covered services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and attack- related emergencies. Aetna Better Health of Florida offers an after-regular business hours provider services line that is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. This will not be construed to mean that the provider must obtain verification before providing emergency services and care.

- The Plan will provide pre-hospital and hospital-based trauma services and emergency services and care to members. See ss. 395.1041, 395.4045 and 401.45, F.S.
- The Plan will authorize a minimum of three (3) days' coverage of emergency behavioral health inpatient services and care when provided according to this provision and resulting from a Baker Act admission.
- When a member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists will be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.
- The physician, or the appropriate personnel, will indicate on the member's chart the results of all screenings, examinations, and evaluations.
- The Plan will cover all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member's condition is an emergency medical condition.
- If the provider determines that an emergency medical condition does not exist, the Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.
- If the provider determines that an emergency medical condition exists, and the member notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is a member of the Plan, the hospital must make a reasonable attempt to notify:
  - The member's PCP, if known, or
  - The Plan, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.
- If the hospital, or any of its affiliated providers, do not know the member's PCP, or have been unable to contact the PCP, the hospital must:
  - Notify the Plan as soon as possible before discharging the member from the emergency care area; or
  - Notify the Plan within twenty-four (24) hours or on the next business day after the member's inpatient admission.
- If the hospital is unable to notify the Plan, the hospital must document its attempts to notify the

Plan, or the circumstances that precluded the hospital's attempts to notify the Plan. The Plan will not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.

- If the member's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the member, the Plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the member within the scope of the physician's hospital staff privileges.
- The Plan will advise all members of the provisions governing emergency services and care. The Plan will not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Plan will not deny payment for treatment obtained when a representative of the Plan instructs the member to seek emergency services and care in accordance with s. 743.064, F.S.

- The Plan will cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the Plan can safely transport the member to a participating facility. The Plan may transfer the member, in accordance with State and federal law, to a participating hospital that has the service capability to treat the member's emergency medical condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) and 42 CFR 457.1228 as responsible for coverage and payment.

- In accordance with 42 CFR 438.114, 42 CFR 457.1228 and s. 1932(b)(2)(A)(ii) of the Social Security Act, the Plan will cover post-stabilization care services without authorization, regardless of whether the member obtains a service through a participating or nonparticipating provider. Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non- emergency services. The Plan can choose not to cover non-emergency services if they are provided by a non-participating provider, except in any circumstances detailed below.

    - Post-stabilization care services that were pre-approved by the Plan.
    - Post-stabilization care services that were not pre-approved by the Plan because the Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request.
    - The treating provider could not contact the Plan for pre-approval.

- The Plan will provide emergency services and care without any specified dollar limitations.

- The Plan will authorize payment for non-participating physicians for emergency ancillary services provided in a hospital setting. The Plan will provide emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV. Emergency service providers will make a reasonable attempt to notify the Plan within twenty-four (24) hours of the member's presenting for emergency behavioral health services. In cases in which the member has no identification or is unable to identify himself/herself orally when presenting for behavioral health services, the provider will notify the Plan within twenty-four (24) hours of learning the member's identity.

- The Plan will not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

The Plan will ensure providers not known to Florida Medicaid that rendered services during a disaster or emergency declared by a Governor's Executive Order, as confirmed by the Agency, complete the Agency's provisional (temporary) enrollment process to obtain a provider identification number for services rendered to members.

Weather and emergency-related closings

At times, emergencies such as severe weather, fires, or power failures can disrupt operations. In such instances, it is important for Aetna Better Health of Florida to be kept informed of your status. This is of real significance if you have an active authorization for a member.

- AHCA resources can be found at this link:
  - **http://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml**
- Emergency Status System:
  - Web-based system for reporting and tracking health care facility status before, during, and after an emergency: **https://ahca.myflorida.com/health-care-policy-and-oversight/hfrs**
    - Health Facility Reporting System (HFRS): **https://apps.ahca.myflorida.com/HFRS/**

You will need to register your facility. If you have a member and need assistance with the registration process, please contact our Provider Engagement department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC).

Provider Responsibilities

This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Florida Medicaid (MMA), Comprehensive Long Term Care (LTC), HIV/AIDS Specialty Product and Serious Mental Illness (SMI) Specialty Product programs, your Provider Agreement, and requirements outlined in this manual. Aetna Better Health of Florida may or may not specifically communicate such terms in forms other than your Provider Agreement and this Manual.

Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, the Agency for Health Care Administration (AHCA), Department of Health (DOH), Medicaid Program Integrity Bureau (MPI), the Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of Inspector General (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Providers must use of the most current diagnosis and treatment protocols and standards established by Agency for Health Care Administration (AHCA) and the medical community. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

A provider must complete an application, Provider Agreement and be fully credentialed to be approved for participation and treat any members. Upon execution of the agreement a copy will be returned to the provider for his/her records along with a welcome letter advising of product participation and effective dates.

The Plan may execute provider agreements pending the outcome of the provider enrollment process. The Plan will terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or upon expiration of the sixty (60) day period without enrollment of the provider and notify affected members in accordance with 42 CFR 438.602(b)(2).

For Public Health Providers, providers are required to contact the Plan before providing health care services to members and are required to provide the Plan with results of the office visit, including test results.

Changes to provider information or status

Please notify the Plan in writing within sixty (60) days or in accordance with your agreement of any additions, deletions or changes to the topics listed below. Failure to notify the Plan timely could negatively impact claims processing.

- Tax identification number (submission of W-9 required). Changing a tax identification number will require a new agreement with the new tax identification number.
- Office or billing address.
- Telephone or fax number.
- Specialty (may require additional credentialing).

- New physician additions to the practice (please allow time for credentialing).
- Licensure (DEA, state licensure or malpractice insurance).
- Group affiliation.
- Hospital privileges.

If you have any changes, notification is required as far in advance as possible to the Plan's Network Operations department. Notification of any changes may be submitted to Aetna Better Health through any of the following ways:

Email: FLMedicaidProviderRelations@aetna.com

Fax:

1-844-235-1340

Use our Provider Contact Us Form to tell us more about your specific request or inquiry.

Mail:

Aetna Better Health of Florida
ATTN: Provider Relations
261 N University Drive
Plantation, FL 33324

By providing the information prior to the change, the following is ensured:

- The practice address is properly listed in the Provider Directory.
- All claim payments are properly reported to the Internal Revenue Service (IRS).
- There is no disruption in claims payments and claims are processed accordingly.
- Members are notified in a timely manner if a change to their PCP becomes necessary or if they desire as a result of a provider address change or inability to continue participation.

Staff/administration changes and training

Providers are responsible to notify our Provider Engagement Department on any changes in professional staff at their locations. This includes any physicians/medical director, physician assistants, or clinician practitioners. Aetna Better Health understands that changes in office staff may result in the need for additional training. Contact our Provider Engagement Department to schedule staff training.

Continuity of care (COC)

Providers terminating their contracts without cause are required to provide a 60-day notice before terminating with Aetna Better Health of Florida. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services.

Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health of Florida is not responsible for payment of services rendered to members who are not eligible.

Aetna Better Health accepts any written documentation of prior authorization of ongoing covered services for a period of up to one hundred and twenty (120) days after the effective date of enrollment. Prior authorization of ongoing medical and behavioral health services must have written documentation that includes the following, if the services were arranged prior to enrollment with Aetna Better Health:

- Prior existing orders
- Prior authorizations
- Provider appointments (i.e., transportation, surgeries, etc.)
- Treatment plan/plan of care
- Prescriptions (including prescriptions at non-participating pharmacies)

Continuity of Care shall not exceed six (6) months after the termination date of the provider. ABHFL will continue the complete course of treatment with the member's current provider which may extend beyond one hundred and twenty (120) days continuity of care period for the following services:

- Prenatal and postpartum care
  - Regardless of the trimester in which care was started, pregnant members who have begun a course of prenatal care may continue to receive care from a terminated provider throughout the completion of pregnancy and postpartum period (6 weeks after birth).
- Transplant services (through the first-year post-transplant).
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment)
- Full course of therapy Hepatitis C treatment drugs

Continued of care requests should be submitted to the Utilization Management Department. You can contact our Member Services department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC) for any questions or submissions.

Unique identifier/national provider identifier (NPI)

Providers who provide services to Aetna Better Health of Florida members must obtain identifiers. Each provider is required to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. You may apply for an NPI number by visiting the National Plan & Provider Enumeration Systems (NPPES) website: **https://nppes.cms.hhs.gov**.

Providers are required to submit their NPI on every claim.

If you provide direct health care services to members, you need to add your national provider identifier (NPI) number to claims. Claims may be rejected or denied when submitted without an NPI or with an invalid NPI, depending on the method of submission. Be sure to:

- Use the NPI you registered with Florida Medicaid.
- Bill for services as you are registered on the Florida Provider Master List (PML). You can verify this information:
- Online: **mymedicaid-florida.com**
- Phone: Florida Medicaid Provider Enrollment Call Center at **1-800-289-7799**, Option 4.

Florida Medicaid Provider Number

Providers participating in a Florida Medicaid managed care plan are federally required to enroll in Florida Medicaid. AHCA requires that every provider who participates with Medicaid beneficiaries maintain an active status on their Medicaid ID. Failure to keep an active status disqualifies providers from receiving payment.

If your Medicaid ID shows an enrollment type of "Registered" status on AHCA's Provider Master List (PML), **claims received under your NPI will deny for Medicaid ineligibility. If you don't take action by your PML expiration date, you will be terminated from the Aetna Better Health network on your PML expiration date.**

In order for your Medicaid ID to remain active, you must update your enrollment type to "Enrolled" or "Limited Enrollment" by the PML expiration date.

You must be assigned a valid Florida Medicaid ID. You can register to obtain a valid Medicaid ID by:

- Applying directly to Medicaid by submitting a LIMITED enrollment application via the state's

online Enrollment Application (located at http://portal.flmmis.com > Provider Services > Enrollment > Online Enrollment Wizard).

- Applying directly to Medicaid by submitting a FULL enrollment application via the state's online Enrollment Application (located at http://portal.flmmis.com > Provider Services > Enrollment > Online Enrollment Wizard).

Verifying member eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. Providers are NOT 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. The provider is responsible for verifying a member's current enrollment status before providing care.

Member eligibility can be verified through one of the following:

- **Telephone Verification:** Call our Member Services department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC). To protect member confidentiality, providers are 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. Additional member eligibility requirements are noted in Section 08 of this manual.
- **Secure Availity Provider Portal**: The Secure Web Portal is a web-based platform that allows us to communicate member health care information directly with providers. Providers can perform many functions within this web-based platform.

The following information can be obtained from the Secure Web Portal:

- Member Eligibility Search – Verify current eligibility of one or more members.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Electronic Remittance Advice (ERA) Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Look up Tool – Search for provider authorizations by member, Provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
    - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously.
- Review Prior Authorization requirement by specific procedures or service groups.
- Receive immediate details as to whether the codes (s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information.
- Export CPT/HCPS code results and information to Excel.
- Verify staff is working with the most up-to-date information on current prior authorization requirements.
- Submit Authorizations – Submit an authorization request on-line.

- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member's compliance with any of the HEDIS measures. A "Yes" means the member has measures that they are not compliant; a "No" means that the member has met the requirements.
- Provider manuals.
- Provider newsletters.
- Pharmacy information.
- Electronic Fund Transfer (EFT) form – Direct deposit information to improve payment consistency.
- Network Vendor List.
- Provider notifications including all fax blast and provider bulletins.

For additional information regarding the Secure Web Portal, please visit the link https://www.aetnabetterhealth.com/florida/providers/portal.html.

Educating members on their own health care

Aetna Better Health of Florida does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care, or treatment options, including any alternative.
- treatment that may be self-administered.
- Any information the member needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Acceptance of members

Provider shall accept as patients all members that select or are assigned to a provider unless otherwise agreed upon in writing with our Provider Engagement Department. Written approval is required for a provider's panel to be frozen preventing or refusing new members. Upon approval, provider's panel may remain open only to existing patients who are members at the time the provider's panel is frozen ("Existing Members"). In such case, if a member desires to select a provider with a panel open only to existing members, the Plan will contact the provider to verify that the member meets the criteria for an existing member. If the provider confirms that this is an existing member, we will open the panel to allow that member to select the provider. Upon a provider's acceptance of a member, provider may terminate the member from its panel or as its patient only upon satisfaction of applicable provisions of these Manual and applicable laws and regulations.

If a member is non-compliant or does not comply with the member rights and responsibilities as set forth herein, the provider may notify the member of the situation in writing. However, the provider may not terminate the member from their panel or services. Provider must request, in writing, that a member be removed from their panel; provided, however, that no such request can be based on the member's medical condition, which request shall be determined by the Plan's sole discretion. Such request must be sent to our Provider Engagement Department.

The Plan shall make reasonable efforts to confirm or deny eligibility using the most current information available; provided however, that providers' compliance with such verification procedures and/or confirmation of a member's eligibility does not constitute a guarantee of such member's eligibility or the Plan's coverage of any services provided by providers in reliance on such confirmation. Providers may verify eligibility by contacting a Provider Engagement.

Managing the member's health care

Under certain member Contracts, a referral or prior authorization must be obtained prior to the provision of certain covered services, as set forth in this manual and as required by the applicable coverage plan and the agreement. All prior authorizations and referrals can be done electronically via **aetnabetterhealth-florida.aetna.com.** If a paper version is preferred, it can be downloaded and printed from the **Document Library** in the **Preauthorization Lists** section of the Plan's Provider secure website portal at **AetnaBetterHealth.com/Florida**.

No PCP referral is required for any care listed under the Direct Access provision of this manual. Except in the case of emergency services, urgently needed services, as otherwise permitted under this manual or applicable state or federal law, upon the prior written approval of a medical director or his/her designee, or as otherwise permitted under the applicable member contract, all referrals shall be made and prior authorizations obtained by providers in accordance with this manual, the agreement and the applicable member contract. Any laboratory services provided to members in providers' offices shall not be reimbursable covered services, unless otherwise expressly provided in the agreement.

PCP shall use his/her best efforts to provide members with any necessary referrals or obtain any required prior authorization while the member is in PCP's office.

Providers are required to participate in the Plan's Peer Review, Grievance and Appeals, QI, and UM activities, as directed by the Plan.

Authorizing treatment for members

Authorization is not a guarantee of payment. All providers must contact the Plan via **aetnabetterhealth-florida.aetna.com** or the Authorization Department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC) or by fax at **1-860-607-8056** to obtain a prior authorization before scheduling a member for any medical service subject to prior authorization. The Plan may require the submission of clinical information to support a prior authorization request. Hospitals shall notify the Plan of an admission occurring subsequent to the provision of emergency services.

Emergency services do not require prior authorization

IMPORTANT: The following services may not be covered under all member contracts even though such services are listed below. Members should refer to their schedule of benefits or evidence/certificate of coverage for information regarding their covered services. This applies to all member contracts.

- Drug Order for Home Use
- Chemotherapy Drug Replacement
- Physician Office Medications

Providers must contact the Plan via **aetnabetterhealth-florida.aetna.com** or the Authorization Department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC) or by fax at **1-860-607-8056** to obtain a prior authorization for services for medically necessary services for members under twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitation Handbook, Florida Medicaid Fee Schedules or Coverage Policy. This is also applicable for medically necessary services typically not covered by the Plan or for services typically limited in amount, frequency, or duration.

Timeliness of authorizations

Providers are encouraged to submit their requests for authorization of services utilizing the Provider portal at **aetnabetterhealth-florida.aetna.com**. Best efforts shall be utilized to provide requested prior authorizations promptly; provided, however, that providers agree to take a pending or tracking number in the event further information is required to make the coverage decision or if the request is subject to clinical review. For Medicaid members, routine prior authorization requests will be completed within four (4) calendar days of receipt of the request. A four (4) day extension can be provided if additional information is needed. All medical denial determinations will be made by a Florida licensed Medical Director. Denial letters will be sent to the member by U.S mail and provider by fax or U.S. mail.

It is critical to allow enough time to process standard requests in a timely manner and only submit expedited requests when truly necessary. Expedited authorization is appropriate when a provider indicates, or the Plan determines, that following the standard timeline could seriously jeopardize the members life or health or ability to attain, maintain or regain maximum function.

Urgent prior authorization requests will be processed within 48 hours of the Plan's receipt of the request unless additional information is required. The determination, approval or denial, will be verbally communicated or faxed to the requesting provider and/or the member at the time the decision is rendered followed by written notice of a denial determination to the provider and the member within (2) calendar days.

Authorization status can be obtained by using **aetnabetterhealth-florida.aetna.com**.

Membership assigned to PCPs.

Members may choose a PCP from the Provider Directory. Every month, PCPs receive a membership listing of the members that have chosen them as their PCP. PCPs shall contact any new Medicaid members within 30 days of being assigned to their panel to ask if they need any assistance or to schedule an office visit for continued medical care.

Each PCP office shall designate an encounter/referral coordinator to ensure that encounters and referrals are completed and submitted to the Plan and/or the member. Encounters may be submitted electronically or on a CMS1500 form.

Hospitalist program

Under the Plan's Hospitalist Program (the "Program"), PCP acknowledges and agrees that hospitalist physicians provide primary care services which PCP is otherwise obligated to provide under the agreement on behalf of members assigned to PCP ("PCP Members") who present as observation or as inpatients to a hospital, including, but not limited to (i) evaluation of PCP members presenting to the hospital's emergency room; (ii) conducting daily hospital rounds of PCP members; (iii) coordinating care of PCP members and ensuring timely provision of covered diagnostic tests and procedures; (iv) communicating regularly with PCP, PCP members and the PCP members' families, as appropriate; and (v) overseeing and coordinating discharge planning of PCP members with the PCP, The Plan and the hospital. PCPs who elect to participate in the program shall assign responsibility of PCP members to hospitalist physicians when PCP members present to the emergency department or are inpatients of a hospital.

In cases where a PCP elects not to participate in the program, the PCP shall continue to perform all other primary care services with respect to PCP members, including, but not limited to (i) resuming responsibility for all care, including follow-up care, of a PCP member immediately upon the PCP

member's discharge from the hospital; (ii) communicating all medical information/history to the hospitalist physician or other physician attending to a PCP member which is necessary to the PCP member's care and treatment in the hospital; and (iii) performing any and all other requirements as requested by the Plan in connection with the PCP's participation in the program.

Hospitals acknowledge and agree that if a PCP member presents to the emergency department, the hospital shall notify PCP member's PCP and/or hospitalist physician participating in the Plan's hospitalist program. There is no provision that prohibits the PCP from providing inpatient services in a participating hospital to a member if such services are determined to be medically necessary and covered services under the SMMC contract.

Specialist physicians

The member's PCP is responsible for coordinating the provision of specialist services. The Specialist and the PCP work together to coordinate medical care for the member.

Referrals for specialist services

Except for (i) emergency services; (ii) urgently needed services; (iii) as otherwise permitted under this Manual, the applicable member contract or applicable state or federal laws; or (iv) upon the prior written approval of the Plan's medical director or his/her designee, specialist shall not provide specialist services to members whose member contract has a referral requirement unless the member furnishes specialist with a completed referral from the member's PCP.

Follow-up care

Specialist shall coordinate the provision of specialist services with the member's PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, shall not provide any follow- up or additional specialist services to members other than the covered services indicated on the applicable referral form provided to specialist by the Plan or the PCP. Within ten (10) business days of providing specialist services to a member, specialist shall furnish the member's PCP with a written report regarding the member's medical condition in such form and detail reasonably acceptable to the member's PCP and the Plan. Specialist shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional, or follow-up covered services.

Except in the case of emergency services, **Urgently Needed Services**, as otherwise permitted under the applicable member contract, applicable law or upon the prior written approval of the Plan's medical director or his/her designee, specialist shall refer members back to the member's PCP in the event specialist determines the member requires the services of another specialist physician.

Urgently Needed Services/Urgent care

Covered Services for conditions that (i) though not life- threatening, could result in serious injury or disability to the member unless medical attention is received or (ii) substantially restrict a member's activity; and (iii) which are provided (a) when a member is temporarily absent from the service area or; (b) under unusual and extraordinary circumstances, when the member is in the service area but all participating providers are temporarily unavailable or inaccessible when such covered services are medically necessary (as defined under Medicaid) and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain

the covered services through a participating provider.

Examples include, without limitation, high fever, animal bites, fractures, severe pain, infectious illness, flu, and respiratory ailments.

Obstetricians

The obstetrical notification form should be completed during a members' first prenatal visit. The form is located in the Document Library under the Preauthorization Lists section of the Plan's website at **AetnaBetterHealth.com/Florida.** The obstetrical notification form should be faxed to Aetna Better Health at **1-860-607-8726**.

Prescriptions from OB/GYN

A gynecologist or obstetrician may issue prescriptions for (i) covered services which do not otherwise require prior authorization in accordance with this Manual; and (ii) covered services provided by gynecological oncologists, maternal and fetal medicine specialists, reproductive endocrinologists, and uro-gynecologists. The gynecological oncologist, maternal and fetal medicine specialist, reproductive endocrinologist, or uro-gynecologist must contact Aetna Better Health at **1-800-441-5501** directly for prior authorization prior to providing services to members.

Hospital services

For Hospital Services, members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand. Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.

Hospital emergency services

In the case of an emergency medical condition, hospitals are not required to obtain prior authorization from the Plan prior to providing emergency services to members; provided, however, that upon admitting a member into the hospital, the hospital shall immediately notify the hospitalist physician participating in the Plan's hospitalist program or other designated provider of such admission and obtain the required prior authorization by going to **aetnabetterhealth-florida.aetna.com** or contacting the Prior Authorization Department at **1-800-440-5501** in accordance with this manual.

Except for emergency services, coverage of all services rendered to members by hospital is subject to the Plan's sole determination of whether such service is a covered service under the applicable member contract. In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, hospital must comply with all prior authorization requirements as set forth in this manual prior to providing any non-emergency services to a member.

Hospital's failure to obtain all required prior authorizations for non-emergency services may, in the Plan's sole discretion, result in the Plan's denial of payment for such services as set forth in the agreement.

Hospital shall comply with this manual and the agreement in providing non-emergency services to members. Hospital acknowledges and agrees that the Plan has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay in accordance with the Manual.

Follow-up care

To facilitate safe discharge, hospitals are expected to ensure post-discharge appointments are scheduled prior to discharge. These post-discharge appointments are to be communicated to the health plan. Hospital shall coordinate the provision of hospital services with the member's PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, as otherwise permitted under the manual or applicable state or federal law or upon the prior written approval of the Plan's medical director or his/her designees', shall not provide any follow-up or additional hospital services to members other than the covered services in accordance with the prior authorization for such services.

At all times, the hospital shall promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate prior authorization should a member require additional, or follow-up covered services.

Individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways.

Regular provider office visits will be conducted by our Provider Engagement staff to verify that network providers are compliant.

Child health checkup

A child health checkup is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 20. Child health checkups are performed according to a periodic schedule to help children have routine health screenings to identify and correct medical conditions before the conditions become more serious and potentially disabling. Child Health Checkup (CHCUP) is Florida's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

A child health checkup is composed of the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history, and health status.
- Nutritional assessment.
- Developmental assessment.
- Comprehensive unclothed physical examination.
- Dental screening, including dental referral, when required.
- Vision screening, including objective testing, when required.
- Hearing screening, including objective testing, when required.
- Laboratory test, including blood lead testing, when required.
- Appropriate immunizations.
- Health education, anticipatory guidance.
- Diagnosis and treatment.
- Referral and follow-up, as appropriate.

Well child visits are performed based on age and developmental needs. There is no limit to the number of visits.

Adult health screening services

One adult health screening every 365 days, for recipients age 21 years and older.
Note: Aetna Better Health of Florida will allow a 30-day grace period for adult health screening visits prior to the 365 days.

Early and periodic screening, diagnosis, and treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information on how to obtain an authorization, please refer to Authorizing Treatment for Members.

Family planning services

The Agency for Healthcare Administration (AHCA) requires that Medicaid members younger than 18 receive family planning services provided the member is married, a parent, pregnant, has written consent from a parent or legal guardian or, in the opinion of a physician, the member may suffer health hazards if the services are not provided.

Family planning and supplies

The Plan will provide family planning services to help members make comprehensive and informed decisions about family size and/or spacing of births. The Plan shall provide the following services: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Practitioner Services Coverage and Limitations Handbook.

This information should be documented in the patient's medical record to meet the contractual requirement. Aetna or AHCA may audit your medical records to confirm compliance with this contractual clause.

Members can choose from any Medicaid doctor for family planning services. Prior approval is not needed.

Hysterectomies, sterilizations, and abortions

Participating providers must maintain a log of all hysterectomy, sterilization and abortion procedures performed on members. The log must include, at a minimum, the member's name and identifying information, date of procedure and type of procedure. The participating provider should provide abortions only in the following situations:

- If the pregnancy is a result of an act of rape or incest; or
- The physician certifies that the woman is in danger of death unless an abortion is performed.

Access to care and service standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Engagement Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet standards for timely access to care and services, considering the urgency of and the need for the services.

Primary care physicians

Aetna Better Health of Florida established standards for member access to primary care services are included in the participation criteria that are a part of each participating physician contract.
In addition, all participating primary care physicians must have a reliable 24-hour-a-day, 7-day-a-week answering service or paging system. A recorded message or answering service that refers members to the emergency room is not acceptable.

Specialist physicians

For access standards specific to your state and specialty, refer to your contract.
Primary care physicians (PCP) are responsible for coordinating and managing the health care of their assigned members in accordance with the applicable member contract, this manual, and the agreement. The primary care physician provides primary care services to all their patients and coordinate all other covered services, including specialist services defined as those covered services generally provided by specialist physicians in their respective fields of training and experience.

Access and Appointment Availability Standards Guidelines

Timely access-standards for hours of operations for PCPs: General appointment accessibility – 20 hours per week per practice location		
Practitioner type	**Appointment type**	**Accessibility standards**
Primary Care Practitioner (PCP)	Preventive care & routine (non-urgent)	Within thirty (30) days of a request.
	Urgent care	Within forty-eight (48) hours that do not require authorization. OR Within ninety-six (96) hours that require prior authorization.
	Emergency services -- non-life threatening	Immediately or referred to ED facility
Specialty Referral	Preventive care & routine (non-urgent)	Within sixty (60) days of a request after the appropriate referral is received by the specialist.
	Urgent care	Within forty-eight (48) hours that do not require prior authorization. OR Within ninety-six (96) hours that do require prior authorization.
	Non-urgent	Within thirty (30) days of a request after the appropriate referral is received by the specialist.
	Emergency services --non-life threatening	Within 24 hours of a request
Behavioral Health/Substance Use	Preventive care & routine (non-urgent)	Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment. OR Within fourteen (14) days for initial outpatient behavioral health treatment.
	Routine/follow-up (non-urgent, symptomatic conditions)	Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment. OR

		Within fourteen (14) days for initial outpatient behavioral health treatment.

Practitioner type	Appointment type	Accessibility standards
Behavioral Health/Substance Use *(continued)*	Urgent care	Within forty-eight (48) hours do not require prior authorization. OR Within ninety-six (96) hours that do require prior authorization.
	Emergency Services- non life threatening	Within forty-eight (48) hours that do not require prior authorization. OR Within ninety-six (96) hours that do require prior authorization.
Lab and Radiology Services	Preventive care & routine (non-urgent)	Within fourteen (14) days of a request
	Urgent care	Within forty-eight (48) hours that do not require prior authorization. OR Within ninety-six (96) hours that do require prior authorization.

Non-symptomatic office visits will include, but will not be limited to, well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.

Physicals:	
Baseline Physicals for New Adult Members	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Children Members and Adult Clients of DDD (degenerative disk disease)	Within ninety (90) days of initial enrollment, or in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.
Routine Physicals	Within four (4) weeks for routine physicals needed for school, camp, work, or similar.
Prenatal Care: Members will be seen within the following timeframes:	
Three (3) weeks of a positive pregnancy test (home or laboratory)	
Three (3) days of identification of high-risk	
Seven (7) days of request in first and second trimester	
Three (3) days of first request in third trimester	

Office waiting time

Aetna Better Health of Florida's waiting time standards require that members, on average, should not wait at a PCP's office for more than 45 minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating a member with a difficult medical need, the waiting time may be expanded to one hour. The above access and appointment standards are provider contractual requirements. Aetna Better Health of Florida monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Telephone accessibility standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available or having on call arrangements in place with other qualified participating Aetna Better Health of Florida providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including authorizing care and verifying member enrollment.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and/or emergent health care issues are held to the same accessibility standards regardless of if after hours coverage is managed by the PCP, current service provider or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. Each provider must have a reliable twenty-four (24) hour a day, seven (7) days a week answering service or machine with a beeper or paging system. An after-hours phone call from the on-call provider within an hour of the member contacting the office is required. A recorded message or answering service that refers members to the emergency room is not acceptable. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all the following situations:

- Answering the member telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs).
- Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.

- Response time for telephone callback waiting times:
  - 30 to 45 minutes for after-hours telephone care for non-emergent, symptomatic issues
  - Same day for non-symptomatic concerns
  - 15 minutes for crisis situations
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours.
- Protocols shall be in place to provide coverage in the event of a provider's absence.

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable	Unacceptable
An active provider response, such as: • Telephone is answered by provider, office staff, answering service, or voicemail. • The answering service either: — Connects the caller directly to the provider. — Contacts the provider on behalf of the caller and the provider returns the call. — Provides a telephone number where the provider/covering provider can be reached; or — The provider's answering machine message provides a telephone number to contact the provider/covering provider.	• The answering service: — Leaves a message for the provider on the PCP/covering provider's answering machine; or — Responds in an unprofessional manner. • The provider's answering machine message: — Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations; or — Instructs the caller to leave a message for the provider. • No answer. • Listed number no longer in service. • Provider no longer participating in the contractor's network. • On hold for longer than 5 minutes. • Answering service refuses to provide information for survey. • Telephone lines persistently busy despite multiple attempts to contact the provider.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, members. These include offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.

If a PCP fails to meet telephone accessibility standards, a Provider Engagement Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Telemedicine

Aetna Better Health is offering telehealth services in the state of Florida to support our members with receiving healthcare services or in their provider's office. Telehealth is widely viewed as an effective care delivery alternative that can support and complement traditional face-to-face visits for both medical and behavioral care (e.g., face-to-face consultations, assessments, or examinations). Aetna's telehealth program seeks to improve our members' health by permitting real-time interactive communication between the member, their primary care provider, care team or other skilled practitioner located at a distant site. Our telehealth program is designed and modeled on the state's regulations which states:

- Telemedicine is the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care.

  Aetna Better Health of Florida offers telehealth services for both physical health and tele-behavioral health services as part of the behavioral health delivery strategy. The use of telehealth can provide increased access to mental health services to children and adults that meet certain criteria. The Plan's telehealth program will include the following services:

- Provider to member direct service- the core of our programming is to support our members receiving care in the in a state-recognized clinic site via a secure virtual connection.

  This program will incorporate the key objectives of our Integrated Care Management program where appropriate including:

- Facilitation of timely access to a continuum of services based on the intensity and complexity of each member's need.
- Collaboration with the member, family, community supports, physical health and behavioral health providers to enhance care outcomes.
- The telehealth program will allow transformation of medical and behavioral health practices to incorporate the following actions typically in a sequential fashion:
  - Adopt a member-centric care delivery method.
  - Improve quality of care on targeted metrics.
  - Improve member access to timely care.
  - Tailoring care to each individual needs and desires.

Telecommunications platform and equipment

The telehealth technology permits real-time encryption of the interactive audio and video exchanges with the consulting provider and member. The platform is HIPAA compliant, following the protocol outlined by the Health Information Technology for Economic and Clinical Health Act, or HITECH, signed into law in 2009 to promote the adoption of health information technology.[1, 2] Telehealth services may include real- time streaming via the use of:

- Computer
- Webcam
- Mobile device (smart phone, tablet)
- Microphone
- Monitor

Provider licensure/enrollment requirements

All providers engaged with our telehealth program must be licensed and contracted to provide telehealth services in accordance with all relevant laws in Florida. To receive payment for services delivered through telehealth technology from Aetna Better Health of Florida participating healthcare practitioners must meet all the following requirements (but not limited to):

- Act within their scope of practice.
- Be licensed in Florida for the service for which they bill Aetna Better Health of Florida OR may not engage in the practice of medicine across state lines via telehealth, unless he or she holds a telehealth permit issued by the board in Florida.
- Be enrolled and contracted with Aetna Better Health of Florida.
- Be located within the continental United States.
- Be credentialed by Aetna Better Health of Florida or credentialed via the telehealth vendor to provide Medicaid healthcare services in Florida.
- Providers must not currently be excluded from participating in Medicaid or Medicare by the state or per any federal sanction.
- Providers must engage the use of HIPAA compliant telehealth technology and complete all necessary training on its use, maintenance, and regulatory requirements.
- Providers must be trained in emergency and crisis intervention where appropriate.

Confidentiality, privacy, and electronic security

The provider must implement confidentiality protocols that comply with all HIPAA and relevant federal and state requirements. Aetna will follow AACAP Practice Parameters for telepsychiatry and American telehealth Association Practice Guidelines. The details of which include, but are not limited to:

- All telehealth transmissions must be performed through the Aetna Better Health designated telemedicine platform or a similar platform that is HIPAA compliant.
- Specifying the individuals who have access to electronic records; and
- Usage of unique passwords or identifiers for each employee or other person with access to the client records; and,
- Ensuring a system to prevent unauthorized access, particularly via the internet; and
- Ensuring a system to routinely track and permanently record access to such electronic medical information.
- Ensuring that the distant site is a secure, private location which protects the confidentiality of the client and the telecommunications exchanged between the two sites.

These protocols and guidelines must be available for inspection at the telehealth site and to Florida regulators upon request. All federal and state and laws and regulations must be followed to ensure full compliance by any contracted provider entity. All telehealth vendors must complete Aetna's rigorous Global Information Security review that validates a vendor meets all legal and industry standard protocols to ensure internal and external compliance and data security requirements are met and followed as a standard part of their business operations.

Telehealth requirements and limitations

Below Aetna Better Health describes the general telehealth program requirements and limitations that must be followed to implement and participate in our telehealth program. The major features are outlined but not limited to thefollowing:

- The service must be medically necessary, written in the member's treatment plan and follow generally accepted standards of care.
- The service provided by the distant provider must be a service covered by Aetna Better Health or be reimbursable per the health plan benefits package.
- The member must be able to verbally communicate, either directly or through a representative, with the distant site providers, must be able to receive services via telehealth and must have provided consent for the use of telehealth; consent is required to assure that the member receiving services is a willing participant in the telehealth delivered service and to assure that the member retains a voice in their treatment and care plan; (See "Informed Consent" below for additionalinformation).
- Prior approval or authorization for telehealth-delivered services is not required, but the Distant Site provider must obtain prior approval for any other covered services which would normally require prior approval.
- The Distant Site provider must be located within the continental United States; Federal regulations preclude payment to providers using banking institutions located outside of the U.S.
- The Distant Site provider must meetall enrollment requirements.
- Claims must be completed and submitted according to Aetna Better Health billing instructions.
- The same procedure codes with modifier GT and rates apply as for services delivered in person.
- All service providers are required to develop and maintain written documentation in the form of evaluations and progress notes, the same as if originated during an in-person visit or consultation, including the mode of communication (telehealth); providers may opt to use electronic medical records in place of paper-based written records.
- All interactive video telecommunication must comply with HIPAA patient privacy and confidentiality regulations at the distant site and during all aspects of the transmission process.
- Telehealth policies and procedures must be documented at the receiving site and originating site where applicable.

Informed consent

The provider should obtain written consent from the member agreeing to participate in services delivered via the means of telehealth. If a member has a personal representative, legal guardian or other legal representative, then local customary laws should be followed to obtain the consent. The consent should outline the benefits and risks as well as alternatives to receiving the service via telehealth as defined per state laws and regulations. The member has the right to refuse these services at any time and must be made aware of any alternatives, including any delays in service, need to travel, or risks associated with not having services provided via telehealth. The format used by the consulting provider to obtain written consent is left to the provider but must meet state and federal law, be maintained in the client's records, and must identify that the covered medical service was delivered by telehealth.

Home health electronic visit verification program

This rule applies to providers enrolled directly in the Florida Medicaid program that furnish home health services (home health visits, private duty nursing, and personal care services) to recipients through the fee-for-service delivery system as specified on the Agency for Health Care Administration's (AHCA) website at http://ahca.myflorida.com/Medicaid/home_health/dmv.shtml in accordance with Section 409.9132, Florida Statutes (F.S.).

Direct service provider – An individual who personally (face-to-face) provides services to recipients in accordance with Rule 59G-4.261, 59G-4.215 or 59G-4.130, Florida Administrative Code (F.A.C.). All providers must comply with Section 409.9132, F.S.

The Agency for Health Care Administration contracts with a vendor to electronically verify the delivery of home health services provided to recipients in their residence or other authorized setting.

1) Providers must document the home health service encounter for each recipient served (in accordance with the recipient's approved plan of care) and verify the delivery of the services rendered using AHCA's designated vendor's electronic visit verification (EVV) system.
2) Direct service providers must verify delivery of the service using the vendor's system at the beginning and end of each home health service encounter.
3) Providers must submit claims through AHCA's designated vendor's system to the Florida Medicaid fiscal agent for services rendered and verified in accordance with the prior authorization in the Florida Medicaid Management Information System.

Providers that fail to comply with the Home Health Electronic Visit Verification Program are subject to potential denial or non-payment of claims, sanctions, fines, and suspension or termination from the Florida Medicaid program, in accordance with Rule 59G-9.070, F.A.

Member Rights and Responsibilities

In accordance with 42 CFR 438.100, Aetna Better Health of Florida is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health of Florida requires compliance with member rights and responsibilities, especially treating members with respect and dignity.

Understanding member' rights and responsibilities is important because you can help members to better understand their role in and improve their adherence with treatment plans.

It is Aetna Better Health of Florida's policy not to discriminate against members based on race, color, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law.

Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that Aetna Better Health of Florida is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of Florida will initiate an investigation into the matter and report the findings to the Quality Management Oversight Committee and further action may be necessary.

In the event Aetna Better Health of Florida is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of Florida will make good faith efforts to address the issue with the member; and educate the member on their responsibilities.

Member rights

As a recipient of Medicaid and a member in a Plan, members have certain rights. Members have the right to:

- Be treated with courtesy and respect.
- Always have your dignity and privacy considered and respected.
- Receive a quick and useful response to your questions and requests.
- Know who is providing medical services and who is responsible for your care.
- Know what member services are available, including whether an interpreter is available if you do not speak English.
- Know what rules and laws apply to your conduct.
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you.
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law.
- Be given full information about other ways to help pay for your health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Know if the provider or facility accepts the Medicare assignment rate.

- To be told prior to getting a service how much it may cost you.
- Get a copy of a bill and have the charges explained to you.
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any health emergency that will get worse if you do not get treatment.
- Know if medical treatment is for experimental research and to say yes or no to participating in such research.
- Make a complaint when your rights are not respected.
- Ask for another doctor when you do not agree with your doctor (second medical opinion).
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed.
- Have your medical records kept private and shared only when required by law or with your approval.
- Decide how you want medical decisions made if you can't make them yourself (advanced directive).
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services.
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan.
- Speak freely about your health care and concerns without any bad results.
- Freely exercise your rights without the Plan or its network providers treating you badly.
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation.
- Receive information on beneficiary and plan information.
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS)). A right to make recommendations regarding the organization's member rights and responsibilities policy.

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive services in a home-like environment regardless where you live.
- Receive information about being involved in your community, setting personal goals and how you can participate in that process.
- Be told where, when and how to get the services you need.
- To be able to take part in decisions about your health care.
- To talk openly about the treatment options for your conditions, regardless of cost or benefit.
- To choose the programs you participate in and the providers that give you care.

Member rights under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal

opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, based on disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits.
- Deny access to programs, services, benefits, or opportunities to participate because of physical barriers.

Member responsibilities

Aetna Better Health of Florida members, their families, or guardians are responsible for:

- Give accurate information about your health to your Plan and providers.
- Tell your provider about unexpected changes in your health condition.
- Talk to your provider to make sure you understand a course of action and what is expected of you.
- Listen to your provider, ask questions and follow instructions for care you have agreed to with your practitioner.
- Keep your appointments and notify your provider if you will not be able to keep an appointment.
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions.
- Make sure payment is made for non-covered services you receive.
- Follow health care facility conduct rules and regulations.
- Treat health care staff and case manager with respect.
- Tell us if you have problems with any health care staff.
- Use the emergency room only for real emergencies.
- Notify your case manager if you have a change in information (address, phone number, etc.).
- Have a plan for emergencies and access this plan if necessary for your safety.
- Report fraud, abuse and overpayment.

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-Term Care program.
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager.

Requirements Regarding Background Screening

Aetna Better Health of Florida has established and verified provider credentialing and re-credentialing criteria that includes a determination of whether the provider, employee or volunteer of the provider, meets the definition of "Direct Service Provider" and completion of a Level 2 criminal history background screening on each Direct Service Provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S. Any Provider, employee, or volunteer of the provider meeting the definition of "Direct Service Provider" who has a disqualifying offense is prohibited from providing services to members.

No additional Level 2 screening is required if the individual is qualified for licensure or employment by AHCA pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.)

- Aetna Better Health of Florida must maintain a signed affidavit from each provider attesting to its compliance with this requirement, or with the requirements of its licensing agency, if the licensing agency requires Level 2 screening of Direct Service Providers.
- Aetna Better Health of Florida must include compliance with this requirement in its provider contracts and subcontracts and verify compliance as part of its subcontractor and provider monitoring activity.

Physicians and subcontractors shall be subject to background checks. Aetna Better Health shall consider the nature of the work physician, subcontractors or agents performs in determining the level and scope of background checks for all treating providers not currently enrolled in Medicaid's fee-for-service program, in accordance with the following: Aetna Better Health shall ensure providers not currently enrolled in Medicaid's fee-for-service program submit fingerprints electronically following the process described on the Agency's Background Screening website. Aetna Better Health shall verify Medicaid eligibility through the background screening system.

Aetna Better Health of Florida shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s.435.04, F.S. Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening.

Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.

Community Outreach and Marketing Activities

Provider may not:

1. Offer marketing/appointment forms, make phone calls or direct, urge or attempt to persuade recipients to enroll in Aetna Better Health of Florida based on financial or any other interests of the provider.
2. Mail marketing materials on behalf of Aetna Better Health of Florida.
3. Offer anything of value to induce recipients/members to select them as their provider.
4. Offer inducements to persuade recipients to enroll in Aetna Better Health of Florida.
5. Conduct health screening as a marketing activity.
6. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
7. Distribute marketing materials within an exam room setting.
8. Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan. For a complete list of community outreach and marketing activities, refer to **AetnaBetterHealth.com/Florida.**

In accordance with the following regulatory requirements, providers are not authorized to send referrals to Comprehensive Assessment and Review for Long Term Care Services (CARES) offices.

- In accordance with 42 CFR 438.104(b) (1) (iv), the contractor and its subcontractors will not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- In accordance with 42 CFR 438.104 (b) (1) (v), the contractor and its subcontractors will not, directly, or indirectly, engage in door-to-door, telephone, or other cold-calling marketing activities.
- In accordance with 42 CFR 438.104 (b)(2)(i), the contractor and its subcontractors will not, directly make any assertion or statement (whether written or oral) that the beneficiary must enroll with the contractor in order to obtain (Medicaid State Plan benefits) or in order to not lose benefits (Medicaid State Plan benefits).
- In accordance with s. 409.912(21) (B), F.S., and 42 CFR 438.104 (b) (2) (ii), the contractor and its subcontractors will not make any inaccurate false or misleading claims that the contractor is recommended or endorsed by any federal, state or county government, the Agency, CMS, department, or any other organization which has not certified its endorsement in writing to the contractor.

Provider compliance

Aetna Better Health of Florida will verify, through provider education and outreach, that its health care providers are aware of and comply with the following requirements:

- Health care providers may display Aetna Better Health of Florida -specific materials in their own offices.
- Health care providers cannot orally or in writing compare benefits or provider networks among Aetna Better Health of Florida, other than to confirm whether they participate in Aetna Better Health of Florida's network.
- Health care providers may announce a new affiliation with Aetna Better Health of Florida and give their patients a list of managed care plans with which they contract.
- Health care providers may co-sponsor events, such as health fairs and advertise with Aetna Better

Health of Florida in indirect ways, such as television, radio, posters, fliers, and print advertisement.

- Health care providers will not furnish lists of their Medicaid patients to Aetna Better Health of Florida, or any other entity, nor can providers furnish other Managed Care Plans' membership lists to Aetna Better Health of Florida, nor can providers assist with Managed Care Plan enrollment.
- For Aetna Better Health of Florida, health care providers may distribute information about non-Managed Care Plan-specific health care services and the provision of health, welfare and social services by the State of Florida or local communities, as long as any inquiries from prospective members are referred to the member services section of Aetna Better Health of Florida or the Agency's enrollment broker.

Fraud, Waste, and Abuse

Aetna Better Health of Florida has an aggressive, proactive fraud, waste, and abuse program that comply with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to appropriate State and federal agencies as mandated by Florida Administrative Code. During the investigation process, the confidentiality of the patient and people referring the potential fraud and abuse case is maintained.
Aetna Better Health of Florida uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Engagement, Member Services, Medical Management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Fraud, waste, and abuse defined

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of fraud, waste, and abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services.
- Billing for items or services that should not be paid for by Medicaid.
- Billing for services that were never rendered.
- Billing for services at a higher rate than is actually justified.
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of Florida due to improper payments to providers, or overpayments.
- Physical or sexual abuse of members.
- Fraud, waste, and abuse can incur risk to providers:
- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information.

- Falsifying information in order to justify coverage.
- Failing to provide medically necessary services.
- Offering a cash payment as an inducement for individuals to enroll in a specific Plan.
- Selecting or denying members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for 20 nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health of Florida and the member, or billing Aetna Better Health of Florida and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, waste, and abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death.
- Falsely billed procedures create an erroneous record of the member's medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addition.

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition to illegally receive the drug benefit.
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another member's ID).
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults several doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Reporting suspected fraud, waste, and abuse

Fraud, Waste and Abuse training is provided by the health plan annually to all subcontractors, providers, and vendors. Participating providers are required to report to Aetna Better Health of Florida all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- ABH-FL Fraud hotline :**1-855-415-1558 (TTY:711)**
- Special Investigation Unit (SIU) Hotline: **1-800-338-6361**
- Email the SIU: **FL-FraudandAbuse@Aetna.com**
- Fax the SIU: **1-860-975-9719**
- FL Medicaid Program Integrity Office: **1-888-419-3456**
- Medicaid Fraud and Abuse Complaint Form:
- **https://apps.ahca.myflorida.com/mpi-complaintform/**
- FL Attorney General's Office: **1-866-966-7226**
- CVS Health Ethics Line: **1-877-287-2040, Ethics.BusinessConduct@CVSHealth.com**
- By visiting our website: **AetnaBetterHealth.com/Florida/fraud-abuse**

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free **1-866- 866-7226** or **850-414-3990**). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Prevention of fraud, waste and abuse

A provider's best practice for preventing fraud, waste and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program.
- Monitor claims for accuracy - verify coding reflects services provided.
- Monitor medical records – verify documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communication with colleagues and members.
- Ask about potential compliance issues in exit interviews.
- Take action if you identify a problem.
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Special investigations unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and in responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full- time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health of Florida encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna Better Health's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing,

treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Elements of a compliance plan

An effective Compliance Plan includes seven (7) core elements:

- Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of Florida's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
- Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
- Effective Compliance Training: Development and implementation of regular, effective education, and training.
- Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
- Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
- Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, and directors and members of the Compliance Committee, as well as related entities.
- Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
- Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of Florida.
- Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant laws

There are several relevant laws that apply to Fraud, Waste, and Abuse: The Federal False Claims Act (FCA) (31 U.S.C. § 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval.
- Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

Providers contracted with Aetna Better Health of Florida must agree to be bound by and comply with all applicable State and federal laws and regulations.

- Anti-Kickback Statute
    - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Self-Referral Prohibition Statute (Stark Law)
    - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.
- Red Flag Rule (Identity Theft Protection)
    - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
    - Health Insurance Portability and Accountability Act (HIPAA) requires:
    - Transaction standards
    - Minimum security requirements
    - Minimum privacy protections for protected health information
    - National Provider Identification (NPIs) numbers
- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. § 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claim's penalty is to be adjusted periodically for inflation in accordance with a federal formula.
- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health of Florida services through Florida Medicaid and Comprehensive Long Term Care.
- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of Florida providers will follow federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health of Florida services through the Florida Medicaid and Comprehensive Long Term Care program.
- The Florida False Claims Act (FFCA) s. 68.081 F.S. authorizes civil actions by individuals and the state against persons who file false claims for payment or approval by a state agency. Under the FFCA any person who knowingly presents or causes to be presented a false or fraudulent claim or payment or approval; knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim; conspires to commit a violation of act; has possession, custody, or control of property or money used or to be used by the state and knowingly delivers or causes to be delivered less than all of the money or property is knowingly makes, uses or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and

improperly avoids or decreases an obligation to pay or transmit money or property to the state is liable to the state for a civil penalty not less than $5,500 and not more than $100,000 and for the treble the amount of damages the state sustains because of the act of that person.

- Under the Florida Anti-Tampering Act s. 501.001 F.S., refers to any drug which means any agent or product recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or nay supplement thereof; any agent or product intended for use in the diagnosis, cure, mitigation, treatment, therapy, or prevention of disease. It also refers to any device which means any apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is:
  - To affect the structure or any function of the body of humans.
  - In addition, which does not achieve any of its principal intended purposes through chemical action within or on the body of humans and is not dependent upon being metabolized for the achievement of any of its principal intended purposes.
  - Whoever, with reckless disregard for the risk that another person will be placed in danger of death or bodily injury, tampers with, or conspires or attempts to tamper with, any consumer product or the labeling of, or container for, any such product is guilty of a felony of the first degree, punishable as provided in s. 775.082 or s. 775.083.or whoever, with intent to cause serious injury to the business of any person, tampers with any consumer product or renders materially false or misleading the labeling of, or container for, a consumer product is guilty of a felony of the second degree, punishable as provided in s.775.082 or s. 775.083. or whoever knowingly communicates false information that a consumer product has been tampered with, if such tampering, had it occurred, would create a risk of death or bodily injury to another person, is guilty of a felony of the second degree, punishable as provided in s. 775.082 or s. 775.083. or "Communicates false information" means to communicate information that is false, and that the communicator knows is false, when the information may reasonably be expected to be believed. Alternatively, whoever knowingly threatens, under circumstances in which the threat may reasonably be expected to be believed, that he or she will commit or cause to be committed an act which would violate paragraph (a) is guilty of a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083.
- Under the Medicaid Provider Fraud Act s. 409.920 F.S., refers to any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim or payment; or in the case of a claim based on costs, any entry in the cost report, books of amount, or other documents supporting such claim.
- A person may not:
- Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.
- Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.
- Knowingly charge, solicit, accept, orreceive anything of value from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.
- Knowingly make or in any way cause to be made any false statement or false representation of a

material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider.

- Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.
- Knowingly submit false or misleading information or statements to the Medicaid program for being accepted as a Medicaid provider.
- Knowingly use or endeavor to use a Medicaid Provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and Providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities (LEIE) database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
- Automatic disbarment
- Prison time

Exclusion lists & reports

We are required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any other such databases as the Agency for Health Care Administration (AHCA) may prescribe.

Aetna Better Health of Florida does not participate with or enter into any Provider agreement with any individual or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers and who have been terminated from the Medicaid or any

programs by AHCA for fraud, waste, or abuse. The provider must agree to assist Aetna Better Health of Florida as necessary in meeting our obligations under the contract with the AHCA to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional resources for fraud, waste & abuse

- **http://ahca.myflorida.com/http://laws.flrules.org/**
- **http://www.flsenate.gov/**
- **http://oig.hhs.gov/hotline.html**

Details may be included in the State's *Medicaid Provider General Handbook*. For Florida see *Section 5, Medicaid Fraud, and Abuse*.

The Florida Bureau of Medicaid Program Integrity audits and investigates providers suspected of overbilling or defrauding Florida's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

Cultural Competency

Aetna Better Health of Florida and its Florida affiliates recognize that a person's cultural norms, values, and beliefs shape how they approach and utilize health care services. Numerous cultural variables including, but not limited to, ethnicity, race, gender, age, socio-economic status, primary language, English proficiency, spirituality, religion and literacy level influence the way in which a person seeks and utilizes health services and the manner in which a person approaches and manages recovery.

The Cultural Competency Plan (CCP) has been developed to outline the methods used by Aetna Better Health of Florida (the Plan) to ensure that members receive care that is delivered in a culturally and linguistically sensitive manner. The CCP is comprehensive and incorporates all members, employees, and providers. The Health Plan recognizes that respecting the diversity of our members has a significant and positive effect on outcomes of care and have adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards, as developed by the Department of Health and Human Services, Office of Minority Health, as guidelines for providing culturally and linguistically competent services.

These 15 standards are organized by themes:

- Principle Standard (Standard 1)
- Governance, Leadership, and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement and Accountability (Standards 9-15)

The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that may experience unequal access to health services.

Cultural competence definition

Cultural and linguistic competence is a set of coinciding behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross- cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities (Rural Assistance Center, 2008).

Stated more simply, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Also, cultural competence can be defined as services that are sensitive and responsive to cultural differences whereby caregivers are aware of the impact of culture and possess the skills to help provide services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation or physical disability.

Goals of the Cultural Competency Plan

The purpose of the Plans' Cultural Competency Plan is to implement enterprise-wide methodologies and processes that measure and improve clinical care and services that are mindful of the language and cultural needs of the Plans' members. Providers are expected to ensure physical access, reasonable

accommodations, culturally competent communications, and accessible equipment for Medicaid members with special health care needs.

Aetna Better Health of Florida has implemented procedures to help our staff and providers develop awareness and appreciation of cultural customs, values, and beliefs, and provide educational information and references to facilitate their incorporation into the assessment of, treatment of, and interaction with our members.

We encourage our staff to share and utilize their own cultural diversity to enhance the services provided to our members.

Program activities

Cultural Competency Workgroups

Cultural Competency Workgroups are formed on an ad hoc basis to support the Plan in implementing portions of the CLAS project plan. An annual Cultural Competency Work Plan/Project Plan (CCP) is developed to guide the activities of the Plan and the Company's affected functional areas. The CCP Annual Evaluation is used to assess the progress of initiatives and make recommendations to the Quality Improvement Committee and executive leadership when barriers are identified.

Member Outreach

Aetna Better Health of Florida requests voluntary information on race and language from members and utilize this information to improve linguistic and cultural services.

Member Satisfaction Assessment

Member satisfaction survey data is reviewed annually, paying special attention to those who identify themselves with limited English proficiency, to determine any identifiable clinical care and service gaps.

Member and Provider Education

Cultural Competency information and links are posted on the provider, member, and employee web portals or via Aetna Better Health of Florida's approved communication venues. Provider and employee surveys are conducted to determine how best to assist providers and employees in meeting the cultural needs of the population we serve. The Plan monitors complaints on an ongoing basis from providers and subcontractors to ensure complaints regarding cultural and linguistically services are identified and resolved in a timely manner.

Program evaluation and assessment

Annually, Aetna Better Health of Florida conducts an evaluation of the Cultural Competency Plan to assess overall effectiveness and to determine future directions. The evaluation serves as the foundation for planning the upcoming year's plan and activities relating to elevating cultural awareness.

Providers and subcontractors are required to comply with the plan's Cultural Competency Plan.

Aetna Better Health of Florida supports activities promoting health literacy and ensures member communications are in plain language.

Aetna Better Health of Florida has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement proven methods for responding to those challenges.

Providers receive education about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment.
- The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.
- History of the disability rights movement and the progression of civil rights for people with disabilities.
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care.
- Our Provider Engagement Representatives will conduct initial cultural competency training during provider orientation meetings. The Quality Interactions® course series is designed to help you:
    - Bridge cultures.
    - Build stronger patient relationships.
    - Provide more effective care to ethnic and minority patients.
    - Work with your patients to help obtain better health outcomes.

To access the online cultural competency course, please visit:
aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html.

If you have any questions or would like to request a free copy of our Cultural Competency Plan, please contact a Member Service representative at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC).

Abuse, Neglect, and Exploitation

The Plan will ensure that all staff and providers are required to report adverse incidents to the Florida Abuse Hotline at **1-800-962-2873** or the Plan Member Service Department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC) immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the member's identity, description of the incident and outcomes including current status of the member. If the event involves a health and safety issue, the Plan and case manager will arrange for the member to move from his/her current location or change providers to accommodate a safe environment and provider of the member's choice.

Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a file, separate from the member's case file, that is designated as confidential. Such file shall be made available to the Agency upon request.

Member quality of care issues must be reported to and a resolution coordinated with the Plan's Quality Management Department.

Mandated reporters

As mandated by Florida Administrative Code and Florida Statues (F.L.F. A.C. 65C-29.002), all providers who work or have any contact with any Aetna Better Health of Florida members, are required as "mandated reporters" to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency. A full version of the Florida Administrative Code (FAC) can be found on the State of Florida Administrative Code & Administrative Register website at **https://www.flrules.org/**.

Vulnerable adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following state agencies:

- The National Domestic Violence Hotline at **1-800-799-SAFE(7233)**
- The State of Florida Department of Elder Affairs at **1-800-963-5337** or **1-800-962-2873 (1-800-96- ABUSE)** or **http://elderaffairs.state.fl.us/index.php**
- For members age 60 or older living in a long term care community, providers may report any suspected or known physical abuse verbally or in writing to the following:
- Toll-free at **1-888-831-0404** or in writing via fax at **850-414-2337**

Reporting identifying information

Any provider who suspects that a member may need protective services should contact the appropriate State agencies within 24 hours with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location.
- Information about family members or caretakers if available.
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information).

Abuse can be reported by calling the Florida Abuse Hotline, which is a statewide, toll-free telephone number, at **1-800-96-ABUSE (1-800-962-2873)**. Documentation related to the suspected abuse,

neglect, or exploitation, including the reporting of such, must be kept in a file, separate from the member's case file, that is designated as confidential. Such file will be made available to the Agency upon request.

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Florida's Compliance Hotline at **1-844-645-7371**. Aetna Better Health of Florida may be required to verify that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation. It is your responsibility as the provider to verify that abuse, neglect, and exploitation training occurs and to maintain necessary documentation of this training for the employees that have contact with Aetna Better Health of Florida members. You may be requested to make such documentation available. You may use the "Adult Abuse, Neglect and Exploitation Guide for Professionals" as a training tool. It is available at:

- **www.dcf.state.fl.us/programs/aps/docs/GuideforProfessionals.pdf.**

In the event you feel a member will be seen by a direct care staff without such training, please bring that to the attention of the Case Manager prior to accepting their authorization for your services.

Updated information on most current Department of Elder Affairs State Elder Abuse Prevention Coordinator may be found on Department of Elder Affairs website:

- **http://elderaffairs.state.fl.us/doea/abuse_prevention.php.**

For further information or assistance in filing a report, you may contact the Department of Elder Affairs State Elder Abuse Prevention Coordinator:

Region	Elder Abuse Prevention Coordinators
6	Patricia Henderson Senior Connection Center, Inc. 8928 Brittany Way Tampa, FL 33619 **813-676-5609** patricia.henderson@agingflorida.com Counties Served: Hillsborough, Manatee Polk, Hardee, Highlands
7	Pedro Portuondo Senior Resource Alliance 988 Woodcock Road, Ste. 200 Orlando, FL 32803 **407-514-1800** pedro.portuondo@sraflorida.org Counties Served: Seminole, Orange, Osceola, Brevard
11	Alina Becker Alliance for Aging, Inc. 760 NW 107th Ave., Ste. 214 Miami, FL 33172 **305-670-6500** beckera@allianceforaging.org Counties Served: Monroe, Miami-Dade

Our providers must fully cooperate with the investigating agency and will make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to determine abuse or neglect

When a State agency notifies Aetna Better Health of Florida of a potential case of neglect and abuse of a member, our case managers will work with the agency and the member's Primary Care Practitioner (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health of Florida also notifies the appropriate regulatory agency of the report.

Depending on the situation, Aetna Better Health of Florida case managers will provide member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, behaviors, and signs of member abuse, neglect and/or exploitation

Abuse

Potential Symptoms/Signs of Abuse:

- Bruises (old and new).
- Burns or bites.
- Pressure ulcers (bed sores).
- Missing teeth.
- Broken bones/sprains.
- Spotty balding from pulled hair.
- Marks from restraints.
- Domestic violence.
- Behaviors of Abusers (Caregiver and/or Family Member):
    - Refusal to follow directions.
    - Speaks for the patient.
    - Unwelcoming or uncooperative attitude.
    - Working under the influence.
    - Aggressive behavior.

Neglect

Types of Neglect:

- The intentional withholding of basic necessities and care.
- Not providing necessities and care because of lack of experience, information or ability.

Signs of Neglect:

- Malnutrition or dehydration.
- Un-kept appearance; dirty or inadequate.
- Untreated medical condition.
- Unattended for long periods or having physical movements unduly restricted.
  Examples of Neglect:
    - Inadequate provision of food, clothing, or shelter.
    - Failure to attend health and personal care responsibilities, such as washing, dressing and bodily functions.

Financial Exploitation

Examples of Financial Exploitation:

- Caregiver, family member, or professional expresses excessive interest in the amount of money being spent on the member.
- Forcing member to give away property or possessions.
- Forcing member to change a will or sign over control of assets.

Identifying victims of human trafficking

Human trafficking is a public health issue that impacts individuals, families, and communities. Traffickers disproportionately target at-risk populations including individuals who have experienced or been exposed to other forms of violence (child abuse and maltreatment, interpersonal violence and sexual assault, community and gang violence) and individuals disconnected from stable support networks (runaway and homeless youth, unaccompanied minors, persons displaced during natural disasters).

Definition of Trafficking in Persons

- The Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. § 7102), defines "severe forms of trafficking in persons" as:
- Sex trafficking: the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; (and)
- Labor trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Human trafficking may occur in the following situations:

- Prostitution and escort services.
- Pornography, stripping, or exotic dancing.
- Massage parlors.
- Sexual services publicized on the Internet or in newspapers.
- Agricultural or ranch work.
- Factory work or sweatshops.
- Businesses like hotels, nail salons or home-cleaning services.
- Domestic labor (cleaning, childcare, eldercare, etc. within a home)
- Restaurants, bars, or cantinas.
- Begging, street peddling, or door-to-door sales.
- Victims of human trafficking may exhibit any of the following:
- Evidence of being controlled either physically or psychologically.
- Inability to leave home or place of work.
- Inability to speak for oneself or share one's own information.
- Information is provided by someone accompanying the individual.
- Loss of control of one's own identification documents (ID or passport).
- Have few or no personal possessions:
  - Owe a large debt that the individual is unable to pay off.
  - Loss of sense of time or space, not knowing where they are or what city or state they are in.
  - The National Human Trafficking Hotline provides assistance to victims in crisis through safety planning, emotional support, and connections to local resources. For more information on human trafficking visit: **www.acf.hhs.gov/trafficking**.

- Call: **1-888-373-7888**
- Text: HELP to BEFREE (233733)
- Email: **help@humantraffickinghotline.org**
- Visit: **www.humantraffickinghotline.org**

Additional resources for abuse, neglect & exploitation:

- **https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/ltss-focus-areas/elder-abuse-prevention**
- The Florida Department of Elder Affairs
- Florida Association of Assisted Living
- DCF
- Veterans Affairs
- Social Security Administration
- Department of Elder Affairs
- Medicare
- My Florida
- AHCA Nursing Home Rates
- Florida Health Finder

Advanced Directives and the Patient Self-Determination Act

Providers are required to comply with the Patient Self-Determination Act (PSDA), and the Florida Health Care Advance Directive State Statute (FLSA 765), including all other State and federal laws regarding advance directives for adult members.

Advance directives

Aetna Better Health of Florida advance directives serve as a written instruction, such as a living will or durable power of attorney for the provision of health care when the individual is incapacitated.

The advance directive must be prominently displayed in the adult member's medical/case record. Requirements include:

- Providing written information to adult members regarding everyone's rights under State law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientiousobjections).
- Documenting in the member's medical/case record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educating patients on Advance Directives (durable power of attorney and living wills).

For advance directive forms and frequently asked questions, please visit:

- **www.fhca.org/consumers/health_care_advanced_directives.**

Patient self-determination act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions due to illness.

The PSDA requires all health care agencies (hospitals, Long Term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health of Florida requires network providers to comply with this act.

For additional information about the PSDA, please visit:

- **www.gapna.org/patient-self-determination- act-psda.**

Concerns

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health of Florida as a grievance or complaint or with the Agency for Health Care Administration at **1-888-419-3456.**

Provider Engagement Department

Provider Engagement Department overview

Our Provider Engagement Department serves as a liaison between the Health Plan and the provider community. Our staff is comprised of Network Relations Analysts (internal) and Network Relations Managers (external) Representatives. Our Network Relations Managers conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Network Relations Analyst are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Direct deposit and checks inquiries
- Credentialing status inquiries
- Becoming a new Aetna Better Health provider
- General provider education
- Tax ID Number (TIN) or National Provider Identification (NPI) confirmation and adjustments
- Provider portal registration and education
- Assistance with claim issues and remittance advices

Our Provider Engagement Department also supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards.

Our staff is responsible for the creation and development of provider communication materials, including the provider manual, periodic provider newsletters, bulletins, Fax/Email blasts, website notices, and the provider orientation kit.

Provider orientation

Aetna Better Health of Florida provides initial orientation for newly contracted providers within 30 days after they join our network. Orientation should occur before you see members. In follow up to initial orientation, Aetna Better Health of Florida provides a variety of provider educational forums for ongoing provider training and education such as: routine provider office visits, group or individualized training sessions on select topics (i.e. appointment time requirements, claims coding, appointment availability standards, member benefits, Aetna Better Health of Florida website navigation), distribution of periodic provider newsletters and bulletins containing updates and reminders, and online resources through our website at **www.AetnaBetterHealth.com/Florida**.

Provider inquiries

Providers may contact us at **1-844-645-7371** Monday through Friday from 8 AM and 7 PM or email us at **FLProviderEngagement@Aetna.com** for all questions including checking on the status of an inquiry, complaint, grievance, and appeal. Our Provider Engagement staff will respond within 48 business hours.

Network and Contracting Department

Provider selection criteria

Our network is open for application by a particular provider/provider specialty type if at least one of the following criteria is met:

1. Access and availability standards are not being met in that area.
2. There appears to be a need in the marketplace for a particular specialty due to referral patterns.
3. Member, group, or provider self-nomination (Depending upon product and geography any provider requesting a direct contract, provider information will be shared with the specialty network for review and consideration.)

Prohibition Against Discriminatory Practices

The Plan will not discriminate with respect to participation, reimbursement, or indemnification as to any provider, who is acting within the scope of provider's license, or certification under applicable state law solely on the basis of such license or certification in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997).

The Plan will not discriminate against any provider serving high-risk populations or those that specialize in conditions requiring costly treatments (42 CFR 438.12(a)(2); 42 CFR 438.214(c)).

Minority recruitment and retention plan

Aetna Better Health makes every effort to recruit and retain providers of all ethnicities to support the cultural preferences of its members. Our provider networks are not closed to new provider participation barring provider willingness to accept contractual requirements, contractual rates and satisfy all credentialing and regulatory requirements. The Plan reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Aetna Better Health's provider network.

As part of this process, Aetna Better Health collects and publishes spoken languages and ethnicity in our provider directories. Please be sure to accurately indicate all languages spoken in your office(s) on your Aetna Better Health re-credentialing application and/or CAQH application or contact your Provider Engagement representative to have updates completed.

Native Americans

Aetna Better Health does not impose enrollment fees, premiums or similar charges on Native Americans served by a Native American Healthcare provider; Native American Health Service, a Native American Tribe, Tribal Organization or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Interested providers

Aetna Better Health of Florida has several networks available to licensed providers that meet our contracting criteria and network needs. If you are interested in joining our Florida network, please visit our website at **AetnaBetterHealth.com/Florida**, and complete the letter of intent forms which can be located under "How to join" or by simply clicking the direct link below:

- **https://www.aetnabetterhealth.com/florida/providers/join-network.html**

Your completed form can be faxed directly to Network and contracting department at **1-860-262-9414,** emailed to **FLMedicaidContracting@aetna.com** or you can mail your application to:

Aetna Better Health of Florida
ATTN: Aetna Network Team
PO BOX 818043
Cleveland, OH 44181-8043

To determine if Aetna Better Health of Florida is accepting new providers in a specific region, please contact our Provider Services Department at the number located above.

If you would like to speak to a representative, about the application process or the status of your application, please contact our Provider Engagement Department at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC).

Please note this is for all medical service providers including (HCBS, LTC, Ancillary, and Hospital, etc.).

Below are some time periods to note in regard to contracting:

- Applications must be completed within 60 days of provider signature.
- If Letter of Agreement or Single Case Agreement is used, it will have an expiration date and need to be replaced by full application and agreement.
- Re-credentialing will occur every 3 years.
- Out of network or other authorizations are limited to the terms of the authorization.

Change of Ownership

Change of Ownership (CHOW) means an event in which the licensee sells, or o otherwise transfers its ownership to a different individual or entity as evidenced by a change in federal employer identification number or taxpayer identification number, or an event in which fifty-one percent (51%) or more of the ownership, shares, membership, or controlling interest of a licensee is in any manner transferred or otherwise assigned. A change of ownership application, fees, and all other required forms must be received by AHCA at least 60 days prior to the date of change of ownership.

When notifying the Plan with a CHOW, please supply the following information:

- A letter from the facility explaining the change of ownership.
- Change of Ownership Form (CHOW) –this form is inclusive of State rate structure).
- New Medicaid ID Number.
- W-9 Form.
- Requests can be submitted to the Provider Engagement Department via e-mail or fax at:
- E-mail: **FLMedicaidContracting@aetna.com**
- Fax: **1-860-262-9414**

Value Based Services (VBS)

Aetna Better Health offers a broad spectrum of models in our value-based continuum. Programs are selected based on the provider practice size and specialties, membership panel and population as well as on the level of clinical and technological capabilities. Our Value-Based Program (VBP) arrangements are based on collaboration between provider and plan.
The collaboration supports both clinical and financial success and aims at achieving key objectives:

- Increase access to care for our members in the regions we serve.
- Reduce medical costs.

- Improve quality of care and outcomes.

This collaboration supports providers in their transition from pay-for volume (fee for service) to pay-for-value by improving access, quality and affordability in the healthcare system. We offer performance-based reimbursement, care management collaboration as well as performance reporting and analytics. The performance-based reimbursement may be tied to clinical and/or financial outcomes.

The types of models offered* are Pay For Quality (P4Q), Patient Centered Medical Home (PCMH) and become more advanced with shared savings (SS) and various risk models. No two practices are the same, so we have a variety of models available to meet the provider group where they are in their pay for value transformation. It is our goal to have the majority of our membership assigned to network practitioners and providers in value-based contracts that concentrate on improving quality, reducing costs and increasing member satisfaction.

Credentialing and Re-Credentialing

Aetna Better Health of Florida uses current NCQA standards and guidelines for the review, credentialing, and re- credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source for all provider types. The Universal Credentialing Data Source was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing Data Source is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing Data Source Program allows providers to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information.

Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. The CAQH gathers and stores detailed data from more than 600,000 providers nationwide. All new providers, (except for hospital-based providers) joining Aetna Better Health of Florida, must complete the credentialing process and be approved by the Credentialing Committee.

Aetna Better Health of Florida is authorized to take whatever steps are necessary to ensure that the provider is recognized by the Agency and its agent(s) as a participating provider of Aetna Better Health of Florida and that the provider's submission of encounter data is accepted by the Agency;

A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program, in accordance with the following:

- Aetna Better Health of Florida will verify providers not currently enrolled in Medicaid's fee-for- service program submit fingerprints electronically following the process described on the Agency's Background Screening website. Aetna Better Health of Florida will verify Medicaid eligibility through the background screening system.
- Aetna Better Health of Florida will not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S. Individuals already screened as Medicaid providers or screened within the past 12 months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but will document the results of the previous screening.
- Individuals listed in s. 409.907(8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.
- For additional and detailed information please visit the AHCA website: **http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/index.shtml.**

Practitioner re-credentialing process

We reassess a provider's qualification practice and performance history every three (3) years, depending on state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for re-credentialing and whose applications are complete within CAQH. We'll send providers (whose applications aren't complete within CAQH) three reminder letters. The letters will ask them to update their re-credentialing data. If they don't respond to the letters, we'll call them.

Non-traditional and traditional re-credentialing process

Aetna Better Health of Florida has established and verified additional provider credentialing and re-credentialing criteria with respect to the applicable SMMC program as follows:

- Aetna Better Health of Florida will verify the additional criteria specified in the LTC Exhibit.
- Aetna Better Health of Florida will verify the additional criteria specified in the LTC Exhibit for LTC Providers.

Providers are re-credentialed every three (3) years and must complete the required reappointment application. Updates on malpractice coverage and state medical licenses are also required (where applicable). Please note you may NOT treat members until you are credentialed. Providers must also be board certified where applicable.

Aetna Better Health of Florida will verify during the credentialing and re-credentialing process that a home-like environment and community integration exists in facilities they intend to contract with as well as in existing network ALFs.

HCBS members residing in assisted living facilities and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms.
- Roommate for semi-private rooms.
- Locking door to living unit.
- Access to telephone and unlimited length of use.
- Eating schedule.
- Activities schedule.
- Participation in facility and community activities.

Ability to have:

- Unrestricted visitation.
- Snacks as desired.

Ability to:

- Prepare snacks as desired.
- Maintain personal sleeping schedule.

Licensure and accreditation

Health delivery organizations such as skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

How can I check the status of my re-credentialing application?

Call our Provider Engagement department at **1-800-441-5501**.

How do I add a new provider to my group?

Go to the **Join the Network** section of our website to start the application process.

Office site visits are made to network practitioners after receiving a member's complaint to evaluate the physical accessibility, physical appearance, adequacy of waiting and examining room space, the medical

record keeping practices are also evaluated to assess methods used to maintain confidentiality of member information and for keeping information in a consistent, organized manner ready for accessibility. No site visit is required for complaints regarding availability or medical records keeping.

The Aetna Better Health Office Assessment criteria are stated in the practitioner agreements and business criteria of the practitioner agreements. The medical record keeping practice standards are stated in the Aetna Better Health Medical Records Criteria that are distributed to practitioners.

Discrimination laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR 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.
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our Aetna Better Health network providers must comply with all applicable laws, rules, regulations, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member based on health status.

The Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider, who is acting within the scope of provider's license, or certification under applicable state law solely on the basis of such license or certification in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997). The Plan shall not discriminate against any provider serving high-risk populations or those that specialize in conditions requiring costly treatments.

Provider Data Services

Our Provider Data Services department is available by email **FLMedicaidProviderRelations@aetna.com** to provide electronic support to all providers. Below are some of the areas where we provide assistance:

- Data and demographic maintenance.
- Delegated Rosters.
- Non-delegated rosters.
- Adding provider to existing group.
- Recredentialing process.
- Provider terminations requests.
- Tax ID Number (TIN) or National Provider Identification (NPI) confirmation and adjustments.

Any change in a provider's name, address, telephone number, e-mail address, tax ID number, or Medicaid ID number needs to be reported in writing immediately to Provider Data Services Department via the **FLMedicaidProviderRelations@aetna.com** email or using the **Provider Contact US Form**.

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can be arranged in advance and sign language services are also available. These services can be arranged in advance by calling Aetna Better Health of Florida's Member Services Department at **1-844-645-7371**.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health of Florida is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services.

Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills.
- Those with diverse cultural and ethnic backgrounds.
- The homeless.
- Individuals with physical and mental disabilities.

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health of Florida makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible to associated

costs.

Our language interpreter vendor provides interpreter services at no cost to providers and members. Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health of Florida Member Services Representatives will assist the member via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services Staff dial the language interpretation service and use an
- Interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health of Florida staff (e.g., case managers) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of Florida to link with an interpreter.

Aetna Better Health of Florida provides alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Aetna Better Health of Florida offers sign language and over-the-phone interpreter services at no cost to the provider or member. Please contact Aetna Better Health of Florida at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC) for more information on how to schedule these services in advance of an appointment.

Medical Records Standards

The Plan shall ensure maintenance of medical/case records for each member in accordance with this section and with 42 CFR 431 and 42 CFR 456. Medical/case records shall include the quality, quantity, appropriateness, and timeliness of services performed under the contract.

Providers shall prepare and maintain complete medical records for members under their care in a manner that complies with the following:

- Applicable federal and state laws.
- Licensing, accreditation, and reimbursement rules and regulations applicable to Aetna Better Health.
- Accepted medical practice.

In accordance with federal and state law and the agreement, each provider must protect the confidentiality of members' patient records. To fulfill this obligation, providers must designate a person to review the provider's medical records, and such person's responsibilities include, but are not limited to, the following duties in accordance with federal and state law and the agreement:

- Maintaining the confidentiality, security, and physical safety of patient records.
- Retrieving member records in a timely manner upon the request of an authorized party, and
- Supervising the collection, processing, maintenance, storage, retrieval, and distribution of records Patient medical/case records shall comply with the following medical records standards:
    1. Include the member's identifying information, including name, member identification number, date of birth, gender identification, and legal guardianship (if any).
    2. Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications.
    3. Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
    4. Document referral services in members' medical/case records.
    5. Each record shall be legible and maintained in detail.
    6. All records shall contain an immunization history.
    7. All records shall contain information relating to the member's use of tobacco, alcohol, and drugs/substances.
    8. All records shall contain summary of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up.
    9. All records shall reflect the primary language spoken by the member and any translation needs of the member.
    10. All records shall identify members needing communication assistance in the delivery of health care services.
    11. All entries shall be dated and signed by the rendering health care provider.
    12. All entries shall indicate the chief complaint of purpose of the visit, the objective, diagnoses, medical findings or impression of the provider and the recommended treatment plan.
    13. All entries shall indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports the signature or initials of the provider.
    14. All entries shall include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up and outcome of services.
    15. Include copies of any consent or attestation form used or the court order for prescribed

psychotherapeutic medication for a child under the age of thirteen (13).

16. All records shall contain documentation that the member was provided with written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive. Providers shall not require the member to execute or waive an advance directive as a condition of treatment.

In accordance with the agreement and this manual, the medical records must be available for utilization review, risk management and peer review studies, member service inquiries, grievance and appeals, and quality improvement initiatives.

All records should be kept confidential and maintained for ten (10) years. All member information should be available to be transferred upon request by the member, or authorized representative, to any organization with which the member may subsequently enroll, or to a provider to ensure continuity of care.

Providers must keep our members' information confidential and stored securely. Providers must also ensure all staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that providers let us use your performance data for this purpose.

Medical records requests

Providers must respond and submit requested medical records to the Plan's Grievance and Appeals and/or Quality Management departments promptly to enable the Plan to comply with Federal and Florida laws governing grievances and appeals and complaint investigation. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports.

Advance directives

Providers must document whether or not a member executed advance directive(s) in a prominent part of the member's medical record. Providers shall certify if a member cannot implement an advance directive on grounds of conscience as permitted by state law.

Medical record alteration or falsification

Alteration or falsification of medical records is unethical conduct for any medical professional. Any incident relating to unethical behavior regarding medical record documentation is subject to the following process:

1. All incidents of possible medical record falsification are reported to the Plan's Peer Review Committee and the Special Investigation Unit (SIU).
2. The Peer Review Committee reviews the records in question and allows the provider to explain the circumstances.
3. The Peer Review Committee makes the final decision regarding the allegations of unethical conduct and takes appropriate actions.
4. Health professionals not subject to the peer review process (nurse, lab personnel, etc.) may be reported to the appropriate agency and/or governing body.

Transfer of medical records upon termination of the agreement

Upon the effective date of termination of the agreement (and the expiration of any period of any continuing care obligation), or such earlier date as a member may select or be assigned to another provider regardless of whether the agreement then remains in effect, pursuant to a member's or the Plan's request, provider shall copy all such member's medical records in provider's possession and forward such records, at no cost to the Plan or to the member, to (i) such other provider as designated by the Plan; (ii) the member; and (iii) the Plan, as requested by the Plan or the member.

Medical records: member consent

Where required by law, providers shall obtain specific written authorization from a member prior to releasing such member's medical records. Providers acknowledge and agree that the consent by a member in the applicable member contract enrollment form and/or providers' standard consent form is hereby deemed satisfactory member consent for the release of members' records, to the extent required by applicable law.

Member's rights to access medical records

Providers shall ensure timely access by members to review, amend and obtain a copy of their medical records upon request, to the extent required by applicable law.

Medical record audits

Aetna Better Health of Florida or AHCA may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities, or quality of care issues.

Providers must respond to these requests promptly within 30 days of request. Medical records must be made available to AHCA for quality review upon request and free of charge.

Access to records

Providers are required to retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health of Florida for inspection, evaluation, and audit for the longer of:

- A period of five years from the date of service; or
- Three years after final payment is made under the provider's agreement and all pending matters are closed.

Confidentiality and accuracy of member records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Aetna Better Health of Florida member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, our network providers must:

- Maintain accurate medical records and other health information.
- Help verify 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.

Provider must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations. **(www.hhs.gov/ocr/privacy/)**.

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, Health Plans, and health care clearinghouses that transmit health care information electronically. HIPAA established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **www.hhs.gov/ocr/hipaa/**.

In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium.

To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA.
- Consider the patient sign-in sheet.
- Keep patient records, papers and computer monitors out of view.
- Have electric shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C.§1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual's past, present or future physical or mental health, or condition.
  - The provision of health care to theindividual
  - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
  - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of Florida.
  - Release of data to third parties requires advance written approval from the department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order,

subpoena, or law.

Additional privacy requirements are located throughout this manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

For additional training or frequently asked questions, please visit U.S. Department of Health & Human Services. Direct website link: **http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm Member privacy rights.**

Aetna Better Health of Florida's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable Federal, State, local laws/regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of Florida personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health of Florida's practices regarding their PHI.
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI.
- Providing consistent review, disposition, and response to privacy requests within required time standards.
- Documenting requests and actions taken.

Member privacy requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint.
- Receive a copy of all or part of the designated record set.
- Amend records containing PHI.
- Receive an accounting of health plan disclosures of PHI.
- Restrict the use and disclosure of PHI.
- Receive confidential communications.
- Receive a Notice of Privacy Practices.

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of Florida in writing.

Quality Improvement

Quality Improvement (QI) program

In accordance with 42 CFR 438.204, 438.240 and accreditation standards, the Plan has a QI Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its members. The Quality Management department monitors, evaluates and improves the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys and related activities. Providers are expected to participate in the Plan's QI activities. To the extent required by applicable laws, regulations and the accreditation standards, the Quality Management department monitors and analyzes:

- Medical continuity and coordination of care to facilitate continuous and appropriate care for member and strengthen continuity and coordination of care among medical practitioners and providers.
- The coordination and continuity of care across health care network settings and transitions in those settings. e.g., Medical record reviews against documentation and record-keeping standards, including but not limited to the presence of medical and/or behavioral health consultant reports, home health continuing care plans and discharge summaries post hospitalization (for medical or behavioral diagnosis).
- HEDIS and state-defined performance measure data.
- Member complaints, grievances and appeals and quality of care issues.
- Utilization of services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, DME companies and pharmacies. This includes over- and under-utilization of medical resources and high-volume, high-risk services and use of acute/chronic care services based on demographic and epidemiological distributions of members.
- Facility audits and medical record reviews to monitor services provided by PCPs and high-volume specialists (OB-GYNs).
- Continuity and coordination of care between medical providers (PCPs, specialists, and behavioral health providers) and transition of care across health care settings and/or from one PCP to another (PCP changes) and movement from a terminated provider
- Annual provider and member satisfaction survey results.
- Provider compliance with practice guidelines, including preventive health guidelines.

The Plan reports on these monitoring activities through its QI committee structure, such as the Quality Management Oversight Committee, UM/QM Committee, Service Improvement Committee, Peer Review Committee and Credentialing Committee.

Measuring quality performance

Healthcare effectiveness and information data sets (HEDIS)

The National Committee on Quality Assurance (NCQA) defines HEDIS as "a set of standardized performance measures designed to ensure that purchasers and consumers have the information they

need to reliably compare the performance of health care plans." HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations. Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives, and preventive care programs.

- All managed care organizations that are NCQA accredited perform HEDIS reviews at the same time each year.
- HEDIS is a retrospective review of services and performance of care from the prior calendar year.
- HEDIS consists of over 80 measures across domains of care that address important health issues and preventive care.

  These include:
  - Effectiveness of Care
  - Chronic Disease Management
  - Behavioral Health
  - Access/Availability of Care
  - Experience of Care
  - Utilization
- HEDIS data is collected through two primary methods:
  - Administrative data: comes from submitted claims and encounters year-round.

Hybrid data: comes from chart collection/review typically performed February through May annually. To learn more about HEDIS requirements, receive HEDIS information specific to your practice or obtain an electronic version of our Provider HEDIS Resource Guide, send an email to **FLMedicaidQualityDept@Aetna.com** or contact your Provider Engagement representative.

Why does the Plan need to review medical records when it has claims data for each encounter?
Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data. Typically, an employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the Plan may ask the provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the Plans?
HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the Plan may ask for copies of records for audit purposes. We also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the Plan?
The HIPAA privacy rule permits a provider to disclose protected health information to a health plan for the quality–related health care operations of the health plan, including HEDIS, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c) (4).

May the provider bill the Plan for providing copies of records for HEDIS?
Providers may bill the Plan for copies of medical records related to HEDIS, in accordance to the terms of the provider agreement.

How can providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the provider and the Plan to collect HEDIS data in the most efficient manner possible. Options for reducing this burden include granting key staff at Aetna Better Health of Florida remote access to the provider's electronic medical records (EMR) and setting up a secure electronic data exchange from the provider's EMR to Aetna Better Health of Florida. For more information, please contact the Quality team at **FLMedicaidQualityDept@Aetna.com** or contact your Provider Engagement representative.

How can providers obtain the results of medical record reviews?
The Quality team can share the results of the HEDIS medical record reviews performed at your office and show you how your results compare to that of the Plan overall. For more information, please send an email to **FLMedicaidQualityDept@Aetna.com** or contact your Provider Engagement representative.

LTC Performance Measures

Additionally, the Quality team monitors and reports on LTC performance measures annually, as defined by AHCA for the LTC program. There are eight performance measures that provide information about the assessment and care planning processes within the LTC program. Of those performances measures, two relate specifically to the Primary Care Practitioner (PCP):

- Shared Care Plan with PCP – which looks at the percentage of LTC members whose care plan was transmitted to their PCP or other documented medical care practitioner identified by the member within 30 days of its development by the health plan.
- Screening Risk Assessment and Plan or Care to Prevent Future Falls – which looks for the treatment plan instituted to help prevent future falls and PCP/physician orders/referral for physical therapy or exercise program (including balance/gait training).
- Aetna Better Health of Florida reports the LTC Performance Measures to AHCA on July 1 each year. These results are subject to a rigorous review by a HEDIS-certified auditor to ensure the validity and reliability of the data reported.

Identifying opportunities for improvement

Aetna Better Health of Florida identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data Aetna Better Health of Florida monitors to identify opportunities for quality improvements include:

- **Formal Feedback from External Stakeholder Groups**: Aetna Better Health of Florida takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems -CAHPS), or focus groups with individuals, such as members and families, providers, and state and community agencies.
- **Findings from External Program Monitoring and Formal Reviews***:* Externally initiated review activities, such as an annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process assists Aetna Better Health of Florida in identifying specific program activities/processes needing improvement.
- **Internal Review of Individual Member or Provider Issues**: In addition to receiving grievances and appeals from members, providers, and other external sources, Aetna Better Health of Florida proactively identifies potential quality of service issues for review through daily operations (i.e. member services, prior authorization, and case management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our case

management processes, access to provider care and covered services, and quality of care), Aetna Better Health of Florida is able to identify specific opportunities for improving care delivered to individual members.

- **Findings from Internal Program Assessments**: Aetna Better Health of Florida conducts several formal assessments/reviews of program operations and providers that are used to identify opportunities for improvement. This includes, but is not limited to, record reviews of contracted providers, credentialing/re-credentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment, and assessment of provider accessibility and availability.
- **Clinical and Non-Clinical Performance Measure Results**: Aetna Better Health of Florida uses an array of clinical and non-clinical performance standards (e.g., call center response times, and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, Aetna Better Health of Florida can identify opportunities for improvement in clinical and operational functions. These measures include:
  - Adherence to nationally recognized best practice guidelines and protocols.
  - Prior authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals).
  - Provider availability and accessibility, including:
  - Length of time to respond to requests for referrals.
  - Timeliness of receipt of covered services.
  - Timeliness of the implementation of members' care plans - Availability of 24/7 telephonic. assistance to members and caregivers receiving home care services.
- **Data Trending and Pattern Analysis**: With our innovative information management systems and data mining tools, Aetna Better Health of Florida makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- **Other Service Performance Monitoring Strategies**: Aetna Better Health of Florida uses a myriad of monitoring processes to confirm effective delivery of services to all our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health of Florida monitors include, but are not limited to:
  - High-cost, high-volume, and problem prone aspects of the Long Term care services our members receive.
  - Effectiveness of the assessment and service planning process, including its effectiveness in assessing a member's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization.
  - Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services.

Potential quality of care (PQoC) concerns

Aetna Better Health of Florida has a process for identifying Potential Quality of Care (PQoC) concerns related to our provider network including Home and Community-Based Services (HCBS), researching, and resolving these care concerns in an expeditious manner, and following up to make sure needed interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna Better Health of Florida tracks and trends PQoC cases and prepares trend reports that we organize according to provider, issue category, referral source, number of verified

issues, and closure levels. Aetna Better Health of Florida will use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Better Health Credentialing and Performance Committee or identify the need for possible quality improvement initiatives.

Performance improvement projects (PIP)

Performance improvement projects (PIPs), a key component of our QI Program, are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs follow CMS protocols. Aetna Better Health of Florida participates in state-mandated PIPs and selects PIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of members' care and services over time.
- Address clinical or non-clinical topics.
- Identify quality improvement opportunities through one of the identification processes described above.
- Reflect Aetna Better Health of Florida membership composition in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease.

Our Quality team prepares PIP proposals that are reviewed and approved by our Medical Director, Quality Management Oversight Committee prior to submission to AHCA for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health of Florida, as well as from network providers who are members of our committee.

The Quality team evaluates and measures the performance of the study indicator(s) throughout the life-cycle of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance over time, Aetna Better Health of Florida immediately conduct additional analyses to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Peer review

Peer review activities are evaluated by the Credentialing and Performance Committee and/or the Practitioner Appeals Committee. This committee may take action if a quality issue is identified. Such actions may include, but are not limited to, development of a corrective action plan (CAP) with time frames for improvement, evidence of education, counseling, development of policies and procedures, monitoring and trending of data, limitations, or discontinuation of the provider's contract with the Plan. The peer review process focuses on the issue identified, and, if necessary, could extend to a review of utilization, medical necessity, cost, and health provider credentials, as well as other quality issues.

Although peer review activities are coordinated by the Quality team, they may require the participation of Utilization and Case Management, Provider Engagement, or other departments. Aetna Better Health of Florida may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plans peer review process adheres to Aetna policies, is conducted under applicable State and federal laws, and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in the Aetna Better Health of Florida

network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension, or termination of a contract under specific circumstances.

Satisfaction surveys

Aetna Better Health of Florida conducts member and provider satisfaction surveys to gain feedback regarding members and providers' experiences with quality of care, access to care, and service/operations. Aetna Better Health of Florida uses member and provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

Member satisfaction surveys

Aetna Better Health of Florida is committed to a better health care system. We continue to solicit feedback from consumers, physicians, hospitals, employers, LTC service providers, government and regulatory organizations to provide information clearly, useful, and relevant.

Aetna Better Health of Florida conducts a member satisfaction survey annually to assess the quality of its member experience. They survey is conducted by a qualified, Agency-approved, NCQA certified survey vendor is required under the State contract. The Agency specifies the survey requirements including survey specifications, survey questions and any applicable supplemental items. The survey tool, sampling methodology, administration protocol, analysis plan and reporting description along with evidence of NCQA certification of the survey vendor are approved by AHCA annually. The results of the member satisfaction survey are submitted to AHCA each year and reviewed through the Aetna Better Health's Quality Improvement Oversight Committee.

Provider satisfaction surveys

Aetna Better Health of Florida works hard to support providers and members to create a culture of better health: connected, simpler, intuitive, convenient, affordable, and powerful.

Providers influence consumer satisfaction and Aetna Better Health of Florida empowers them with better tools, information, and payment models. Surveys are important tools for us to measure and assess how we impact our network providers.

Aetna Better Health of Florida conducts an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and Aetna Better Health of Florida's response to inquiries. We use the survey results to make administrative and operational changes in areas that may require improvement. In addition to the annual survey, Aetna Better Health of Florida encourages provider feedback and suggestions through the Provider Service department at **1-800-441-5501** (MMA) or **1-844-645-7371** LTC).

External quality review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), for States to contract with an independent external review body, to perform an annual review of the quality of services furnished under State contracts with Managed Care Organizations, including the evaluation and analysis of quality outcomes, timeliness, and access to services furnished to members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

Aetna Better Health of Florida cooperates fully with external clinical record reviews assessing our network's quality of services, access to services, and timeliness of services, as well as any other studies

determined necessary by AHCA. Aetna Better Health of Florida assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. Aetna Better Health of Florida also provides complete records to the External Quality Review Organization (EQRO) within the time frame allowed. Aetna Better Health of Florida's contracted providers are required to provide the records needed for the EQRO review.

The results of the EQR are shared with providers and incorporated into our overall QI and Medical Management programs as part of our continuous quality improvement process.

Risk Management Program

Providers shall participate in and cooperate with the Plan risk management program. The Managed Care Plan shall require participating and direct service provider to report adverse incidents to the Managed Care Plans within twenty- four (24) hours of the incident. The Plan will ensure that all participating and direct service providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the member's identity, description of the incident and outcomes including current status of the member. The Plan developed and implemented an incident reporting system to minimize injury/incidents to members, employees, and visitors. The risk management program and incident reporting policy and procedures comply with §59A-12.012, Florida Administrative Code (Internal Risk Management Program for HMOs) and §641.55, Florida Statute (Internal risk management program for HMOs).

Adverse or Untoward Incident

An event, as defined in Chapter 395.0197(5) of the Florida statutes, over which provider could exercise control, which is more probably associated, in whole or in part, with the medical intervention rather than the medical condition for which such medical intervention occurred, and which results in one of the following:

a) Death
b) Brain or spinal damage
c) Permanent disfigurement
d) Fracture or dislocation of bones or joints
e) A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility
f) Any condition that required specialized medical attention or surgical intervention resulting from non- emergency medical intervention, other than an emergency medical condition, to which the member has not given his/her informed consent; or
g) Any condition that required the transfer of the member, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the member's condition prior to the adverse incident, including:
    1. The performance of a surgical procedure on the wrong patient, a wrong surgical procedure or wrong- site surgical procedure, or a surgical procedure otherwise unrelated to the member's diagnosis or medical condition.
    2. Required surgical repair of damage resulting to a member from a planned surgical procedure where the damage was not a recognized specific risk, as disclosed to the Member and documented through the informed consent process.
    3. A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
    4. Any complaint or allegation of sexual misconduct and abuse or contact by provider employee or agent of provider.

If an adverse or untoward incident occurs to a member, provider shall report the adverse or untoward incident (as defined under Florida law) to the Plan's risk manager within twenty-four (24) hours after its occurrence. Provider shall (i) participate in and cooperate with the Plan's risk management program; (ii) provide such medical and other records without charge within ten (10) days of receipt of written notice; (iii) share such investigation reports and other information as may be required or requested by the Plan's risk manager to determine if an adverse or untoward incident is reportable as a "Code 15" to AHCA; and

(iv) in all other respects comply with and abide by this Manual. A provider's failure to comply with these requirements may be deemed a material breach of the agreement, at the Plan's sole discretion.

When an incident occurs:

- Complete the **incident report form** (located in our Aetna Better Health of Florida website) immediately upon becoming aware of an adverse or untoward incident.
- Fill each blank on the form, using N/A when not applicable to the particular occurrence.
- Write legibly or type the information on the form.
- Describe the incident carefully. Be brief, but include important information, including who, what, where, when, and how of the event/situation.
- Indicate the body part injured, the location and extent of injury and document fully, including lack of injury.
- Report any pertinent action taken in response to the occurrence.
- Obtain the name and location information for any witnesses, including employees.
- Sign and date the report. Include title/designation and contact phone number.
- Email to the Aetna Better Health of Florida Provider Engagement mailbox at **FLProviderEngagement@aetna.com**.

For assistance in completing the incident report form or any questions contact us at:
MMA: 1-800-441-5501, **LTC: 1-844-645-7371**.

Incident reports are part of risk management files only and copies of incident reports must be maintained separately from member's medical records.

All incident reports will be reviewed, and date stamped upon receipt. Appropriate action will be initiated when indicated. Incident reports will not be used to penalize providers; however, failure to report an adverse or untoward incident may result in further action.

Critical incident reporting

Providers shall implement a systematic process for incident reporting. Providers will notify Aetna Better Health of Florida within 24 hours of an occurrence of an incident that may jeopardize the health, safety, and welfare of a member or impair continued service delivery. Licensed facilities must provide notification within 15 days in accordance with Florida Law 400.147, 429.23, Section 39 and Section 415, Reportable conditions include but are not limited to:

- Closure of provider locations or facilities due to license violations.
- Provider financial concerns/difficulties.
- Loss or destruction of member records.
- Compromise of data integrity.
- Fire or natural disasters.
- Critical issues or adverse incidents that affect the health, safety, and welfare of members.

In the member's record, the provider will contain a brief summary of the problem(s) and proposed corrective action plans and timeframes for implementation within a reasonable time after the incident is reported.

Provider will inform Aetna Better Health of Florida within 30 days of the occurrence date, using a secure process (secure email) for proper handling of HIPAA related information.

Providers will also report adverse events involving our Long Term Care members to the LTC Case Manager and assist the Case Manager with the review. Such adverse events would include the following:

- Adverse events required by rule or law to be reported to regulatory authorities such as neglect, abuse, exploitation, and fraud.
- Adverse events related to the following:
  - Decline in management of medications.
  - Significant worsening of ADLs.
  - Significant change in toileting ability.
  - Falls or accidents (with or without injury).
  - Disaster that leaves provider facility diminished.

All adverse event reporting and reviews are part of the quality initiatives for both Aetna Better Health of Florida and the provider. This quality initiative and risk management process anticipates the information will not be included in the discoverable elements of the member file.

Medical Management

Comprehensive Assessment and Review for Long Term Care Service (CARES)

Aetna Better Health of Florida also assesses members through the Comprehensive Assessment and Review for Long Term Care Service. (CARES). Aetna Better Health of Florida staff members go over the CARES assessment with the member or caregiver during a telephone call made to each member to welcome them to the Health Plan. The CARES assessment gathers:

- Member contact information.
- Medical home information.
- Member's health history and self-rated assessment of health.
- Medication usage.

CM business application systems

Our case management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses an assessment, condition-specific questionnaires and care plans and allows case management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use in future cases. The system interfaces with our predictive modeling software, the inpatient census tool and allows documents to be linked to the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in case management.

Concurrent review

Aetna Better Health of Florida conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the MCG® (Milliman Care Guidelines) or ASAM (American Society of Addiction Medicine) Criteria. MCG Admission certification is conducted within one business day of receiving notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses and behavioral health clinicians conduct these reviews. The clinicians work with the Medical Directors in reviewing medical record documentation for hospitalized members. Our medical directors complete rounds on site as necessary.

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) and Transition of Care clinician works with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex and

multiple discharge needs.

- Providing hospital staff and attending physician with names of network Providers (i.e., home health agencies, durable medical equipment (DME)/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Discharge from a Skilled Nursing Facility

All discharges from a Skilled Nursing Facility (SNF) must be coordinated with the member's Case Manager. In accordance with Section 83 of Title 42 of the code of Federal Regulations, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of reason, the member, his or her representative, and the member's Case Manger must be involved in discharge planning.

Prior authorization and referral process

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. When service needs are identified, the member must be given information about available providers, so that an informed choice of providers can be made. All services for the Long-Term Care program require a review and approval by the case manager. The Plan will verify that, applicable criteria is utilized when making authorization decisions. These authorized decisions will be made with consideration given to characteristics of the local delivery systems available for specific members as well as member specific factors, such as member's age, co-morbidities, complications, progress in treatment, psychosocial situation, home environment, and to promote the concept of appropriate care for the appropriate condition in the most cost-effective setting. 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 medically necessity before a denial of service authorization occurs. The case managers will send you the Authorization Forms if applicable.

The requesting provider is responsible for complying with Aetna Better Health of Florida's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of Florida will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health of Florida. This includes maters about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Prior authorization and coordination of benefits

If other insurance is the primary payer before Aetna Better Health of Florida, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Medical necessity criteria

To support prior authorization decisions, Aetna Better Health of Florida uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Florida policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Florida uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Florida's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency such as Florida's Medicaid coverage and limitations policy.
- Applicable clinical guidelines (MCG Guidelines ®, ASAM Criteria) as the primary decision support for most medical, behavioral health, and substance use diagnoses and conditions.
- Aetna BetterHealth of Florida Clinical Policy Bulletins (CPBs).
- Aetna Better Health of Florida Policy Council Review.

If the MCGs state "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of Florida CPBs, should be consulted and utilized.

Medical, dental, and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Fee Schedule Maintenance and Reimbursement Determinations

The schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes is from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by the Plan or the provider's usual charge for the service, whichever is less. In many cases, the Plan allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare laboratory and Durable Medical Equipment (DME) rates. Your contract will outline the specific fee schedule methodology used to determine your rates.

Medicaid fee schedule

The Plan updates all Medicaid based fee schedules as published by Medicaid and in accordance with Medicaid effective dates assigned to codes and reimbursement.

Upon publication of codes previously not valued by Medicaid, the Plan will update Medicaid-based schedules accordingly. The Plan will request code specific discrepancy reports be pulled; claims will be reviewed and over and underpayments will be handled accordingly with providers.

The Plan will reprocess any provider claims affected by new codes upon provider's written request.

Laboratory and pathology services

Laboratory and pathology services must be performed by a participating laboratory. The Plan maintains a contract with LabCorp and Quest Diagnostics to provide outpatient lab services for members. LabCorp and Quest Diagnostics provides all necessary supplies; request forms; specimen pick-up; accurate and prompt test results.

Laboratory and pathology services provided by an outside or reference lab that is not the contracted laboratory provider (LabCorp and Quest Diagnostics) will not be reimbursed to the provider of service by the Plan. Laboratory and pathology services include but are not limited to clinical labs, nonclinical labs, pathology, and dermatology. If services are performed in office, the provider may not bill the member/patient or for the laboratory/pathology services. LabCorp and Quest Diagnostics must be used for all Medicaid members.

Although we maintain a contract with LabCorp and Quest Diagnostics to provide lab and path services, we recognize the need for urgent lab work to make a diagnosis or to treat the patient while in the provider's office. When this situation occurs, providers may bill and receive reimbursement for lab procedures.

All lab procedures below will be reimbursed at 100 percent of Medicaid allowable for non-participating providers when authorized or based on the **Plan Participating Provider Agreement**:

CPT	Code Description
36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
80305	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipstick, cups, cards, cartridges)
80306	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) read by instrumented assisted direct optical observation (e.g., dipstick, cups, cards, cartridges)
80307	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, by instrument chemistry and analyzers (e.g., utilizing immunoassay [EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (DAT, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81025	Urine pregnancy test, by visual color comparison methods
82247	Bilirubin; total
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening

CPT	Code Description
82465	Cholesterol, serum or whole blood, total
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose blood; reagent strip
83655	Lead
84520	BUN - Assay of urea nitrogen (HEDIS Code)
85002	Bleeding time test
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85013	Blood count; spun micro hematocrit
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85610	Prothrombin time;
86308	Heterophile antibodies; screening
86510	Skin test; histoplasmosis
86580	Skin test; tuberculosis, intradermal
87081	Culture, presumptive, pathogenic organisms, screening only;
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87880	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A

All preadmission laboratory testing should be performed by a contracted lab. For members scheduled for elective admission, all preadmission diagnostic work-ups including lab, radiology, and supporting specialty consultations, must be referred to free-standing contracted providers. If needed, lab services may be performed at that facility within seven (7) days of the event. Any laboratory service required prior to the seven (7) days must be performed as described above.

CLIA certification

Physician office laboratories must hold either a CLIA certificate or a CLIA waiver to perform laboratory tests for members. When billing for laboratory services, please be sure to include your CLIA number on the claim form.

Maternity Case Management

Aetna Better Health® of Florida has contracted with **ProgenyHealth®** to deliver a comprehensive maternity case management program **at no cost to you or your patients**. The program provides your patients with clinical, behavioral, and social support for issues that may arise throughout pregnancy and up to 12 months postpartum. The program supports your patients between office visits with care planning, education, and connection to resources.

Here's How it Works:

- **Step One:** Aetna Better Health of Florida eligible patients – pregnant women between the ages of 13-55 – enroll in the program, empowering them to take a more active role in their maternity journey. Enrollment options are listed below.
- **Step Two:** The ProgenyHealth team will reach out to your patient and complete a full health risk assessment and assign a Case Manager or Care Coordinator based on the results. Regardless of risk, all patients receive ongoing communication and risk monitoring.
- **Step Three:** Patients create a personali zed profile on the ProgenyHealth mobile app to track their pregnancy. They also have direct access to our team for questions or concerns.
- **Step Four:** ProgenyHealth can update you and your team if your patient reports any changes. If your team identifies any concerns, you can notify us, and we will support your patient.
- **Step Five:** Throughout pregnancy and postpartum, we will continue to educate and support your patient, help schedule routine or specialist appointments, and connect your patient with non-clinical resources to ensure a healthier pregnancy journey.

If you think your **Aetna Better Health of Florida** patients could benefit from this program, referring them is simple:

- **Submit the Florida Medicaid Pregnancy Notification Form:** Via sFax to 1-860-607-8726.
  (or)
- **Encourage Your Patients to Self-Enroll**: Ask your patients to download our mobile app by scanning the QR code found on this member flyer: **English (PDF) | Spanish (PDF)**. Once they have the app, they can enroll directly into the program.
  (or)
- You or your patient can call us at: **1-855-231-4730**, Monday - Friday, 8:30 AM - 5:00 PM ET or email us at: **maternity@progenyhealth.com**
  Together, we can provide exceptional care and support for expectant mothers throughout their pregnancy and postpartum journey.

Claims Standards

Claims and encounter submission protocols and standards are available in this section. Additional claims and encounter submission protocols and standards are available through provider communications and bulletins. These communications and bulletins may be found on the Aetna Better Health of Florida website **AetnaBetterHealth.com/Florida.** Providers shall submit claims in accordance with applicable state and federal laws. Provider shall submit timely, complete, and accurate claims to the Plan in accordance with the requirements of Section X.D., Information Management and Systems of the SMMC contract. 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.

Aetna Better Health of Florida general claims payment information

Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health providers will be paid in accordance with Original CMS claim processing rules.

Timely Filing and Prompt Pay Guidelines Grid

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. (SMMC Contract) (Section VII) (D).
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 VII.)(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 VII)(D)(2).
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 VII) (E) (1)(k).
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(3)(c)(2) and (4)(c)(2).

Clean claims

For a claim to be paid, it must be a clean claim. Per Rule 59G-1.010 (42), F.A.C., "clean claim" means a claim that:

- Has been completed properly according to Medicaid billing guidelines.
- Is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment; and
- Can be processed and adjudicated without obtaining additional information from the provider or from a third party.

A clean claim includes a claim with errors originating in the claim system. It does not include a claim from a provider who is under investigation for fraud, abuse, or violation of state or federal Medicaid laws, rules, regulations, policies, or directives or a claim under review for medical necessity.

Aetna Better Health of Florida will comply with the following standards regarding timely claims processing:

- Aetna Better Health of Florida will pay 85 percent of all clean claims submitted within 7days.
- Aetna Better Health of Florida will pay 95 percent of all clean claims submitted within 10days.
- Aetna Better Health of Florida will pay 98 percent of all clean claims submitted within 20days.

For more information regarding clean claim submission review our **claims provider training**.

How to file a claim

Select the appropriate claim form (refer to table below) and complete the claim form.

Service	Claim Form
Medical and professional services	CMS 1500 Form
Hospital inpatient, outpatient, skilled nursing and emergency room services	CMS UB-04 Form
Dental services that are considered medical services (oral surgery, anesthesiology)	CMS 1500 Form

Instructions on how to fill out the claim forms can be found on our website at:
AetnaBetterHealth.com/Florida.

- Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
- The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
- Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health of Florida at the correct address. Claims may be submitted through:
  - Electronic Clearing House.
- Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic

claims.

- Availity is our preferred EDI vendor.
- Contact your software vendor directly for further questions about your electronic billing.
- Contact our Provider Engagement department for more information about electronic billing.
  - All electronic submission will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Florida policies and procedures.
- Through the mail:

  Aetna Better Health of Florida
  P.O. Box 982960
  El Paso, TX 79998-2960

Correct coding initiative

Aetna Better Health of Florida integrates The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) program to promote national correct coding methodologies and reduce improper coding, with the overall goal of reducing improper payments of claims. Aetna Better Health of Florida performs editing and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit: **https://www.cms.gov/national-correct-coding-initiative-ncci.**

Aetna Better Health of Florida utilizes *ClaimXten (CXT)* as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through *Clear Claim Connection*.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through *CXT*. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in *CXT*.

Providers will have access to *Clear Claim Connection* through our website through a secure login. *Clear Claim Connection* coding combinations can be used to review claim outcomes after a claim has been processed.

Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.

- Billing separate codes forrelated services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service to use an additional code when one higher level, more comprehensive codeis appropriate.

Modifiers

Appropriate modifiers must be billed to reflect services provided and for claims to pay appropriately. Aetna Better Health of Florida can request copies of operative reports or office notes to verify services provided. Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Coordination of benefits

Coordination of Benefits ("COB") provision applies when a member has health care coverage under more than one plan. In the event that the Plan is the secondary payer, coordination of benefit claims must be submitted within ninety (90) days after final determination by the primary organization as evidenced by the primary carrier's Explanation of Payment (EOP) or Explanation of Benefits (EOB) as required under applicable law and regulation. (See Florida Statute 641.3155(2)). All explanations of payment or denials from the member's primary carrier must be provided with the claim. Information should be sent to:

Aetna Better Health of Florida
P.O. Box 982960
El Paso, TX 79998-2960

Claim status

You may use Availity to check the status of claims with dates of service within the last year (365 days) or by calling the Claims Inquiry Claims Research (CICR) department. To check the status of a disputed, resubmitted, and reconsidered claim, please contact the CICR department.

Calling the Claims Inquiry Claims Research department

The Claims Inquiry Claims Research (CICR) department is also available to:

- Answer questionsabout claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization departmentdirectly).
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections).
  - Please be prepared to give the service representative the following information:
- Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
- Member name and member identification number
- Date of service
- Claim number from the remittance advice on which you have received payment or denial of the claim.

Claim Resubmission/Reconsideration

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
    - 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(3)(c)(2) and (4)(c)(2).
- Was incorrectly paid or denied because of processing errors.
    - Reference the Timely Filing and Prompt Pay Guidelines Grid above for claim submission timeframes.

You can resubmit a claim through Availity or by mail utilizing the **Claim adjustment request/claim reconsideration form (PDF)** and include the documents below:

- An updated copy of the claim — all lines must be rebilled.
- A copy of the original claim (reprint or copy is acceptable.)
- A copy of the remittance advice on which we denied or incorrectly paid the claim.
- A brief note describing the requested correction.
- Any other required documents
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

If resubmitting via mail:

Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

Please note: Providers will receive a Remit when their claim has been reprocessed. Providers may call our CICR department during regular office hours to speak with a representative about their claim. The CICR department will be able to verbally acknowledge receipt of the resubmission/reconsideration. Our staff will be able to discuss, answer questions, and provide details about status. Providers can utilize Availity to check the status of a resubmitted/reprocessed and adjusted claim.

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms. Aetna Better Health of Florida encourages providers to submit Corrected Claims electronically via EDI or the Availity portal. Reference the Timely Filing and Prompt Pay Guidelines Grid above for claim submission timeframes.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper claims)
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 claim form (paper claims)
- Original Claim number MUST be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the

CMS-1500 paper claim form, or the corresponding 837 transaction loop when submitting corrected claims electronically.

- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 paper claim form, or the corresponding 837 transaction loop when submitting corrected claims electronically.

Medicare and other primary payer sources

Eligible members can access services that are covered by Medicare through fee-for-service Medicare or a Medicare Advantage product. In the Comprehensive LTC program, Aetna Better Health of Florida is the payer of last resort for Medicaid-covered services. As applicable, providers must bill third party insurance before submitting a claim to Aetna Better Health of Florida. We will pay the difference between the primary insurance payment and the state allowable amount. If the payment from the primary payer is greater than or equal to the amount allowable under the terms of the Provider Agreement with Aetna Better Health of Florida, we have no further obligation. Providers cannot balance bill members.

Aetna Better Health of Florida does not require any co-payment or cost sharing by members except the patient responsibility amount for nursing facilities or assisted living services or any co-payments established under state law for beneficiaries of the State's Medicaid Program. Typically, Aetna Better Health of Florida is financially responsible for Medicare co-insurance and deductibles for covered services. Aetna Better Health of Florida would then reimburse providers for Medicare deductibles and co- insurance according to Medicaid Guidelines or the rates negotiated by Aetna Better Health of Florida with the provider.

Aetna Better Health of Florida is responsible for collecting patient responsibility as determined by DCF and we have policies and procedures to ensure that, where applicable, members are assessed for and pay their patient responsibility. Some members have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility. Aetna Better Health of Florida may transfer the responsibility for collecting its members' patient responsibility to residential providers and compensate these providers net of the patient responsibility amount. If Aetna Better Health of Florida transfers collection of patient responsibility to the provider, the provider contract will specify complete details of both parties' obligations in the collection of patient responsibility. Aetna Better Health of Florida will either collect patient responsibility from all its residential providers or transfer collection to all its residential providers. Aetna Better Health of Florida has a system in place to track the receipt of patient responsibility at the member level irrespective of which entity collects the patient responsibility. This data will be available upon request by the Agency. Aetna Better Health of Florida or its providers shall not assess late fees for the collection of patient responsibility from members. Aetna Better Health of Florida submits a Patient Responsibility Report annually to AHCA.

If a member's patient responsibility exceeds the reported Medicaid Home and Community Based service expenditure, the Agency will employ the reconciliation process to determine if a payment adjustment is required.

If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to Aetna Better Health of Florida for a coverage determination. It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to Aetna Better Health of Florida. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential for Aetna Better

Health of Florida to coordinate benefits. If a service is non-covered or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for members where third-party insurance is indicated will be denied in most cases. Providers have a maximum of 180 days from the date of the EOB for Coordination of Benefits, unless the claim is a Medicare cross over claim, these must be submitted within 36 months of the original submission to Medicare.

Remittance advice

Aetna Better Health of Florida generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call our Provider Services department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Florida for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Florida due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Florida after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.

- The Claim Header area of the remit lists information pertinent to the entire claim. This includes: Member Name, ID, Birth Date, Account Number, Authorization ID, if obtained, Provider Name, Claim Status, Claim Number, Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be attained. To qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claims by EFT. You must also be able to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Engagement department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare, and one check from Medicaid.

All Aetna Better Health of Florida Registration Services (EERS) are managed by ECHO Health. EERS gives payees multiple ways to set up EFT and ERA in order to receive transactions from multiple payers.

To enroll in EERS visit the Aetna Better Health ECHO portal at
https://enrollments.echohealthinc.com/EFTERAInvitation.aspx.

Editing guidelines

The Plan uses multiple editing systems to process claims through its practice management application. These systems are configured to comply with applicable state and federal regulations, with respect to timely filing, coding combinations, maximum units, place of service and other editing guidelines. Claim denials resulting from editing that conflict with contractual obligations will be reviewed by our Clinical Editing Review Committee and a payment determination will be made based on the Provider's agreement and correct coding initiatives.

A reduction in payment as a result of claims policies and/or editing procedures is not an indication that the service is a non-covered service.

Note: Claims processed after the implementation date, regardless of date of service, will process according to the most recent version. No retrospective claim payment changes are made for processing changes that are a result of new editing rules.

High dollar claims (with expected payable amounts over $50,000)

All claims submitted to the Plan with an **expected payable amount** of over $50,000 ("high dollar") require the accompaniment of an itemized statement. High dollar claims not accompanied by itemization are subject to denial. If a hospital provider receives such a denial, the claim should be marked as a resubmission and resubmitted with the itemization for processing.

The purpose of the itemization review is to identify items billed under routine services in an inpatient setting that are not separately billable. Such items include but are not limited to:

- Minor medical and surgical supplies such as Band-Aids, cotton balls, Q-tips, swab sticks, drapes, saline solutions irrigation/flush, syringes, gloves, drapes, bed linen, gowns.
- Other identified nursing charges.

- IV nursing care, procedural charges for an IV flush and or administration is considered a routine cost.
- Equipment permanently stored or housed in a room such as a cardiac/heart monitor in the intensive or cardiac unit (ICU/CCU), a blood pressure (BP) monitor or respiratory, ventilation and oxygen equipment.
- Continuous pulse oximetry monitoring in critical care or step-down units.
- Personal items such as slippers, lotions, powders, deodorant, admission kits (except MD), toothbrushes, denture care kits or under pads.

Anesthesia unit billing guidelines

When billing anesthesia services be sure to submit claims with the total anesthesia service time. The Plan's claims payment system will automatically convert the service time into units. Any portion of a 15-minute increment equals one unit.

Include the appropriate HCPCS modifiers. These modifiers identify monitored anesthesia and whether a procedure was:

- Personally performed.
- Medically directed.
- Medically supervised.

HCPCS Codes

There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicaid billing requirement rules, which could result in separate billing for claims under Aetna Better Health.

While most claims can be processed under both Medicare and Medicaid, there may be instances where separate billing may be required.

HCPCS codes for drugs and national drug code (NDC) requirements

Providers who bill HCPCS codes for drugs must enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in the shaded area of item 24. Begin entering the information above 24 A. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See Chapter 4 in the Florida Medicaid Provider General Handbook for instructions for crossover claims for J3490, Unclassified Drugs, and J9999, Not Otherwise Assigned, Antineoplastic Drugs.

Florida Medicaid will only reimburse for drugs for which the manufacturer has a federal rebate agreement per Section 1927 of the federal Social Security Act *[42 U.S.C. 1396r-8]*.

The current list of manufacturers who have drug rebate agreements is available on AHCA's website at **http://ahca.myflorida.com.**

Click on: **Medicaid**, ***scroll down*** to What **is Occurring in Medicaid**, and then ***click*** on: **Current List of Drug Rebate Manufacturers**

The NDC must be entered with 11 digits in a 5-4-2-digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and **the last two digits are the package size.**

Note: Aetna Better Health recommends using the NDC number on the box (outer packaging) if the medication comes in a box with multiple vials.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:
For a 4-4-2-digit number, add a 0 to the beginning. For a 5-3-2-digit number, add a 0 as the sixth digit. For a 5-4-1-digit number, add a 0 as the tenth digit.

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point.

The Unit Qualifiers are:

- F2 – International Unit GR – Gram
- ML – Milliliter UN – Unit

Retroactive eligibility changes

- Eligibility under a benefit contract may change retroactively if:
- We receive information an individual is no longer a patient.
- The individual's policy/benefit contract has been terminated.

The eligibility information we receive is later determined to be false.

If you have submitted a claim(s) affected by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the remittance advice.

Balance billing

Providers shall accept payment from Aetna Better Health of Florida for Covered Services provided to Aetna Better Health of Florida Members in accordance with the reimbursement terms outlined in the Agreement. Payment made to providers constitutes payment in full by Aetna Better Health of Florida for covered benefits, except for Member Expenses. For Covered Services, providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of Aetna Better Health of Florida's claims policies and/or procedures does not indicate that the service provided is a non-Covered Service, and Members are to be held harmless for Covered Services.

For more information on balance billing, refer to the Florida Statutes 641.3154 and 641.3155 (5)a.(8). Additionally, Providers shall not charge Members for missed appointments.

Vaccine for children program

Aetna Better Health providers are required to provide immunizations in accordance with the childhood immunization schedule as approved by the Advisory Committee on Immunization Practices of the U.S. Public Health Service and the American Academy of Pediatrics or when it is shown to be medically necessary for the child's health in accordance with Section 409.912 (32)(d), F.S. Immunizations are provided to members from age 0 through 20 who are eligible at the time of each visit.

Florida Medicaid providers must be registered with the Vaccines for Children (VFC) program. The VFC is administered by the Department of Health, Bureau of Immunizations. This program supplies providers with vaccines for children 0-18 years of age at no charge to physicians and eliminates the need to refer children to County Health Departments (CHDs) for immunizations.

Aetna Better Health of Florida (ABHF) covers the administrative fee for these vaccines. In order for

providers to get reimbursed for the administration of these vaccines they must bill the vaccine itself with a modifier of "SL" and the applicable administrative service code. This modifier indicates that the vaccine is state supplied. This requirement complies with national correct coding guidelines. It is critical for providers to add this modifier to get properly reimbursed and for the Plan to count the administration of vaccines in the HEDIS and quality measures.

Aetna Better Health is enrolled as a data partner with Florida SHOTS. Additional information regarding ordering VFC program vaccines is available on the Florida SHOTS website at **http://flshotsusers.com**.

VFC Resources are available on the following link: **http://flshotsusers.com/training/training-guides**.

Some useful resources include:

- Healthcare providers can verify their participation in the VFC program on the Florida Health website:
  - Active VFC Providers: **http://www.floridahealth.gov/programs-and-services/immunization/vaccines-for-children/active-vfc-providers.html.**
- It is important for providers to maintain an adequate vaccine inventory. Providers who are directly enrolled in the VFC program must maintain adequate vaccine supplies.
  - Managing VFC Inventory for Your Site: **http://flshotsusers.com/sites/default/files/uploads/2013/07/Managing-Your VFC- Vaccine-Inventory_12.09.15.pdf.**

Providers are required to provide immunization information to the Department of Children and Families (DCF) upon receipt of the member's written permission and DCF's request, for members requesting temporary cash assistance from DCF.

Title XXI MediKids Members do not qualify for the VFC program. Providers should bill Medicaid Fee-For-Service directly for immunizations provided to Title XXI MediKids participants. The Plan covers and reimburses participating providers for immunizations covered by Medicaid, but not provided through VFC.

National provider Identifier (NPI)

NPI is the standard unique health identifier for health care providers adopted by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. You may apply for an NPI number online at **https://nppes.cms.hhs.gov**.

Providers are required to submit their NPI on every claim.

If you provide direct health care services to members, you need to add your national provider identifier (NPI) number to claims. Claims may be rejected or denied when submitted without an NPI or with an invalid NPI, depending on the method of submission. Be sure to:

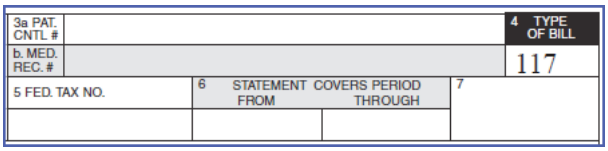
- Use the NPI you registered with Florida Medicaid.
- Bill for services as you are registered on the FloridaPML You can verify this information:
  - Online: **mymedicaid-florida.com**.
  - Phone: Florida Medicaid Provider Enrollment Call Center at **1-800-289-7799**, Option 4.

Corrected or voided claim via paper

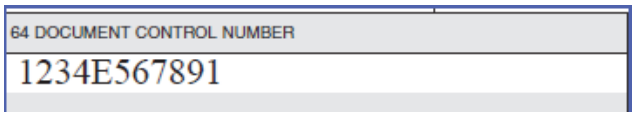
For Institutional claims, provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards.

Examples:

- Box 4 – Type of Bill: the third character represents the "Frequency Code":

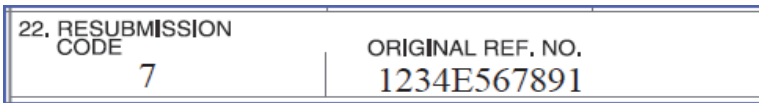


- Box 64 – Place the Claim number of the Prior Claim in Box 64:



For Professional claims, provider must include the original Aetna Better Health of Florida claim number and bill frequency code per billing standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:



Any missing, incomplete, or invalid information in any field may cause the claim to be rejected.

Please Note: If the provider handwrites, stamps, or types "Corrected Claim" on the claim form without entering the appropriate Frequency Code (7 or 8) along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.

When processing a Corrected or Voided Claim, a Payment Reversal may be generated which may produce a negative amount, which will be seen on a later Remittance Advice than the Remittance Advice that is sent for the newly submitted corrected claim.

Electronic data interchange (EDI) claim

Electronic claim submission to the Plan is easy to establish. Contact your practice management system vendor or clearinghouse to initiate the process. Electronic claim submissions can be routed to Office Ally through Availity who will review and validate the claims for HIPAA compliance and forward them directly to the Plan.

EDI claim submitters should review the electronic claim submission requirements below:

1. **EDI Specifications:** The 837-claim transaction is utilized for electronic professional and institutional claims and encounters. We use the ASC X12N 837 Professional Health Care Claim and the ASC X12N 837 Institutional Health Care Claim implementation guides. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at **www.wpc-edi.com**.

   This document contains clarifications and payer specific requirements related to data usage and content with submitting an EDI claims to the Plan. Please note that this document is intended to list only those elements where payer specific requirements or clarifications apply.

Specific Payer Edits: All EDI claims submitted will be subject to specific payer edits (unless indicated for one transaction only) that are in place. **EDI Acknowledgement and Reject Reports:** For every claim filed electronically, the provider should monitor whether or not that claim has been rejected by reviewing EDI acknowledgement and reject reports on a regular basis.

Monitoring your EDI reports

Please note that claims appearing on the **initial reject report** have not met the initial clearinghouse criteria approved by the Plan and have not been sent to the Plan for adjudication. Any claims appearing on this report must be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the initial accept report, but still be rejected. Claims rejected will appear on the **payer reject report**. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

Timely Filing

The Plan must accept a claim within its timely filing limit, or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payer reports on a regular basis, please contact your clearinghouse or Office Ally. A provider can avoid timely filing issues through understanding and regular monitoring of EDI Reports. This process will help to ensure all rejected claims are re-filed timely and electronically.

Common rejection reasons

Review the following tips for assistance with resolving the most common rejections received by providers. The most common claim reject reason is "Member not found." **Use Availity or an integrated solution through your vendor or clearinghouse to verify/validate member's eligibility prior to submitting claims.**

- **Member Identification Number** - Submit the 10 or 11-digit number as displayed on the patient's ID card.
- **Patient Date of Birth** - Submit a valid date of birth for the patient.
  - Do not send "00" for the month or date.
  - Do not send dummy dates such as "17760704".
  - Do not send a date of birth greater than the date of service.
- **A claim** will be rejected if a valid date of birth does not match the date of birth on file in the system. If this is the case, please verify the patient date of birth with the patient or policyholder.
- **Date Format** - Submit all dates in the following format CCYYMMDD unless otherwise specified.
  - Submit valid dates of service.
  - Do not submit future dates of service.
- **Monetary Amount Format** - Include the decimal point in all monetary amounts unless otherwise specified.
  - Do not submit negative dollar amounts.
- **Coding Detail** - Consider the following when verifying service codes and/or modifiers that have been rejected.
  - Submit service codes and modifiers appropriate to the age and gender of the patient.
  - Submit service codes and modifiers appropriate to the date of service.

– Submit service codes to their greatest level of specificity.

Corrected or voided EDI claims

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines.

To submit a Corrected or Voided Claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating to replace '7' or void '8'.
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number).
- Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim to be replaced.).
- Example: REF*F8*Aetna Better Health of Florida Claim number here.
- These codes are not intended for use for original claim submission or rejected claims.

EDI assistance

The Clearinghouse - typically, your first point of contact for resolving an EDI issue is your practice's specific clearinghouse or vendor.

Office Ally - The Office Ally customer service center can track all EDI submissions received by them. Office Ally also maintains the status message returned on an EDI claim from the health plan.

Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) Registration Services (EERS)

EERS offers our providers a more streamlined way to access payment services. It gives you a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Visit the link below to get started:

https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?tp=MDA0MDU=

Electronic funds transfer (EFT)

EFT makes it possible for us to deposit electronic payments directly into your bank account. Some benefits of setting up an EFT include:

- Improved payment consistency
- Fast, accurate and secure transactions

Electronic remittance advice (ERA)

ERA is an electronic file that contains claim payment and remittance info sent to your office. The benefits of an ERA include:

- Reduced manual posting of claim payment info, which saves you time and money, while improving efficiency.
- No need for paper Explanation of Benefits (EOB) statements

How and when to enroll?

ECHO Health processes and distributes claims payments to providers. To enroll in EERS, visit the Aetna Better Health ECHO portal. You can manage electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollments with multiple payers on a single platform.

- Sign up to EFT:
  - To sign up for EFT, you'll need to provide an ECHO payment draft number and payment amount for security reasons as part of the enrollment authentication. Find the ECHO draft number on all provider Explanation of Provider Payments (EPP), typically above your first claim on the EPP. Haven't received a payment from ECHO before? You'll receive a paper check with a draft number you can use to register after receiving your first payment.
- Update your payment or ERA distribution preferences:
  - You can update your preferences on the dedicated Aetna Better Health ECHO portal.
- Use our portal to avoid fees:
  - Fees apply when you choose to enroll in ECHO's ACH all payer program. Be sure to use the Aetna Better Health ECHO portal for no-fee processing. You can confirm you're on our portal when you see "Aetna Better Health" at the top left of the page.

- Be aware — you may see a 48-hour delay between the time you receive a payment, and an ERA is available.

Additional resources may be found on the Aetna Better Health of Florida website https://www.aetnabetterhealth.com/florida/providers/file-submit-claims.html:

- ECHO companion document (PDF)
- ECHO enrollment form (PDF)
- ECHO payments innovation for health plans (PDF)
- ECHO portal guide (PDF)
- ECHO frequently asked questions from providers (PDF)

If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 888.834.3511.

Instruction for Specific Claims Types

Skilled nursing facilities (SNF)

Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health of Florida, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp**.

Home health claims

Providers submitting claims for Home Health should use CMS 1500 Form.

Providers must bill in accordance with contract. Non-participating health care providers must bill according to CMS requirements and the specific Home Health Prospective Payment System (HHPPS) rules for Aetna Better Health. For additional information regarding CMS HHPPS, please refer to the following CMS website address**: www.cms.gov/HomeHealthPPS/**.

Durable medical equipment (DME) rental claims

Providers submitting claims for Durable Medical Equipment (DME) Rental should use CMS 1500 Form. DME rental claims are only paid up to the purchase price of the durable medical equipment.

Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Please ensure you are using the appropriate modifiers as needed.

Same day readmission

Providers submitting claims for inpatient facilities should use CMS UB-04 Form.

There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission within 24 hours.

- Example**:**
  Discharge Date: 10/2/10 at 11 AM
  Readmission Date: 10/3/10 at 9 AM
  Since the readmission was within 24 hours, this would be considered a same day readmission per above definition.

Hospice claims

Aetna Better Health of Florida will comply with the following requirements:

- For Medicaid-only members residing in a nursing facility and receiving hospice services, Aetna Better Health of Florida will pay the hospice provider the per diem rate set by the Agency for hospice services.
- For dually eligible members residing in a nursing facility and receiving hospice services, the hospice provider will bill Medicare for the per diem rate for hospice services.

Encounters Overview

An encounter or a claim is an interaction between a patient and provider (MCO, HMO, rendering physician, pharmacy, lab, etc.) that delivers services or is professionally responsible for services delivered to a patient. Encounters can be reimbursed to the provider for fee for service or capitation by the health plan.

Providers must have a nine-digit Medicaid ID prior to submitting claims/encounters to the Plan.

- Providers can register with the State of Florida at: http://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_EnrollmentForms/tabid/58/Default.aspx?desktopdefault=%20.

Providers who do not currently hold a Medicaid ID have three options for requesting one. They can register through a plan, apply directly to Medicaid via the online enrollment wizard for Limited Enrollment, or apply directly to Medicaid via the online enrollment wizard for Full Enrollment. Any of these three options would result in assignment of a Medicaid ID which can be used by the plans to submit encounter data.

To apply directly to Medicaid, providers can submit either a Limited Enrollment or a Full Enrollment application via the online Provider Enrollment Wizard. NOTE: Full Enrollment is required if the provider is to bill Medicaid as fee-for-service.

Alternatively, providers can register for a Medicaid ID by downloading and completing the *Florida Medicaid Provider Registration Form*. Completed forms must be submitted to a Medicaid health plan prior to submission to Medicaid. See the *Florida Medicaid Provider Registration Guide* for directions for successfully completing the form.

We will notify providers and take necessary steps to ensure that the provider's claims/encounters are recognized by the Agency for Health Care Administration (AHCA).

Providers required to bill on the CMS-1500 Claim Form or Professional EDI submission:

- Physicians
- Advanced Registered Nurse Practitioners
- Ambulance, Land and Air
- Ambulatory Surgical Centers
- Assistive Care Providers
- Audiologists
- Birthing Centers
- Child Health Check-Up Providers
- Children's Health Services Targeted Case Management
- Chiropractors
- Community Mental Health Services Providers
- County Health Departments - Advanced Registered Nurse Practitioners
- County Health Departments - Certified Match Dentists
- Durable Medical Equipment
- Early Intervention Services
- Federally Qualified Health Centers
- Hearing Aid Specialist
- Home-and Community-Based Waiver Services Home Health
- Independent Laboratories

- Licensed Midwives
- Medicaid Certified School Match
- Medical Foster Care
- Mental Health Targeted Case Management
- Therapy Providers

Providers required to bill on the UB-04 Claim Form or Institutional EDI submission:

- Freestanding Dialysis Centers
- Hospitals
- Hospital-Based Skilled Nursing Facilities Hospice
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Nursing Facilities
- Rural Swing Bed Providers
- State Mental Hospitals
- Statewide Inpatient Psychiatric Program (SIPP) Waiver Providers

Florida Medicaid Provider Reimbursement Handbook, CMS-1500 and **Provider Reimbursement Handbook, UB-04** provides additional information on the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbook provides descriptions and instructions on how and when to complete forms, letters, or other documentation.

In support of Health Insurance Portability and Accountability Act (HIPAA) and its goal of administrative simplification, we encourage physicians and medical providers to submit claims electronically. Electronic claims submission can have a significant, positive impact on the productivity and cash flow for your practice.

Our Claims Inquiry Claims Research (CICR) department is responsible for claims adjudication, resubmissions, and claims inquiry/research.

Aetna Better Health of Florida is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD- 10CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) 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. Important notes: The ICD-10 CM codes must be to the highest level of specificity: assign three- digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub- classification for that subcategory and assign the fifth-digit sub-classification code for those subcategories where it exists.
- Provider must also follow the service and product standards specified in the Agency's Medicaid Services Coverage & Limitations Handbooks available on the AHCA web site.
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical/case record provides adequate documentation for assignment of a more specific code.

- Aetna Better Health of Florida is authorized to take whatever steps are necessary to ensure that the provider is recognized by the Agency and its agent(s) as a participating provider of Aetna Better Health of Florida and that the provider's submission of encounter data is accepted by the Agency.
- Review of the medical/case record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

Encounter data management (EDM) system

Aetna Better Health of Florida uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to AHCA requirements. The EDM System also warehouses encounter data from vendors and formats it for submission to AHCA. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness, and we then submit encounter data to AHCA. Our EDM System processes CMS1500, UB04 (or UB92) and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II). Our provider contracts require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our encounter protocol is the requirement for providers to utilize NDC coding in accordance with the department's requirements.

The EDM System has top-of-the-line functionality to track encounters accurately and consistently throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA-compliant 837 (I and P) electronic claim transaction, 835 Claim Payment/Advice transaction and the NCPDP D.O. or PAH transaction in standard format and we require our providers and their clearinghouses to send electronic claims in these formats.

We collect claims information from multiple data sources into the EDM System for processing, including data from our QNXT™ claims adjudication system as well as data from third-party vendors under contract to process various claims, such as dental, vision, transportation, and pharmacy. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Claims processing

Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all claims data into EDM System using a transfer validation report. The Encounter Management Unit research, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Encounter staging area

One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and third-party vendors (e.g., Pharmacy Benefit Management, dental or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain encounters in the

staging area until the Encounter Management Unit validates that each encounter contains all required data and is populated with appropriate values.

Our Encounter Management Unit directs, monitors, tracks, and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

Encounter data management (EDM) system scrub edits

This EDM System feature allows the Encounter Management Unit to apply AHCA edit profiles to identify records that may be unacceptable to the AHCA. Our Encounter Management Unit can customize our EDM System edits to match the edit standards and other requirements of the AHCA. This means that we can align our encounter edit configuration with the AHCA's configuration to improve encounter acceptance rates.

Encounter tracking reports

Encounter Tracking Reports are another unique feature of our EDM System. Reports are custom tailored for each plan.

Our Encounter Management Unit uses a series of customized management reports to monitor, identify, track, and resolve problems in the EDM System or issues with an encounter file. Using these reports our Encounter Management Unit is able to identify the status of each encounter in the EDM by claim adjudication date and date of service. Using these highly responsive and functional reports, our Encounter Management Unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into EDM System, submission to and acceptance by the department. Reports are run to verify that all appropriate claims have been extracted from the claims processing system.

Data correction

As described above, the Encounter Management Unit is responsible for the EDM System. This responsibility includes managing the data correction process should it be necessary to resubmit an encounter due to rejection of the encounter by the department.

Our Encounter Management Unit uses two processes to manage encounter correction activities:

- Encounters requiring re-adjudication and those where re-adjudication is unnecessary. If re-adjudication is unnecessary, the Encounter Management Unit will execute corrections to allow resubmission of encounter errors in accordance with the department encounter correction protocol.
- Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system, the adjusted claim is imported into the EDM for resubmission to the Agency in accordance with the encounter correction protocol, which is tailored to the Agency's requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement, and corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the Agency's acceptance process, we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EDM System scrub and edit described above. In this way, we will expand our EDM System scrub edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

Our Encounter Management Unit is important to the timely, accurate, and complete processing and submission of encounter data to the AHCA. Our Encounter Management Unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and are responsible for oversight and monitoring of encounter files submissions to the AHCA. The team includes a Technical Supervisor and a Project Manager to monitor the program.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from the Agency and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age.

This data facilitates the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to verify the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical/case records to support randomly selected claims to verify the accuracy of diagnosis codes submitted.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because we may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to adjust payments fairly and accurately made to Aetna Better Health of Florida by CMS based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

The CMS uses the Hierarchical Condition Category (HCC) 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 us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna Better Health of Florida and payments made by Aetna Better Health of Florida to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for a member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as

"probable"", suspected", "questionable," "rule out" or "working" diagnosis. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by Aetna Better Health of Florida. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules, and regulations. The Centers for Medicare and Medicaid Services (CMS) may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at **http://csscoperations.com/**.

Risk pool criteria

If the claims paid exceed the revenues funded to the account, the providers will fund part or the entire shortfall. If the funding exceeds paid claims, part or all the excess is distributed to the participating providers.

Concurrent Risk Adjustment (CRA) by Edifecs

Aetna Better Health is working with Edifecs to enable CRA, a solution designed to alert providers when diagnosis codes are potentially missing from a claim. This is accomplished by sending the biller the standard unsolicited claim status (277CA) associated with claim rejections that are integrated into the claim submission process. The automated rejection messages appear in the billing solution alert queue and are triggered on claims that may be incomplete or inaccurate for patients with historic claim data, such as evidence of an established diagnosis of a chronic condition that is not present on the current claim.

Sample Alert Message (277CA):

The following is an example of the type of alert and rejection you will receive if there is a suspected diagnosis coding gap, presenting up to five (5) diagnosis codes:

> Patient history includes ICD: [ICD-10 Code History Here]; review the medical record for DOS, validate claim Dx codes are complete and accurate; resend claim. Questions, visit https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm.

If Your Office Receives a Rejection/alert Message (277CA):

Once CRA is enabled, your office may receive this message for those members with evidence of an existing diagnosis of a chronic condition within medical history. At that time, you should take the following actions:

- **Engage a qualified coder** or appropriate professional to review the patient's medical record to confirm that the diagnosis(es) coded on the claim are complete and accurate.

- If the coding on the **claim is complete** as-is, resubmit the claim for clearinghouse processing maintaining the original patient control number (CLM01/CMS-1500-Box26).

- If **changes are necessary**, make the changes where appropriate and resubmit the claim maintaining the original patient control number (CLM01/CMS-1500-Box26).

- If a **diagnosis is added to** or **removed from** the claim, billers should ensure that the medical record for the date of service completely supports the revised claim. Also ensure that all affected claim fields are aligned appropriately (i.e., order of the diagnoses reported, Diagnosis Pointers), being careful to consider Centers for Medicaid and Medicare Services Form 1500 and ICD-10 CM Coding Guidelines.

Please visit https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm and register for a provider CRA educational session and review the support materials provided, which includes a Question and Answer resource.

If there are additional **questions about a claim status message or general program questions**, visit www.AetnaBetterHealth.com and select your state to be guided to your state specific Provider Services Call Center.

Member Appeals and Grievances

Important information about member appeal right

An **appeal** is a formal complaint about a service that is denied. An **appeal** may be filed within sixty (60) days of receiving the notice of adverse benefit determination. If the appeal is filed orally (except for an expedited appeal), it must be followed up with a written notice within ten (10) calendar days of calling in the appeal.

A Medicaid member may file an appeal, or a provider acting on the Medicaid members behalf with written authorization, may file a Medicaid appeal.

The address and telephone number to contact the Grievance and Appeals department is:

Aetna Better Health of Florida
Attention: Medicaid Appeals and Grievance
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
1-800-441-5501 (MMA**)** or **1-844-645-7371** (LTC)

You can contact Member Service department to file a grievance or appeal and request the form by calling **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC), Monday through Friday, 8 AM to 7 PM ET. The Plan and/or the provider must give the Medicaid member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The grievance coordinator will send an acknowledgement letter within five (5) business days of the receipt of the Medicaid grievance or within five (5) business days of getting an appeal. The Medicaid appeal will be reviewed as expeditiously as the Medicaid member's health requires or in a reasonable amount of time, not to exceed thirty (30) days.

An "expedited appeal" can be requested if the provider or member feels that waiting 60 days for a decision could put the member's life, health, or ability to attain, maintain, or regain maximum function in danger. This can be done by phone or in writing, but you need to make sure to ask for the appeal to be expedited. We may not agree that the appeal needs to be expedited, but we will let you know of our decision. If we do not expedite the appeal, it will be processed under normal time frames.

If we do expedite the appeal, we will advise of the decision within forty-eight (48) hours after receiving the expedited appeal request.

For decisions that involve an appeal of a denial that is based on medical necessity, a Medicaid grievance regarding the denial of an expedited resolution of an appeal, or a grievance/appeal that involves clinical issues, the decision maker will be someone other than the person involved in making the initial determination, and who has the clinical expertise in the Medicaid members condition or disease.

The Medicaid member or their representative will have an opportunity to review the case file, including medical records and any other documents and records.

How to ask for a Fair Hearing

A member, or his or her authorized representative, who has completed the appeal process can request a Fair Hearing. A fair hearing can be requested by phone or in writing. A provider may request a hearing on behalf of a member, but the member must give written approval to the provider to request a hearing

on their behalf. A Fair Hearing can be requested any time up to 120 days after getting our decision on the member's appeal. A Fair Hearing can be requested by calling **1-850-488-1429** or in writing to:
State Agency at Florida
State Agency at Agency for Health Care Administration
Medicaid Hearing Unit
PO Box 60127, Ft. Myers, FL 33906

Toll-free: **1-877-254-1055**
Fax: **239-338-2642**
Email: **MedicaidHearingUnit@ahca.myflorida.com**

NOTE: MediKid members are not eligible to participate in the Medicaid Fair Hearing Process.

How to ask for services to continue

If a member was receiving a service that was reduces, suspended, or terminated, they have the right to keep getting those services until a final decision is made in an appeal or Fair Hearing. The member **must** file the appeal or request for Fair Hearing within the following time frames:

For an appeal

File the appeal with Aetna Better Health of Florida not later than ten (10) days from the date the Notice of Action letter was mailed OR no later than 10 days after the first day our action will take place, whichever is later. The appeal can be requested by phone but must be followed up with a request in writing. **The member MUST tell us they want their services continued.**

For a Fair Hearing

The member must file the request with the Office of Appeal Hearings no later than ten (10) days after the notice of action letter was mailed or before the first day the action will take place, whichever is later. **The member should tell the hearing officer they want their services to continue.**

If services are continued and our decision is upheld in an appeal or Fair Hearing, we may ask that the member pay for the cost of the services. We will not take away the member's Medicaid benefits. We cannot ask the member's family or legal representative to pay for the services.

Aetna Better Health is required to continue the Medicaid member's benefits while a Medicaid fair hearing is pending if:

- The Medicaid fair hearing is filed timely, meaning on or before the latter of the following:
  - Within ten (10) days of the date on the notice of action.
  - The intended effective date of Aetna Better Health's proposed action.
  - The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.
  - The services were ordered by an authorized provider.
  - The authorization period has not expired; and.
  - The Medicaid member requests an extension of benefits.

Medical necessity reconsideration

The Plan is not obligated to pay for unauthorized services. If the provider does not agree with the determination and the matter cannot be resolved informally, the Plan maintains a reconsideration process through which all providers (physician, facility, or ancillary) may request reconsideration (on behalf of a member) of a medical management issue or benefit determination.

If a provider does not agree with a denial for lack of medical necessity, he/she may request a reconsideration of the decision. This may be done by providing additional information in one of two ways.

A Peer-to-Peer Review with the Medical Director who made the decision may be requested by calling the Peer-to-Peer coordinator at **959-299-7999**.

A request for reconsideration may be made by providing additional information by phone at **1-800-447-3725**, by fax at **860-607-7894** or by mail to:

Aetna Better Health of Florida
Florida Medical Management
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Reconsiderations of prior authorization decisions must be received within five (5) business days of the date the denial of coverage determination fax was sent, prior to services being rendered and prior to the receipt of a claim or request for an appeal. Hospital concurrent review reconsideration requests for peer-to-peer review must be received within two (2) business days of the issuance of the verbal denial.

Provider Complaint System

The provider complaint system allows providers to dispute any aspect of Aetna Better Health of Florida's policies, procedures, administrative functions, including proposed actions, claims, billing disputes and prior authorizations.

Aetna Better Health of Florida will inform providers through this Provider Manual and other methods, including periodic Provider newsletters, training, provider orientation, the website and by the provider calling their Provider Services Representative about the provider complaint system processes.

Dedicated Provider Engagement staff are available to answer questions, assist in filing a provider complaint and review/resolve any issues that the providers may have. Requests and inquiries are responded within 72 hours or 3 business days by sending an acknowledgment letter.

A provider may also contact the Provider Engagement team, via the following email: **FLProviderEngagement@aetna.com** or by calling at **1-800-441-5501** (MMA) or **1-844-645-7371** (LTC).

Both network and out-of-network providers may file a dispute verbally or in writing direct to Aetna Better Health of Florida to resolve any dispute. Providers can file a verbal dispute with Aetna Better Health of Florida by calling Provider Engagement department at **1-800-441-5501** (MMA) **or 1-844-645-7371** (LTC).

To file a dispute in writing, providers should write to:

Aetna Better Health of Florida
Appeals and Grievances
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

The provider may also be asked to complete and submit the dispute form with any appropriate supporting documentation. The dispute form is accessible on Aetna Better Health of Florida's website, via fax or by mail.

If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department. For all disputes, Aetna Better Health of Florida will notify the provider of the dispute resolution by phone, email, and fax or in writing.

A provider may also contact the Provider Engagement team, via the following email: **FLProviderEngagement@aetna.com**.

Dedicated staff are available to answer questions, assist in filing a provider complaint and resolve any issues. Requests and inquiries are responded to within 72 hours or 3 business days.

Provider complaints

Both network and out-of-network providers may file a formal complaint verbally or in writing directly with Aetna Better Health of Florida in regard to our staff behavior, vendor behavior, policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a dispute that is not requesting review of an action. Provider complaints are an expression of dissatisfaction not related to an action. Provider complaints must be filed within 45 calendar days from when the provider became aware of the issue for issues not related to claims or within ninety (90) calendar days from the dispute resolution. All provider complaints concerning claims issues are processed and resolved in

accordance with s. 641.3155, F.S. and s. 408.7057, F.S. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their claim within the appropriate time frame, they may submit proof.

Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Aetna Better Health of Florida, or similar receipt from other commercial delivery services. All disputes concerning claims payment issues must be filed in writing.

To file a provider complaint, please submit it via e-mail **FLAppealsandGrievancesAetna.com** or write to:

Aetna Better Health of Florida
Appeals and Grievances
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

The Provider Engagement department assumes primary responsibility for coordinating and managing Provider complaints, and for disseminating information to the Provider about the status of the complaint.

An acknowledgement letter will be sent within three (3) business days summarizing the complaint, including the expected date of resolution and instructions on how to:

- Revise the complaint within the timeframe specified in the acknowledgement letter.
- Withdraw a complaint at any time until Grievance Committee review.

If the complaint requires research or input by another department, the Provider Engagement department will coordinate with the Appeals and Grievances department. The Appeal and Grievance department will forward the information to the appropriate department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Florida's written policies and procedures, collecting pertinent facts from all parties.

Aetna Better Health of Florida will provide a status update on the complaint every 30 calendar days and will resolve all provider complaints within 90 calendar days of receipt of the complaint. The provider will be notified of the resolution within 3 business days of the decision.

The Plan has a process for participating providers to resolve issues between the participating provider and the Plan that may result in a change in network status of the provider, as such network status change relates to the Plan's review of the providers professional competency and/or conduct or clinical quality. A provider may be denied continued participation status for quality concerns based on the competence or professional conduct of a provider, which affects or could affect the health or welfare of a patient or patients.

Examples of such quality concerns include but are not limited to:

- Evidence of substandard treatment rendered to patients.
- Malpractice judgments/settlements.
- In any instance where corrective action will be required to be reported to the National Provider Data Bank (NPDB).
- In any instance where a Provider's Contract with Aetna Better Health is terminated for cause under the terms of the Contract.

- Current Medicare or Medicaid sanctions.
- Loss of accreditation or certification status if a facility or ancillary provider.

Prior to taking any final action to deny continued participation status to a provider for quality concerns, the provider will be entitled to pursue the appeal process.

If the Credentialing Committee has made the determination to not renew a provider's reappointment for reasons based on quality concerns, the provider shall be notified in writing by the Medical Director of the decision and the reasons for it. The provider may request an appeal, within thirty (30) days of receipt of the decision letter. The provider must make this request to the Medical Director in writing.

Provider claim disputes

The Plan's process for provider complaints concerning claims issues will be in accordance with s. 641.3155, F.S. and will identify staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems. Disputes between the Plan and the provider maybe resolved as described ins. 408.7057, F.S.

For provider disputes, providers must follow the Timely Filing Guidelines indicated on the table below. Disputes filed after the time indicated on the Timely Guidelines Grid will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Aetna Better Health, or similar receipt from other commercial delivery services. All disputes concerning claims payment issues must be filed in writing.
Providers have forty-five (45) days to file a written complaint for issues not related to claims payment.

Aetna Better Health of Florida must utilize the Agency's contracted dispute resolution vendor, as described in s. 408.7057, F.S., for managing, addressing, and resolving provider complaints related to claims issues. The process shall be in compliance with s. 641.3155, F.S. and the Plan must comply with all terms and conditions set forth in any orders and instructions issued by the Agency or its designee as a result of the claim dispute resolution process.

Effective 3/11/2024, the Agency for Health Care Administration (AHCA) will be utilizing a new independent dispute resolution vendor, Capitol Bridge. Capital Bridge is accepting claims disputes between health care providers and health insurance plans.

Capitol Bridge:
FLCDR@capitolbridge.com
1 -800-889-054

Provider complaints will be resolved within ninety (90) days of receipt. Written status notification will be provided after thirty (30) days and every thirty (30) thereafter if the complaint remains open. A final disposition notification will be provided within three (3) business days of the resolution.

Timely filing guidelines grid

Claim Type	Guideline
Underpayment/ Overpayment	Providers have **365 calendar days** after receipt of the notification (EOB/EOP/ Remit) to submit an underpayment claims dispute or submit additional information or documentation. (F.S. 641.3155)
Claim Denial	Providers have **90 calendar days** from the time of a claim denial to file a provider claims dispute or submit additional information or documentation. (SMMC Contract) (Section VIII) (D)(5)(d)(1)
Return of request additional information (Itemized bill, ED records, med records, attachments)	A Provider must submit any additional information or documentation as specified, within thirty-five (35) days after the 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)

Dedicated Provider Engagement staff is available to answer questions, assist in filing a provider complaint and review/resolve any issues that the providers may have. Requests and inquiries are responded within 72 hours or 3 business days by sending an acknowledgment letter.

A provider may also contact the Provider Engagement team, via the following email: **FLProviderEngagement@aetna.com** or by calling **1-800-441-5501.**

To file a dispute in writing, providers should write to:

Aetna Better Health of Florida
Appeals and Grievances
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Overpayment recovery

Should an overpayment be made to any provider, the provider is required to return the overpayment to the Plan within 60 calendar days after the date in which the overpayment was identified. Payment must be returned to the address below, along with written notice explaining the reason for the return of payment. If the Plan identifies that a claim is overpaid, the provider will receive a letter via U.S. mail from the Plan requesting the return of monies paid in error in accordance with Florida statute.

Providers are able to access and view their overpayment recovery detail through our website at **aetnabetterhealth.com/Florida** under the "Tasks' section." If there are any questions about the information in the notice, on the website or concerns about an explanation of payment entry for a negative amount, please email the Plan's Provider Engagement Department at **FLProviderEngagement@aetna.com** or via mail to:

Aetna Better Health of Florida
Provider Finance Department
4500 E Cotton Center Blvd
Phoenix, AZ 85040

Oversight of the provider complaint system processes

The Appeals and Grievances department has the responsibility for oversight of the provider complaint system processes. The Appeal and Grievance Manager has overall responsibility for management of the provider complaint system processes and reports to the Director of Operations. This includes:

- Documenting individual complaints in the G&A database.
- Coordinating resolutions.
- Maintaining the appeal and grievance database.
- Tracking and reviewing complaint and appeal data for trends in quality of care or other service-related issues.
- Reporting all data to the Provider Advisory Committee (PAC) and Quality Management
- Committee (QMOC).

Aetna Better Health of Florida's Provider complaint system processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility of the grievance system processes includes:

- Review of individual complaints.
- Aggregation and analysis of complaint and appeal trend data.
- Use of the data for quality improvement activities including collaboration with credentialing and re-credentialing processes as required.
- Identification of opportunities for improvement.
- Recommendation and implementation of corrective action plans as needed.

The Aetna Better Health of Florida Appeal and Grievance Manager will serve as the primary contact person for the complaint system processes with the Aetna Better Health of Florida Appeal and Grievance Coordinator serving as the back-up contact person. The Member Services department, in collaboration with the QM department and Provider Engagement Department, is responsible for informing and educating members and providers about a member's right to file a complaint, grievance, appeal, or State Fair Hearing and for assisting members in filing a complaint, grievance, or appeal throughout the Member Grievance System and the Provider Complaint System.

Providers receive this information via the Provider Manual during provider orientations, within the Provider Agreement and on Aetna Better Health of Florida's website.

Managed Medicaid Program

Florida Medicaid Program

Florida Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. The Florida Medicaid program is responsible for policies, procedures, and programs to promote access to quality acute and long term medical, behavioral, therapeutic, and transportation services for Medicaid beneficiaries. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the families or individual's income and assets.

Statewide Medicaid Managed Care Program

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children, seniors, disabled adults, and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for medical assistance (MMA) and one for Long Term Care (LTC).

Florida Agency for Health Care Administration's Medicaid Coverage and Limitations Handbook

Providers may access the Florida Agency for Health Care Administration's Medicaid Coverage and Limitations Handbook on the state's website at **www.fdhc.state.fl.us** or handbooks may be obtained from AHCA. The handbooks provide more detail on the medical care, treatment, and rights of Medicaid members.

Aetna Better Health of Florida and providers shall comply with applicable AHCA handbooks and shall not be more restrictive than the limitations and exclusions in such handbooks.

Continuity of care in enrollment

Aetna Better Health of Florida shall be responsible for coordination of care for new members transitioning into the Plan. In the event a new member is receiving a prior authorized, ongoing course of treatment for a covered service with any provider, the Plan shall be responsible for the costs of continuation of such course of treatment without regard to whether such services are being provided by participating or non-participating providers.

For Medicaid members, Aetna Better Health will honor documented authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment. Pregnant members who've initiated a course of prenatal care, regardless of the trimester in which care was initiated, continuation will be provided until the completion of postpartum care.

The Plan will provide continuation of Medicaid services until the member's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the member's treatment plan, which shall be no more than sixty (60) calendar days after the effective date of enrollment. **Providers with transitioning members to cooperate in all respects with providers of other managed care plans to assure maximum health outcomes for members.**

Important information for Medicaid members

All Medicaid PCP's are required to post a copy of the Florida Patient's Bill of Rights and Responsibilities in open and conspicuous view of Medicaid members. PCPs are also required to post the Florida HMO Hotline number, **1-888-419-3456**, in the open and conspicuous view of all Medicaid Members.

If copayments are waived as an expanded benefit, the provider must not charge members copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for fee-for-service (FFS) Managed Care Plans, the Medicaid fee schedule amount, less any applicable copayments.

Important information about Medicaid member complaint rights

Complaint - Any oral or written expression of dissatisfaction by a member submitted to the Managed Care Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or a Managed Care Plan employee, failure to respect the member's rights, Managed Care Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Managed Care Plan's Contract. A complaint is a subcomponent of the grievance system.

Grievance - An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or a Managed Care Plan employee or failure to respect the member's rights.

All provider complaints will be thoroughly investigated using applicable regulatory and contractual provisions, collecting all pertinent facts from all parties, and applying the Plan's written policies and procedures. The Plan will also ensure that the appropriate decision makers with the authority to implement corrective action are involved in the provider complaint process. The Plan shall provide a written notice of the outcome of the review to the provider.

All complaints disputing the policies, procedures, or any aspect of the administrative functions of the Plan can be oral or written. The complaint must be filed no later than 90 calendar days from the date the provider becomes aware of the issue generating the complaint. Provider policy-related complaints may be filed in writing.

A Medicaid member may file a Medicaid complaint/grievance either orally or in writing anytime after the date of occurrence that initiated the grievance. The address and telephone number to contact the Appeals and Grievance department is:

Aetna Better Health of Florida
Attention: Medicaid Appeals and Grievance
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

1-800-441-5501 (toll free)

You or the member can contact the Member Services Department to file a grievance and request the form by calling **1-800-441-5501** Monday through Friday 8 AM to 7 PM Eastern Time. The Plan and/or the provider must give the Medicaid member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The Medicaid Member or their representative will have an opportunity to review the case file, including

medical records and any other documents and records.

The following individuals can be designated by the member to assist a member in filing a grievance or appeal:

- The Health Plan.
- Legal guardian of a member.
- Provider rendering services to a member.

The appeals and grievance coordinator will send an acknowledgement letter within five (5) business days of the receipt of the Medicaid grievance. The Medicaid grievance will be reviewed as expeditiously as the Medicaid member's health requires, or in a reasonable length of time not to exceed 30 days from initial filing by the Medicaid member, or provider acting on their behalf. If an extension is necessary, The Plan will notify the Medicaid member of the delay, which is not to exceed fourteen (14) calendar days.

Providers are encouraged to advocate on behave of members in any part of the grievance and appeal system or UM process, or individual authorization process to obtain medically necessary services (42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408).

Managed Medicaid Covered Services

The table below provides the listing of if the covered services*.

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction.	As medically necessary and recommended by us.	Yes
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness.	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots.	No
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities.	Covered as medically necessary.	Yes, authorization required for hospital-to hospital transfers only.
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	As medically necessary and recommended by us.	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient).	Covered as medically necessary.	Yes, authorization required for some procedures.
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures.	Covered as medically necessary.	No
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication.	We cover 365/366 days of services per year, as medically necessary.	Yes
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover recipients under the age of 21 years requiring medically necessary services	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders.	We cover, as medically necessary: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day).	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program.	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning.	Yes
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program.	As medically necessary and recommended by us.	Yes
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system.	We cover the following as prescribed by your doctor, when medically necessary: - Cardiac testing - Cardiac surgical procedures - Cardiac devices.	Yes, prior authorization required for some tests and procedures.
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services OR Services provided to children (ages 0 – 20) who use medical foster care services.	Child must be enrolled in the DOH Early Steps program OR Your child must be receiving medical foster care services.	No
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs.	We cover, as medically necessary: - 24 patient visits per year, per member - X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified health	Visits to a federally qualified health center or rural health clinic visit, medically	No

Service	Description	Coverage/Limitations	Prior Authorization Requirements
	center, or a rural health clinic.	necessary.	
Community- Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility.	As medically necessary and recommended by us.	Yes
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	As medically necessary and recommended by us.	Notification is required within 24 hours of admission. Authorization is provided for the first 3 days of an emergency involuntary (Baker Act) admission. Prior authorization is required for continued stay.
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys.	We cover the following as prescribed by your treating doctor, when medically necessary: - Hemodialysis treatments - Peritoneal dialysis treatments.	Yes
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing.	As medically necessary and recommended by us.	No
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away.	As medically necessary, some service and age limits apply. Call Member Services at 1-800-441-5501 (MMA –Medicaid) or 1-844-645-7371 (LTC) or TTY: 711 for more information.	Yes, prior authorization required for certain equipment and supplies.

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions.	We cover medically necessary: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week.	No
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency.	Covered as medically necessary.	No
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness.	We cover medically necessary: - One adult health screening (check-up) per year - Well child visits are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions.	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional.	We cover medically necessary: - Up to 26 hours per year.	No
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment.	As medically necessary and recommended by us.	No
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system.	We cover: - Covered as medically necessary.	Yes, prior authorization required for certain tests and procedures.
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system.	We cover: - Covered as medically necessary.	Yes, prior authorization required for

Service	Description	Coverage/Limitations	Prior Authorization Requirements
			certain tests and procedures.
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional.	We cover medically necessary: - Up to 39 hours per year.	No
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs.	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	No
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury.	We cover, when medically necessary: - Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients.	Yes
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	- Covered as medically necessary - Copayment: See information on Patient Responsibility for copayment information you may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility.	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional.	We cover medically necessary: - Up to 26 hours per year	No
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children.	As medically necessary and recommended by us.	Yes
Inpatient Hospital	Medical care that you get while you are in the hospital.	We cover the following inpatient hospital services	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Services	This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	based on age and situation, when medically necessary: - Up to 365/366 days for recipients ages 0-20 - Up to 45 days for all other recipients (extra days are covered for emergencies).	
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases.	Covered as medically necessary.	Yes, prior authorization required for certain tests and procedures.
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases.	Covered as medically necessary.	Yes, prior authorization required for genetic testing.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes.	Must be in the custody of the Department of Children and Families.	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction.	Covered as medically necessary.	No
Medication Management Services	Services to help people understand and make the best choices for taking medication.	Covered as medically necessary.	No
Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness.	As medically necessary and recommended by us.	Yes
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses.	Covered as medically necessary.	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes.	As medically necessary and recommended by us.	No
Multisystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment.	As medically necessary and recommended by us.	Initial prior authorization not required. If the service exceeds 104 units, prior authorization is required.
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system.	Covered as medically necessary.	Yes, prior authorization required for certain tests and procedures.
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	We cover the following services for recipients who have no transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary.	Yes, prior authorization is needed for travel over 50 miles.
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term.	We cover 365/366 days of services in nursing facilities as medically necessary. Copayment: See information on Patient Responsibility for room & board copayment information.	Yes
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
		evaluation per 5 years We cover for people of all ages, as medically necessary: - Follow-up wheelchair evaluations, one at delivery and one 6-months later.	
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity.	Covered as medically necessary.	Yes
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints.	Covered as medically necessary.	Yes, prior authorization required for certain tests and procedures.
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	- Emergency services are covered as medically necessary - Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over.	Yes, prior authorization required for certain tests and procedures.
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided.	Covered as medically necessary. Some service limits may apply.	Yes
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us.	Yes
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition.	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years.	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
		We cover for people of all ages, as medically necessary: - Follow-up wheelchair evaluations, one at delivery and one 6-months later.	
Podiatry Services	Medical care and other treatments for the feet.	We cover, as medically necessary: - Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the foot, ankle and lower leg - Surgery on the foot, ankle or lower leg.	Yes, prior authorization required for certain tests and procedures.
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider.	We cover, as medically necessary: - Up to a 34-day supply of drugs, per prescription - Refills, as prescribed.	Yes, prior authorization required for some drugs.
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care.	We cover, as medically necessary: - Up to 24 hours per day.	Yes
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	As medically necessary and recommended by us.	No
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas.	We cover, as medically necessary: - 10 hours of psychological testing per year.	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores.	We cover, as medically necessary: - Up to 480 hours per year.	Yes
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays.	Covered as medically necessary.	Yes, prior authorization required for some studies.
Regional Perinatal	Services provided to pregnant women and newborns in	Covered as medically necessary.	No

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Intensive Care Center Services	hospitals that have special care centers to handle serious conditions.		
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family.	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system.	We cover medically necessary: - Respiratory testing - Respiratory surgical procedures - Respiratory device management.	Yes, prior authorization required for certain tests and procedures.
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease.	We cover medically necessary: - One initial evaluation per year - One therapy re-evaluation per 6 months - Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day).	Yes
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness.	As medically necessary and recommended by us.	No
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders.	We cover the following medically necessary: - Assessments - Foster care services - Group home services.	No

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better.	We cover the following medically necessary services for children ages 0-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following medically necessary services for adults: - One communication evaluation per 5 years.	Yes
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital.	Covered as medically necessary for children ages 0-20.	Yes
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders.	As medically necessary and recommended by us.	Yes
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders.	As medically necessary and recommended by us.	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility.	We cover medically necessary services: - Up to 9 hours per month.	No
Transplant Services	Services that include all surgery and pre and post-surgical care.	Covered as medically necessary.	Yes
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following medically necessary services when prescribed by your doctor: - Two pairs of eyeglasses	No

Service	Description	Coverage/Limitations	Prior Authorization Requirements
		for children ages 0-20 - One frame every two years and two lenses every 365 days for adults ages 21 and older - Contact lenses - Prosthetic eyes	
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes.	Covered as medically necessary	Yes

*In accordance with the American Recovery and Reinvestment Act of 2009, Aetna Better Health of Florida does not impose fees, premiums or charges on Indians served by an Indian Health Care Provider, Health Service, Indian Tribe or Tribal Urban Organization or through referral under contract health services.

Early intervention services (EIS)

Early intervention services (EIS) provide for the early detection and treatment of recipients from 0-36 months of age who exhibit developmental delays or related conditions. EIS promotes a parent-coaching model intended to support the child in meeting certain developmental milestones. Reimbursable services include:

- Screenings to identify the need for more intensive evaluation and assessment activities, if necessary
- Evaluations conducted by a multidisciplinary team to identify the presence of a developmental delay or disability
- Weekly individual or group EIS sessions that include:
- Family and caregiver support and education
- Parent training to implement intervention strategies

Children ages 0-36 months of age enrolled in the Florida Department of Health's (DOH) Early Steps program can receive EIS. Anyone can refer a child to the Early Steps program; however, being referred does not necessarily mean that a child is eligible for EIS.

An eligible member must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in Early Intervention Services Medicaid Policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

For Florida Medicaid's policies and reimbursement rates, please refer to the Early Intervention Services Coverage Policy and Early Intervention Services Fee Schedule. The coverage policy also provides information on services that are excluded from this benefit. Health plans cannot be more restrictive than what is stipulated in the coverage policy.

Quality Enhancement Services

In addition to the covered, excluded, and non-covered services specified above, Aetna Better Health of Florida will offer and coordinate access to quality enhancements (QEs). Aetna Better Health of Florida is not offering these services as expanded benefits. Aetna Better Health of Florida is required to offer QEs as follows:

- Aetna Better Health of Florida has written policies and procedures to implement QEs.
- Aetna Better Health of Florida will offer QEs in community settings accessible to members.
- Aetna Better Health of Florida will actively collaborate with community agencies and organizations.
- If Aetna Better Health of Florida involves the member in an existing community program for purposes of meeting the QE requirements, Aetna Better Health will verify documentation in the member's medical/case record of referrals to the community program and follow up on the member's receipt of services from the community program.

Aetna Better Health of Florida will offer quality enhancements (QE) to members as specified below:

- Safety concerns in the house and fall prevention.
- End of life issues, including information on advanced directives; and
- Ensuring that case managers and providers screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.
- If Aetna Better Health of Florida involves the member in an existing community program for purposes of meeting the QE requirements, Aetna Better Health will verify documentation in the member's medical/case record and follow up on the member's receipt of services from the community program.

Managed Medicaid Expanded Benefits

Expanded benefits are extra goods or services we provide to the member free of charge. Call Member Services to obtain more information on the expanded benefits.

Medical expanded benefits

Service	Description	Coverage/Limitations	Prior Authorization Requirements
After School Activities	Members ages 5-18 have access to a $50 stipend per year for after-school activities. No prior authorization required.	Ages 5-18, $50 per year.	No
Asthma Home Care	Members with an asthma diagnosis have access to hypoallergenic bedding and a $150 stipend for carpet cleaning and pest control. Prior authorization required.	One set of bedding per year, $150 per year for carpet cleaning and pest control.	Yes
Baby Item Stipend	Members may get $150 stipend per pregnancy for baby items such as crib, stroller and car seat. Prior authorization required.	$150 per pregnancy.	Yes
Behavioral Health Integration Service	Care management services provided by doctors.	As medically necessary.	No
Blue Jeans for Teens	Members ages 13-21 may get a $150 stipend per year for clothing with a qualifying well-visit with their primary care doctor. Prior authorization required.	Ages 13-21, $150 per year.	Yes
Calming Comfort Collection	Members may get one calming box per year that includes items to support mental health concerns and trauma. Prior authorization required.	One box per year.	Yes
Career Closet	Members 18+ may get a $100 clothing stipend to support workforce development. One time only. Prior authorization required.	Members 18+, $100 per lifetime.	Yes
Childcare Support	Members may get $150 per quarter to pay for childcare during pregnancy, up to 12 months. Benefit may be extended through postpartum period. Prior authorization required.	$150 per quarter, up to 12 months.	Yes
Developmentally Delayed Stipend	Members 18+ may get a $500 stipend to cover expenses related to the following: · Education/job training · Pursuing volunteer opportunities or faith-based activities · Services that provide improvements for the home · Supports that address barriers to access to care (transportation or provider	Members 18+, $500 per year.	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
	consultations not otherwise covered by Medicaid). Prior authorization required.		
Diaper Club	Infants up to 30 months may get a $45 diaper stipend per month. No prior authorization required.	$45 per month for each child under 30 months.	No
Doula Services	Members may get unlimited doula services to support prenatal and postpartum care. No prior authorization required.	No limit for pregnant female members 14 to 55 years of age.	No
Durable Medical Equipment	Members ages 10+ may get one blood pressure monitor per year. Prior authorization required.	Members ages 10+, one per year.	Yes
Financial Literacy Book	Members ages 6-18 may get one financial literacy book. No prior authorization required.	Members age 6-18, one book per lifetime.	No
Food Assistance: Food as Medicine	Members with certain chronic conditions may get a $50 food stipend per month. Prior authorization is required.	Members with certain chronic conditions; $50 per month.	Yes
Food Assistance: Home Delivered Meals Post-Discharge	Members may get three meals per day for up to 12 weeks after discharge from a facility. Prior authorization is required.	Three meals per day for up to 12 weeks after discharge from a facility.	Yes
GED Support and Job Skills Training	Members ages 18+ (16-17 with parental, custodial or legal guardian consent and school district permission) may access a job skills training platform. The platform has GED preparation courses, preparation materials, and practice tests to help members with a GED. The costs of GED tests may be covered. No prior authorization required.	Members ages 18+ (16-17 with parental, custodial or legal guardian consent and school district permission). One per year.	No
Grooming and Hygiene Stipend	Members ages 18+ with a qualifying well visit with their primary care doctor will receive a $50 stipend per quarter to support workforce activities. Prior authorization required.	Members ages 18+ with a qualifying well visit with their primary care doctor, $50 per quarter.	Yes
Hearing Benefits for Adults	Members ages 21+ get one annual hearing exam and a set of hearing aids every two years. No prior authorization required.	Members ages 21+, one annual hearing exam and a set of hearing aids every two year.	No
Home Delivered Meals – Hurricane Preparedness	Home and Community-Based members may request three home-delivered, shelf-stable meals per day for up to 12 weeks to prepare for hurricane season. Prior authorization required.	Home and Community-Based members, three meals per day for 12 weeks, may be requested May through November.	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Housing Assistance: Hardship Grants	Members 18+ may get a $1000 stipend per year for crisis events that impact housing stability or maintenance. Prior authorization required.	Members 18+, must have a qualifying crisis event, $1000 per year.	Yes
Housing Assistance: LTSS Housing/Utility Stipend	Members 18+ needing help may get a $500 stipend per year for housing issues such as utility payments. Prior authorization required.	Members 18+, $500 per year.	Yes
Housing Assistance: Legal Services	Members 18+ who are tenants may get $500 to use toward legal services related to housing issues such as eviction or repairs. No prior authorization required.	Members 18+, one per year.	No
Laundromat Stipend	Members 18+ with a qualifying well visit with their primary care doctor may get a $25 stipend per quarter for laundromat services. Prior authorization required.	Members 18+ with a qualifying well visit with their primary care doctor, $25 per quarter.	Yes
Medication Lockbox	Members who are prescribed a medication and have children in their home may get one lockbox per year to secure medications. No prior authorization required.	Members who are prescribed a medication and have children in their home, one lockbox per year.	No
Newborn Circumcision	Infants up to 28 days old may get newborn circumcision. No prior authorization required.	Infants up to 28 days old, one per lifetime.	No
Non- Emergency Transportation	Members ages 18+ may get ten one-way trips per month to access resources such as food banks, local organizations, faith-based groups, and other activities. No prior authorization required.	Members ages 18+, ten one-way trips per month	No
Occupational Therapy for Adults	Members ages 21+ may get occupational therapy, including: · Evaluation and re-evaluation every year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years Prior authorization required.	Members ages 21+ · One evaluation and one re-evaluation per year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years	Yes
Over-the- Counter (OTC) Benefit	Members may get $65 per household per month for OTC products. No prior authorization required.	$65 limit per household per month on select OTC items	No
Over-the- Counter Period Stipend	Female members ages 11+ may get $20 per month for menstrual products. No prior authorization required.	Female members ages 11+, $20 per member per month on select OTC items.	No
Physical Therapy for Adults	Members ages 21+ may get physical therapy, including:	Members ages 21+ · One evaluation and one re-evaluation per year	Yes

Service	Description	Coverage/Limitations	Prior Authorization Requirements
	· Evaluation and re-evaluation every year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years. Prior authorization required.	· Up to seven therapy treatment units per week · Wheelchair fitting once every two years.	
Prenatal/ Postpartum Services – Breast Pump	Members may get a breast pump.	One hospital grade breast pump per year for rent, one non-hospital grade breast pump every two years.	Yes, prior authorization required.
Prenatal/ Postpartum Services –Visits	Members may get expanded prenatal and postpartum visits. No prior authorization required.	Up to 14 prenatal visits for low-risk pregnancy and 18 visits for high-risk pregnancy before baby is born. After baby is born, three visits within 90 days of delivery.	No
Primary Care Visits for Adults	Members 21+ have access to unlimited primary care visits. No prior authorization required.	Members 21+	No
Tutoring for Children and Teens	Members ages 6-18 may get individualized tutoring and mentoring sessions. No prior authorization required.	Members ages 6-18	No
Vision and Hearing Flex Card	Members ages 21+ may get $400 stipend every two years for extra vision and hearing services. No prior authorization required.	Members ages 21+, $400 every two years	No
Vision Services for Adults	Members ages 21+ may get a six-month supply of contact lenses with prescription, eyeglasses with prescription, and one eye exam per year. No prior authorization required.	Members ages 21+, six-month supply of contact lenses with prescription, eyeglasses with prescription, and one eye exam per year.	No
Waived Copayments	Members have access to unlimited waived copayments on all Medicaid covered services. Prior authorization required for non-participating providers.	No limit	No prior authorization required for participating providers. Prior authorization required for non-participating providers.
Young Adult Life Coaching Services	Members ages 16-30 may have access to online education for support with developing life skills. No prior authorization required.	Members ages 16-30	No

Utilization Management

The Plan will provide oversight and monitor services rendered to members as described below:

Our utilization management policy

Our utilization management program helps our members get medically necessary health care services in the most cost- effective setting under their benefit package. We work with members and physicians to evaluate services for medical appropriateness, timeliness, and cost.

- Our decisions are based entirely on appropriateness or care and service and the existence of coverage, using nationally recognized guidelines and resources.
- We do not pay or reward practitioners, employees, or other individuals for denying coverage of care.
- Financial incentives do not encourage our staff to make denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.
- We do not encourage utilization decisions that result in under-utilization.

Medically necessary or medical necessity

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided (FS 409.9131 (2) (b)).

Providers may obtain service-specific coverage requirements and medical necessity criteria on the Listing of Medicaid Covered Services table or by calling Provider Engagement at **1-800-441-5501.**

Services provided in accordance with 42 C.F.R. 438.210 (a)(4) and as defined in Section 59G, 1.010(166), F.A.C., to include those medical or allied care, goods, or services furnished or ordered must:

1. Meet the following conditions:
    a. Be necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain.
    b. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not more than the member's needs.
    c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational .
    d. Be reflective of the level of service that can be safely furnished, and for which equally effective and more conservative or less costly treatment is not available, statewide.
    e. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or Provider.
    f. For those services furnished in a hospital on an inpatient basis, medical necessity means

that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

g. "Medically Necessary" or "Medical Necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

2. The fact that provider prescribed, recommended, or approved medical or allied goods, or services does not make such care, goods, or services medically necessary, a medical necessity or a Covered Service.

In accordance with 42 CFR 440.230, each Medically Necessary service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

Out of Network

Any services rendered by non-participating providers or facilities must be prior authorized by Aetna Better Health of Florida and must meet the member's medical need for specialized or unique services which Aetna Better Health of Florida considers unavailable within the existing network. Aetna Better Health will prior authorize as in-network, certain services rendered by non-participating providers or facilities only when the member's medical needs require specialized or unique services which Aetna Better Health of Florida considers unavailable within the existing network. If Aetna Better Health of Florida approves the member to go out of network, the cost to the member is not greater than it would be if the service was provided in-network.

Behavioral health

Coordination of care between the Primary Care Physician (PCP) and the Behavioral Health Practitioners (BHP) is critical to the well-being of the patient. Some of the indicators that the Plan may review on an annual basis are the exchange of information between behavioral healthcare and primary care physicians; the appropriate diagnosis, treatment and referral of behavioral health care disorders commonly seen in primary care; the appropriate use of psychopharmacological medications; management of treatment access and follow-up of members with co-existing medical and behavioral disorders; and primary or secondary preventive behavioral health care program implementation.

Skilled nursing admissions

Skilled nursing facility (SNF) admissions require prior authorization. The concurrent review nurse, as part of the discharge planning process, will coordinate the prior authorization of SNF admissions. Following the admission, the concurrent review nurse will review the stay via the telephone with the facility case manager or designated facility review staff. A provider may also obtain the required prior authorization by going to **AetnaBetterHealth.com/Florida** or contacting the Utilization Department at **1-800-441-5501.**

Rehabilitation admissions

Admissions to rehabilitation facilities require prior authorization, which is often coordinated by the concurrent review nurse as a part of discharge planning. Concurrent review of acute rehabilitation admissions may be performed telephonically or onsite. A provider may also obtain the required prior authorization by going to **AetnaBetterHealth.com/Florida** or contacting the Utilization Department at **1-800-441-5501**.

Discharge planning

The concurrent review nurse will begin the discharge planning process at the time of an inpatient, skilled nursing, or rehabilitative facility admission. The concurrent review nurse will collaborate with the hospital discharge planner and the member's physician to ensure that the member receives all medically necessary covered services available within the member's contract at the time of discharge.

Second opinions

Florida Statute 641.51 requires that the Plan provide members with access to a second medical opinion in any instance in which the member disputes the Plan's or the provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious illness or injury. If requested, the member may select a provider or a non- participating provider in the geographical service area of the Plan.

If the member selects a participating provider, PCPs may issue a referral for the second opinion. If the member selects a non-participating provider, the PCP must request a prior authorization from the Plan.

New medical technologies

The Plan evaluates benefit coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input from appropriate regulatory bodies.
- Scientific evidence that supports the technology's positive effect on health outcomes.
- The technology's effect on net health outcomes as it compares to current technology.

The evaluation process includes a review of the most current information obtained from a variety of authoritative sources including medical and scientific journals, medical databases and publications from specialty medical societies and the government.

Healthy Behaviors Program

The Plan offers programs to our members, who want to stop smoking, lose weight, or address any substance use problems. We will reward members with incentives, including gift cards for those who join and meet certain goals. Gift cards are non-transferrable and if the member disenrolls from the Plan or loses Medicaid eligibility, they will lose the rewards as well. For more information about these programs call Member Service at **1-800-441-5501** (MMA) **or 1-844-645-7371** (LTC) or visit **AetnaBetterHealth.com/Florida.**

Care Management Programs

Care management

Care Management Services are provided to members who have suffered a traumatic injury or illness or have a significant medical condition necessitating ongoing follow-up, treatment, and care coordination. Proper medical management of a catastrophic case in intended to assure the continuity of high-quality care in a cost-effective manner. Care Managers follow patient care cases where extensive services are needed for chronic conditions.

Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and a family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. Care Management is a collaborative process that promotes quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational heath of individuals. It includes assessing, planning, implementation, coordinating, and evaluating health-related service options.

Each care manager works in conjunction with the member's primary or specialist physician as appropriate and coordinates their work activities with the Medical Director as deemed appropriate. Referrals to case management may be received from a variety of sources, such as the Primary Care Physician, Specialist Physician, Utilization Management team members, Medical Director, member/family, internal departments, employer groups, etc. 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 determine that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan. We work with the member, the member's family, physician(s), and other health care professional(s) in formulating the plan of care.

Integrated care management program

Aetna Better Health of Florida has an integrated care management program that includes biopsychosocial assessment, planning, facilitation, care coordination, evaluation and advocacy for service and support options to meet a member's and/or their family/representative's comprehensive care needs to promote quality and cost-effective outcomes. The integrated care management program is stratified by the complexity of the member's needs. All levels of care management include assistance to members with chronic conditions. We provide them with education and encouragement to learn self-management skills. We also coordinate access to appropriate services and support.

Members may self-refer, and providers may refer members to the Plan's case management program. Providers may request assistance in the development of plans of treatment for members with complex

or serious medical conditions. To make such a referral or to request assistance, please contact Care Management at **1-800-441-5501**. To refer a member to one of these programs, use the disease and care management referral form in the forms section of this manual. Fax the completed form to **1-844-847-5979.**

A care manager will work with the provider, the member and the member's family in an effort to help decrease the risk of complications, support coordination of care and provide education. The care manager will work with providers to assess, plan and monitor options and services for members with chronic illness or injury.

Care management and transition of care services are also offered to members upon discharge from the hospital, to help facilitate the receipt of post-discharge services administered by their provider.

Obstetrical (OB) care management program

An obstetrical nurse works with Obstetricians and Perinatologists to help coordinate services during pregnancy for members with high-risk conditions. The care manager also monitors the mother and newborn progress through the sixth week postpartum follow-up visit. Call Member Services at **1-800-441-5501** and ask to speak to someone on our Care Management team to enroll a patient. Members can choose to join or leave the program at any time.

Pediatric care management program

Pediatric members with catastrophic or chronic diseases are supported by a pediatric nurse who works with the member's providers and family, while the child is in the hospital or at home. The nurse works to identify participating providers, and resources in the area to meet the child's needs as defined by the providers. Call Member Services at **1-800-441-5501** and ask to speak to someone on our Care Management team to enroll a patient. Members can choose to join or leave the program at any time.

Transplant care management program

Transplant candidate members should be referred to the transplant coordinator. Call Member Services at **1-800-441-5501** and ask to speak to someone on our Care Management team to enroll a patient. Members can choose to join or leave the program at any time.

Disease management programs

Our disease management programs are designed to help your patients work with their doctors to effectively manage ongoing health conditions and improve outcomes. Disease management programs are available for asthma, cancer, dementia/ Alzheimer's, diabetes, HIV, AIDS, COPD, hypertension, mental and substance use issues. Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship, and reinforcing compliance with their physicians' care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessments, physician referral, caregiver referral, or self-referral. Providers may refer a member to a disease management program by calling the Disease Management call center at **1-800-441-5501**. The Clinical Practice Guidelines that support each of our disease management programs are found on our website at **AetnaBetterHealth.com/Florida.**

Clinical Practice Guidelines

The Plan's employees make clinical decisions regarding members' health based on the most appropriate care and service available. The Plan makes these decisions based on appropriate clinical criteria. The criteria used in the decision-making process will be provided upon request by contacting the Member Services Representative number listed on the back of the member's ID card. Criteria may be viewed on **AetnaBetterHealth.com/Florida** or a hard copy may be requested.

Aetna Better Health adopts evidence based clinical practice guidelines (CPG) from national recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care.

Aetna Better Health reviews the CPGs every two years or more frequently if national guidelines change within the two- year period. CPGs that have been formally adopted can be found on the Aetna Better Health website at **AetnaBetterHealth.com/Florida.**

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Diabetes clinical practice guidelines

Purpose

As part of our goal of providing quality care and improved health outcomes, as well as improving Provider awareness, The Plan supports the use of evidence-based medicine to reduce unnecessary variations in care. For diabetes management, The Plan has adopted the current recommendations from the American Diabetes Association, a recognized, national, expert source on diabetes management. A summary of the standards may be accessed at: **http://care.diabetesjournals.org/content/33/Supplement_1/S4.full.pdf**[3]

This is intended solely as a guide and information source. The Plan recognizes that any management plan should be individualized and developed in coordination with the physician, health care team, patient, and family, as deemed necessary.

Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of Long-Term complications. Diabetes care is complex and requires that many issues, beyond glycemic control, be addressed. A large body of evidence exists that supports a range of interventions to improve diabetes outcomes.

Guidelines components to be monitored:

- Hemoglobin A1C testing.
- Percentage of members with Hemoglobin A1c greater than 9% (poor control).
- Percentage of members with Hemoglobin A1c less than 8% (good control).
- LDL screening rates.
- LDL-C control (Less than 100 mg/dL).

[3] Please note that not all health insurance and group health plans cover all recommended services. Please check the member's benefit documents to determine whether their health insurance or group health plan covers these services

- Diabetic nephropathytesting.
- Diabetes – eye examinations.

Interventions:

- By evaluating claims data, the Plan will collect data to verify provider and member compliance with the guideline recommendations for the above components.
- Educational information and individual provider feedback will be provided where compliance rates do not meet benchmark goals.
- All members with diabetes will be assessed for participation in the diabetes disease management program, to facilitate achievement of clinical outcome goals.

Clinical outcome goals:

- Hemoglobin A1C level < 8.0%
- Lipid control: LDL-C < 100 mg./dL
- Annual eye examination.
- Urine albumin and serum creatinine testing annually.

Asthma clinical practice guidelines

Purpose

In its efforts to improve provider and member awareness of nationally established practice guidelines for common disease states, the Plan supports the clinical practice guideline for asthma outlined in 2007 by the National Asthma Education and Prevention Program of the National Institutes of Health. Members and providers may access the asthma clinical practice guideline in its entirety at **www.nhbli.nih.gov/guidelines/asthma/index.htm.**

Physicians are encouraged to familiarize themselves with the guideline and to incorporate the guideline into their daily patient management. As with all guidelines, it is intended to offer evidence-based guidance for treating this disease, with the understanding that a physician's treatment plan for any particular patient will be individualized. It offers a consensus opinion on the standard of care, keeping in mind that variations from it are expected when a patient's particular clinical circumstances so require.

The Plan intends to select several standards from within the guideline each year for particular focus and will monitor rates of adherence to those standards (referenced below as a "monitored standard"). Again, it is understood that deviations from any particular standard may occur based on physician judgment.

Nevertheless, the overall rates of compliance will be instructive, and it is the Plan's goal to improve overall compliance on those standards for appropriate patients.

Definitions

Asthma severity is classified in persons 5 years of age and older by assessing the level of impairment. The severity level is based on the child's/caregiver's recall of the 2-4 weeks just prior to the assessment.

- Severe persistent – continual daytime symptoms, frequent nighttime symptoms, and extreme limitation of normal activity.
- Moderate persistent – daily daytime symptoms or symptoms more than one night per week, and some limitation of normal activity.
- Mild persistent – daytime symptoms more than twice per week but less than once a day or symptoms more than two nights per month, and minor limitation of normal activity.
- Intermittent – daytime symptoms less than or equal to two days per week and less than or equal

to two nights per month, and no limitation of normal activity.

Guideline components to be monitored.

The Plan will monitor:

- The use of inhaled corticosteroids in asthmatic members age five and older with two or more emergency department visits and/or one inpatient admission for asthma in the past year.
- The use of long-acting bronchodilators in asthmatic members age five and older with two or more emergency department visits and/or one inpatient admission for asthma in the past year.
- The number of asthma-related emergency department visits annually in members age 5 and older.
- The number of asthma-related inpatient admissions annually in members age five and older

Data tracking

The Plan will track all pharmacy claims for inhaled corticosteroids and inhaled long-acting beta agonists and record the following specifics for each claim:

- Member name.
- Provider name/ whether provider is PCP or specialist.
- Panel size of provider.

The Plan will track claims for the two pharmaceutical agents above and compare claims per 1000 members against established benchmarks for utilization of these two agents (allowing for mail order claims for up to 90 days of medication per claim).

Clinical outcome goals

- Increased use of inhaled corticosteroids in asthmatic members.
- Increased use of long-acting bronchodilators in asthmatic members.
- Reduction in number of asthma-related emergency department claims for members.
- Reduction in number of asthma-related inpatient claims for members.

Congestive heart failure clinical practice guidelines

Purpose

Congestive Heart Failure (CHF) is a prevalent disease in elderly members and that prevalence is reflected in the Plan membership.

To improve provider and member awareness of nationally established practice guidelines for common disease states, the Plan encourages providers and members to use clinical practice guidelines as reference tools for giving and receiving care. Providers are encouraged to familiarize themselves with applicable guidelines and to refer to them in their daily patient management.

The Plan recognizes the guideline for CHF management developed by the American College of Cardiology (ACC). A complete copy of the guideline, may be found at**:**
http://content.onlinejacc.org/cgi/reprint/53/15/e1.pdf[4]

This is intended solely as a guide and information source. The Plan recognizes that any management plan should be individualized, and developed in coordination with the physician, healthcare team,

[4] Please note that not all health insurance and group health plans cover all recommended services. Please check the member's benefit documents to determine whether their health insurance or group health plan covers these services

patient, and family, as deemed necessary.

Guideline components to be monitored

- Prescription fill rates of ACEI/ARB
- Prescription fill rates of beta blockers
- Annual lipid testing rates

Interventions

- By evaluating claims data, the Plan will collect data to verify member and provider compliance with ACEI/ARB, beta blocker and lipid testing, as recommended by the guideline.
- Educational information and individual provider feedback will be provided where compliance rates do not meet benchmark goals.
- All members with diabetes will be assessed for participation in the CHF disease management program to facilitate achievement of clinical outcome goals.

Clinical outcome goals

- Increased use of ACEI/ARB increased use beta blockers
- Appropriate lipid testing rates

Aetna Better Health adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources. These guidelines are available on our website at **AetnaBetterHealth.com/Florida**. Once on the site, go to >Providers>Practice Guidelines. We review guidelines every two years unless updates from recognized sources warrant more frequent review.

Pharmacy

The Preferred Drug List (PDL)

The purpose of the Plan's Preferred Drug List (PDL), also known as the formulary, is to encourage use of the most cost-effective drugs. The PDL is necessary because the cost of prescription drugs, especially specialty drugs, is rising faster than other health care costs. Some of the reasons for this trend include:

- More advertising for newer high-cost drugs.
- An aging population that uses more drugs.
- The high cost of research and development for new drugs

Without a PDL, the Plan members would end up paying more for health care coverage, due in part, to rising drug costs. Our PDL allows us to continue providing cost-effective pharmacy benefits.

The Florida Medicaid Preferred Drug List (PDL) is developed and maintained by the Agency for Health Care Administration (AHCA). The Pharmacy & Therapeutics (P&T) Committee is made up of doctors and pharmacists. The P&T Committee develops formulary recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product. They keep up-to-date on the newest developments in medicine, and they continually improve our formularies based on the latest research, including the following (where applicable):

Drug labeling

- Clinical outcome studies from peer-reviewed published medical literature.
- Standard drug reference compendia.
- Regulatory status.
- Evidence-based guidelines published by medical associations, government agencies or national commissions.
- Views of professionals in relevant clinical areas.
- Other related factors.
- The P&T Committee makes recommendations for how drugs will be covered on the formulary based on the following criteria:
- **Efficacy:** Preferred drugs must be as good as, or superior to, other currently available alternatives for most of the population.
- **Safety:** Preferred drugs must be as safe as, or safer than, other currently available alternatives.
- **Health Outcomes (when available):** Preference is given to drugs which have been shown to improve overall health outcomes.
- **Drug Interactions:** Preferred drugs must have similar or less potential for drug interactions compared to other currently available alternatives.
- **Pharmacokinetics:** Consideration is given to drugs with evidence showing that less frequent dosing increases patient compliance and outcomes.
- **Contraindications:** Consideration is given to drugs that do not have factors which would restrict their use of specific patient populations.
- **Cost:** When two or more drugs produce similar clinical results, cost is considered in determining whether a drug makes it onto our formulary.
  Note: Formulary decisions are based on cost differences only after safety; effectiveness, possible side effects, and therapeutic need have been established.

- **Generic availability:** Decisions to add generics to the formulary are based on safety, cost, established equivalence to the brand name, and compliance with existing drug contracts.

  Comments and suggestion on the formulary are welcomed and should be directed to the Plan's Pharmacy department. Doctors may submit a written request to have a medication added to the formulary by contacting Provider Engagement at **1-800-441-5501**. At a minimum, written requests should include:

  – Advantages and disadvantages of the drug compared to current formulary alternatives.
  – Indications for use, efficacy, and a review of side effects.

We do not require that doctors only prescribe preferred formulary drugs. However, members may save time and money if a prescribed drug is on the Plan formulary. In most case, there are at least two formulary alternatives to choose from.

You can find the formulary, including any restrictions and preferences, on our website at **https://www.aetnabetterhealth.com/florida/drug-formulary.html**. Click on the Preferred Drug List link to view the AHCA PDL. There is also a link to the **Summary of Drug Limitations** which provides quantity limits and age limits on drugs that are on the formulary. The formulary applies only to outpatient prescription medications dispensed by participating pharmacies. It does not apply to inpatient medications, or the medications obtained from and/or administered by doctors.

New drugs may be added, and existing drugs may be removed throughout the year. A summary of the most recent formulary changes can be found on our website at:

- **https://www.aetnabetterhealth.com/florida/drug-formulary.html**

In addition to the drug limitations and restrictions called out in the formulary, certain classes of drugs (such as those for cosmetic uses) may not be covered. Member should refer to their benefit document or call Member Services at the number on their ID card, to determine which drugs are excluded under their benefit plan.

Doctors may request an exception to the formulary. In fact, doctors can request a coverage exception for any drug that he/she considers to be medically necessary by following the steps outlined under the section of this document entitled "Processes for Requesting a Medication Coverage Exception."

Prior authorization

One of the Plan's tools to help manage rising prescription drug costs is to require prior approval, or authorization, before drugs are covered. Drugs which require prior authorization are often not suggested as the first-line treatment option, and/or may have limited diagnoses for which they are recommended. Prior authorization may also be required for drugs that are very expensive. The prior authorization program helps to ensure that drugs are used in a safe, appropriate and cost-effective manner.

The P&T Committee determines which drugs require prior authorization and the criteria for coverage. Drugs that require prior authorization will be rejected at the member's pharmacy until the Plan has reviewed the necessary clinical information provided by the doctor and approves coverage.

Step therapy (Auto-PA)

Step therapy is a form of prior authorization. It involves an electronic review of a member's drug history to ensure that appropriate generic or first-line drugs have been tried already. If the member has already tried the prerequisite drug(s), the claim will process as usual. If the prerequisite drug(s) are NOT in the member's drug history, the claim will reject at the pharmacy and the doctor will need to provide additional

clinical information to the health plan for further review.

Which drugs require prior authorization or step therapy?

You can identify drugs that require prior authorization or step therapy by referring to our printable formulary document, on our website at:

- **https://www.aetnabetterhealth.com/florida/providers/pharmacy-prior-authorization.html.**

Each of these resources is available on our website. Prior authorization and step therapy criteria and specific coverage request forms can also be found on our website at:

- **https://www.aetnabetterhealth.com/florida/providers/pharmacy-prior-authorization.html.**

The drugs that have a step therapy requirement are noted on the preferred drug list with an Auto PA requirement.

Generic substitution/therapeutic interchange

Depending on a member's benefit plan, **generic substitution** may be required for brand-name drugs where the U.S. Food and Drug Administration has determined that the generic is equivalent to the brand.

However, this requirement is based on the availability of the generic and state regulations regarding drug product selection. If a doctor states that the brand is required, or a member requests the brand when a generic equivalent is available, the Plan may cover the brand name drug.

For Medicaid, the Plan requires the doctor to submit a completed "Multisource Drug and Miscellaneous.

Prior Authorization" form indicating that the member has had an adverse reaction to the generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug. There may be additional requirements for coverage of a brand name drug. These requirements may be found on our website at **https://www.aetnabetterhealth.com/florida/providers/pharmacy-prior-authorization.html.**

Specialty drugs

Specialty drugs are defined by the Plan. They are typically high-cost drugs, including, but not limited to, the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Characteristics of specialty drugs are:

- Used to treat and/or diagnose rare and complex diseases.
- Require close clinical monitoring and management.
- Frequently require special handling.
- May have limited access or distribution.

Specialty drugs require prior authorization and are subject to quantity limits, unless otherwise indicated. Refer to the formulary to identify specialty drugs and to determine if prior authorization and/or quantity limits apply. The formulary is available on our website at:

- **https://www.aetnabetterhealth.com/florida/drug-formulary.html.**

CVS Specialty, Publix Specialty pharmacy, and certain hospital-based pharmacies are our participating specialty pharmacies. Once authorization has been approved, a doctor can call a prescription into the specialty pharmacy. Once authorization has been approved, a doctor can call a prescription into a specialty pharmacy. Once authorization has been approved, a doctor can call a prescription into a

specialty pharmacy. For CVS Specialty pharmacy, call 1-800-237-2767, Monday through Friday, from 7:30 AM to 9:00 PM. For Publix Specialty pharmacy, call 1-855-797-8254, Monday through Friday, from 8:30AM through 7PM. Members should refer to their health plan documents or call our Member Service Department at **1-800-441-5501** with any questions regarding specialty drug coverage.

Pharmacy benefit information

The Plan members can get personalized, real-time prescription drug pricing information, by calling Member Services at **1-800-441-5501**. They can easily complete the following actions:

- Determine their financial responsibility for a drug, based on their pharmacy benefit.
- Initiate the exceptions process for drugs that have restrictions.
- Order a refill for an existing, unexpired mail-order prescription.
- Find the location of an in-network pharmacy.
- Conduct a pharmacy proximity search based on ZIP code.
- Determine potential drug-drug interactions.
- Determine a drug's common side effects and significant risks.
- Determine the availability of generic substitutes.

Informed consent for psychotropic medications

Documentation of the express written and informed consent of the member's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for a member under the age of thirteen (13) years. In accordance with s. 409.912(16), F.S., the Plan will ensure the following requirements are met:

- The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription.
- The prescriber must ensure completion of an appropriate attestation form. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link: **http://ahca.myflorida.com/Medicaid/Prescibed_Drug/med_resource.shtml.**
  - The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.
  - Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
  - Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
  - The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.
  - Providers should call their Provider Engagement representative at **1-800-441-5501** with any questions related to the Plan's Pharmacy benefits.

Long Term Care Program

Comprehensive Long-Term Care management

Aetna Better Health of Florida's Comprehensive Long Term Care Management program uses a person-centered case management approach. Aetna Better Health provides Long Term Care (LTC) to our aging and disabled members in the most integrated and least restrictive care environment possible. Our Comprehensive Long Term Care program recognizes the complex medical, psychological, and social issues which must be addressed for our members, and we help coordinate the response to their needs and desires. Our model for LTC is driven by the unique needs of the member. Services and supports are integrated the fullest extent possible, including the coordinate of services and support not covered by Medicaid and community resources/referral networks.

Care management role

We will assign a case manager once a member enrolls in our plan. The case manager is your contact person. The case manager helps the member arrange their services. The case manager will contact the member within five (5) business days after they have joined our Plan. If the member lives in a nursing facility, the case manager will contact you and the member/representative within seven (7) business days after the member joins our Plan. The case manager and you or your representative will discuss which services are right for the member and will help choose a provider for service deliveries.

Medical necessity

Services provided in accordance with 42 C.F.R. 438.210 (a)(4) and as defined in Section 59G. 1.010(166), F.A.C., to include those medical or allied care, goods, or services furnished or ordered must: Meet the following conditions:

- Be necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs.
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- Be reflective of the level of service that can be safely furnished, and for which equally effective and more conservative or less costly treatment is not available, statewide.
- Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or provider.
- For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- "Medically Necessary" or "Medical Necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- The fact that provider prescribed, recommended, or approved medical or allied goods, or services does not make such care, goods or services medically necessary, a medical necessity or

a Covered Service.

You can view a current list of the services that require authorization on our website at: **AetnaBetterHealth.com/Florida.** If you are not already registered for the secure web portal, download an application from the Florida Providers section of the site. If you have questions or would like to get training on the secure Provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Services Department at **1-844-645-7371**.

Long Term Care Providers

Long Term Care providers are responsible for providing services in accordance with the accepted community standards of care and practices. The Long Term Care provider is responsible for verifying member eligibility prior to providing services.

When a Long Term Care provider refers the member to a different Long Term Care provider, the original Provider must share the records, upon request, with the accepting provider or Long Term Care provider. The sharing of the documentation should occur at no cost to the member, other Long Term Care provider, or other providers.

Referrals and direct access

Members may self-refer directly to access some services. These services include hearing care and vision care, member must obtain these self-referred services from an Aetna Better Health of Florida provider.

Skilled nursing facility (SNF) providers

Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to members that need continuous care, but do not need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members.
For purposes of this section, the term "Direct Service Provider" means a person 18 years of age or older who, pursuant to a program to provide services to the elderly:

- Has direct, face-to-face contact with a client while providing services to the client or
- Has access to the client's living areas or
- To the client's funds or
- Personal property (which includes personal information)

This term includes coordinators, managers, supervisors of residential facilities and volunteers.

Home and Community-Based Services (HCBS)

Home and Community Based providers are required to work with Aetna Better Health of Florida case managers. Case managers will complete face-to-face assessments with our members, in their residence, at least every 90 days. Based on the assessment, case managers will identify the appropriate services that meet the members functional needs, including determining which network providers may be available to provide services to the member in a timely manner. The case managers will create authorizations for the selected provider and fax/e-mail these authorizations accordingly. The Plan follows up with the provider within 7-days to confirm services have started and within 14-days with the

member to confirm satisfaction of services.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for the member. While services may have been authorized for caregivers and agencies, providers should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Example:

Member is authorized to receive 40 hours of personal assistant per week over a 5-day period. The member is receiving 8 hours of care a day.

The member is admitted into the hospital on January 1 and is discharged from the hospital on January 3. There should be no billable hours for January 2, as no services were provided on that date since the member was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the member on the example above, since no services could be performed on January 2. This is also true for any in-home service.

Personal assistants and community agencies are responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the personal assistants and agencies will be required to pay back any monies paid by Aetna Better Health of Florida. Aetna Better Health of Florida will conduct periodic audits to verify this is not occurring.

Home and Community-Based Services (HCBS) in Assisted Living Facilities

The OIG published this report in December 2012:

HOME AND COMMUNITY-BASED SERVICES IN ASSISTED LIVING FACILITIES, OEI-09-08-00360

OIG recommend that CMS issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver. CMS concurred with our recommendation. CMS has also published expectations regarding person-centered plans of care and to provide characteristics of settings that are not home and community-based to verify state compliance with the statutory provisions of section 1915(c) of the Act.

What this means for residential HCBS providers such as assisted living facilities is summarized as follows:

- *A focus on quality of services provided.*
- *An Individualized Person-Centered Care Plan.*
- *A community integration goal planning process.*
- *The right to receive home and community-based services in a home-like environment.*

As a result, Aetna Better Health of Florida may take interventions or remediation steps that the state would expect to see. Aetna Better Health of Florida will work with the Assisted Living Facilities (ALF) administrators and staff to correct any identified deficiencies within a timeframe mandated by the state. The following are some examples of such interventions or remediation steps Aetna Better Health may implement upon discovery that an assisted living facility (ALF) is not maintaining a home-like environment:

- Aetna Better Health of Florida will not refer new members to the non-compliant ALF until outstanding deficiencies are resolved.
- Aetna Better Health of Florida will terminate from its network ALFs that consistently fail to exhibit home-like characteristics and that do not resolve outstanding issues.

- As a last resort, Aetna Better Health of Florida may counsel a member who is not residing in a home- like environment that he/she will not be able to continue to receive home and community-based services in a non-compliant facility. If the individual wishes to remain in the ALF, he/she may face disenrollment.
- If Aetna Better Health of Florida terminates a contract with an ALF, and the member agrees to move to a different ALF, Aetna Better Health of Florida would facilitate transferring the member to an ALF that meets the home-like environment requirements.

Residential facility providers agree to comply with the home-like environment and community integration language provided by the State. Such language is included in your provider agreement. All providers must also comply with the applicable Resident Bill of Rights and attest to being in compliance as part of the monitoring and credentialing process. The verbatim wording used by Aetna Better Health of Florida in support of the Home and Community based Tool and the ALF and AFCH provider agreements is as follows:

Assisted Living Facilities (ALF) and Adult Family Care Homes (AFCH) must maintain Home-Like Environment (HLE) characteristics according to mandates.

Additionally, waiver member residing in Assisting Living Facilities (ALFs) and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms.
- Roommate for semi-private rooms.
- Locking door to living unit.
- Access to telephone and unlimited length of use.
- Eating schedule.
- Activities schedule.
- Participation in facility and community activities.

Ability to have:

- Unrestricted visitations.
- Snack as desired.

Ability to:

- Prepare snacks as desired; and,
- Maintain personal sleeping schedule.

Note – Home and Community Based Services (HC.BS) providers may not submit claims when the member has been admitted to a hospital or nursing home. The day of admission or discharge is allowed, but the days in between are not. Providers submitting claims for the days in between may be subject to Corrective Action Plan (CAP).

Home delivered nutrition program

Providers must verify all home delivered nutrition programs and stay in compliance with Florida Standards for the Home Delivered Meals program. All food handling must comply with s.381.0072 F.S., "Food Service Protection". Additionally, the State Department of Health, AHCA, Department of Business and Professional Regulation, the Department of Agriculture and Consumer Services and the Department

of Children and Families personnel will conduct routine unannounced operational inspections of all caterers, kitchens, and sites involved in the program annually or as often as deemed necessary. Follow-up inspections are conducted, and legal action may be initiated when conditions warrant.

Out-of-Network Providers

When a member with a special need or service is not able to obtain services through a contracted provider in a near location, Aetna Better Health of Florida will authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through Aetna Better Health of Florida's medical transportation provider. If needed, our Provider Network Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development team for recruitment to join the Provider network. The member may be transitioned to a provider network when:

- Treatment or service has been completed.
- Member's condition is stable enough to allow a transfer of care.

Requesting a member transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask Aetna Better Health of Florida member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific Provider-patient relationship termination:

1) The provider must send a letter informing the member of the termination and the reason(s) for the termination to:

   Aetna Better Health of Florida
   ATTN: Provider Engagement
   9675 NW 117th Ave, Suite 202
   Miami, FL 33178

   A copy of this letter must also be sent to **FLProviderEngagement@aetna.com**

2) The provider must support continuity of care (COC) for the member by giving sufficient notice and opportunity to make other arrangements for care.

3) 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.

Financial liability for payment for services

Provider should NOT bill a member under any circumstance (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health of Florida. 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 Better Health of Florida, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health of Florida for services furnished by providers that have been authorized by Aetna Better Health to service such members, as long as the member follows Aetna Better Health's rules for accessing services described in the approved 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 must verify that the member is aware of his or her obligation to pay in full for such non-covered services.

Monitoring gaps

A gap in care is the difference between the number of hours scheduled in a member's plan of care and the hours that are delivered to that member on any given day.

Gap requirements

Aetna Better Health of Florida contractually requires that all providers, both self-directed and agency Providers to:

- Submit a non-provision of service log monthly, which identifies every time service is not provided as scheduled.
- Log to be submitted through our on-line portal system at any time or may be faxed to the Long Term Care (LTC) Case Management department.

Each provider of essential HCBS is required to submit by the fifth business day of the current month a report identifying all occurrences of non-provision of service for the previous month. This includes any provider working under a participant direction entity. Providers are educated on this process when they contract with the Plan, and re-education occurs as the need arises.

Any gap in care reported to the LTC Case Manager will be documented in the web-based case management application. A member may file a grievance for any gap in care. Upon learning of any reported gap in care, the LTC Case Manager immediately contacts the member, acknowledges the gap, works with the provider, and provides detailed explanation to the member regarding the reason for the gap. Most importantly, the LTC Case Manager then works with the provider or if necessary, another provider to resolve the gap and allow the member's immediate needs to be met to address the member's safety.

All non-provision of service gap report documents are provided to the Director of LTC or their designee. These logs include the county code for the provider, the service type, the member preference level at the time of the occurrence and the member preference level as determined by the last documented Case Manager event, the reason the gap occurred, and the resolution. The gap report identifies the original hours authorized, the hours provided to resolve the gap and the length of time before services were provided. The log also identifies if the member preference level was met and why and if the total authorized services were replaced and why. If unpaid caregivers are used to fill the gap, that information is collected as well.

Upon receiving the non- provision of service log, the Director of LTC or their designee reviews the reports and identifies if the gaps are true gaps or if the non-provision was not a true gap due to:

- The member was not available to receive the service when the caregiver arrived at the member's home at the scheduled time.
- The member refused the caregiver when she/he arrived at the member's home, unless the caregiver's ability to accomplish the assigned duties was significantly impaired by the caregiver's condition or state (for example drug and alcohol intoxication on the part of the caregiver).
- The member refused service.
- The member and regular caregiver agreed in advance to reschedule all or part of a scheduled service.

All non-provision of service gaps and true gaps are reported to the LTC Case Manager so that they can be entered into the web-based case management application.

All non-provision of service logs are reviewed and split between non-provision of service and true gaps. They are tracked, aggregated, reviewed, analyzed, and trended quarterly for presentation to the Director of LTC or their designee, Quality Management Committee, and the Compliance Department. The number and types of gaps, providers, and provider types are reviewed to identify any patterns of non-provision of services. Each month, the total number of service gap hours are calculated along with the total percentage of gaps hours per member per month and compared with the previous month.

Information is looked at in aggregate and by provider agency. For example, if a particular agency is found to have re-occurring gaps, a recommendation would be made for the Provider Engagement Department to work with that agency to identify strategies to reduce the occurrence of gaps. Continued high numbers of gaps in service would require a corrective action plan to be put in place for that agency. Provider Engagement will also intervene if a case manager has reported gaps in care that were not reported by the servicing provider. This is a contract compliance issue, and a corrective action plan will be required.

Network management may be involved if gaps in care are occurring in certain areas or for a certain service as it may mean that additional contracted providers are necessary to meet the needs of the member population. In this case, the Network Department would be requested to identify and contract with additional services providers to allow the members improved access to care that can meet their needs.

Should gaps in care result in a quality of care concern, the information will be reported to our Quality Management Department who will investigate the gap and determine if a corrective action plan is necessary or if there is additional action that must be taken. The Quality Management Department will be involved if it is identified that a particular gap resulted in a critical incident or if a particular worker or agency was frequently causing gaps. In these types of cases, the Quality Department may work with the service provider agency to further investigate and take appropriate action. This action may include reporting the provider to the state, implementing a corrective action plan, or recommending contract termination. The Credentialing Department reviews provider history in the gap in care process as a part of the credentialing or re-credentialing process. All critical incidents are tracked and trended and are a part of the credentialing file. In addition, as part of the standard credentialing process, the Credentialing Department utilizes the Office of the Inspector General Sanction Practitioners list to identify any providers that have been sanctioned or barred from providing Medicare and Medicaid services.

Long Term Care Covered Services

Service	Description	Prior Authorization Requirements
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping.	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during mealtimes, you can eat there.	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home.	Yes
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury.	Yes
Behavioral Management	Services for mental health or substance abuse needs.	Yes
Caregiver Training	Training and counseling for the people who help take care of you.	Yes
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	Yes
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to your home.	Yes
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores.	Yes

Service	Description	Prior Authorization Requirements
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Yes
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time.	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Yes
Medication Administration	Help taking medications if you can't take medication by yourself.	Yes
Medication Management	A review of all the prescription and over-the-counter medications you are taking.	Yes
Nutritional Assessment/ Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy.	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology.	Yes
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene.	Yes
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime.	Yes
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Facility.	Yes

Service	Description	Prior Authorization Requirements
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	Yes
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition.	Yes
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	Yes
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	Yes
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility.	We may offer the choice to use this service instead of nursing facility services.
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	Yes

Long Term Care Non-Covered Services

Aetna Better Health of Florida does not cover certain services except for urgent care outside of the service area or for emergency care anywhere. In addition, Aetna Better Health of Florida does not cover:

- Acupuncture.
- Health services not authorized by Aetna Better Health of Florida.
- Chiropractic services
- Christian Science practitioners' services.
- Cosmetic surgery- Services in connection with cosmetic surgery: cosmetic surgery (plastic and reconstructive), and any other service and supply to improve the covered persons appearance or perception, but it not expected to significantly restore normal bodily functions, including, not limited to, mammary reduction or augmentation, face lifts, cleft lip, cleft palate, varicose veins, correction of baldness; includes the diagnosis or treatment which arises as a complication of a non-covered cosmetic surgery.
- Experimental and investigational procedures and items which are items and procedures determined by Medicaid not to be generally accepted by the medical community.

Excluded services

If Aetna Better Health of Florida does not cover a service a member needs but Medicaid does, the

member can get those services through other Medicaid programs. This includes the Fee-For-Service Medicaid system. The members' Case Manager can help the member arrange these services based on the members' need. If additional help is needed, you and the member can reach out to the local AHCA office or the Aging and Disability Resource Center. The members' Case Manager will inform you and the member about possible costs the member may have to pay.

Quality enhancement services

In addition to the covered, excluded, and non-covered services specified above, Aetna Better Health of Florida will offer and coordinate access to quality enhancements (QEs). Aetna Better Health of Florida is not offering these services as expanded benefits. Aetna Better Health of Florida is required to offer QEs as follows: Aetna Better Health of Florida has written policies and procedures to implement QEs.

- Aetna Better Health of Florida will offer QEs in community settings accessible to members.
- Aetna Better Health of Florida will actively collaborate with community agencies and organizations.
- If Aetna Better Health of Florida involves the member in an existing community program for purposes of meeting the QE requirements, Aetna Better Health will verify documentation in the member's medical/case record of referrals to the community program and follow up on the member's receipt of services from the community program.

Aetna Better Health of Florida will offer quality enhancements (QE) to members as specified below:

- Safety concerns in the house and fall prevention.
- End of life issues, including information on advanced directives; and,
- Ensuring that case managers and providers screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.
- If Aetna Better Health of Florida involves the member in an existing community program for purposes of meeting the QE requirements, Aetna Better Health will verify documentation in the member's medical/case record and follow up on the member's receipt of services from the community program.

Long Term Care Expanded Benefits

Expanded benefits are extra services we provide to the member at no cost. Talk to the case manager about to obtain more information on the expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization Requirements
Calming Comfort Collection	Members may get one calming box per year that includes items to support mental health concerns and trauma. Prior authorization required.	One box per year.	Yes

Members With Special Needs

Adults with special needs include our members with complex and chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, and developmental disabilities. Members may be identified as having special needs because they are homeless.

Aetna Better Health of Florida developed methods for:

- Health promotion and disease prevention for adults and children identified as having special needs.
- Coordination and approval for specialty care when required.
- Diagnostic and intervention strategies to address the specific special needs of these members.
- Coordination and approval of home therapies and home care services when indicated.
- Case management for adults with special needs to address self-care education to reduce Long Term complications and to coordinate care so that long term complications may be treated as necessary.
- Case management systems to verify that children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis.
- Access to specialty centers for diagnosis and treatment of rare disorders.

The Assessment and Review for Long Term Care Service (CARES) for new members will assist us in identifying those with special needs. We will also review hospital and pharmacy utilization data.

Additionally, we rely on you, our network providers, to identify members who are at risk of or have special needs. Once identified, we will follow up with a needs-assessment for each of these members.

Aetna Better Health of Florida has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Aetna Better Health of Florida will develop care plans that address the member's service requirements with respect to specialist all care or services they may need. Our case management and utilization management teams collaborate closely so that all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out of our network.

Aetna Better Health of Florida works to provide immediate transition planning for a new member with complex and chronic conditions or any special needs. The planning will be completed within a time frame appropriate to the member's condition, but in no case later than 10 business days from the effective date of enrollment when indicated on the Plan Selection form or within 30 days after special conditions are identified by a provider. The transition plan will include the following:

- Review of existing care plans.
- Preparation of a transition plan to maintain continual care during the transfer to the Plan.
- Coordination and follow-through to approve and provide any necessary DME if it was ordered prior to the member's enrollment with us and it was not received by the date of enrollment with us.

Outreach and enrollment staff is trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English and use the FL Relay system and American Sign Language interpreters, if necessary.

After-hours protocol for members with special needs is addressed during initial provider trainings and,

in our Provider Manual. Providers must be aware that a non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Aetna Better Health of Florida clinician Line is available 24 hours a day 7 days a week for members with an urgent or crisis situation.

Aetna Better Health of Florida requires our contracted providers to use of the most current diagnosis and treatment protocols and standards established by the Agency for Health Care Administration (AHCA) and medical community. During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

SMI and HIV/AIDS Specialty Product

Aetna Better Health of Florida is proud to offer an enhanced program for individuals living with a Serious Mental Illness and/or HIV/AIDS. This product requires that members who fit this criteria opt-in to this program by contacting Choice Counselors at 1-877-711-3662 (TDD: 1-866-467-4970) or by visiting flmedicaidmanagedcare.com.

As part of the both the SMI and HIV/AIDS Specialty Product, members who have enrolled into this product are immediately assigned an Aetna Better Health of Florida Case Manager who completes comprehensive assessments and aids in coordination of all their healthcare and health related social needs. Case management empowers and educates members to take the lead in their healthcare. Members can depend on their case manager to provide education on their disease condition and connect them to both internal and external resources which may include peer support, community health workers, expanded benefits, coordinate transportation, make referrals to healthcare providers and community-based agencies, and ensure that there is a closed loop on each referral.

This enhanced case management program consists of more frequent touchpoints with the member and their providers and includes face to face visits in the community.

Eligibility Requirements for SMI and HIV/AIDS Specialty Product

SMI:

- At least six (6) years or older
- Diagnosed with a serious mental illness, which typically includes one or more of the following diagnostic categories: psychotic disorders, bipolar disorder, major depression, schizophrenia, delusional disorder, or obsessive-compulsive disorder.

HIV/AIDS:

- Diagnosed with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).

Training Requirements for Providers

Treating members in our SMI and HIV/AIDS Specialty Product requires specialized training to enable our providers to deliver high quality, integrated and patient-centered care. ABHFL offers training opportunities to our Specialty Product providers to ensure professional development and compliance with regulatory changes. ABHFL will offer trainings in-person or via webinar and such topics will include: the use of assessment tools, assessment instruments and identification of individuals with unmet health needs and are evidenced based. ABHFL will also educate providers on training opportunities in the community as they are available. Formal trainings or verification of trainings are required for all providers who are providing care to our specialty product members.

Performance Measures for Specialty Product Enrollees

In addition to the required performance measures, for individuals with a serious mental illness and in the specialty product, we will track the following:

- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
- Cardiovascular Monitoring for People with Cardiovascular Disease and

Schizophrenia (SMC)

- Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use (BMD)

For those individuals living with HIV/AIDS and enrolled in the specialty product, we will track the following:

- Prescription of HIV Antiretroviral Therapy
- HIV Medical Visit Frequency

Coordination Between Physical Health and Behavioral Health Services

We are committed to coordinating and integrating medical and behavioral care for members. Members should be appropriately screened, evaluated, treated and /or referred for physical health, behavioral health, or substance use disorder, dual or multiple diagnoses and/or intellectual or development disabilities. Coordination of behavioral and medical care includes communication between medical and behavioral health professionals, appropriate diagnosis, treatment and referrals.

PCPs are encouraged to use behavioral health screening tools, treat behavioral health conditions that are within their scope of practice and refer/consult with behavioral health/substance use disorder providers about the member's medical condition, mental status, psychosocial functioning, and family situations when making referrals or during treatment. We encourage that PCPs use all available communication methods to coordinate treatment and document those methods in the member's medical record.

Members seen by behavioral health practitioners should be screened for co-existing medical conditions and are asked to refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment, with the members consent. In addition, we encourage PCP's and behavioral health providers work collaboratively on a plan of care.

For assistance with identifying network providers, or to connect with our case management department for specialty product members, please call Provider Engagement at MMA 1-844-441-5501, LTC 1-844-645-7371.

Revisions

REVISIONS		
Date	**Revised Information**	**Page #**
06/09/2025	COC Prior Authorization (PA) information updated from 90 days to 120 days.	21-22, 26