Provider Manual

Aetna Better Health℠ Premier Plan
(Medicaid-Medicare Plan) A
MI Health Link Plan

AetnaBetterHealth.com/Michigan

86.05.805.1-MI

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Linking Medicare and Medicaid for you

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CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH PREMIER PLAN

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Welcome

Welcome to Aetna Better Health Premier Plan. Our ability to provide excellent service to our enrollees is dependent on the quality of our provider network. By joining our network, you are helping us serve those Michiganders who need us most.

Who We Are

Aetna Medicaid has been a leader in managed care since 1986 and currently serves more than 2 million individuals in 15 states. Aetna Medicaid affiliates currently own, or administer, or support Medicaid Programs in Arizona, Florida, Illinois, Kentucky, Michigan, New York, Pennsylvania, Ohio, Texas, Louisiana, New Jersey, Kansas, California, Virginia, and West Virginia.

Aetna Medicaid has more than 25 years' experience in managing the care of the most medically vulnerable, using innovative approaches to achieve both successful health care results and maximum cost outcomes. Aetna Medicaid has particular expertise in serving high-need Medicaid enrollees, including those who are dual eligible for Medicaid and Medicare.

Experience and Innovation

We are dedicated to enhancing enrollee and provider satisfaction, using tools such as predictive modeling, care management, and state-of-the-art technology to achieve cost savings and help enrollees attain the best possible health through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living. Aetna provides care management services to hundreds of thousands of high-costs, high-need Medicaid enrollees. Aetna utilizes a variety of delivery systems, including fully capitated health plans, complex care management and administrative service organizations.

Aetna Better Health Premier Plan understands that our holistic approach to managing an enrollee's health is the best way to achieve expected goals. By assessing the enrollee's physical, mental, sociological, economical, linguistic, and cultural needs, we are able to identify and prioritize enrollee needs, removing or minimizing barriers to goals wherever possible. As a result of this understanding, Aetna Better Health Premier Plan embraces and supports an integrated model of care approach. We have extensive experience in engaging the entire Integrated Care Team (ICT), including the enrollee, PCP, mental health provider, as well as other service providers when managing care. We routinely engage our enrollee's PCP as a means of communicating and collaborating on enrollee needs, conducting biweekly and monthly collaborative rounds with our behavioral health partners to discuss and coordinate care between the enrollee's physical and behavioral health needs. This often requires coordination and communication with Community Mental Health providers. Our care supports team, which includes bachelor's -prepared social workers, community health workers and other staff is essential in assisting us to connect identified enrollees with available community resources, screening for depression and coordinating with behavioral health providers when indicated.

About Aetna Better Health Premier Plan, a MI Health Link Program

Aetna Better Health Premier Plan is proud to partner with the Michigan Department of Health and Human Services (MDHHS) to participate in the State of Michigan's MI Health Link Program, which provides services to select individuals who are currently eligible for both Medicare and Medicaid. This program provides individuals with a single healthcare plan that encompasses both Medicare and Medicaid benefits. This program seeks to:

- Arrange for care and services by specialists, hospitals, and providers of long-term services and supports (LTSS) and other non-Medicaid community-based services and supports

- Allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services
- Cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals
- Utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid

About the MI Health Link Program

The Michigan Department of Health and Human Services (MDHHS) authorized by the Patient Protection and Affordable Care Act of 2010 (ACA), will enroll people who receive Medicare and full Medicaid benefits in managed fee- for-service or capitated managed care plans that seek to integrate benefits and align financial incentives between the two programs.

The Michigan Department of Health and Human Services (MDHHS) has chosen the capitated managed care model offered by the Centers for Medicare and Medicaid Services (CMS). Through the MI Health Link Program managed by MDHHS, Michigan developed a fully integrated care system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare and Medicaid enrollees, including Long Term Services and Supports (LTSS). MDHHS chose several Integrated Care Organizations (health plans) to implement the MI Health Link Program which is designed to integrate Medicare-Medicaid benefits to selected regions across the state.

Aetna Better Health Premier Plan provides the following features to dual eligible enrollees enrolled in our Aetna Better Health Premier Plan Program:

- Seamless access to all physical health, behavioral health, and LTSS
- A choice of providers, with choices being facilitated by an independent, conflict-free Enrollment Broker
- Care planning and care coordination by an Integrated Care Teams (ICTs) that are centered around each enrollee
- Consumer direction for personal care services
- An independent, conflict-free, Participant Ombudsman to aid the participant in any questions or problems
- Continuity of care provisions to make certain seamless transition into the program
- Articulated network adequacy and access standards
- Fully coordinated care, including covered and non-covered services
- New Health Education and Wellness benefits
- Medicare Part D and Medicaid prescription drugs

Who Are the Duals?

Duals are defined as Individuals who reside in Michigan, are dually enrolled in Medicare and Medicaid are elderly, disabled or both. These dually enrolled individuals usually have complex health needs including a broad range of medical issues such as chronic health conditions, and functional or cognitive impairments (including mental health conditions or developmental disabilities), many have both.

About this Provider Manual

The Provider Manual serves as a resource and outlines operations for Aetna Better Health Premier Plan. Through the Provider Manual, providers should be able to locate information on a majority of issues that may affect working with us. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Experience Department at **1-855-676- 5772** for concerns.

Our Provider Experience Department updates this Provider Manual at least annually and distributes update bulletins as needed to incorporate any revisions/changes. Please check our website at **AetnaBetterHealth.com/Michigan** for the most recent version of the Provider Manual and/or updates. The Aetna Better Health Premier Plan Provider Manual is available in hard copy form or electronic form, at no charge, by contacting our Provider Experience Department at **1-855-676-5772**. Otherwise, for your convenience, we will make the Provider Manual available on our website at **AetnaBetterHealth.com/Michigan**.

About Patient-Centered Medical Homes (PCMH)

A medical home, also referred to as a "Patient-Centered Medical Home" is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The medical home features a personal care clinician who partners with each enrollee, their family and other caregivers to coordinate aspects of the enrollee's health care needs across care settings using evidence-based care strategies that are consistent with the enrollee's values and stage in life.

Service Areas

Aetna Better Health Premier Plan offers coverage for the MI Health Link Program in the following regions (service areas):

Regions	Counties within Region
Region 4	• Barry • Berrien • Branch • Calhoun • Cass • Kalamazoo • St. Joseph • Van Buren
Region 7	• Wayne
Region 9	• Macomb

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the MI Health Link Program, and with your Aetna Better Health Premier Plan Provider Agreement, including all requirements described in this Manual, in addition to all state and federal regulations governing a provider. While this Manual contains basic information about Aetna Better Health Premier Plan, providers are required to fully understand and comply with MDHHS and CMS requirements when administering covered services.

Please refer to the MDHHS and CMS websites for further information:

- **www.michigan.gov/mdhhs**
- **www.cms.hhs.gov/**

Aetna Better Health Premier Plan Policies and Procedures

We employ comprehensive policies and procedures throughout our entire Health Plan operations to ensure compliance with all regulatory standards/requirements. Our policies and procedures are reviewed and updated annually as needed.

Model of Care

Our model of care offers an integrated care management approach, which offers enhanced clinical assessment and management for our enrollees. The processes, oversight committees, provider collaboration, care management and coordination efforts jointly applied to address enrollee needs results in the development of an individualized, comprehensive integrated plan of care for each enrollee.

The integrated model of care addresses the needs of enrollees who are often frail, elderly, or coping with disabilities, and have compromised daily living activities, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues.

Our program's combined provider and care management activities, coordinated through our Integrated Care Team (ICT) model, are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across healthcare settings and providers
- Promote appropriate utilization of services and cost-effective service delivery

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:

- Review of network for adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.

Many components of our integrated care management program influence enrollee health. These include:

- Comprehensive enrollee assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow enrollees to reside in the least restrictive environment possible.
- Assessments and person-centered service planning and care plans that identify an enrollee's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Case Manager referrals and predictive modeling software that identify enrollees at increased risk for nursing home placement, functional decline, hospitalization, emergency department visits, and death. This information is used to intervene with the most vulnerable enrollees in a timely fashion.

CMS and MDHHS Website Links

We administer our MI Health Link Program in accordance with the contractual obligations, requirements, and guidelines established by CMS and MDHHS. There are several manuals on the CMS and MDHHS websites that may be referred to for additional information. Key CMS and MDHHS On-Line Manuals are listed below:

- Medicare Managed Care Manual –**www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326**
- Medicare Prescription Drug Manual – **www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals**
- MDHHS MI Health Link - **www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html**
- MDHHS Policies, Letters, & Forms - **www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448_78465---,00.html**

CHAPTER 2: CONTACT INFORMATION

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Providers with additional questions can refer to the following Aetna Better Health Premier Plan contact centers for assistance:

Important Contacts	Phone Number	Hours and Days of Operation (excluding State of Michigan holidays)
Aetna Better Health Premier Plan	**1-855-676-5772** (follow the prompts in order to reach the appropriate departments) Provider Relations Department Member Services Department (Eligibility Verifications) AetnaBetterHealth.com/Michigan	8 AM - 5 PM EST Monday-Friday 8 AM -5 PM EST Monday-Friday 24-hours-a-day, 7-days-a-week
Aetna Better Health Premier Plan Prior Authorization Department	See Program Numbers Above and Follow the Prompts	6 AM -8 PM EST Monday -Friday
Aetna Better Health Premier Plan Nurse Advice Line	See Program Numbers Above and Follow the Prompts	24-hours-a-day, 7-days-a-week
Aetna Better Health Premier Plan Compliance Hotline (Reporting Fraud, Waste or Abuse)	**1-855-676-5820**	24-hours-a-day, 7-days-a-week through Voice Mail inbox
Aetna Better Health Premier Plan Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)	**1-800-338-6361**	24-hours-a-day, 7-days-a-week

Aetna Better Health Premier Plan Department Fax Numbers	Facsimile
Member Services	**1-855-854-3245**
Provider Experience	**1-844-300-7473**
Medical Prior Authorization	**1-844-241-2495**
Pharmacy Prior Authorization (CVS Caremark)	**1-844-242-0914**
Grievances & Appeals for Providers	**1-860-975-3615**
Grievances & Appeals for Members	**1-844-321-9567**

Community Resource	Contact Information
State of Michigan Quit Line	**1-800-QUIT-NOW (1-800-784-8669)** Website: **michigan.quitlogix.org/**

Contractors	Phone Number	Facsimile	Hours and Days of Operation
DentaQuest (Dental Vendor) www.dentaquest.com	Enrollee Line: **1-855-925-7581** **(TTY 1-800-502-6975)** Provider Line: **1-888-249-8841**	N/A	Monday – Friday 7 AM 4 PM CST

Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired, oral translation, and oral interpretation.	Please contact our Member Services Department at **1-855-676-5772** (for more information on how to schedule these services in advance of an appointment)	N/A	24-hours-a-day, 7-days-a-week
Vision Services Plan Insurance Co. (VSP) (Vision Vendor) **www.vsp.com**	Enrollee Line: **1-800-877-7195 (TTY: 1-800-428-4833)** Provider Line: **1-800-615-1883**	N/A	Enrollee Line: Monday – Friday 5 AM 8 PM. PST Saturday 7AM - 8 PM PST Sunday 7 AM - 7 PM PST Provider Line: Monday – Friday 5 AM - 8 PM PST Saturday 7 AM – 8 PM PST Sunday 7 AM - 7 PM PST
Access2Care (A2C) (Non-Emergent Transportation Vendor) https://access2care.com/	Enrollee Line: Contact Aetna Better Health Premier Plan directly Provider Line: **888-513-1612** (providers call to make standing order reservations for patients)	N/A	24-hours-a-day, 7-days-a- week
CVS Caremark	Pharmacy Help Desk **1-855-319-6287** Or **1-888-624-1135**	**1-844-242-0914**	8 AM -6 PM EST Monday-Friday Pharmacist available after hours for prior authorizations, 24-hours-a-day, 7-days-a-week.

Important Contacts	Phone Number	Facsimile	Hours and Days of Operation
Change Healthcare Customer Service Email Support: **allpayer@echohealthinc.com** **Submit Electronic Claims: https://www.echohealthinc.com/**	**1-800-845-6592**	N/A	24-hours-a-day, 7-days-a-week
Michigan Relay	Dial 711	N/A	24-hours-a-day, 7-days-a-week

Reporting Suspected Neglect or Fraud		
Office of Services to the Aging The Long-Term Care Ombudsman Program (LTC Ombudsman)	**1-866-485-9393**	24-hours-a-day, 7-days-a-week
Michigan Department of Human Services	Centralized Intake for Abuse and Neglect Hotline: **1-855-444-3911**	24-hours-a-day, 7-days-a-week
Michigan Attorney General's Office	Report abuse either online at **www.michigan.gov/ag** or call the "HOTLINE" at	24-hours-a-day, 7-days-a-week

	1-800-24-ABUSE (22873)	
The National Domestic Violence Hotline	**1-800-799-SAFE (7233)**	24-hours-a-day, 7-days-a-week
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**	24-hours-a-day, 7-days-a-week

Important Addresses	
Aetna Better Health Premier Plan (Claims Submission & Resubmissions and Participating Provider Disputes)	Aetna Better Health Premier Plan PO Box 982963 El Paso, TX 79998

CHAPTER 3: PROVIDER EXPERIENCE DEPARTMENT

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Provider Experience Department Overview

Our Provider Experience Department serves as a liaison between the Aetna Better Health Premier Plan and our provider community partners. Our Provider Experience staff is comprised of Field Based Liaisons and internal team members ready to assist on all matters. Our Provider Liaisons conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

We also have a Claim Investigation Claims Research (CICR) team as a component of our Provider Experience Department who 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:

- Assistance with provider address change request
- Information about recent Health Plan and/or regulatory updates
- Assistance on how to locate forms
- Assistance with general provider questions
- Assistance with reviewing claims or remittance advices including questions surrounding claims and billing
- Information on provider denials
- Instructions for those providers needing to file a complaint and/or challenging or appealing the failure of the Health Plan to provide covered services (including state services)
- Information on enrollee grievance and appeals
- Information on translation/interpreter services
- Information about enrollee covered services
- Instruction on how to submit a prior authorization and/or cover determination (including exceptions)
- How to look up services that need a prior authorization (through Secure Web Portal)
- Information about provider orientations
- Information about coordination ofservices
- Information about providerresponsibilities
- Assistance with checking enrollee eligibility
- Assistance with reviewing enrollee information on the Member Care Portal
- Instructions on how to locate a participating provider or specialist in our network
- Instructions on how to search the Preferred Drug List
- Assistance with processing provider terminations
- Assistance with changing practice information (moving from one practice to another etc.)
- Assistance with a Tax Identification Number (TIN) or National Provider Identification (NPI) number update in our system
- Assistance with obtaining a Secure Web Portal and or Member Care Login username and or password

Provider Toll-Free Help Line

The Provider Toll-Free Help Line at **1-855-676-5772** is staffed by Provider Experience CICR team members between the hours of 8 AM – 6 PM, EST, Monday through Friday, excluding State of Michigan holidays.

An automated system and secure voicemail is also available to providers between the hours of 6:01 PM and 8 AM., EST, Monday through Friday and 24 hours on weekends and holidays.

Informed Health Line

Enrollees and providers are able to use our Informed Health® Line (IHL), which provides enrollees with access-ready telephonic clinical support from experienced Registered Nurses (RNs) 24-hours-a-day, 7-days-a-week. Providers are also able to use this line to verify enrollee eligibility after-hours.

Provider Orientation

Our Provider Experience Department provides initial orientation for newly contracted providers within 180 days of joining network. In follow up to initial orientation, our Provider Experience Department provides a variety of forums for ongoing provider training and education support, such as routine office/site visits, webinars, group or individualized training sessions on select topics, (e.g., claims coding, enrollee benefits, website navigation). Also we routinely distribute Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/Michigan.**

Interested Providers

If you are not currently a participating provider in the Aetna Better Health Premier Plan network and are interested in applying for participation, please visit our website at **AetnaBetterHealth.com/Michigan** and complete the provider nomination form. If prefer to speak to a representative instead, please contact our Provider Experience Department at **1-855-676-5772**. Participation acceptance is based on provider ability to meet credentialing requirements and overall network composition needs.

CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

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Provider Responsibilities Overview

This section outlines general provider responsibilities; in addition to service specific responsibilities included throughout this Manual. These responsibilities represent requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the MI Health Link Program, their Provider Agreement and all requirements contained within this Manual. Aetna Better Health Premier Plan may specifically communicate responsibilities and requirements in forms other than the Provider Agreement and this Manual, such as Provider Bulletins.

Providers must act lawfully in their scope of practice of treatment, management, and advisement on medically necessary care delivered to enrollees. Providers are also expected to advocate appropriate medical care with or on behalf of enrollees.

Providers must also act lawfully in their scope when providing information regarding the nature of treatment options inclusive of communication of treatment risks, alternative treatments, and the availability of alternative therapies, consultation, or tests that may be self- administered. Providers are expected to communicate to enrollees all relevant risk, benefits, and consequences of non-treatment.

Providers must also ensure to use the most current diagnosis and treatment protocols and standards established by the medical community and relevant regulatory agencies. Advice given to potential or enrolled enrollees should always be given in the best interest of the enrollee. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

Providers who are excluded from participation in any federally or state funded health care program are not eligible to for Aetna Better Health Premier Plan network participation.

Unique Identifier/National Provider Identifier

Providers who service our enrollees must have the proper identifiers for billing and confirmation of their ability to deliver services. Each provider is required to have a unique identifier (taxid), and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Centers of Medicare and Medicaid (CMS). We understand that some provider types (i.e., assisted living, certified family homes, boarding homes, supervised independent living, and community residential facilities) may not have an NPI numbers. If a provider does not have an NPI number due to their provider type, we will associate the provider to a system default NPI for atypical providers (9999999995). For questions, please contact our Provider Experience Department at **1-855-676-5772**.

Appointment Availability Standards

Providers are required to schedule appointments for eligible enrollees in accordance with minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Experience Department will routinely monitor provider compliance with minimum appointment availability standards and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from those providers not meeting accessibility standards. Providers are contractually required to meet the Michigan Department of Health and Human Services (MDHHS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

The tables below show appointment availability standards by provider type:

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Routine & Preventive Care	Wait Time in Office Standard
PCP	• Within 24 hours	• Within 24 hours	• Within 72 hours	• Within 28 calendar days	• No more than 45 minutes
Specialty Referral (includes high-volume specialty care)	• Within 24 hours	• Within 24 hours	• Within 72 hours	• Within 28 calendar days	• No more than 45 minutes
Oncologist and other High Impact Specialist	• Within 24 hours	• Within 24 hours of referral	• Within 72 hours	• Within 28 calendar days	• No more than 45 minutes

Appointments for routine care are made within four (4) weeks or twenty-eight (28) days of the member's request. This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every twenty-eight (28) calendar days. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating an enrollee with a difficult medical need, the waiting time may be expanded. The above access and appointment standards are provider contractual requirements. Our Provider Experience Department monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Maternity Appointment Timeframes

Aetna Better Health contractually requires its providers to comply with the following prenatal care appointment access standards:

- First Trimester – Appointments made available within seven (7) calendar days of request
- Second Trimester – Appointments made available within seven (7) calendar days of request
- Third Trimester – Appointments made available within three (3) business days of request

Dental Services Appointment Timeframes

Aetna Better Health contractually requires its dental providers to comply with the following prenatal care appointment access standards:

- Emergency Dental Services - Appointments made available immediately, with availabilitytwenty four (24) hours/day and seven (7) days/week
- Urgent Detnal Service - Appointments made available within forty eight (48) hours
- Routine Dental Service - Appointments made available within twenty one (21) business days of request
- Preventative Dental Service - Appointments made available within six (6) weeks of request
- Initial Appointment - Appointments made available within eight (8) weeks of request

Behavioral Health Appointment Timeframes

Aetna Better Health contractually requires its providers to comply with the following behavioral health care appointment access standards. (Measured separately for prescribing versus non prescribing providers):

Provider Type	Emergency Services	Non-Life-Threatening Urgent Care	Urgent-no immediate danger	Preventive and Routine Care	Wait Time in Office Standard
Behavioral Health	• Immediately	• Within 6 hours	• Within 48 hours	• Initial visit: within 10 business days of original request	• No more than 45 minutes

Non-life threatening urgent: There is no immediate danger to self or others and/or if the situation is not addressed within six (6) hours may escalate to be a risk to self or others:

- Extreme anxiety
- Parent child issues
- Passive suicidal ideation
- Excess drug or alcohol usage

Urgent-no immediate danger: There is no immediate danger to self or others and/or if the situation Is not addressed within forty-eight (48) hours, it may escalate to be a risk to self or others:

- Follow-up to a crisis stabilization
- Escalating depression
- Escalating anxiety
- Escalating drug/alcohol usage
- Escalating behavioral issues in children

Additionally, behavioral health providers are contractually required to offer:

Provider Type	Follow-up BH Medication Mgt.	Follow-up BH Therapy	Next Follow-up BH Therapy
Behavioral Health	• Within 3 months of first appointment	• Within 10 business days of first appointment	• Within 30 business days of first appointment

Telephone Accessibility Standards

Providers are responsible for making 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 Premier Plan providers for the purpose of rendering medical advice, determining the need for emergency and after-hours services including, authorizing care and verifying enrollee enrollment with us.

Aetna policy does not allow network providers to utilize 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 after-hours coverage 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 provides access to primary care 24hours-a-day, 7-days-a-week. In addition, Aetna encourages 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 enrollees, their PCPs, and practice staff. Aetna routinely measures provider compliance with these standards as follows:

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

Providers must comply with telephone protocols under the following conditions:

- Answering the enrollee telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by an enrollee
- Identifying and rescheduling broken and no-show appointments
- Identifying special enrollee needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental staff to provide covered services within normal working hours. Protocols should be in place to provide coverage in the event of a provider's absence.

Providers must ensure their hours of operation are convenient to, and do not discriminate against, MI Health Link enrollees. This includes offering hours of operation that are no less than those for non-enrollees, commercially insured or public fee-for-service individuals.

If a PCP fails to meet telephone accessibility standards, a Provider Experience 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. Should accessibility failures by practice continue to be observed, the provider may be asked to submit a corrective action plan.

Covering Providers

Our Provider Experience Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health Premier Plan. This notification must occur in advance of providing authorized services. Failure to notify our Provider Experience Department of the covering provider's affiliation may result in claim denials, resulting in the Aetna contracted provider being liable for any reimbursement due to the non-contracted covering provider.

Verifying Enrollee Eligibility

All providers, regardless of contract status, must verify an enrollee's eligibility status prior to the delivery of non- emergent, covered services. An enrollee's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to enrollees no longer eligible or who were not assigned to the PCPs panel (unless, s/he is a physician covering for the provider).

Enrollee eligibility can be verified through one of the following ways:

- **Telephone Verification:** Call our Member Services Department to verify eligibility at **1-855-676-5772**. To protect the enrollee's confidentiality, providers are asked for at least three pieces of identifying information such as the enrollees' identification number, date of birth and or address before any eligibility information can be released.
- **Monthly Roster:** Monthly rosters can be accessed on our Secure Website Portal. Contact our Provider Experience Department for additional information about securing a confidential username and password to access the site. Note rosters are only updated once a month and are only available to PCPs and those providers acting as PCPs.

Note: Additional enrollee eligibility requirements are noted in Chapter 7 of this Manual.

Care Bridge

The Care Bridge is a web-based platform that allows us to communicate enrollee healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be obtained from the Secure Web Porta/Care Bridge:

- Enrollee Eligibility Search – Verify current eligibility of one or more enrollee
- Panel Roster – View the list of enrollees currently assigned to the provider as the PCP
- Provider List – Search for a specific provider by name, specialty, or location
- Claims Status Search – Search for provider claims by enrollee, provider, claim number, or service dates. Only claims associated with the user's account / provider ID will be displayed.
- Remittance Advice 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 enrollee, 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 Procedure Coding System (CPT/HCPCS) codes simultaneously
  - Review Prior Authorization requirement by specific procedures or service groups
  - Receive immediate details as to whether CPT/HCPC or ICD codes 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
  - Make certain staff works from the most up-to-date information on current prior authorization requirements

- Submit Authorizations – Submit an authorization request on-line. Three types of authorization types are available:
  - Medical Inpatient
  - Outpatient
  - Durable Medical Equipment – Rental
  - ***Note:*** *Long term support services also require authorization. These services are authorized directly by enrollee assigned care managers after direct contact with enrollees and their providers.*
- Healthcare Effectiveness Data and Information Set (HEDIS®) – Check the status of the enrollee's compliance with any of the HEDIS measures. A "Yes" means the enrollee has measures that they are not compliant with; a "No" means that the enrollee has met the requirements.

To register for the Secure Web Portal, go to **AetnaBetterHealth.com/Michigan** to download our Secure Web Portal Agreement. Contact our Provider Experience Department for additional information or to schedule training.

The Care Bridge for enrollee's and others on the enrollees Integrated Care Team (ICT)allows for views of care management and relevant clinical data, and securely interact with the Integrated Care Team (ICT).

Providers can do the following on Care Bridge: For their Practice:

- Providers can view their own demographics, addresses, phone, and fax numbers for accuracy.
- Providers can update their own fax number and email address.
- Provider can look up enrollees not on their panel (provider required to certify treatment purpose as justification for accessing records)

Providers, enrollees, and others designated as participants by the enrollee of the ICT can access the following:

- View and print enrollee's care plan* and provide feedback to Case manager via secure messaging.
- View an enrollee's profile which contains:
  -Enrollee's contact information
  - Enrollee's demographic information
  - Enrollee's Clinical Summary
  - Enrollee's Gaps in Care (individual enrollee)
  - Enrollee's Integrated Individual Care and Service Plan
  - Enrollee's Assessments responses*
  - Enrollee's Care Team: List of enrollee's ICT and contact information (e.g., specialists, caregivers) *, including names/relationship
- Detailed enrollee clinical profile: Detailed enrollee information (claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*
- High-risk indicator* (based on existing information, past utilization, and enrollee rank)
- Conditions and Medications reported through claims
- Enrollee reported conditions and medications* (including Over- The- Counter (OTC), herbals, and supplements)
- View, update and provide feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their enrollee panel*
- Secure messaging between provider and Case manager

*An enrollee can limit access to clinical data. All enrollees must sign a disclosure form and list specific providers and IDT enrollees who can access their clinical data.

For additional information regarding the Care Bridge, please access the Navigation Guide located on our website.

Enrollee Temporary Move Out-of-Service Area

The Centers of Medicare and Medicaid (CMS) defines a temporary move as an absence from the service area (where the enrollee is enrolled in the Premier Plan) of six (6) months or less.

Enrollees are covered while temporarily out of the service area for emergent, urgent, post-stabilization, and out-of-area dialysis services. If an enrollee permanently moves out of our service area or is absent for more than six (6) months, the enrollee will be disenrolled from the Premier Plan by MDHHS following confirmation of the permanent relocation.

Coverage of Renal Dialysis – Out of Area

We pay for renal dialysis services obtained by a Premier Plan enrollee from a contracted or non-contracted certified physician or health care professional while the enrollee is temporarily out of our service area (up to six (6) months). Prior authorization guidelines should be followed to establish this service for enrollees accordingly.

Preventive or Screening Services

Providers are responsible for providing appropriate preventive care to enrollees. These preventive services include, but are not limited to:

- Age-appropriate immunizations (flu), disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female enrollees may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral).
- Age and risk appropriate health screenings.

Mental Health (MH / Substance Abuse (SA

For information about provider responsibilities surrounding MH/SA services, please see Chapter 10 of this Manual.

Educating Enrollees on their own Health Care

Aetna Better Health Premier Plan does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of an enrollee and to advise them on:

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

No punitive actions will be taken against providers acting on behalf of members in appealing coverage or care decisions and is strictly prohibited by Aetna Better Health Premier Plan staff/agents.

Urgent Care Services

As the provider, you must serve the medical needs of Aetna enrollees; you are required to adhere to the all appointment availability standards. In some cases, it may be necessary for you to refer enrollees to an in-network urgent care center (after-hours in most cases). Please reference the "Find a Provider link" on the Aetna Better Health Premier Plan website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in our network. Our website can be accessed at: **AetnaBetterHealth.com/ Michigan**

Periodically, we review unusual urgent care and emergency room utilization to identify trends stemming from appointment unavailability. Trends will be shared and may result in increased provider monitoring of appointment availability.

Primary Care Providers (PCPs)

The primary role and responsibilities of a PCP includes, but is not be limited to:

- Providing primary and preventive care and acting as the enrollee's advocate
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services,
- Maintaining continuity of enrollee care
- Maintaining the enrollee's medical record

Primary Care Providers (PCPs) are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our enrollees. These services will include, at a minimum, the treatment of routine illnesses, flu/immunizations, health screening services, and maternity services, if applicable.

Primary Care Providers (PCPs) in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to enrollees assigned to them. Primary Care Providers (PCP) should attempt to coordinate quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring enrollees to providers or hospitals within our network, as appropriate, and if necessary, referring enrollees to out-of-network specialty providers;
- Referring enrollees to MH/SA providers for services that may be coordinated by prepaid inpatient health providers (PIHP)
- Coordinating with our Prior Authorization Department on required prior authorization procedures for enrollees;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned enrollees by other providers, specialty providers and/or hospitals; and
- Coordinating the medical care for the programs the enrollee is assigned to, including at a minimum:
    - Oversight of drug regimens to prevent negative interactive effects;
    - Follow-up for all emergency services;
    - Coordination of inpatient care;
    - Coordination of services provided on a referral basis, and
    - Assurance that care rendered by specialty providers is appropriate and consistent with each enrollee's health care needs.

After an enrollee has been discharged from an acute impatient setting to a home setting, the PCP must follow up with the enrollee. During the meeting, the PCP must make certain that all services for the enrollee have been ordered; address any new concerns and/or the enrollee needs, make appropriate referrals for specialty services, and resume any ongoing care for the enrollee.

Primary Care Providers (PCPs) are responsible for establishing and maintaining hospital admitting privileges sufficient to meet the needs of enrollees or entering into formal arrangements for management of inpatient hospital admissions of enrollees. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

Primary Care Providers (PCPs) may not close their panels immediately upon contracting with Aetna Better Health Premier Plan. Our Provider Experience Department reviews each PCP's panel to automatically stop assigning new enrollees to their practice once their patient capacity limit is reached. If the PCP site employs Certified Registered Nurse Practitioners/Physician Assistants, the Provider site will be permitted to add an additional agreed upon number of enrollees to the panel. Please contact our Provider Experience Department for additional information.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted medical community standards of care and practices. Specialists should only provide services to enrollees upon receipt of a written referral form from the enrollee's PCP or from another Aetna Better Health Premier Plan participating specialist. Specialists are required to coordinate with the PCP when enrollees need a referral to another specialist. All providers are responsible for verifying enrollee eligibility prior to providing services, including specialists.

When a specialist refers the enrollee to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the enrollee, other specialists or other providers.

Primary Care Providers (PCPs) should only refer enrollees to Aetna Better Health Premier Plan network specialists. If the enrollee requires specialized care from a provider outside of our network, a prior authorization is required.

Hospitals and nursing homes are prohibited from imposing a requirement for a three (3) day hospital stay prior to covering a nursing home stay. If you have question regarding this requirement, please contact the enrollee's Case manager.

It is important to remember that only covered services will be reimbursed by Aetna Better Health Premier Plan for approved facilities and/or contracted providers.

Please contact the Provider Experience Department for further clarification on how enrollees access these services at **1-855-676-5772**. For a list of current behavior health contracted providers, please search our web directory located on our website at **AetnaBetterHealth.com/Michigan**

Specialty Providers Acting as PCPs

In limited situations, an enrollee may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the enrollee has a complex, chronic health condition that requires a specialist's care over a prolonged time span and exceeds the capacity of the non-specialist PCP (i.e., enrollees with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis etc.)
- When an enrollee's health condition is life threatening or so degenerative and/or disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-enrollee relationship would leave the enrollee without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the enrollee vulnerable or at risk for not receiving proper care or services.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in the beginning of Chapter 3. This includes arraigning for coverage 24-hours-a-day, 7-days-a-week. Please contact our Provider Experience Department at **1-855-676-5772** to learn more about acting as a PCP.

Nursing Facility (Home Providers

Nursing facility or nursing homes provide services to enrollees that need consistent care, but do not require hospitalization or require daily care from a physician. Many nursing homes provide additional services, or other levels of care, to meet the special needs of enrollees. Nursing facility services should be coordinated with the Aetna Better Health Premier Plan Prior Authorization Department and or our Clinical Health Services team who will work with the enrollee and family on the most appropriate location for enrollee placement.

Home and Community Based Services (HCBS

Home and Community Based Services (HCBS) providers work closely with our Case Managers in assessing and supporting enrollee long term support service's needs. Case Managers complete face-to-face assessments with our enrollees, in their residence, to identify supports needed to remain independent as frequent as state requirements or as enrollee's, condition warrants. Based on the assessment, Case Managers will then identify the appropriate services required to meet the enrollee's functional needs; including determining which network provider may be available to provide services to the enrollee in a timely manner. Upon completion, our Case Managers then create authorizations for the selected provider and communicate these authorizations accordingly. Case Managers will also follow up with enrollees the day after services are to start, to confirm selected providers have started the services as authorized.

There may be times when a service interruption may occur, due to an unplanned hospital admission or short-term nursing home stay, for the enrollee. While services may have been authorized for caregivers and agencies, providers

should not bill 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: Enrollee is authorized to receive forty (40) hours Personal Assistant service, per week, over a five (5) day period. The enrollee is receiving eight (8) hours of care a day.

The enrollee is admitted into the hospital on January 1, 2010 and is discharged from the hospital on January 3, 2010. There should be no billable hours for January 2, 2010, as no services were provided on that date since the enrollee was hospitalized for a full twenty-four (24) hours.

Caregivers are not able, or allowed, to claim time with the enrollee in the example above, since no services could be performed on January 2, 2010. This is also true for any in-home service.

Personal Assistants and Community Agencies are responsible for following this process: Claims may not be submitted when the enrollee has been admitted to a hospital or nursing home for the full twenty-four (24) hours. The day of admission or discharge is allowed, but the days in between are not. Personal Assistants and Community Agencies submitting claims for the days in between will be required to pay back any monies paid by Aetna Better Health Premier Plan. Periodic audits are conducted to verify compliance.

For additional information about HCBS providers, please review our HCBS Quick Reference Guide located on our website, located at: **AetnaBetterhealth.com/Michigan**

Supportive Living Facilities

Supportive living facilities are obligated to collect room and board fees from enrollees (includes alternative residential settings). Room and board includes, however is not limited to:

- Debt service costs
- Maintenance costs
- Utilities costs
- Food costs (includes three meals a day or any other full nutritional regimen)
- Taxes
- Boarding costs (includes room, hotel and shelter-type of expenses) Federal

regulations prohibit Medicaid from paying room and board (R&B) costs. Please be aware

that:

- Payments issued are always the contracted amount minus the enrollee's room and board;
- The room and board agreement identifies the level of payment for the setting, placement date, and R&B amount the enrollee must pay; and
- The R&B agreement is initially completed by the Aetna Better Health Premier Plan Case Manager at the time of placement; and
- The R&B agreement form is completed at least once a year, or more often if there are changes in income; and
- The R&B amount may periodically change based on an enrollee's income.

Note: Home and Community Based Services (HCBS) providers may not submit claims when the enrollee is 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 in the days in between may be subject to a Corrective Action Plan (CAP) and payment recoupment.

Second Opinions

An enrollee may request a second opinion from a provider within the Aetna Better Health Premier Plan network. Providers should refer the enrollee to another network provider within an applicable specialty for the second opinion.

Provider Requested Enrollee Transfer

Participating providers may ask an enrollee to leave their practice, when persistent problems prevent an effective provider-patient relationship. Such requests cannot be based solely on the enrollee filing a grievance, an appeal, a

request for a Fair Hearing or any 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 to be terminated:

1. The provider must send a letter informing the enrollee of the termination and the reason(s) for the termination. The letter must be provided to the enrollee at least thirty (30) days prior to the removal. A copy of this letter must also be sent to:
   Aetna Better Health Premier Plan
   Provider Experience Manager 1333
   Gratiot Avenue
   Suite 400
   Detroit, MI 48207
2. The provider must support continuity of care for the enrollee by giving sufficient notice and opportunity to make other arrangements for care.
3. Upon request, the provider will provide resources or recommendations to the enrollee to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, Aetna Better Health Premier Plan will work with the enrollee to inform him/her on how to select another Primary Care Provider (PCP).

Medical Records Review

Our standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards to which our provider network must adhere. Consistent organization and documentation of medical records is required as a component of our Quality Management initiatives to maintain continuity and effective, quality patient care. Below is a summary list of our medical record review criteria/required components:

- Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health Premier Plan enrollees, immediately and completely available for review and copying by the MDHHS and/or federal officials at the provider's place of business, or forward copies of records to the MDHHS upon written request without charge.
- Medical records must reflect the different aspects of patient care, including inpatient and ancillary services. The enrollee's medical record must be legible, organized in a consistent manner, remain confidential and accessible only to duly authorized persons only.
- All medical records, where applicable and required by regulatory agencies, must be made available electronically.
- All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:
  - Enrollee identification information on each page of the medical record (i.e., name, Medicaid or the MDHHS Identification Number, or CMS MBIN Number).
  - Documentation of identifying demographics including the enrollee's name, address, telephone number, employer, Medicaid and or the MDHHS Identification Number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
  - Complying with all applicable laws and regulations pertaining to the confidentiality of enrollee medical records, including, but not limited to, obtaining any required written enrollee consents to disclose confidential medical records for complaint and appeal reviews.
  - Initial history for the enrollee that includes family medical history, social history, operations, illnesses,

accidents, and preventive laboratory screenings.

- Past medical history for all enrollees that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies, and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received.
- Immunization records (recommended for adult enrollees if available).
- Dental history if available, and current dental needs and/or services.
- Current problem list (The record should contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)
- Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum: oHistory and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints.
    - Plan of treatment
    - Diagnostic tests
    - Therapies and other prescribed regimens
    - Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
    - Referrals, recommendations for specialty, MH/SA, dental and vision care, and results thereof.
    - Other aspects of patient care, including ancillary services
- Fiscal records - Providers will retain fiscal records relating to services they have rendered to enrollees, regardless of whether the records have been produced manually or by computer.
- Current medications (Therapies, medications and other prescribed regimens - Drugs prescribed as part of the treatment, including quantities and dosages, should be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record should have a notation to the effect.)
- Documentation, initialed by the enrollee's PCP, to signify review of:
    - Diagnostic information including:
    - Laboratory tests and screenings;
    - Radiology reports;
    - Physical examination notes; and
    - Other pertinent data.
- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health Premier Plan and (2) prior admissions asnecessary.)
- Mental Health/Substance Abuse (MH/SA) health history and MH/SA health referrals and services provided, if applicable, including notification of MH/SA providers, if known, when an enrollee's health status changes or new medications are prescribed.
- Documentation as to whether an adult enrollee has completed advance directives and location of the document (advance directives include Living Will, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for release of information and subsequent releases.
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific enrollee was transmitted to the PCP and other providers, including MH/SA providers, as appropriate to promote continuity of care and quality management of the enrollee's health care.
- Entries - Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider should countersign care rendered by ancillary staff. Alterations of the record will be signed and dated.
- Provider identification - Entries are identified as to author.
- Legibility – The record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Record Audits

Aetna Better Health Premier Plan, CMS or MDHHS 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 an enrollee or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests promptly. Medical records must be made available to MDHHS and CMS for quality review upon request and free of charge.

Access to Facilities and Records

Medicare laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to an enrollee or their Provider Agreement with Aetna Better Health Premier Plan for inspection, evaluation, and audit for the longer of:

- A period of ten (10) years from the end of the Provider Agreement with Aetna Better Health Premier Plan;
- The date the MDHHS or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Documenting Enrollee Appointments

Providers must verify eligibility and document the enrollee's information in the enrollee's medical record when scheduling an appointment with an enrollee over the telephone or in person (i.e. when an enrollee appears at your office without an appointment). You may access our website to electronically verify enrollee eligibility or call our Member Services Department at 1-855-676-5772. Also, eligibility may be confirmed by accessing the State of Michigan CHAMPS website at **milogintp.michigan.gov/eai/tplogin/authenticate?URL=/.**

Missed or Cancelled Appointments

Providers must:

- Document in the enrollee's medical record, and follow-up on missed or canceled appointments.
- Conduct affirmative outreach to an enrollee who misses an appointment by performing the minimum reasonable efforts to contact the enrollee.
- Notify our Member Services Department when an enrollee continually misses appointments. Member Services can assist enrollees in rescheduling or coordinating transportation to eliminate any barriers to them accessing services.

Documenting Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and MH/SA providers within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant enrollees.

Confidentiality and Accuracy of Enrollee Records

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

Providers must further ensure enrollees are able to access all medical records maintained on them without barrier. Specifically, our network providers must:

- Maintain accurate medical records and other health information.
- Help make certain timely access by enrollees to their medical records and other health information. Abide by all state and federal laws and our contracts with CMS and MDHHS regarding confidentiality and disclosure of mental health records, medical records, other health information, and enrollee information.

Providers must follow both required and voluntary provision of medical records consistent with 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. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, Integrated Care Organizations (ICOs), 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 enrollees 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 enrollee 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 to capture only minimum necessary information;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred bins available
- Maintain HIPAA/confidentiality policies for the safeguard and handling of confidential information The

following enrollee 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 the individual.
  - 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 Premier Plan.
  - Release of data to third parties requires advance written approval from the MDHHS, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by enrollees or releases required by court order, subpoena, or law.

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

Breach of PHI[1]

If a provider and or his or her staff discovers a breach (i.e., an incident that involves the impermissible use or disclosure of PHI becomes first known), a notification will need to be sent to affected patients without unreasonable delay and in no case later than sixty (60) calendar days after the date of the breach (unless requested by law enforcement). The

sixty (60) daytime period should be seen as an outer limit. If the risk analysis and the necessary information to provide notification is completed earlier, waiting until the sixtieth day (60) for notification is seen as an unreasonable delay.
However, if during the sixty (60) day period a prompt risk analysis and investigation is conducted and concludes that no breach occurred, then no notification is necessary.

The breach notification should be sent to patients in written form by first-class mail at the last known address. If a patient agrees to receive a notification via e-mail and this agreement has not been rescinded, then the written notification can be sent electronically. In the case of minors or patients who lack legal capacity due to a mental or physical condition, the parent or personal representative should be notified. If the provider knows that a patient is deceased, the notification should be sent to the patient's next of kin or personal representative (i.e., a person who has the authority to act on behalf of the decedent or the decedent's estate), if the address is known. In urgent situations where there is a possibility for imminent misuse of the unsecured PHI, additional notice by telephone or other means may be made. However, direct written notice must still be provided.

Substitute notice must be provided if contact information is not available for some or all affected patients or if some notifications were sent are returned as undeliverable. The form of the substitute notice is based on the number of patients for whom contact information was unavailable or out-of-date. If the number of patients is fewer than ten (10), the provider should choose a form that can be reasonably calculated to reach the individual who should be notified. Possible forms may be an e-mail message, a phone call (keeping in mind that sensitive information should not be left on voicemail or in messages to other household members), or possibly a web posting if no other contact information is available and this is reasonably calculated to reach the patient. If the number of patient is ten (10) or more, the provider should place a conspicuous notice that includes a toll-free number: (1) on its homepage or a hyperlink that conveys the nature and important of the information to the actual notice, or (2) in major print or broadcast media in geographic areas where the affected individuals of the breach likely live. If the provider can update the contact information and provide written notice to one or more patients to bring the total number of patients for whom contact information is unavailable or out-of-date to less than ten, then the conspicuous notice requirement can be avoided.

For additional details surrounding media coverage and notification to the Secretary of the Department of Health and Human Services, please visit the following site at: **www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/PrivacyandSecurity/coveredentities.html**

For additional training or Q&A, please visit the following site at **aspe.hhs.gov/admnsimp/final/pvcguide1.htm**

Providers must notify Aetna Better Health Premier Plan if a breach occurs regardless of the number of patients impacted immediately. Notification will be provided via formal written communication, email, or telephonic contact to their assigned Provider Experience representative to immediately apprise of the occurrence and risk to enrollees.

Enrollee Privacy Rights

Aetna Better Health Premier Plan enrollees are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements as codified in our compliance policies. Our privacy policy conforms with 45 C.F.R. relevant sections of the HIPAA that provide enrollee privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528) and with other applicable federal and state privacy laws.

Our policy also assists our staff and providers in meeting the privacy requirements of HIPAA when enrollees or authorized representatives exercise privacy rights through privacy request, including:

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

Enrollee Privacy Requests

Enrollees 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 enrollees' or their authorized representative. An enrollee's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the enrollee or the deceased enrollee's estate. Except for requests for a health plan Notice of Privacy Practices, requests from enrollees or their authorized representative must be submitted to Aetna Better Health Premier Plan in writing.

Advance Directives

Providers are required to comply with state and federal law regarding advance directives for adult enrollees. The advance directive must be prominently displayed in the adult enrollee's medical record. Advance Directives maintenance requirements include:

- Providing written information to adult enrollees regarding their rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the enrollee's medical record whether the adult enrollee has been provided the information and if an advance directive has been executed.
- Not discriminating against an enrollee because of his or her decision to execute or not an advance directive and not making it a condition for the provision of care.

For additional information about Advance Directives, please see Chapter 13 in this Manual.

Provider Marketing

Providers must adhere to all applicable Medicare and Medicaid laws, rules, and regulations relating to marketing guidelines. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting the MI Health Link Program, informing enrollees that they may enroll in the MI Health Link Program, explaining enrollment benefits and applicable program rules, or explaining how services are covered under the MI Health Link Program. Regulations prohibit Aetna Better Health Premier Plan from conducting sales activities in healthcare settings.

Providers may discuss, in response to an individual patient's inquiry, the various benefits of the MI Health Link Program. Providers are encouraged to display approved plan enrollee materials for all health plans with whom they participate. Providers can also refer their patients to **1-800-MEDICARE**, Enrollment Broker, or CMS's website at **www.medicare.gov** for additional information.

Providers cannot accept MI Health Link Program enrollment forms. Aetna Better Health Premier Plan complies with the Federal Anti-Kickback Statute and CMS marketing requirements, governing MI Health Link Program marketing activities conducted by providers and related to program. Payments made to providers for covered items and/or services will be fair market value, consistent with an arm's length transaction, for bona fide and necessary services, in compliance with relevant laws and requirements, including the Federal Anti-Kickback Statue.

For a description of laws, rules, regulations, guidelines and other requirements applicable to the MI Health Link Program marketing activities conducted by providers, please refer to Chapter 3 of the Medicare Managed Care Manual, which can be found on CMS's website at **http://www.cms.hhs.gov/manuals/downloads/mc86c03.pdf**.

Providers may engage in discussions with a prospective enrollee when they seek advice. However, providers must remain neutral when assisting with enrollment decisions:

- Providers May NOT:
  - Offer scope of appointment forms.
  - Accept MI Health Link Program enrollment applications.
  - Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in a specific plan based on financial or any other interests of the provider.
  - Mail marketing materials on behalf of Aetna better Health Premier Plan.
  - Offer anything of value to induce plan enrollees to select them as their provider.
  - Offer inducements to persuade potential enrollees to enroll in a specific plan or organization.
  - Conduct health screening as a marketing activity.
  - Accept compensation directly or indirectly from the plan for potential enrollee enrollment activities; and
  - Distribute materials/applications within an exam room setting. (Following Section 1140 of the Social Security Act Under Section 1140 of the Social Security Act, 42 U.S.C. § 1320b–10, it is forbidden for any person to use words or symbols, including "Medicare," "Centers for Medicare & Medicaid Services," "Department of Health and Human Services," or "Health & Human Services" in a manner that would convey the false impression that the business or product mentioned is approved, endorsed, or authorized by Medicare or any other government agency, including indicating that it's approved by MDHHS).
- Providers MAY:
  - Advise potential enrollees their participation status with Aetna Better Health Premier Plan.
  - Make available and/or distribute Aetna Better health Premier Plan marketing materials (provider must include other Managed Care Organizations material when distributing Aetna better Health Premier Plan materials).
  - Refer their patients to other sources of information, such as Aetna better Health of Michigan's Member Services Department, Enrollment Broker, CMS's website, or to **1-800-MEDICARE.**
  - Share information with potential enrollees from CMS's website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from **http://www.medicare.gov**), or other documents that were written by or previously approved by CMS.
  - Providers may announce their affiliation with Aetna Better Health Premier Plan through general advertising, (e.g., radio, television, and websites). Providers may make the affiliation announcements within the first thirty (30) days of the new Provider Agreement. Provider may announce to patients once, through direct mail, e-mail, or phone, a new affiliation, which names only one Managed Care Organization. The provider and or PCP must contact Aetna's Provider Experience Department to review the guidelines surrounding this process. Requirements are outlined in Chapter 3, Section 70.12.1 of the Medicare Managed Care Manual.
  - Providers may distribute printed information provided by Aetna better Health Premier Plan to potential enrollees comparing the benefits of all plans with which they contract as long as it is completed by a third party. Materials may not "rank order" or highlight specific plans and should include only objective information. The provider and or the PCP must contact our Provider Experience Department to review the guidelines surrounding the process.

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Enrollees 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. Aetna expects our providers to treat all enrollees with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

We have 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 enrollees' diverse backgrounds, including the various cultural, racial, and linguistic barriers that enrollees encounter. Aetna has developed and implemented methods for eliminating these barriers to ensure access to care with consideration of the most culturally appropriate delivery method.

Upon orientation and routinely thereafter, participating providers are educated about such important topics as:

- Addressing enrollee reluctance to discuss physical and mental health issues and seek treatment based on cultural norms.
- Impact of enrollee's religious and/or cultural beliefs on health outcomes (e.g., belief in non- traditional healing practices).
- Addressing health illiteracy gaps and how 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.

Your assigned Provider Experience Representatives will conduct initial cultural competency training during provider orientation meetings. Our *Quality Interactions*® course series is available to physicians who wish to learn more about cultural competency. This course 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 contact your Provider Experience Representative.

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. We support the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between enrollees and providers.

For an Ask Me 3 poster to be displayed in your office, visit the following website:
http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Interpretation and Translation Requirements

Providers participating in Aetna better Health of Michigan's network are required to identify the language needs of enrollees and facilitate the provision of oral translation, oral interpretation, and sign language services to enrollees. To assist providers with this, Aetna better Health Premier Plan makes telephone language interpretation services and sign language interpretation services available to providers to facilitate enrollee interaction. These services are free to the enrollee and provider offices. Use of Aetna interpretation resource use is not compulsory and providers may choose to use other interpretation services resources at their expense.

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 Premier Plan is required to make certain that Limited English Proficient (LEP) enrollees 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.

Enrollees 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 enrollees with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all enrollees, including:

- Individuals with LEP or reading skills
- Individuals requiring culturally-linguistically, or disability competent care
- Individuals with diverse cultural and ethnic backgrounds
- Individuals who are homeless
- Individuals with physical and mental disabilities
- Individuals with hearing impairments
- Individuals who have cognitive limitations

Providers are required to identify the language needs of enrollees and arrange oral translation, interpretation, and sign language services to enrollees. To assist providers with this, Aetna provides telephonic language interpretation service available to providers to facilitate enrollee interactions. These services are free to enrollees and providers. Use of Aetna resources is not compulsory; however, providers are financially responsible when utilizing resources for interpretation services not provided by Aetna. Providers are encouraged to utilize standard services such as The Michigan Relay for communicating with hearing impaired members. The Michigan Relay number is available for enrollees by calling 7-1-1. Our Member Services staff is trained and available to take TTY phone calls from enrollees.

Our language interpreter vendor provides interpreter services at no cost to providers and enrollees. Translation services via Aetna's vendor can be accessed by calling Member Services at **1-855-676-5772**.

Language interpretation services are available to medical, MH/SA, community-based and facility-based LTSS, and pharmacy providers for use in the following scenarios:

- If an enrollee requests interpretation services, Aetna Member Services Representatives will assist the enrollee via a three-way call to communicate in the enrollee's native language.
- For outgoing calls, Aetna Member Services Staff dials the language interpretation service and uses an interactive voice response system to conference with the enrollee and the interpreter.
- For face-to-face meetings, Aetna staff (e.g., Case Managers) can conference in an interpreter to communicate with an enrollee 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 Premier Plan Member Services to link with an interpreter.

Alternative Formats

Aetna Better Health Premier Plan provides alternative methods of communication for enrollees who are visually impaired, including large print, Braille and/or other formats. If an enrollee has a question about alternative formats, please contact Aetna Member Services Department at **1-855-676- 5772**.

We strongly recommend the use of professional interpreters, rather than family or friends. Providers must also deliver information in a manner that is understood by the enrollee.

The following vendors are used when offering LEP services to our enrollees:

- Voiance: Telephonic interpretation services
- Akorbi: In person sign language interpretation services

Please call our Provider Experience Staff at **1-855-676-5772** for further assistance/questions surrounding these vendors.

Americans with Disabilities Act (ADA)

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.

Providers must provide physical accessibilities for their offices in accordance with the requirements defined in accordance with the U.S. Department of Justice ADA guidance and Civil Rights Act, which include but are not limited to:

- The providers obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities (e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, large doorways, and diagnostic equipment must be accessible).
- Utilizing waiting room and exam room furniture that meets needs of all enrollees, including those with physical and non-physical disabilities.
- Accessibility along public transportation routes and/or provides enough parking.
- Utilize clear signage and way finding (e.g., color and symbol signage) throughout facilities.
- Provide appropriate accommodations such as large print materials etc.

Providers must comply with requirements to accommodate access to care to enrollees with special needs, which includes but is not limited to offering extended office hours to include night and weekend appointments, offering extended hours and adopting a flexible appointment scheduling system. Regular provider office/site visits will be conducted by our Provider Relations staff to confirm network provider compliance with ADA requirements. Providers who fail office/site visit assessments may receive a CAP (Corrective Action Plan) until the issue discovered is resolved. Failure to resolve may warrant termination from the Program.

Additional Resources:

- **http://www.ada.gov/civilrights.htm**
- **http://www.ada.gov/**
- **http://www.ada.gov/adastd94.pdf**

Olmstead Decision and Impact on ADA Compliance

The Olmstead decision also provides significant insight into the requirements to which providers and organizations must adhere to ensure accommodations are in place to support health care delivery to individuals with disabilities is not impeded. Below is a summary of the Olmstead Decision:

In Olmstead v. L.C., 527 U.S. 581, 119 S.Ct. 2176 (1999) ("the Olmstead decision"), the Supreme Court construed Title II of the ADA to require states to place qualified individuals with mental disabilities in community settings, rather than in institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities. The Department of Justice regulations implementing Title II of the ADA require public entities to administer their services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. In Olmstead, the Supreme Court stated that institutional placements of people with disabilities who can live in, and benefit from, community settings perpetuates the unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. The Supreme Court stated that "recognition and unjustified institutional isolation of persons with disabilities is a form of discrimination reflect[ed] two evident judgments": 1) "Institutional placements of people with disabilities who can live in, and benefit from, community settings perpetuates the unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and 2) "confinement in an institution severely diminishes everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Olmstead, 119 S.Ct. 2176, 2179, 2187 [emphasis added]. This decision effects not only all persons in institutions and segregated settings, but also people with disabilities who are at risk of institutionalization, including people with disabilities on waiting lists to receive community-based services and supports.

The Court indicated that one-way states can show they are meeting their obligations under the ADA and the Olmstead decisions is to develop a "comprehensive, effective working plan for placing qualified people with mental disabilities in less restrictive settings". Based on this, almost all states are in the process of developing, or have already developed such plans.

Aetna Better Health Premier Plan complies with the Olmstead decision, and require our providers to deliver care/services in accordance with the specified decision for all enrollees under the MI Health Link Program. Additional resources:

- **http://www.worksupport.com/resources/printView.cfm/376**
- MI Olmstead Information: **http://www.dnmichigan.org/comm-based-living.aspx**
- **http://www.ada.gov/olmstead/**

Filing an Olmstead Complaint

You can file an ADA complaint, including any complaint alleging Olmstead violations, alleging disability discrimination against a state or local government or a public accommodation by mail or email. To learn more about filing an ADA complaint, visit www.ada.gov/fact_on_complaint.htm To file an ADA complaint you may fill out this form and mail or fax the form to:

US Department of Justice 950
Pennsylvania Avenue,

NW Civil Rights Division
Disability Rights Section – 1425 NYAV Washington,
D.C. 20530
Fax: (202) 307-1197

You may also file a complaint by E-mail at **ADA.complaint@usdoj.gov.**

If you have questions about filing an ADA complaint, please call: ADA Information Line: **1-800-514-0301 (voice)** or **1-800-514-0383 (TTY)**.

Clinical Guidelines

Aetna Better Health Premier Plan utilizes Clinical Guidelines and treatment protocols available to providers to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to enrollees and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the enrollee;
- Constitute procedures for, or the practice of, medicine by the party distributing the guidelines; or,
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Guidelines are available on our website at
AetnaBetterHealth.com/Michigan/providers/practice-guidelines

Office Administration Changes and Training

Providers are responsible to notify our Provider Experience Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience Department to schedule staff training.

Providers are also responsible for notifying Aetna Better Health Premier Plan of address, phone number, acceptance of new patients and office hour changes. Please notify Aetna Better Health's Provider Experience Department within 2 weeks of these changes.

Additions or Provider Terminations

In order to meet contractual obligations and state and federal regulations, providers are required to report any affiliate practitioner terminations or additions to their agreement at least sixty (60) days prior to the change in order for Aetna Better Health Premier Plan to comply with regulatory and accreditation requirements. Practitioners being added to network provider rosters must complete credentialing activities prior to being recognized as able to service enrollees. Participating providers are required to submit monthly rosters demonstrating any changes or updates to their practice.

Should providers decide to terminate their contract with Aetna Better Health Premier Plan, they are required to give at least ninety (90) days prior written notification. Providers are required to continue providing services to enrollees throughout the termination period and support coordination of care activities on a case by case basis post termination.

The Centers of Medicare and Medicaid (CMS) require that Aetna Better Health Premier Plan make a good faith effort to provide written notice of termination of a network provider at least sixty (60) days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose Provider Agreement is terminating. However, please note that all enrollees who are patients of that PCP must be notified when a provider termination occurs.

Continuity of Care

Provider who leave the Aetna Better Health Premier Plan network must continue to treat our enrollees until the treatment course is completed or care is transitioned. An authorization may be necessary for these services. Enrollees 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. We are not responsible for payment of services rendered to ineligible enrollees. Our Integrated Care Team (ICT) is also available for assistance if you have further questions surrounding continuity of care planning on specific cases.

Credentialing/Re-Credentialing

Aetna uses current National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and re-credentialing of participating providers. We also utilize the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source for all provider types.

The Universal Credentialing Data Source program allows practitioners 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 multiple health plans and hospitals requirements participating in the CAQH effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need for multiple organizations contacting the practitioner for the same standard information. Practitioners update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. The Council for Affordable Quality Healthcare (CAQH) gathers and stores detailed data from more than 600,000 practitioners nationwide. Practitioners may not treat enrollees until they become credentialed.

Initial Credentialing Individual Practitioners

Initial Credentialing is the entry point for practitioners to begin the contract process with Aetna. New practitioners, (with the exception of hospital-based providers) including those joining an existing participating practice with Aetna Better Health Premier Plan, must complete the credentialing process, including receiving Credentialing Committee approval for participation.

Recredentialing Individual Practitioners

Aetna re-credentials practitioners on a regular basis (every thirty-six (36) months based on state regulations) to ensure their continued ability to meet health plan standards of care along with meeting regulatory and accrediting bodies (NCQA & URAC) requirements (as applicable to the health plan). Providers failing to meet the thirty-six (36) month timeframe for recredentialing can result in termination from the Aetna network

During the recredentialing process, performance indicators obtained through the quality improvement plan, UM program, grievance and appeals system, member satisfaction surveys and medical record review outcomes are reviewed to assess in conjunction with standard re-cred elements for network participation continuance. An index of provider complaints is maintained via a log and reviewed against standards for identification of any performance issues preventing providers from proceeding with re-credentialing whereby they have failed to meet the established performance benchmark standards.

Facilities (Re)Credentialing

As a pre-requisite for participation or continued participation in our network, applicants must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation and every three years thereafter, Aetna Better Health Premier Plan Credentialing (or entity to which Aetna Better Health Premier Plan has formally delegated credentialing to) will confirm that each Organizational Provider meets assessment requirements.

Ongoing monitoring

Ongoing Monitoring consists of reviews of practitioner and or provider sanctions, or loss of license to help manage potential risk of sub-standard care to our enrollees.

Licensure and Accreditation

Health delivery organizations such as hospitals, nursing homes, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.
Practitioners are held to licensure standards in accordance with state and federal requirements.

Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination

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 C.F.R. part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. part 91;

- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act (including Olmstead Decision);
- 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); and
- HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162, and 164.

Additionally, Aetna network providers must comply with all applicable state and federal Medicare laws, rules and regulations for the MI Health Link Program. As provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any enrollee on the basis of health status.

Financial Liability for Payment for Services

Balance billing enrollees is prohibited under the MI Health Link Program. In no event should a provider bill an enrollee (or a person acting on behalf of an enrollee) for payment of fees that are the legal obligation of Aetna Better Health Premier Plan. This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Providers must ensure:

- They do not hold enrollees liable for payment of any fees that are the legal obligation of Aetna Better Health Premier Plan, and must indemnify the enrollee for payment of any fees that are the legal obligation of Aetna for services furnished that were duly authorized by Aetna to service such enrollees, in accordance with the enrollee Summary of Benefits and or Member Handbook.
- Do not bill an enrollee for medically necessary services covered under the plan and notify enrollees prior to rendering services.
- Clearly advise an enrollee, prior to furnishing a non-covered service, of the enrollee's responsibility to pay the full cost of the services when not authorized or out of scope of their benefit plan.
- When referring an enrollee to another provider for a non-covered services, that the enrollee is made aware of his or her obligation to pay in full for such non-covered services in advance.

Out of Network Providers – Transition of Care

Aetna authorizes service through an Out-of-Network Provider Agreement when an enrollee with a particular need is unable to be served through a contracted provider. Our Medical Management team will arrange care by authorizing services to an out-of-network provider, after attempting to coordinate care with an in-network provider. Additionally, Access2Care will assist with transportation coordination when there are no providers that can meet the enrollee's special need available in a nearby location. If needed, our Provider Experience Department will negotiate a Single Case Agreement (SCA) for services to be rendered out of network and attempt to recruit the provider for full network participation. Enrollees receiving services from out of network providers may be transitioned to an in-network provider at treatment or service completion or when the enrollee's condition is stable enough to allow a transfer of care.

Risk Arrangements

Some providers have special arrangements that provide incentives tied to improved quality outcomes. Providers are not incentive to deny care or reduced services. The results of our risk arrangements are made available, upon request, to specified groups and to interested stakeholders.

CHAPTER 5: COVERED SERVICES

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Aetna Better Health Premier Plan is responsible for administering medically necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) and 1915(c) waiver items and services to covered enrollees under the MI Health Link program. The following services are offered under the Premier Plan:

INPATIENT HOSPITAL-ACUTE
• Inpatient Hospital-Acute Services is offered as a supplemental benefit under Part C • No service-specific Maximum Enrollee Out-of-Pocket Cost • No enrollee Coinsurance • No enrollee Deductible • No Copayment
INPATIENT HOSPITAL PSYCHIATRIC
• Plan provides Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C • No service-specific Maximum Enrollee Out-of-Pocket Cost • No enrollee Coinsurance • No enrollee Deductible • No enrollee Copayment • No referral required for Inpatient Psychiatric Hospital Services • Approve needed for admission (stay) to a psychiatric inpatient hospital
SNF
• 3-day inpatient hospital stay prior to SNF admission • No enrollee Coinsurance • No enrollee Deductible • No enrollee Copayment • No referral required for SNF services
CARDIAC AND PULMONARY REHABILITATION SERVICES
• No enrollee Out-of-Pocket Maximum • No enrollee coinsurance • No enrollee Deductible • No enrollee Copayment
CARDIAC AND PULMONARY REHABILITATION SERVICES
• No enrollee Out-of-Pocket Maximum • No enrollee coinsurance
EMERGENCY CARE
• No enrollee Copayment
URGENTLY NEEDED CARE
• No enrollee Out-of-Pocket Maximum • No enrollee coinsurance • No enrollee Copayment
PARTIAL HOSPITALIZATION
• No enrollee Out-of-Pocket Maximum • No enrollee coinsurance • No enrollee Deductible • No enrollee Copayment

HOME HEALTH SERVICES

- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment
- Plan provides Non-Medicare Home Health Services
- Medicaid home health services must be ordered, in writing, by the enrollee's attending physician (MD, DO) as part of a written plan of care (POC) and reviewed by this physician every 60 days. The physician's order and POC must be only for functions that are within the scope of his current medical practice and Medicaid guidelines.
  Home health services are intended for enrollees who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that enrollees be totally restricted to their home. A clinical determination and supporting documentation is required that the home is the most appropriate setting in which to provide the service(s). Home health services are not provided
  solely based on convenience.

PRIMARY CARE PHYSICIAN SERVICES

- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OCCUPATIONAL THERAPY SERVICES

- Prior authorization required

PHYSICIAN SPECIALIST SERVICES

- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

PHYSICIAN SPECIALIST SERVICES

- Prior authorization required

PHYSICIAN SPECIALIST SERVICES

- No enrollee Out-of-Pocket Maximum

MENTAL HEALTH SPECIALTY SERVICES

- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

MENTAL HEALTH SPECIALTY SERVICES

- Prior authorization required

PODIATRY SERVICES

- Prior authorization required
- Podiatry Services are a supplemental benefit under Part C.
- Enhanced benefit:
  - Routine Foot care
  - 3 visits yearly
  - No enrollee maximum coverage amount
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OTHER HEALTH CARE PROFESSIONAL

- Prior authorization required No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

PSYCHIATRIC SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

PT AND SP SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OUTPATIENT HOSPITAL SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

ASC SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OUTPATIENT SUBSTANCE ABUSE

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment

OUTPATIENT BLOOD SERVICES

- Prior authorization required
- Outpatient Blood Services are a supplemental benefit under Part C
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee copayment
- No enrollee Deductible
- Enhanced benefit:
  - Three (3) pint deductible waived

AMBULANCE SERVICES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee copayment
- No enrollee Deductible

TRANSPORTATION SERVICES

- Prior authorization required by Aetna non-emergent medical transportation (NEMT) vendor. Includes non-emergency medical transportation and gas reimbursement to Health Plan approved services (ie. Physician appointments).
- Prior authorization required by Aetna for Non-Medical transportation to events such as Adult Day Care (requires authorization for such services by care management prior to non- medical transportation vendor arrangement)
- Companion-escorted transportation
- Transportation Services as a supplemental benefit under Part C
- Unlimited for number of trips for Plan-approved Location
- Type of transportation:
  - One-way
- Mode of transportation:
  - Taxi
  - Bus/Subway
  - Van
  - Medical Transport
- No maximum plan benefit coverage amount
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee copayment

DME

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee copayment

DME - MMP

- Prior authorization required
- Non-Medicare Durable Medical Equipment offered
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee copayment
- Additional Durable Medical Equipment is provided in accordance with published Michigan Medicaid policy. Requirements for referral, physician order, and assessment apply along with limitations on replacement and repair.

PROSTHETICS/MEDICAL SUPPLIES

- Prior authorization required
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee copayment

PROSTHETICS/MEDICAL SUPPLIES - MMP

- Prior authorization required
- Non-Medicare Prosthetics/Medical Supplies covered
- Non-Medicare Service: Incontinence Products
- No maximum plan benefits
- No enrollee coinsurance
- No enrollee copayment
- This service includes rubber or vinyl gloves, incontinence wipes, reusable or disposable incontinence pads, and incontinence briefs in accordance with published Michigan Medicaid policy. Diapers and Pull-on Briefs - For an enrollee using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed 300 per month. The maximum amount of pull- on briefs is 150 per month even if the enrollee is not using diapers. Diapers of Different
  Sizes - For an enrollee using a combination of different sized diapers, the total quantity must not exceed 300 per month.

DIABETIC SUPPLIES AND SERVICES

- Prior authorization required
- No enrollee out-of-pocket cost
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment
- Diabetic supplies and services from specified manufacturers are limited

END-STAGE RENAL DISEASE

- No enrollee out-of-pocket cost
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment

OTC ITEMS

- Over-The-Counter (OTC) Items are a supplemental benefit under Part C
- OTC Items: Mandatory
- Health Plan will provide $90 per quarter to cover specific retail and mail-order health-related products approved on the OTC provider and product list

ADDITIONAL SERVICES

- Additional services covered:
- Nursing Home Services
- Personal Care Services
- Private Duty Nursing Services
- Adaptive Medical Equipment and Supplies
- Adult Day Program
- Assistive Technology Devices
- Assistive Technology Van Lifts and Tie Downs
- Chore Services
- Community Transition Services
- Environmental Modifications
- Expanded Community Living Supports
- Fiscal intermediary Services
- Home Delivered Meals
  - 2 meals everyday
- Non-medical transportation
- Personal Emergency Reponses System

- Preventive Nursing Services
- Private Duty Nursing Services
  - 16 hours, everyday
- Respite - Waiver Service
- Respite - General Services
- Nursing home services - Intended to be long term custodial care and do not overlap with the skilled nursing care benefit.
- Personal Care Services - Provide hands-on assistance to enrollees with functional limitations to remain in their independent settings for as long as possible and cover activities of daily living (ADLs) and can include instrumental activities of daily living (IADLs) but only when there is also a need for an ADL.
- Scope and duration of services will be determined following MDHHS protocols.
- Private Duty Nursing (PDN) - Services are skilled nursing interventions provided to an enrollee on an individual episode and continuous basis to meet health needs directly related to the enrollee's physical disorder. PDN includes the provision of nursing assessment, treatment, and observation provided by licensed nurses within the scope of the States Nurse Practice Act, consistent with physician's orders and in accordance with the enrollee's plan of care and criteria outlined in the MI Health Link Waiver.
- Other 1 Adaptive Medical Equipment and Supplies - Devices, controls, or appliances that enable enrollees to increase their ability to perform ADLs or to perceive, control, or communicate with the environment in which they live. Equipment can include shower chairs, lift chairs, raised toilet seats, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated/telephone or watches that assist with medication reminders, button hooks or zipper pulls, modified eating utensils, modified oral hygiene to perceive, control, or communicate with the environment in which they live.
- Other 2 Adult Day Program - Services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the plan of care, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the enrollee.
- Other 3 Assistive Technology limits - Hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener, specialized alarm, or intercom.
- Other 4 Assistive Technology Van Lifts and Tie Downs - $15,000 maximum for the duration of the Demonstration.
- Other 8 Expanded Community Living Supports - Provides prompting, cueing, observing, guiding, teaching, and/or reminding to help enrollees complete ADLs like eating, bathing, dressing, toileting, other personal hygiene, etc. If an enrollee qualifies for ADL support, assistance with instrumental IADLs like laundry, meal preparation, transportation, help with finances, medication assistance, shopping, enrollee escort to medical appointments and other household tasks may also be provided. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support for the enrollee to complete IADLs.
- Other 9 Fiscal Intermediary services - Available only to enrollees participating in arrangements supporting self- determination. Providers of other services to the enrollee, his or her family or guardians may not provide Fiscal Intermediary services to the enrollee.
- Other 13 Preventive Nursing Services - Limited to no more than two hours per visit. Enrollees receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services. All providers must be licensed in the State of Michigan as a Registered Nurse or Licensed Practical nurse. This service must not duplicate Home Health Services.
- Other 14 Waiver Respite services – Unlimited
- Other 15 General Respite services - Limited to 14 overnight stays in a 365-day period

ELIGIBLE SUPPLEMENTAL BENEFITS AS DEFINED IN CHAPTER 4

- Eligible Supplemental Benefits are available as defined in Chapter 4 as a benefit under Part C
- Enhanced benefit:
  - Health Education
  - Nutritional Benefit
  - Additional Smoking and Tobacco Use Cessation: Smoking cessation patches/gum and toll-free quit line
  - Web/Phone-Based Technology
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment
- Additional Health Added Value Benefit: Preventative and chronic care educational mailings targeting such conditions as:
  - Obesity: Adult weight management with health coaching to aid in success. Prior authorization required. Please contact Member Services at **1-855-676-5772** for more details.
  - Diabetes
  - High blood pressure

KIDNEY DISEASE EDUCATION SERVICES

- No authorization required
- No enrollee out-of-pocket cost
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment

DIABETES SELF-MANAGEMENT TRAINING

- Prior authorization required No enrollee out-of-pocket cost
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment

MEDICARE PART B RX DRUGS

- Prior authorization required
- No enrollee out-of-pocket cost
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment

PREVENTIVE DENTAL

- Preventive Dental Items are a supplemental benefit under Part C
- Enhanced benefits:
  - Oral Exams, 1 every 6 months
  - Prophylaxis (Cleaning), 1 every 6 months
  - Dental X-Rays, 1, please contact health plan for periodicity
  - No enrollee out-of-pocket cost
  - No enrollee coinsurance
  - No enrollee deductible
  - No enrollee copayment
  - Bitewing radiographs are a covered benefit only once in a 12-month period.
  - A panoramic radiograph is a covered benefit once every five years.
  - A full mouth or complete series is a covered benefit once every five years.

COMPREHENSIVE DENTAL

- Comprehensive Dental Items are a supplemental benefit under Part C
- Select enhanced benefits:
  - Diagnostic Services
  - Endodontics/Periodontics/Extractions
  - Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
- Benefit unlimited for Diagnostic Services
- Endodontics/Periodontics/Extractions

- Visits, 1 every year
- Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
  - Visits, 1, please call health plan for additional information
- $800 plan benefit coverage amount, per year
- No enrollee out-of-pocket max
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment
- Covered periodontics services include full mouth debridement when performed as a therapeutic, not preventive, treatment for enrollees to aid in the condition. It is the removal of subgingival and/or supragingival plaque and calculus. Full mouth debridement is a benefit over once every 365 days. It is not covered when a prophylaxis is completed on the same day. Evaluation and diagnosis of their oral.
- Covered services include surgical extraction only when the removal of bone and the elevation of mucoperiosteal flap and/or sectioning of a tooth is required to multiple extractions in the same quadrant for preparation of complete dentures. The extraction of an impacted tooth is a benefit only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth exhibiting no overt pathology and symptoms is not covered. Facilitate the extraction. Surgical extractions are not a covered benefit in cases of an extraction is not a covered benefit if exfoliation is imminent. No other periodontal procedures are considered to be covered benefits.
- Covered prosthodontic services include complete and partial dentures. Providers must assess the enrollee's general oral health and provide a five-year requested. An upper partial denture assessment must also include the prognosis of six sound teeth. Complete or partial dentures are covered when there are one or more anterior teeth missing, there are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth) or an existing complete or partial denture cannot be made requested. An upper partial denture assessment must also include the prognosis of six sound teeth. Complete or partial dentures are covered when there is one or more anterior teeth missing, there are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth) or an existing complete or partial denture cannot be made serviceable through repair, relining, adjustment, or duplicating (rebasing)procedures. If a partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing partial, extract teeth, add teeth to an existing partial, and remove hyperplastic tissue. Prosthodontics are
  a covered benefit once every 5 years per published Medicaid policy.

EYE EXAMS

- Eye Exams are a supplemental benefit under Part C
- Enhanced benefit:
  - Routine Eye Exams
  - 1 eye exam every year
- No enrollee maximum plan benefit coverage amount
- No enrollee out-of-pocket costs
- No enrollee coinsurance
- No enrollee deductible
- No enrollee copayment

EYEWEAR

HEARING EXAMS

- Hearing Exams are a supplemental benefit under Part C.
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment
- Prior authorization required
- Enhanced benefits:
  - Routine Hearing Exams
  - Fitting/Evaluation for Hearing Aid, unlimited
  - Routine hearing exam – 1, every 2 years

HEARING AIDS

- Hearing Aids are a supplemental benefit under Part C
- No enrollee Out-of-Pocket Maximum
- No enrollee coinsurance
- No enrollee Deductible
- No enrollee Copayment
- Enhanced benefits:
  - Hearing Aids (all types), unlimited
  - Maximum benefit coverage, $800
  - Coverage periodicity, every 3 years

PLAN DEDUCTIBLE (IN-NETWORK)

- No enrollee Deductible

MAX ENROLLEE COST LIMIT (IN-NETWORK)

- No enrollee Out-of-Pocket Maximum

MAX PLAN BENEFIT COVERAGE

- No enrollee maximum plan benefit coverage amount

MMP - MEDICAID/PLAN COVERED COST SHARING

Services covered under Medicaid (Optional):

- Inpatient Hospital Acute
- Inpatient Hospital Psychiatric
- Skilled Nursing Facility (SNF)
- Home Health Services
- Outpatient Blood Services
- Transportation Services
- Durable Medical Equipment (DME)
- Prosthetics/Medical Supplies
- Preventive Dental
- Comprehensive Dental
- Eye Exams
- Eyewear

Services not covered by Medicare or Medicaid (Optional):

- Podiatry Services
- Over-the-Counter (OTC) Items and Services (Select OTC drugs and items are covered with the ADD drugs)
- Comprehensive Dental
- Hearing Exams
- Hearing Aids

MEDICARE RX

- Medicare Prescription drug (Part D) benefits are available
- Enhanced Alternative:
  - Standard Retail
  - Out-of-Network Pharmacy (limited day supply)
  - Standard Mail Order
  - Long Term Care Pharmacy
- Certain drugs have quantity limits
- Prior authorization required for certain drugs
- Some drugs require a step therapy plan
- Part D is a 3-tier formulary

MEDICARE RX - MEDICARE-MEDICAID

- Generic Drugs, Brand Drugs, on-Medicare Rx/OTC Drugs

TIER #1 - MEDICARE-MEDICAID TIER TYPE

- Generic Drugs
- Enhanced Alternative
- Part D Drugs Only

TIER #1 - MEDICARE-MEDICAID TIER TYPE

- Standard Retail – one- month supply
- Standard Retail – two- month supply
- Standard Retail – three- month supply
- Out-of-Network Pharmacy - other day supply
- Standard Mail Order – one- monthsupply
- Standard Mail Order – two- monthsupply
- Standard Mail Order – three-- month supply
- Long Term Care Pharmacy supply

TIER #1 - MEDICARE-MEDICAID RETAIL PHARMACY LOCATION SUPPLY

- Number of days for Standard Retail in your one- month supply: 30
- Number of days for Standard Retail in your two-- month supply: 60
- Number of days for Standard Retail in your three -month supply: 90
- Tier is available with an extended day supply

TIER #1 - MEDICARE-MEDICAID MAIL ORDER LOCATION SUPPLY

- Number of days for Standard Mail Order in your one -month supply: 30
- Number of days for Standard Mail Order in your two- month supply: 60
- Number of days for Standard Mail Order in your three-- month supply: 90

TIER #1 - MEDICARE-MEDICAID OON AND LTC LOCATION SUPPLY

- Number of days for Out-of-Network Pharmacy in your other day supply: 29
- Number of days for Long Term Care Pharmacy one- month supply: 31

ALTERNATIVE - MEDICARE-MEDICAID COPAYMENT

- In-Network Retail Pharmacy Minimum Copayment: $0
- In-Network Retail Pharmacy Maximum Copayment: $0
- Out-of-Network Pharmacy Minimum Copayment: $0
- Out-of-Network Pharmacy Maximum Copayment: $0
- Standard Mail Order Minimum Copayment:$0
- Standard Mail Order Maximum Copayment: $0
- Long Term Care Pharmacy Minimum Copayment: $0
- Long Term Care Pharmacy Maximum Copayment: $0

TIER #2 - MEDICARE-MEDICAID TIER TYPE

- Brand Drugs
- Enhanced Alternative
- Part D Drugs Only

SECTION RX: TIER #2 - MEDICARE-MEDICAID TIER LOCATIONS

- Standard Retail - one -month supply
- Standard Retail – two- month supply
- Standard Retail – three- month supply
- Out-of-Network Pharmacy - other day supply
- Standard Mail Order – one- monthsupply
- Standard Mail Order – two- monthsupply
- Standard Mail Order - three -month supply
- Long Term Care Pharmacy supply

TIER #2 - MEDICARE-MEDICAID RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

- Enter number of days for Standard Retail in your one- month supply: 30
- Enter number of days for Standard Retail in your two--month supply: 60
- Enter number of days for Standard Retail in your three- month supply: 90
- Tier is available with an extended day supply

TIER #2 - MEDICARE-MEDICAID MAIL ORDER LOCATION SUPPLY - PRE-ICL

- Number of days for Standard Mail Order in your one-month supply: 30
- Number of days for Standard Mail Order in your two-month supply: 60
- Number of days for Standard Mail Order in your three-month supply: 90

TIER #2 - MEDICARE-MEDICAID OON AND LTC LOCATION SUPPLY

- Number of days for Out-of-Network Pharmacy in your other day supply: 29
- Number of days for Long Term Care Pharmacy one-month supply: 31

ALTERNATIVE - MEDICARE-MEDICAID COPAYMENT

- Enrollee In-Network Retail Pharmacy Minimum Copayment: $0
- Enrollee In-Network Retail Pharmacy Maximum Copayment: $0
- Enrollee Out-of-Network Pharmacy Minimum Copayment: $0
- Enrollee Out-of-Network Pharmacy Maximum Copayment: $0
- Enrollee Standard Mail Order Minimum Copayment: $0
- Enrollee Standard Mail Order Maximum Copayment: $0
- Enrollee Long Term Care Pharmacy Minimum Copayment: $0
- Enrollee Long Term Care Pharmacy Maximum Copayment: $0

TIER #3 - MEDICARE-MEDICAID TIER TYPE

- Non-Medicare Rx/OTC Drugs
  - Enhanced Alternative
  - Non-Medicare Covered Drugs and/or Non-Medicare Covered OTC Drugs
  - Generic
  - Brand

TIER #3 - MEDICARE-MEDICAID TIER TYPE - PRE-ICL LOCATIONS

- Standard Retail - one-month supply
- Standard Retail - two-month supply
- Standard Retail - three-month supply
- Out-of-Network Pharmacy - other day supply
- Standard Mail Order - one-monthsupply
- Standard Mail Order - two-monthsupply
- Standard Mail Order - three-month supply
- Long Term Care Pharmacy supply

EXTENDED DAY SUPPLY

- Number of days for Standard Retail in your one -month supply: 30
- Number of days for Standard Retail in your two -month supply: 60
- Number of days for Standard Retail in your three- month supply: 90
- Tier available with an extended day supply

TIER #3 - MEDICARE-MEDICAID MAIL ORDER LOCATION SUPPLY

- Number of days for Standard Mail Order in your two- month supply: 30
- Number of days for Standard Mail Order in your two- month supply: 60
- Number of days for Standard Mail Order in your two -month supply: 90

TIER #3 - MEDICARE-MEDICAID OON AND LTC LOCATION SUPPLY

- Number of days for Out-of-Network Pharmacy in your other day supply: 29
- Number of days for Long Term Care Pharmacy one-month supply: 30

Post-Stabilization Services

Aetna covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health Premier Plan authorized the services
- Such services were administered to maintain the enrollee condition stabilization within one (1) hour after a request to Aetna for authorization of further post-stabilization services.
- When Aetna does not respond to a request to authorize further post-stabilization services within one (1) hour, could not be contacted, or cannot reach an agreement with the treating provider concerning the enrollee's care and a contracted provider is unavailable for a consultation. (In this situation, the treating provider may continue the enrollee's care until a contracted provider either concurs with the treating provider's plan of care or assumes responsibility for the enrollee's care.)

Emergency Services

Aetna covers emergency services without prior authorization for enrollees, whether the emergency services are provided by a contracted or non-contracted provider. We cover emergency services provided outside of the service area except in the following circumstances:

- When services are for elective care.
- When care is required as a result of circumstances that could reasonably have been foreseen prior to enrollees' departure from the contracting area.
- When routine delivery, at term, if enrollee is outside the contracting area against medical advice, unless the enrollee is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalization due to complications of pregnancy are covered.

We abide by the determination of the physician regarding whether an enrollee is sufficiently stabilized for discharge or transfer to an in-network facility.

Cost Sharing

Providers are not allowed to balance bill, nor can they bill for the cost sharing (except any applicable Part D copays).

All Medicare-covered services must be medically necessary, and except for emergency or urgently needed care, or otherwise authorized by Aetna Better Health Premier Plan, must be provided by an in-network participating providers. Benefit limits apply.

Providers are required to administer covered services to enrollees in accordance with the terms of their Provider Agreement and enrollee's Members' Handbook and Summary of Benefits

The full array of benefits and supportive services under the Premier Plan include, Medicare (including inpatient, outpatient, hospice, durable medical equipment, nursing homes, home health, and pharmacy) and Medicaid (including behavioral health, long-term institutional and community-based long-term supports and services).

The benefit information provided is a brief summary, not a complete description of the benefits. For more information, contact our Provider Experience Department at **1-855-676-5772** or access the Summary of Benefits on our website at: **AetnaBetterHealth.com/Michigan/assets/pdf/duals-materials/2020/MI-2020-SB-ENG.pdf.**

Note: Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year.

Annual Notice of Change

Benefits are subject to change annually. Enrollees are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period begins in October of each year for enrollees and ends in December. (Specific dates are defined by CMS annually). Providers can access our website on or around October 15th for information on the individual plan and benefits that will be available for the following calendar year.

Medicare Coverage Overview

- **Part A Hospital** – Insurance pays for inpatient care, nursing home care, hospice, and home health care.
- **Part B** – Medical Insurance pays for doctor's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
- **Part C** – Medicare Advantage Plans (MA) combine Parts A and B health benefits through managed care organizations; most plans include Part D (MAPD plans).
- **Part D** – Medicare Prescription Drug Plan helps pay for prescription drugs, certain vaccines, and certain medical supplies (e.g. needles and syringes for insulin); Part D coverage is available as a standalone Prescription Drug Plan (PDP) or integrated with medical benefit coverage (MAPD plans).

CHAPTER 6: ENROLLEE RIGHTS AND RESPONSIBILITES

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In this chapter you will find enrollee rights and responsibilities afforded to members of Aetna Better Health Premier Plan. Members' rights must be honored. Enrollees have the following rights and responsibilities:

Enrollee Rights

Premier Plan enrollees have the following rights:

- To be informed about the plan's benefits and their rights in a way that is easy to understand yearly
- To receive information in a way that they understand
- To receive information in languages other than English and in formats such as large print, braille, or audio and Spanish. To order contact Member Services at **1-855-676-5772 (TTY: 711),** 24 hours, 7 days a week. If enrollees are having trouble getting information from Aetna because of language problems or a disability and want to file a complaint they can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. A complaint can also be filed with Michigan Ombudsman office.
- The right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider is contracted with the health plan and consider "in-network" once credentialed. Members also have the right to change their PCP within the health plan. For more information about choosing a PCP, enrollees can call Member Services or look in the Provider and Pharmacy Directory to learn more about network providers and which doctors are accepting new patients.
- The right to go to a women's health specialist without getting a referral.
- The right to get covered services from network providers within a reasonable amount of time. This includes the right to get timely services from specialists.
- The right to get emergency services or care that is urgently needed without prior approval.
- The right to get prescriptions filled at any of the network pharmacies without long delays.
- The right to know when an out of network provider can be seen.
- To protected personal health information (PHI) as required by state and federal laws. PHI includes information given during enrollment and medical records and other medical and health information.
- The right to see medical records, right to amend or correct information in the medical record. To know if and how PHI has been shared with others. For questions or concerns about the privacy of a member's PHI, enrollees may call Member Services.
- The right to get information from the health plan. If a enrollee does not speak English, free interpreter services are available to answer any questions about the health plan. For an interpreter, enrollees may call **1-855-676-5772 (TTY: 711)** 24 hours a day, 7 days a week. This is a free service. Written materials are also available in Spanish. Interpretation services are available in any other non-English primary language spoken. Information can also be given in large print, braille, or audio.
- If information is requested about any of the following, enrollees can call Member Services for assistance in accessing: how to choose or change plans, the plan's financial information, rates, numbers of appeals, and how to leave the plan, the network providers and pharmacies, covered services and drugs and about rules, and why something is not covered and what can be done about it.
- To not be charged for covered services by doctors, hospitals, and other providers even if the plan pays less than the provider charged.
- The right to leave the plan. Enrollees have a right to get the most of their health care services through Original Medicare or a Medicare Advantage Plan. Medicare Part D prescription drug benefits may be received from a prescription drug plan or from a Medicare Advantage Plan. If another MI Health Link plan is in the enrollee's service area, they may change to a different MI Health Link plan and continue to get coordinated Medicare and Michigan Medicaid benefits. Enrollees may also get their Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.
- The right to know their treatment options and make decisions about their health care. Enrollees have the right to know their choices, know the risks, get a second opinion, say "no", to ask for an explanation of denied care, and ask for a covered service or drug that was denied or usually not covered.

Enrollee Responsibilities

Aetna Better Health enrollees, their families or guardians are responsible for the following. Enrollees may call Member Services for any questions.

- Read the Member Handbook to learn what is covered and what rules should be followed to get covered services and drugs.
- Tell the Health Plan about any other health or prescription drug coverage a member may have. The Health Plan is required to make sure an enrollee is using all of their coverage options. Enrollees with any other coverage should call Member Services.
- Tell their doctor and other health care providers that they are enrolled in Aetna Better Health. Enrollees should show their Member ID Card whenever they receive services or drugs.
- Help their doctor and other health care providers give them the best care.
  - Enrollees should give doctors and health care providers the information they need about themselves and their health. Learn as much as they can about their health problems. Enrollees should follow the treatment plans and instructions agreed upon with the provider.
  - Enrollees should make sure their doctors and other providers know about all drugs currently being taken. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - If a enrollee has any questions, they should be sure to ask. The doctors and other providers must explain things in a way that can be understood. If an enrollee asks a question and the answer is not understood, they should ask again.
- Enrollees should be considerate. All enrollees are expected to respect the rights of other patients and are expected to act with respect in their doctor's office, hospitals, and other providers' offices.
- Enrollees should pay what they owe. Enrollees are responsible for the following payments:
  - Medicare Part A and Medicare Part B premiums. For almost all Aetna Better Health Premier Plan enrollees, Michigan Medicaid pays for the Part A and Part B premium.
  - Any Freedom to Work program premium they may have. For questions about the Freedom to Work program, enrollees may contact their local MDHHS office. Contact information for the local MDHHS office can be found by visiting **https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html**
  - If an enrollee receives any services or drugs that are not covered by the plan, they must pay the full cost.
  - If an enrollee disagrees with the plans decision to not cover a service or drug, they can make an appeal.
- Enrollees should tell the health plan if they are planning to move by calling Member Services.
  - If enrollees move outside of the plan's service area, they will be disenrolled from Aetna by MDHHS. Only people residing in the service area can enroll in Aetna Better Health Premier Plan.
  - Aetna can assist enrollees moving outside the service area. During a special enrollment period, enrollees may switch to Original Medicare or enroll in a Medicare health or prescription drug plan in their new location. Aetna will advise enrollees of health plans is available in the new area.
  - Enrollees should let Medicare and Michigan Medicaid know their new address when they move.
  - If enrollees move within Aetna's service area, they should still notify us
  - Enrollees may call Member Services for help with questions or concerns.
  - Enrollees age 55 and older who are getting long term care services may be subject to estate recovery upon their death. For more information, members may:
    - Contract their Care Coordinator, or
    - Call the Beneficiary Helpline at **1-800-642-3195**, or
    - Visit the website at **www.michigan.gov/estaterecovery,** or
    - Email questions to **MDHHS-EstateRecovery@michigan.gov**

For questions or concerns, please contact our Provider Experience Department at **1-855-676-5772**.

Enrollee Rights under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is protecting qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations receiving 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: 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 enrollees in the Integrated Care Program may not, on the basis of 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 as a result of physical barriers

CHAPTER 7: ELIGIBILITY AND ENROLLMENT

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Aetna Better Health Premier Plan arranges medically necessary covered services for individuals who are enrolled in the MI Health Link Program. This chapter describes eligibility categories, the role of the enrollment broker, and the enrollment and disenrollment processes.

Eligibility

Individuals who meet the following plan eligibility requirements may enroll:

- Age 21 or older at the time of enrollment;
- Eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly PPA; and
- Reside in a Premier Plan region

MDHHS determines eligibility for MI Health Link Program. If an individual loses eligibility for the MI Health Link Program, Aetna is required to end their coverage under the Program.

Non-Eligible Populations

The following populations are not eligible for the MI Health Link Program:

- Individuals under the age of 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 C.F.R. § 438.56
- Individuals not living in a Premier Plan region
- Individuals with Additional Low-Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage
- Individuals without full Medicaid coverage (spend down or deductibles)
- Individuals with Medicaid who reside in a State psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services

Enrollment Broker

MICHIGAN ENROLLS is the enrollment broker contracted with MDHHS, responsible for providing customer service, including providing eligible individuals, family enrollees, and other stakeholder's direct outreach and education presentations, and maintain on –going capacity for outreach, education and individual plan counseling. MICHIGAN ENROLLS will present Aetna and other available health plans in an unbiased manner to potential enrollees or those enrollees seeking to transfer from one Health Plan to another.

Enrollees with questions about MI Health Link program enrollment should be instructed to contact MICHIGAN ENROLLS and or and or the Patient Ombudsman.

Enrollment Effective Dates

All enrollment effective dates are prospective. Enrollees elected enrollment is effective the first calendar day of the month following the initial receipt of the enrollee's request to enroll, or the first day of the month following the month in which an individual enrollee is eligible.

Enrollment Broker (Enrollments and Disenrollment's

MDHHS processes MI Health Link enrollee enrollment and disenrollment's through their authorized agent, MICHIGAN ENROLLS.

Enrollees who have questions about enrollment should be instructed to contact Aetna Better Health Premier Plan and/or the Patient Ombudsman.

Welcome Packet

Welcome packets are issued to enrollees prior to the first day of the month in which the enrollee's enrollment starts. If there is more than one enrollee in one household, every enrollee will receive their own welcome packet.

At a minimum, the welcome packet contains the following:

- Welcome Letter
- Enrollee Identification Card
- Transition of Care form
- Member Handbook/Summary of Benefits (will also be mailed annually)
- Annual Notice of Change (after Aetna Better Health's first year offering the Plan)
- Multi-Language Insert
- Comprehensive or Abridged Formulary

Translated materials, interpretive services, and/or information is available in alternative formats (i.e. braille, large print, CD etc.) as needed or requested by enrollees or potential enrollees. Alternative formats can be requested by contacting Aetna Member Services at **1-855-676-5772**.

PCP Changes

Enrollees may elect their PCP of choice and will be assigned accordingly. If an enrollee did not select a PCP, one will be assigned automatically to them. If an enrollee is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, the enrollee may choose an alternative PCP at any time by calling our Member Services Department. We will promptly grant the request and process the PCP change in a timely manner. Enrollees will receive a new ID card indicating the new PCP's name. Enrollees cannot change PCPs more than once per month.

In cases where a PCP has been terminated for reasons other than cause, we will promptly inform enrollees assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where an enrollee fails to select a new PCP, the enrollee is reassigned to another compatible PCP prior to the PCP's termination date, informing the enrollee of the change in writing.

ID Card

Enrollees should present their Aetna Better Health Premier Plan ID card at the time of service. Providers should always confirm eligibility prior to rendering services. The enrollee ID card contains the following information:

- Enrollee Name
- ID Number
- Health Plan ID Number
- PCP Name
- PCP Phone Number
- Claims address
- Health Plan Name
- Aetna Better Health Premier Plan Logo
- Aetna Better Health Premier Plan Website
- RX Bin Number
- RX PCN Number
- RX Group Number
- RX ID Number

Verifying Eligibility

Presentation of an Aetna Better Health Premier Plan ID card is not a guarantee of eligibility. The provider is responsible for verifying an enrollee's current enrollment status before providing care. Please note that we will not reimburse for services provided to patients who are not enrolled with Aetna Better Health Premier Plan. Providers can verify enrollee eligibility by calling our Member Services Department at **1-855-676-5772**, or online through our Secure Web Portal at **AetnaBetterHealth.com/Michigan/providers/portal**. Providers may also confirm eligibility via the MDHHS verification site CHAMPS at: **milogintp.michigan.gov/eai/tplogin/authenticate?URL=/**

CHAPTER 8: QUALITY MANAGEMENT

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Overview

Aetna Better Health of Michigan's Quality Management (QM) Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. Aetna uses this approach to measure conformance with desired medical standards and develop activities designed to improve patient outcomes.

We perform QM through a Quality Assessment and Performance Improvement (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of our QM Program is to improve the health status of enrollees or maintain current health status when the enrollee's condition is not amenable to improvement.

Our QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively allow for review of our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM process enables us to:

- Assess current practices in both clinical and non-clinical areas.
- Identify opportunities for improvement.
- Select the most effective interventions.
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary.

The use of data in the monitoring, measurement, and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Aetna's QM Program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization, and committees from the Board of Directors to the Enrollee Advisory Committee. This structure allows enrollees and providers to offer input into our quality improvement activities. Our Chief Medical Officer (CMO) oversees the QM program. The CMO is supported in this effort by our QM Department and the Quality Management Oversight Committee (QMOC) and subcommittees.

The QMOC's primary purpose is to integrate quality management and performance improvement activities throughout Aetna and our provider network. The committee is designated to provide executive oversight of the QAPI program and make recommendations to the Board of Directors about our quality management and performance improvement activities and to work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers. Major functions of the QMOC Committee include:

- Oversight and confirmation quality activities are designed to improve the quality of care and services provided to enrollees.
- Review and evaluation of quality improvement activities results.
- Review and approval of studies, standards, clinical guidelines, trends in quality and utilization management indicators and satisfaction surveys.
- Advise and recommendations to improve the Aetna Better Health Premier Plan.
- Review and evaluation of company-wide performance monitoring activities, including care management, customer service, credentialing, claims, grievance and appeals, prevention and wellness, Provider Relations, and quality and utilization management.

Additional committees such as Service Improvement, Credentialing and Performance, Appeals/Grievance, and Quality Management/ Utilization Management further support our QAPI Program. We encourage provider participation on key clinical oversight committees. Providers may contact the Chief Medical Officer (CMO) or inform their Provider Experience Representative if they are interested in participation opportunities.

Our QM staff develops and implements an annual work plan, which specifies projected QM activities. Based on the work plan, an annual QM Program evaluation is conducted, which assesses the impact and effectiveness of QM activities.

The QM Department is an integral part of Aetna. The focus of our QM staff is to review and trend services and

procedures for compliance with nationally recognized standards; and recommend and promote improvements in the delivery of care and service to our enrollees. Our QM and Medical Management (MM) Departments maintain ongoing coordination and collaboration regarding quality initiatives, care management, and disease management activities involving the care of our enrollees.

Aetna Better Health of Michigan's QM activities include, however are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, Aetna, in collaboration with our network providers, is able to monitor and reassess the quality of services provided to our enrollees. Providers are obligated to support and meet Aetna's QAPI and Utilization Management program standards.

Practitioner must cooperate with quality improvement activities to improve quality of care, quality of service and member experience.

Note: Providers must also participate in the Centers of Medicare and Medicaid (CMS) and the Michigan Department of Health and Human Services (MDHHS) quality improvement initiatives by providing reliable and complete information as requested.

Identifying Opportunities for Improvement

Aetna identifies and evaluates opportunities for quality improvement, then deploys appropriate intervention strategies through systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data monitored to identify opportunities for quality improvements include, however are not limited to:

- **Formal Feedback from External Stakeholder Groups:** Aetna Better Health Premier Plan engages external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS®), or focus groups with individuals, such as enrollees 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 ongoing regulatory contract monitoring oversight processes is utilized to identify specific program activities/processes improvement opportunities.
- **Internal Review of Individual Enrollee or Provider Issues**: Aetna Better Health Premier Plan proactively identifies potential quality of service issues for review through daily operations (i.e. enrollee services, prior authorization, and care management), grievance and appeal case review, and provider complaints. Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services, and quality of care), Aetna is able to identify specific opportunities for improving care delivered to individual enrollees.

- **Findings from Internal Program Assessments**: Aetna conducts a number of formal assessments/reviews of program operations and providers utilized to identify risks and improvement opportunities. These internal assessments include however is not limited to record reviews of contracted providers, credentialing/re- credentialing of providers, delegated oversight reviews, inter-rater reliability audits, annual quality management program evaluation, cultural competency assessments, and provider accessibility and availability studies.
- **Clinical and Non-Clinical Performance Measure Results**: Aetna 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, we are able to 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 enrollees' care plans -Availability of 24/7 telephonic assistance to enrollees and caregivers receiving home care services
- Data Trending and Pattern Analysis: With our innovative information management systems and data mining tools, Aetna 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 n uses a myriad of monitoring processes to confirm effective delivery of services to all of our enrollees, such as provider and enrollee profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health Premier Plan monitors include, but are not limited to:
  - High-cost, high-volume, and problem prone aspects of the long-term care services our enrollees receive.
  - Assessment and service planning process effectiveness, including quality of planning enrollee's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization.
  - Delivery of services enhancing enrollee safety and health outcomes. This includes proactive planning to prevent 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 identifies PQoC concerns related to our network providers including Home and Community-Based Services (HCBS), by researching member complaints, medical records and sampling for "never events". We work to resolve these care concerns in an expeditious manner and follow up to ensure required interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna tracks and trends PQoC cases and prepares trend reports according to provider, issue category, referral source, number of verified issues, and closure levels. Aetna utilizes these trend reports to monitor providers for whom there have been previous complaints for continued non-compliance. These reports also identify significant trends warranting review by the Aetna Credentialing and Performance Committee for participation continuance or other quality improvement interventions.

Performance Improvement Projects (PIPs)

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

- Target improvement in areas that will address a broad spectrum of key aspects of enrollees' 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 Premier Plan enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM Department prepares PIP proposals that are reviewed and approved by our Chief Medical Officer (CMO), Quality Assurance Committee, Provider Advisory Committee, and the Quality Management Oversight Committee (QMOC) prior to submission to the MDHHS 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 Premier Plan, as well as from network providers who are enrollees of our Provider Advisory Committee.

The QM Department conducts ongoing evaluation of the study indicator measures throughout the length 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, we 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. 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 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 but, if necessary, could extend to a review of utilization,

medical necessity, cost, and/or health provider credentials, as well as other quality issues.

Although peer review activities are coordinated by the Quality Management Department, they may require the participation of Utilization and Care Management, Provider Relations, or other departments. Aetna Better Health Premier Plan 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 Better Health Premier Plan 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 Premier Plan 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.

Performance Measures

We collect and report clinical and administrative performance measure data to the MDHHS and CMS. The data enables Aetna Better Health Premier Plan, the MDHHS and CMS to evaluate our adherence to practice guidelines, as applicable, and/or improvement in enrollee outcomes.

Satisfaction Surveys

We conduct enrollee and provider satisfaction surveys to gain feedback regarding enrollee and providers' experiences with quality of care, access to care, and service/operations. We use enrollee and provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

Enrollee Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems® (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are subsets of Healthcare Effectiveness Data and Information Set® (HEDIS) reporting. Aetna Better Health Premier Plan contracts with a National Committee for Quality Assurance (NCQA) certified vendor to administer the survey according to HEDIS® survey protocols. The survey is based on randomly selected enrollees and summarizes satisfaction with the health care experience.

Provider Satisfaction Surveys

We conduct an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and Aetna Better Health of Michigan's response to inquiries.

External Quality Review (EQR

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.S.C. § 1396u–2] 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 of quality outcomes, timeliness, and access to services. External Quality Review (EQR) refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to enrollees. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

Aetna Better Health Premier Plan 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 the MDHHS and CMS. Aetna Better Health Premier Plan assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. We also provide complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna's contracted providers are required to provide any records that the EQRO may need for its review.

The results of the EQR are shared with providers and incorporated into our overall QM and medical management programs as part of our continuous quality improvement process.

Provider Profiles

In an effort to promote the provision of quality care, we profile providers who meet the minimum threshold of enrollees in their practices, as well as the minimum threshold of enrollees for specific profiling measures. Individual providers and practices are profiled for multiple measures and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

The Provider Profiling Program is designed to share standardized utilization data with physicians in an effort to improve clinical outcomes. Our profiling program is intended to support clinical decision-making and patient engagement as providers often have little access to information about how they are managing their enrollees or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider- patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

Aetna Better Health Premier Plan includes several measures in the provider profile, which include, but not limited to:

- Frequency of individual patient visits to the PCP.
- HEDIS-type screening tests and evidence-based therapies (i.e. appropriate asthma management linked with correct use of inhaled steroids).
- Use of medications.
- ER utilization and inpatient service utilization.
- Referrals to specialists and out-of-network providers. We

distribute profile reports to providers so they can evaluate:

- Potential gaps in care and opportunities for improvement.
- Information indicating performance for individual cases or specific disease conditions for their patient population.
- A snapshot of their overall practice performance relative to evidence-based quality metrics.

Our Chief Medical Officer (CMO) regularly visits individual network providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our Chief Medical Officer (CMO) investigates potential utilization or quality of care issues that may be identified through profiles. Aetna Better Health of Michigan's medical leadership is committed to collaborating with providers to find ways to improve patient care.

Clinical Practice Guidelines

The evidenced-based clinical practice guidelines used by Aetna Better Health Premier Plan represent best practices and are based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the health plan Chief Medical Officer, applicable medical committees and, if necessary, external consultants. Clinical practice guidelines are reviewed at least every two years, or as often as new information is available.

Clinical guidelines are made available to providers on our website; providers are informed of the availability of new guidelines and updates in the Periodic Provider Newsletter. Providers may request a copy of a guideline at any time by contacting their Provider Relations Department.

CHAPTER 9: MEDICAL MANAGEMENT

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Aetna Better Health Premier Plan focuses on relationship building; promoting choice among enrollees and caregivers; and assisting in the coordination of the full continuum of physical; behavioral; social; financial; and environmental care and services. The objective is to make certain that enrollees receive care in the most integrated, least-restrictive community setting compatible with optimal functioning and personal preferences.

Identifying Enrollees Needs

A licensed and experienced clinical professional will conduct an initial assessment upon enrollment and re- assessments within state required timeframes and if there is a change in the enrollee's condition and or status.

The enrollee will be assigned to a Case Manager that will utilize assessment tools to gain a perspective of the enrollee's status, needs both physically and psychosocially. The Case manager will use the comprehensive assessment to gather enrollee information, concerns, and needs to initiate the enrollee-centric care/service planning process through collaboration with the enrollee, caregiver, and enrollees of the Integrated Care Team (ICT). The Case manager will also consult with the enrollee's Primary Care Provider (PCP), specialist providers, and other relevant professionals involved in the enrollee's care. Aetna Better Health of Michigan's assessment process is holistic, focusing on the individual's medical, social, cultural, financial, and environmental circumstances and long-term care needs.

Integrated Care Team (ICT

The Integrated Care Team (ICT) is a team of individuals that will provide person-centered care coordination and care management to enrollees. The ICT is led by the assigned enrollee Case manager and every enrollee will have a ICT of their choice. At any time, the enrollee may decline care management and the ICT process. Each ICT will be comprised of the enrollee and/or the enrollee's authorized representative/designee, relevant health plan professionals, the PCP, behavioral health professional, the enrollee's home care aide, and other providers either as requested by the enrollee or his/her representative/designee. Additional ICT enrollees may be included as recommended by the Case manager or PCP and approved by the enrollee and/or his/her representative/designee. The Integrated Care Team (ICT) will coordinate the enrollee's service planning, coverage determinations and care coordination. The ICT will meet initially to develop the person-centered care plan and regularly throughout the enrollee's care.

Aetna Better Health of Michigan's ICT will be responsible for coordinating enrollees' care throughout the continuum of covered and non-covered services. The team will employ a number of strategies to accomplish this objective, including:

- Communicating with Enrollees and their Informal Support Systems: The Case manager will regularly communicate with enrollees and enrollees' families/caregivers telephonically, online, and during in-person visits to discuss an array of issues relating to the enrollee's health and well-being, including physician visits, medications, therapies, nutrition, enrollee safety, etc. As needed, or per the request of anyone on the ICT, including the enrollee, the ICT will meet to discuss and make certain referrals, schedule appointments, out- of-network access, transportation, and coordinate any other services needed for the enrollee. These meetings will include follow-up discussions with the enrollee to make certain the services put in place are appropriate and meet not only their needs, but the care planning requirements set forth by the enrollee's providers.
- Communicating with Providers: The Case manager will regularly confer with treating providers and other professionals involved in the delivery of covered and non-covered services to support their prescribed course of treatment and make certain that authorized services and supports are consistent with the enrollee's health-related needs, preferences and meet the person centered service plan agreed upon by the ICT.

Documenting & Communicating Meetings

The enrollee's assigned Case manager will publish a meeting schedule in the Care Bridge Portal, in advance, to support attendance of the ICT enrollees and enrollee attendance.

The participants of each ICT will communicate in-person or via teleconference. At every step-in care management, the enrollee is a partner in developing goals to improve health status and identifying root causes of poor health outcomes and barriers to care. If the enrollee is unable to be an active participant in this process, we will work with their identified family/representative to make sure they are included in the ICT.

The care management and ICT activities/meetings will be documented in the enrollee's care plan in the Aetna Better Health business application system, will be based on the assessed needs, and articulated preferences of the enrollee. If needed, we will transition enrollees to new providers once the care plan is completed

For ICT care management services, please call our toll-free line to be connected to a Case manager.

CHAPTER 10: UTILIZATION MANAGEMENT

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Primary Care Providers (PCPs), assigned Case managers, enrollees of the Integrated Care Team (ICTs), or treating practitioner and or providers are responsible for initiating and coordinating an enrollee's request for authorization. However, specialists and other practitioners, and/or providers, may need to contact the Aetna Better Health of Michigan's Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting providers are responsible for complying with our prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. We will not prohibit, or otherwise restrict, practitioner and providers acting within the lawful scope of practice, from advising or advocating on behalf of, an individual who is a patient and enrollee of the Premier Plan, 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.

For those services requiring pre-service authorization, participating and nonparticipating providers must obtain pre- service authorization from us before providing outpatient referrals, clinical services or procedures, or nonemergency or elective hospitalizations, which require prior authorization. Noncompliance with pre-service authorization policies and procedures may result in denial or delay of reimbursement. A list of services that require prior authorization can be found on our website at **AetnaBetterHealth.com/Michigan**. Unauthorized services will not be reimbursed and authorization is not a guarantee of payment. All out of network services, require authorization.

Emergency Services

In no event will an enrollee, an enrollee's authorized representative/designee, an enrollee's health care provider, any other health care provider, or any other person or entity, be required to inform or contact Aetna Better Health Premier Plan prior to the provision of emergency care, including emergency treatment or emergency admission.

Notification to Aetna Better Health Premier Plan after an emergent admission is encouraged for the purpose of appropriate coordination of care and discharge planning. Our Prior Authorization Department or Concurrent Review Clinicians will document the notification in the enrollee's record.

Services Requiring Authorization

Primary care providers (PCP) or treating practitioner/providers must request authorization for certain medically necessary services.

A current list of services, which require prior authorization, can be found online at **AetnaBetterHealth.com/Michigan**. Providers may also utilize our Prior Authorization Look up Tool, which is located on our MI Care Bridge (Secure Web Portal). The Provider Prior Authorization Look up Tool allows providers to search for authorizations by enrollee, 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 Procedure Coding System (CPT/HCPCS) codes simultaneously
- Review Prior Authorization requirement by specific procedures or service groups
- Receive immediate details as to whether the codes 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
- Make certain staff works from the most up-to-date information on current prior authorization requirements

Please see Chapter 04, of this Manual for additional information about our Care Bridge site (Secure Web Portal) and how to register.

Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized.

Exceptions to Prior Authorizations:

- Service authorization for emergency services including behavioral health care; urgent care; crisis stabilization, including mental health; or post-stabilization services whether provided by an in-network or out- of-network practitioner/provider
- Access to family planning services
- Preventative services
- Well-woman services
- Communicable disease services, including STI and HIV testing
- Out of area renal dialysis services

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Network providers can submit the request through the 24-hours-a-day, 7-days-a-week Secure Provider Web Portal located on our website, or
- Fax the request form to **1-844-241-2495** (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing or call us directly at **1-855-676-5772**.
- For non-participating providers, please call us at **1-855-676-5772** or fax the request for to **1-844-241-2495** (form is available on our website).

A service authorization request for medical necessity must include the following:

- Name, date of birth, sex, and identification number of the enrollee
- PCP or treating practitioner
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Problem/diagnosis, including the International Classification of Diseases, 9th Edition (ICD-10) code
- Reason for the service request
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request.

Aetna Better Health Premier Plan strongly encourages the inclusion of current applicable codes in any service requests for medical necessity. Applicable codes may include the following:

- Current Procedural Terminology (CPT),
- International Classification of Diseases, 9th Edition (ICD-10),
- Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
- National Drug Code (NDC)

All clinical information must be submitted with the original request. Medical management and behavioral health medical necessity criteria and practice guidelines are disseminated to all affected practitioners and or providers upon request.

Timeliness of Decisions and Notifications

We make service authorization decisions and notify providers and applicable enrollees in a timely manner. We adhere to the following decision/notification time standards. Aetna Better Health Premier Plan records all telephonic contacts or attempted telephonic contacts to inform enrollees and providers of approvals and denials of service and requests for extensions of decision timelines in our electronic business system. Departments that handle pre-service authorizations must meet the timeliness standards appropriate to the required services and as the enrollee's condition requires but no more than the following:

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	72 hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	72 hours from receipt of request	Practitioner/Provider Enrollee	Oral and Electronic/Written

Non-urgent pre-service approval	14 Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	14 Calendar Days from receipt of the request	Practitioner/Provider Enrollee	Electronic/Written
Urgent concurrent approval	24 hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent concurrent denial	24 hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	30 calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	30 calendar days from receipt of the request.	Practitioner/Provider Enrollee	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least 10 Calendar Days before the date of the action.	Practitioner/Provider Enrollee	Electronic/Written

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, we will assign a prior authorization number, which refers to and documents the approval. We will then communicate the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, an enrollee may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Our Prior Authorization Department makes such decisions on a case- by-case basis in consultation with the Aetna Better Health Premier Plan Chief Medical Officer (CMO).

Referrals

We do not require referrals from PCPs or treating practitioner/providers.

Pharmacy Prior Authorization – Pharmacy

Aetna Better Health Premier Plan will process coverage determinations and exception requests in accordance with Medicare Part D regulations and/or Medicaid regulations. Medicare Part B drug reviews are conducted by the Utilization Management Team. Requests can be made my phone **1-855676-5772** or fax to **488-241-2495**. Requests will be handled through the prior authorization review process. The prior authorization staff will adhere to approved criteria. The Pharmacy Benefit Manager establishes clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit prior authorization requests by phone, fax, or through our MI Care Bridge site (Secure Web Portal). Providers will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

For Medicare Part D-covered drugs, determination requests will be determined seventy-two (72) hours after receipt of complete information from the provider for Standard determinations. Expedited reviews for Medicare Part D-covered drugs will be determined within twenty-four (24) hours after receipt of complete information from the provider.

For Medicaid-covered drugs, coverage determination requests will be determined fourteen (14) calendar days after receipt of complete information from the provider for Standard determinations. Expedited reviews for Medicaid- covered drugs will be determined within seventy-two (72) hours after receipt of complete information from the provider.

Conditions meeting expedited review include an imminent or serious threat to the health of the Enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Determination notices will be faxed to the provider's office once the decision is made and a letter will be mailed to the enrollee.

To submit a coverage determination or exception request, complete the Coverage Determination/Prior Auth form and fax to **844- 242**-0914 or call **1-855-676-5772**.

Concurrent Review Overview

We conduct concurrent utilization management on each enrollee admitted to an inpatient facility, including nursing homes and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the enrollee's medical record assesses medical necessity for the admission, and appropriateness of the level of care, utilizing Nation and Local Coverage Determination guidelines. Admission certification is conducted within one business day of receiving notification.

Continued stay reviews are conducted by our Utilization Management Clinical staff before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay.

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. Hospital staff and the attending physician are responsible for developing a discharge plan for the enrollee. The enrollee and their family should be involved when implementing the plan.

Our Concurrent Review Clinical staff works with the hospital discharge team and attending physicians to make certain 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 enrollees with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., PIHPs, home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Mental Health/Substance Abuse Services

In order to meet the behavioral health needs of our enrollees, Aetna Better Health Premier Plan provides a continuum of services to enrollees at risk of or suffering from mental, addictive, or other behavioral disorders. We are an experienced health care organization and have contracted with regional Prepaid Inpatient Health Plans (PIHPs) that are experienced in providing behavioral health services to the Michigan population.

Availability

PIHPs must have Mental Health/Substance Abuse (MH/SA) providers accessible to enrollees, including telephone access, 24-hours-a-day, 7 days per week in order to advise enrollees requiring urgent or emergency services. The PIHPs' Mental Health/Substance Abuse (MH/SA) providers are required to meet our contractual standards for urgent and routine behavioral health appointments. For a complete list, please see Chapter 3 of this Manual.

Referral Process for Enrollees Needing Mental Health/Substance Abuse Assistance

Enrollees will be able to self-refer to the specified PIHP within the region without a referral from their Primary Care Provider (PCP).

Primary Care Provider Referral

We endorse early identification of mental health issues so that timely intervention, including treatment and patient education, can occur. To that end, providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem/disorder
- Treat mental health and/or substance abuse disorders within the PCP's scope of practice
- Inform enrollees how and where to obtain behavioral health services
- Understand that enrollees may self-refer to a PIHP without a referral from the enrollee's PCP.

Coordination of Mental Health and Physical Health Services

Partnering with the PIHPs, we coordinate physical and mental health care services for enrollees through our Integrated Care Team (ICT) that is led by each enrollee's assigned Case manager. Coordination and care and services includes screening, evaluations, evidence-based treatment and/or referrals for physical health, behavioral health or substance use disorder, dual or multiple diagnoses, mental retardation and /or developmental disabilities. With the enrollee's permission, our Care Management Staff can facilitate coordination of care management with the PIHPs related to substance abuse screening, evaluation, and treatment.

Enrollees seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer enrollees to the PIHPs when appropriate.
Enrollees seen by the PIHPs must be screened for co-existing medical issues. PIHPs must refer enrollees with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the enrollee's consent. PIHPs are asked to communicate any concerns regarding the enrollee's medical condition to the Care Manager and PCP, with the enrollee's consent if required, and work collaboratively on a plan of care.

Medical Records Standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals must agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in Chapter 3 of this manual.

Specific Screening Tools

Whenever a PCP is concerned about an enrollee who may have a Mental Health/Substance Abuse problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. This level of concern might be triggered by the PCP's clinical judgment and/or by responses on the "Well-Being Tool for Adolescents & Adults: Patient Problem Questionnaire". We strongly recommend the PCP use two screening tools, one for mental illness and one for substance use disorders, when additional screening is indicated. We recognize a high proportion of enrollees with either disorder may have a co-occurring Mental Health or Substance Use disorder, which would require integrated dual diagnosis treatment to achieve optimal clinical outcomes. Partnering with the PIHPs, Aetna Better Health Premier Plan uses the following standard screening tools to facilitate the identification of people with potential Mental Health/Substance Abuse conditions:

DSM-5- Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

The American Psychiatric Association (APA) is offering a number of "emerging measures" for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments' usefulness in characterizing patient status and improving patient care at **https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/provide-feedback**

CHAPTER 12: PHARMACY MANAGEMENT

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Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized prescriber, such as a Primary Care Provider (PCP), specialist, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The formulary identifies all of the prescription and over the counter drugs covered by the Aetna Better Health Premier Plan MI Health Link Program. The formulary drug list has been approved by the Centers of Medicare and Medicaid Services (CMS) and/ or the state and reviewed by the Pharmacy and Therapeutics Committee (P&T Committee) to make certain that they are clinically appropriate to meet the therapeutic needs of our enrollees in a cost effective manner.

- All formulary utilization management restrictions are approved by CMS and the P&T Committee.

Updating the Formulary

Our formulary is continuously reviewed by the P&T Committee and prescription drugs are added or removed based on objective, clinical, and scientific data and market changes. All updates to the formulary must be approved by CMS and/or the state and adhere to all mandated guidance on changes. Considerations include safety, efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change drugs listed in the formulary. Market share shifts, price increases, generic availability, and varied dosage regimens may affect the actual cost of therapy.
- The formulary must adhere to CMS and state requirements.
- Products are not added to the list if there are less expensive, similar products on the formulary unless provide superior outcomes or mandated by CMS or the state.
- When a drug is added to the formulary, other drugs in the same category may be removed.

Notification of Formulary Updates

We must follow CMS and state policy regarding formulary changes. Our Pharmacy Management Department may add drugs to the formulary or delete utilization management requirements at any time during the year. After March 1st of each year, our Pharmacy Management Department may only make maintenance changes to the formulary, such as replacing a brand name drug with a new generic, or modifications to quantity limits based on new drug safety information. The Centers of Medicare and Medicaid Services (CMS) limits non-maintenance formulary changes and must be approved by CMS.

If approved, enrollees currently taking the affected drugs are exempt from the change until the remainder of the calendar year. We will provide notice to affected enrollees at least sixty (60) days prior to removing a covered drug from the formulary or provide the enrollee with a 60-day supply of the drug. If the Federal Drug Administration (FDA) deems a drug unsafe or it is removed from the market by its manufacturer, we will provide a retrospective notice as soon as possible. A list of formulary changes is maintained on our website. Our Provider Relations Department may notify providers of changes to the formulary via direct letter or through our website.

Federal Part D regulations require Aetna Better Health Premier Plan to have a formulary that contains at least two- Part D prescription drugs in each approved category, and substantially drugs in the six special classes listed below:

- Antidepressants
- Antipsychotic
- Anticonvulsants
- Antiretroviral
- Antineoplastic
- Immunosuppressant

Both generic and brand name drugs are covered, but some drugs are statutorily excluded from coverage or are excluded for certain indications. Excluded drugs include, but are not limited to:

- Drugs for anorexia, weight loss or weight gain
- Fertility drugs
- Erectile Dysfunction drugs
- Drugs for cosmetic purposes or hair growth
- Drugs for symptomatic relief of cough and cold (exceptions may apply)
- Prescription vitamins and mineral products (except pre-natal vitamins and fluoride preparations)
- Electrolytes/Replenishers
- Non-prescription drugs (exceptions may apply)
- Drugs covered under Medicare Part A or Part B (exceptions may apply)

Pharmacy Transition of Care Process

New MI Health Link enrollees (within their first ninety (90) days) taking prescription drugs that are not on the formulary, or formulary drugs that are subject to certain restrictions, such as prior authorization or step therapy, will receive a temporary transitional fill of up to a thirty (30) day supply of a non-formulary drug, or a formulary drug requiring prior authorization at a retail pharmacy. Enrollees and their prescribing physician will receive a letter instructing them to consult with their prescribing physician to decide if they should switch to an equivalent drug that is on the formulary or to request a formulary exception in order to get coverage for the drug.

We will not pay for additional fills for the drug(s), unless the prescriber submits a request for a coverage determination or formulary exception, and we approve. If a formulary exception is approved, the approval will be valid through the remainder of the calendar year, unless prescribed for a lesser period.

LTC/ Nursing Facility

If a new enrollee is a resident of a Long-Term Care (LTC) facility, we will cover multiple fills of a temporary transitional fill of up to at least a ninety-one (91) day supply consistent with the dispensing increment (unless the enrollee presents with a prescription written for less), with refills provided if needed during within their first ninety (90) days. We will also cover an additional thirty-one (31) day emergency supply (unless the prescription is for fewer days) for an enrollee past the first ninety (90) days while we process a requested coverage determination.

If the enrollee has unplanned level of care changes, (e.g., discharged from a hospital to a home, or ending a stay at a long term care facility and returning home), we will provide an emergency thirty-one (31) day supply of a currently prescribed drug to transition the enrollee to their new level of care setting. The enrollee and the enrollee's physician will receive a letter notifying them that they will need to transition to a prescription drug on our formulary or request a coverage determination.

Please note that transition policy applies only to prescriptions filled at a network pharmacy.

Part D Pharmacy Co-Payments

Enrollee co-payments for covered prescription products will be $0.

CHAPTER 13: ENROLLEE COVERAGE DETERMINATIONS, EXCEPTIONS, APPEALS, AND GRIEVANCES FOR PART D PRESCRIPTION DRUGS

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Medicare Part D Prescription Drug Coverage Determinations

Prescription drug coverage is included in the Aetna Better Health Premier Plan MI Health Link Program. CVS Caremark is the Pharmacy Benefit Manager (PBM) that Aetna Better Health Premier Plan has contracted with to administer the MI Health Link prescription drug benefit. Enrollees will have access to CVS Caremark participating pharmacies. Aetna Better Health Premier Plan will review and process Medicare Part D Coverage Determinations and Exception requests initiated by our enrollees, their authorized representative and/or their prescribing provider.

While typically prescribing providers submit requests to us to make a coverage determination, enrollees have the right to request a coverage determination concerning a prescription drug they believe they are entitled to receive under their plan, including:

- Basic prescription drug coverage
- The amount, if any, that the enrollee is required to pay for a drug

We will process coverage determinations under the standard timeframe of seventy-two (72) hours of receipt, unless the prescriber has indicated that the enrollee would be harmed if we apply the standard timeframe. In these cases, we will process the review under the expedited timeframe of twenty-four (24) hours, or as fast as the enrollee's health condition requires. If we fail to process the request within the required timeframe, we will submit the request to the Qualified Independent Contractor (QIC), Maximus Federal Services, within twenty-four (24) hours. Should this occur, we will notify both the enrollee, and the prescribing provider, that Maximus Federal Services will conduct the review.

An enrollee, their authorized representative, and/or their prescribing physicians may submit a request directly to us orally or in writing to make a coverage determination for a formulary exception. Written requests should be on the Pharmacy Coverage Determination Request Form. The form is in this Manual and on our website**.** The request for a coverage determination formulary exception must be filed directly with us. If an enrollee or their authorized representative submits an exception request it must include the prescribing provider's supporting statement before this request can be reviewed.

A Pharmacy Coverage Determination Request Form is located on our website for your convenience. Prescribing physicians may initiate a request by electronic prior authorization through our website, calling our Pharmacy Prior Authorization Department at **1-855-676-5772**, Monday through Friday 8 AM to 8 PM EST or faxing your request to **1-844-242-0914**.

A coverage determination is any decision made by us regarding a request for Part D drug benefit or payment. There are two (2) types of coverage determinations:

- **Formulary UM Requirements** – A request for approval for a formulary Utilization Management (UM) requirement such as prior authorization, step therapy and quantity limitations.
- **Formulary Exceptions** – Request for Part D prescription drug not listed on the formulary or a request for an exception to the formulary UM requirements.

Grievance and Redetermination Overview

Enrollees can file a grievance or redetermination, also called an appeal, if they are not satisfied. A prescribing physician, acting on behalf of an enrollee, may file an appeal, QIC, Administrative Law Judge (ALJ), Medicare Appeals Council (MAC), or Judicial Review as applicable. A prescribing physician, acting on behalf of an enrollee, and with the enrollee's written consent, may also file a grievance at any time. Enrollee may also designate a family member, friend or other provider in writing to act on their behalf through the grievance or appeal process.

Upon completion of the appeal process, if we do not make a decision timely, we will automatically forward the case to the QIC within twenty-four (24) hours. If the QIC decision is unfavorable to the enrollee, the enrollee or their representative may request an ALJ, MAC, or Judicial Review in successive order.

We will inform enrollees and providers of the grievance and appeal procedures. This information is contained in the enrollee's Summary of Benefits, Member Handbook and within this Provider Manual and on our website. When

requested, we give enrollees reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, alternate formats, interpreter services and toll-free numbers that have adequate TTY/TTD capability.

Grievances

A grievance may be filed with us orally or in writing either by the enrollee or the enrollee's authorized representative, with valid enrollee written consent including prescribing physicians with valid enrollee written consent at any time. In most cases, a decision on the outcome of the grievance is reached within thirty (30) calendar days of the date the grievance was filed. If we are unable to resolve a grievance within thirty (30) calendar days, we may ask to extend the grievance decision date by fourteen (14) calendar days. In these cases, we will attempt to provide prompt oral notification and provide information describing the reason for the delay in writing to the enrollee within two (2) calendar days and, upon request, to the Centers of Medicare and Medicaid Services (CMS) and as required to the Michigan Department of Health and Human Services (MDHHS).

Enrollees are advised in writing of the outcome of the investigation of the grievance within thirty (30) calendar days of the date the grievance was filed. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the enrollee can speak with someone regarding the decision.

Expedited Grievance Resolution

We resolve grievances effectively and efficiently, as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where we have:

- Taken an extension on prior authorization or appeal decision making timeframe; or
- Determined that an enrollee's request for expedited prior authorization or expedited appeal decision making does not meet criteria and has transferred the request to a standard request
- Waiting the standard timeframe could seriously jeopardize the life or health of the enrollee

Enrollees and their authorized representative if designated are informed of their right to request an expedited grievance in their EOC and in the extension and denial of expedited processing prior authorization and appeal letters.

In these cases, a decision on the outcome of an expedited grievance is reached within twenty-four (24) hours of when the grievance was filed. Enrollees are advised orally of the resolution within the twenty-four (24) hours followed by a written notification of resolution within two (2) calendar days of the oral notification. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the enrollee can speak with someone regarding the decision.

The Integrated Care Organization (ICO) ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

Quality Improvement Organization - Quality of Care Grievances

An enrollee may file a grievance regarding concerns of the quality of care received with Aetna Better Health Premier Plan. For items or services covered by Medicare, an enrollee or their authorized representative may also file a quality of care concern with the CMS contracted Quality Improvement Organization (QIO). In Michigan, the QIO, which is located at:

MPRO Michigan's Quality Improvement Organization 22670
Haggerty Road, Suite 100
Farmington Hills, MI 18335
Phone **1-800-365-5899** TTY: MI
Relay 7-1-1
Fax **248-465-7428**
www.mpro.org

Redeterminations

An enrollee may file a redetermination, also called an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action), with us. Authorized enrollee representatives may file an appeal on the enrollee's behalf with the written consent of the enrollee. A prescribing physician, acting on behalf of

an enrollee, may file and appeal no later than sixty (60) calendar days from the postmark on the Aetna Better Health Premier Plan Notice of Denial. The expiration date to appeal the coverage determination and request a reconsideration is included in the Notice of Denial, sometimes called a Notice of Action.

The Notice of Denial informs the enrollee of the following:

- Our decision and the reasons for our decision
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the enrollee can use to file an appeal by phone
- That the enrollee may represent himself or designate a legal counsel, a relative, a friend, a prescribing physician or other spokesperson to represent them
- The specific regulations that support, or the change in federal or state law that requires the action
- The fact that, when requested by the enrollee benefits will continue if the enrollee files an appeal within the timeframes specified for filing

Appeals may be filed either verbally by contacting our Member Services Department or by submitting a request in writing. Unless the enrollee is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written request.

Enrollees may appeal the decision and request a redetermination of Aetna Better Health of Michigan's actions. Examples include:

- The denial or limited approval of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously approved service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to respond to an appeal in a timely manner
- The denial of an enrollee's request to obtain services outside of the contracting area when Aetna Better Health Premier Plan is the only health plan servicing a rural area.

The Integrated Care Organization (ICO) ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

Enrollees may file a redetermination by:

- Calling our Member Services Department at **1-855-676-5772 TTY/TTD MI Relay 7-1-1**
- Writing Aetna Better Health Premier Plan at:
  Aetna Better Health Premier Plan
  PO Box 818070
  Cleveland, OH 44181
- Fax: **1-844-241-2495**

A brief overview of the appeals process follows:

- Verbal request for appeal must be put into writing and signed.
- Aetna Better Health Premier Plan attempts to verbally acknowledge receipt of an appeal at the time of receipt and may send a written acknowledgment letter.
- Enrollees are advised of their or their authorized representative's rights to provide more information and document for their appeal either in person or in writing.
- Enrollees are advised of their, or their authorized representative's, right to view their appeal file.
- Enrollees or their authorized representative may be present either onsite or via telephone when the Appeal Committee reviews their redetermination.
- Appeals will be resolved within seven (7) days, or twenty-one (21) days if an extension is granted and we provide a reason for the extension, or the enrollee or their authorized representative requests the extension after Aetna Better Health Premier Plan receives the appeal.
- Aetna Better Health Premier Plan makes reasonable effort to provide verbal notice and mails the decision letter within the seven (7) days of receipt of the appeal.
- For untimely decisions, the decision letter includes an explanation for the decision and notification that the appeal has been forwarded to the QIC for review.

- If the QIC does not agree with the enrollee's reconsideration request and the amount in controversy meets the established threshold, the enrollee can ask for an ALJ hearing request to continue receiving benefits that were previously approved while the hearing is pending. If we reverse our original decision and grant the reconsideration, services will begin immediately.

If an enrollee or their authorized representative shows good cause in writing, we may extend the time frame for filing an appeal. The enrollee or their authorized representative must request the appeal in writing and include the reason for good cause. The circumstances considered when making the decision to extend the timeframe for appeal include, but are not limited to:

- The enrollee did not personally receive the adverse Notice of Denial, or he/she received it late;
- The enrollee was seriously ill, which prevented a timely appeal of the decision;
- There was a death or serious illness in the enrollee's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the appeal process; or
- The enrollee lacked capacity to understand the time frame for filing a request for an appeal.

If we deny an enrollee's request for a good cause extension, the enrollee will be notified of the case dismissal. The enrollee has a right to file a grievance with the plan for the denial of a good cause extension.

Expedited Redeterminations

We resolve redeterminations, also called an appeal, effectively and efficiently, as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where an enrollee's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the enrollee's condition cannot be adequately managed without urgent care or services. If the enrollee's ability to attain, maintain, or regain maximum function is not at risk, the request to process the appeal in an expedited time frame may be denied and the appeal processed within the normal seven (7) daytime frame. An enrollee or their authorized representative, including providers, may request an expedited appeal, either verbally or in writing, within sixty (60) days from the day of the decision or event in question. Written confirmation, or the enrollee's written consent, is not required to have the provider act on the enrollee's behalf.

Upon receipt of an expedited appeal, we begin the process immediately. We attempt to acknowledge expedited appeals by telephone and may also send a written acknowledgment on the day the expedited request is received. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue is transferred to the standard appeal process. We make reasonable efforts to give the enrollee prompt verbal notice of the denial of expedited processing and follow up in writing within three (3) days of receipt of the expedited appeal request.

In cases where the health plan determines that, an enrollee's request meets expedited urgency or a provider supports the enrollee's request, our Medical Director will render a decision as expeditiously as the enrollee's health requires, but no later than seventy-two

(72) hours from the receipt of the appeal. We will make reasonable efforts to give the enrollee prompt verbal notice of the appeal decision within the seventy-two (72) hours and will follow up in writing within three (3) days of the verbal notification.

If we are unable to resolve an expedited appeal within the specified timeframe, we may extend the period by up to fourteen (14) days. In these cases, we will provide information describing the reason for the delay in writing to the enrollee and, upon request, to CMS and as required to the Michigan Department of Health and Human Services (MDHHS).

Qualified Independent Contractor (QIC)

If we do no*t* issue a decision timely on a coverage determination or an appeal, we will forward the case to the QIC for review within twenty-four (24) hours. We will notify the enrollee in writing that we have forwarded the case to the QIC for review. The letter will include contact information for the QIC office and the enrollee's right to submit additional evidence that may be relevant to the case, direct to the QIC office.

For all other appeal decisions, if we do not agree with the enrollee's request for an appeal and the coverage determination decision is upheld at appeal in whole or in part, the Redetermination Denial letter will include contact information for the QIC office, the enrollee's right to request a QIC review, and their right to submit additional evidence that may be relevant to the case direct to the QIC office.

The QIC will conduct the review as expeditiously as the enrollee's health condition requires, not exceeding seven (7) calendar days for a standard request, or seventy-two (72) hours for an expedited request. The QIC will notify all parties of their decision and will include the right to an ALJ hearing, and the procedure to request one, if the total dollar amount of the items/services being appealed meets or exceeds the established AIS threshold of $140.00.[2]

Administrative Law Judge (ALJ)

If the QIC does not agree with the enrollee's request for reconsideration, the enrollee or their authorized representative may file a request for an ALJ hearing in writing within sixty (60) calendar days of the QIC Notice of Denial. The request must be in writing to the ALJ hearing office specified in the QIC's denial notice. If we receive a written request for an ALJ hearing from the enrollee, we will forward the enrollee's request to the QIC. The QIC will compile the reconsideration file and forward it to the specified ALJ hearing office.

The ALJ will conduct its review as expeditiously as the enrollee's health condition requires, not to exceed ninety (90) days for a standard request, or ten (10) days for an expedited request and will notify all parties of their decision. The notification will include information about the right to a MAC review and the procedure to request one.

Medicare Appeals Council (MAC)

If the ALJ hearing does not agree with the enrollee's request for reconsideration, the enrollee or their authorized representative may request a MAC review in writing, through a letter to the MAC, within sixty (60) calendar days of the ALJ decision. The request should be submitted directly to the MAC at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6127 Medicare
Appeals Council
330 Independence Avenue,
S.W. Cohen Building, Room G-644 Washington, DC
20201

The MAC will review the appeal and render a decision within ninety (90) calendar days for a standard request, and within ten (10) calendar days for an expedited request and will notify all parties of appeal. If the decision is upheld in whole or in part, notification will include the right and the timeframes to request a Judicial Review.

Judicial Review

Any party, the enrollee, their representative (if designated), or Aetna Better Health Premier Plan, may request judicial review upon completion of the MAC review process when the total dollar amount of the items/services meets or exceeds the Amount in Controversy (AIC) threshold of $1,430.00[2].

The party may combine claims to meet the amount in controversy requirement. To meet the requirement:

- All claims must belong to the same enrollee;
- The MAC must have acted on all the claims;
- The enrollee must meet the sixty (60) day filing time limit for all claims; and
- The request must identify all claims.

To request a Judicial Review any party, must file a civil action in a district court of the United States. The action should be initiated in the judicial district in which the enrollee lives, or where the health plan has its principal place of business. If neither the organization nor the enrollee is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

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[2] This amount is calculated annually and published in the Federal Register prior to the end of each calendar year.

CHAPTER 14: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

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Providers are required to comply with the Michigan Estates and Protected Individuals Code, Act 386 of 1998, as subsequently amended, and all other state and federal laws regarding advance directives for adult patients.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA) of 1990 requires health professionals and facilities, serving those covered by Medicare and Medicaid, to give adult patients written information about their rights to have an advance directive. An advance directive is a legal document through which an enrollee may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Advance directives are used when the patient is unable to make or communicate decisions about his or her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes the patient to be unable to actively make a decision about his or her medical care.

In Michigan, "advance directives" is the term used to describe four types of legal documents an enrollee can complete to express their wishes regarding their future health care:

- **An Michigan Durable Power of Attorney for health care (DPOA)** – Lets a patient name someone, called an “agent”, to make decisions about their medical care including decisions about life-sustaining treatment if the patient can no longer speak for themselves. The durable power of attorney of health care is especially useful because it appoints someone to speak on behalf of the enrollee any time the patient is unable to make their own medical decisions, not only at the end of life. The durable power of attorney for health care becomes effective when the provider determines that the patient has lost the capacity to make informed health care decisions.
- **A Declaration for Mental Health Treatment** – If a patient has a mental illness or has been diagnosed with a mental illness in the past, they may already have a DPOA. The patient may also opt to have a mental health declaration to address issues that might arise and are not specifically covered by their health care DPOA. The mental health declaration lets health care professionals know the patient’s preferences regarding mental health treatment. It also allows the patient to name, in the declaration, their "agent" to advocate for their stated choices and make other decisions in their best interest if the patient has not stated any preferences.
- **A DNR (Do-Not-Resuscitate) Order** – See below for a full description of a DNR.
- **MI Living Will Declaration** – Lets patients state their wishes about their health care in the event that they become terminally ill, or permanently unconscious, and can no longer make their own health care decisions.

Do Not Resuscitate (DNR)

A person who does not wish to have Cardiopulmonary Resuscitation (CPR) performed may make this wish known through a physician’s order called a DNR order. A DNR order addresses the various methods used to revive people whose hearts have stopped functioning or who have stopped breathing. Examples of these treatments include chest compressions, electric heart shock, artificial breathing tubes, and special drugs. These standardized DNR orders allow patients to choose the extent of the treatment they wish to receive at the end of life. A patient may choose to be DNR Comfort Care (DNRCC) or a DNR Comfort Care – Arrest (DNRCC-Arrest).

- **DNR Comfort Care (DNRCC)** – a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life. This protocol is activated immediately when a valid DNR order is issued or when a living will requesting no CPR becomes effective.
- **DNR Comfort Care – Arrest (DNRCC-Arrest)** – a person receives standard medical care until the time he or she experiences a cardiac or respiratory arrest. Standard medical care may include cardiac monitoring or intubation prior to the occurrence of cardiac or respiratory arrest. This protocol is activated when the patient has a cardiac or respiratoryarrest. “Cardiac arrest” means absence of a palpable pulse. “Respiratory arrest” means absence of spontaneous respirations or presence of agonal breathing.

Medical Records

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

- Providing written information to adult patient regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting, in the enrollee's medical record, whether or not the adult patient has been provided the information and whether an advance directive has been executed.
- Not discriminating against an enrollee 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 enrollee's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives.

For additional information about medical record requirements, please visit Chapter 3 of this Manual.

As a pre-requisite for participation or continued participation in our network, all providers must maintain advance directive policies and make them available to Aetna Better Health Premier Plan upon request.

You can find additional information concerning advance directives by visiting the following websites:

- **http://www.nals.org/conferences/nationalforum/handouts/2011/MOLST.pdf**

Please note: Aetna Better Health Premier Plan is not responsible for the content or updating of these websites.

Concerns

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health Premier Plan as a grievance or complaint.

CHAPTER 15: ENCOUNTERS, BILLING AND CLAIMS

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Aetna Better Health Premier Plan processes claims for covered services provided to enrollees in accordance with applicable policies and procedures, and in compliance with applicable state and federal laws, rules and regulations. We use our business application system to process and adjudicate claims. Both electronic and manual claim submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, we encourage providers to submit claims electronically. To facilitate electronic claims

submissions, we have developed a business relationship with ECHO Health, Inc. Aetna Better Health Premier Plan receives Electronic Data Interchange (EDI) claims directly from this clearinghouse, processes them through pre- import edits to maintain the validity of the data, HIPAA compliance and enrollee enrollment, and then uploads them into our business application system each business day. Within twenty-four (24) hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Billing Encounters and Claims Overview

We are required to process claims in accordance with Medicare claim payment rules and regulations.

Providers must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-9 CM) codes, and code to the highest level of specificity. Complete and accurate use of CMS's 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-9 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System. Important notes:

- The ICD-9 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 sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management, and/or treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical 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/or rejection of a claim. Please note that ICD-10 codes will be out soon. Please prepare your office accordingly.

CMS Risk Adjustment Data Validation

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

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 enrollee'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 fairly and accurately adjust payments made to Aetna Better Health Premier Plan by CMS based on the health status and demographic characteristics of an enrollee. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-9 CM as the official diagnosis code set in determining the risk-adjustment factors for each enrollee. 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-9 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 us, and payments made by us to providers, including, but not limited to, provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for an enrollee 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, enrollee 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 Premier Plan. 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. CMS may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the CMS website at **http://csscoperations.com/internet/cssc3.nsf/docsCatHome/CSSC%20Operations.**

Billing and Claims

When to Bill an Enrollee

All providers must adhere to federal financial protection laws and are prohibited from balance billing any enrollee beyond the enrollee's cost sharing.

An enrollee may be billed only when the enrollee knowingly agrees to receive non-covered services under the MI Health Link Program

- Provider MUST notify the enrollee in advance that the charges will not be covered under the program.
- Provider MUST have the enrollee sign a statement agreeing to pay for the services and place the document in the enrollee's medical record.

When to File a Claim

All claims and encounters must be reported to us, including prepaid services.

Clean Claims

We require clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely

manner. Our timely filing limitations are as follows:

- **New Claim Submissions** – Claims must be filed on a valid claim form within 365 days from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.
- **Claim Resubmission** – Claim resubmissions must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

Non-network providers rendering prior authorized services follow the same timely filing guidelines as Original Medicare guidelines.

Injuries Due to an Accident

Medicare law only permits subrogation in cases where there is a reasonable expectation of third-party payment. In cases where legally required insurance (i.e. auto-liability) is not actually in force, we are required to assume responsibility for primary payment.

Claims Submission

Claims Filing Formats

Providers can elect to file claims with us in either an electronic or a hard copy format. Claims must be submitted using either the CMS 1500 or UB-04/1450 formats, based on your provider type as detailed in the table below.

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, we encourage providers to electronically submit claims, through Change Healthcare.
- Please use the following Provider ID and Submitter ID when submitting claims to us for both CMS 1500 and UB-04/1450 forms. You can submit claims by visiting Change Healthcare at www.echohealthinc.com Before submitting a claim through your clearinghouse, please make certain that your clearinghouse is compatible with ECHO Health, Inc.
    - Payer ID# 128MI

Important Points to Remember

- We do not accept direct EDI submissions from our providers.
- We do not perform any 837 testing directly with our providers but perform such testing with ECHO Health, Inc.
- For electronic resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

Paper Claims Submission

Providers can submit hard copy CM 1500 or UB-04/1450 claims directly to us via mail at the following address: Aetna Better Health

Premier Plan
PO Box 982963
El Paso, TX 79998

Risk Pool Criteria

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

How to File a Claim

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

Service	Claim Form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, nursing home and emergency room services	**CMS UB-04/1450 Form**
General dental services	**ADA 2006 Claim 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.

2. Complete the claim form.
    a. Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
        i) How to fill out a CMS 1500 Form: **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf**
        ii) Sample CMS 1500 Form: **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf**
        iii) How to fill out a CMS UB-04/1450 Form**: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf**
    b. 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.
3. Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as enrollees' medical records, clearly label and send to Aetna Better Health Premier Plan at the correct address.
    a. Electronic Clearing House
    Providers who are contracted with us can use electronic billing software. Electronic billing allows 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.

- ECHO Health, Inc. is the EDI vendor we use
- Contact your software vendor directly for further questions about your electronic billing
- Contact our Provider Relations Department for more information about electronic billing

All electronic submission should be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health Premier Plan policies and procedures.

b. Through the Mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health Premier Plan PO Box 982963 El Paso, TX 79998	Through Electronic Clearinghouse **www.echohealthinc.com**

About ECHO Health, Inc.

Aetna Better Health of Michigan Premier Plan is partnering with ECHO to introduce the new EFT/ERA Registration Services (EERS), a streamlined way for our providers to access payment services.

Please complete the ERA/EFT **enrollment form**. Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process. If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 888-834-3511.

To validate your account, please make sure you have an ECHO Health draft number and payment amount so they can validate your enrollment request. A draft number is listed as the EPC draft # on ECHO Health explanation of payments.

If you do not have an ECHO draft number available please dial 888-834-3511.

Correct Coding Initiative

We follow the same standards as Medicare's Correct Coding Initiative (CCI) policy and perform CCI edits 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: **http://www.cms.hhs.gov/NationalCorrectCodInitEd/** .

We utilize ClaimCheck® 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 ClaimCheck. It enables us to share with our providers, the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website and 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 for related services when one code includes all related services
- Breaking out bilateral procedures when one code is appropriate
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. We can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59 – Disting Procedural Services** – must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201- 99499) or radiation therapy codes (77261-77499).
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** – must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- **Modifier 50 – Bilateral Procedure** – If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and the MDHHS when billing for bilateral procedures. Services should be billed on one line, reporting one unit with a 50 modifier.
- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners indicate:

  "*Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.*"

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) Department.

Online Status through our Care Bridge site (Secure Web Portal)

We encourage providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims. To register, go to **AetnaBetterHealth.com/Michigan** to download our Care Bridge (Secure Web Portal) Agreement. Contact our Provider Relations Department for additional information or to schedule training.

Calling the Claims Inquiry Claims Research (CICR) Department

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

- Answer questions about 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 Department directly).
  - 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 NPI number with applicable suffix if appropriate
    - Enrollee name and enrollee identification number
    - Date of service
    - Claim number from the remittance advice on which you have received payment or denial of

the claim

Payment of Claims

We process claims and notify providers of outcomes using a Remittance Advice. Providers may choose to receive checks through the mail or electronically. We encourage providers to take advantage of receiving Electronic Remittance Advices (ERA), which are received much sooner than Remittance Advice received through the mail, enabling you to post payments sooner. Please contact our Provider Experience Department for further information on how to receive ERA.

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. We encourage you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Payment for the MI Health Link Program will be made on separate checks, one check from Medicare, and one check from Medicaid. You may enroll in EFT by submitting an EFT Enrollment Form, which is located on our website, or by contacting our Provider Relations Department. Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT to be established. Our Provider Relations Department can assist you with this process.

Claim Resubmission

Providers have 365 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors Include

the following information when filing a resubmission:

- Use the Resubmission Form located on our website
- 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 the claim was denied or incorrectly paid
- Any additional documentation required
- A brief note describing requested correction
- Clearly label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address. Failure to mail

and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Claim Disputes

Conditions for payment are outlined in your Provider Agreement and fee schedule. Claim payments are adjudicated in accordance with your Provider Agreement. CMS prohibits MI Health Link Programs from applying the mandated Medicare enrollee appeal process to providers. Providers are encouraged to contact the Claims Inquiry Claims Research (CICR) Department with questions on how their claim paid. We will work with the provider to resolve the issue if an error is discovered. In some situations, we may require the provider to resubmit the claim for reprocessing. For additional information about claims disputes, please see the Grievance Systems Chapter in this Manual (Chapter 16).

Instruction for Specific Claims Types

General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your Provider Agreement. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

Nursing Homes

Providers submitting claims for nursing homes should use the CMS UB-04 Form.

Providers must bill in accordance with standard Medicare Resource Utilization Groups (RUGs) billing requirement rules for Aetna Better Health Premier Plan, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp**.

Home Health Claims

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

Home Health Agencies

No payment will be made unless the claim for payment is supported by documentation of the time spent providing services to each enrollee.

Dental Claims

- Claims for dental services should be submitted on the standard American Dental Association form, ADA 2006 Claim Form.
- Services provided by an anesthesiologist, or medically related oral surgery procedure, should be submitted on the CMS 1500 Form.

Personal Emergency Response System

All bills for Personal Emergency Response Systems should contain a dated certification by the provider that the care, services, and supplies itemized have in fact been furnished.

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for DME Rental should use the CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

There is a billing discrepancy rule difference between Days versus Units for DME rentals between Medicaid and the MI Health Link Program. Units billed for MI Health Link equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, in order 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.

Same Day Readmission

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

There may be occasions where an enrollee may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with twenty-four (24) hours of discharge.

Example: *Discharge Date: 10/2/10 at 11 AM. / Readmission Date: 10/3/10 at 9 AM.*

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Hospice Claims

The only claims payable during a hospice election period by Aetna Better Health Premier Plan are additional benefits covered under us that would not normally be covered under the MI Health Link Program covered services. All other claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to hospice services or not.

HCPCS Codes

There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare billing requirement rules, which could result in separate billing for claims under Aetna Better Health Premier Plan. While most claims can be processed under both the MI Health Link Program, and Medicaid, there may be instances where separate billing may be required.

For HCBS providers, please review the HCBS Quick Reference Guide located on our website for additional details and codes.

Remittance Advice

Provider Remittance Advice

We generate 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 make certain 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 Relations 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 Premier Plan for previous overpayments not yet recouped or funds advanced.
- We will provide notification to providers via mail, 18 days prior to any recoupment efforts. It provides you with an opportunity from the print date of the letter to dispute our findings. It also includes instructions on how to issue a refund to the overpayment, if applicable.
- 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 Agreement.
- 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 Premier Plan 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 Premier Plan 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 EFT Reference # and EFT Amount are listed, along with the last four digits of the bank account to which 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. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
  - Enrollee 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 obtained. In order to qualify for Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability 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 Relations Department for assistance with this process.

Encounter Data Management (EDM) System

Aetna Better Health Premier Plan uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to the MDHHS requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to the MDHHS. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness and we then submit encounter data to the MDHHS. Our EDM System processes CMS1500, UB04 (or UB92), Dental, Pharmacy and Long-Term Care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-10, CPT-4, HCPCS-I, II). Our Provider Agreements 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 MDHHS's requirements.

The EDM System has top-of-the-line functionality to accurately, and consistently tracks encounters throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA-compliant 837 (I and/or 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 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 the business application system claims data into EDM System using a transfer validation report. The Encounter Management Unit researches, 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 the 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 the MDHHS's edit profiles to identify

records that may be unacceptable to the MDHHS. Our Encounter Management Unit is able to customize our EDM System edits to match the edit standards and other requirements of the MDHHHS. This means that we can align our encounter edit configuration with the MDHHS'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 program. 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 the EDM System, to submission and acceptance by the MDHHS. Reports are run to make certain 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 MDHHS. Our Encounter Management Unit uses two processes to manage encounter correction activities:

1. 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 MDHHS encounter correction protocol.
2. Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system. The adjusted claim is imported into the Encounter Data Management System (EDM) for resubmission to the MDHHS in accordance with the encounter correction protocol, which is tailored to the MDHHS's requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement and/or corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the MDHHS'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 MDHHS. 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 encounter 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 MDHHS. 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 MDHHS 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.

Enrollee Grievance System Overview

Aetna Better Health Premier Plan takes grievances and appeals very seriously. We want to know what is wrong so we can make our services better. Enrollees can file a complaint, grievance or appeal if they are not satisfied. A network provider, acting on behalf of an enrollee and with the enrollee's written consent, may file a grievance, appeal, State Fair Hearing, Patient Right to Independent Review Act (PRIRA), Medicare Appeals Council (MAC), or Judicial Review as applicable.

For Medicaid only covered items/services, an enrollee or their authorized representative may request a State Fair Hearing through the Michigan Department of Community Health (MDHHS) at the same time as, in lieu of, or after the appeal process. Enrollees may also request a PRIRA review within 60 calendar days of the appeal decision letter.

For Medicare only covered items/services, if we uphold the coverage decision in whole or in part, we will automatically forward the case to the Independent Review Entity (IRE). If the IRE upholds the decision and the total of the item/services appealed, meets the Amount in Controversy (AIC) established dollar amount, the enrollee or their authorized representative may request an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review in successive order.

For items/services covered by Medicaid and Medicare, upon completion of the appeal process, if we uphold the coverage decision in whole or in part, we will automatically forward the case to the Independent Review Entity (IRE). The enrollee or their authorized representative may request a State Fair Hearing through the MDHHS within 90 calendar days of the IRE Decision Letter, at the same time as, in lieu of a request for ALJ hearing. In instances where a case is reviewed both by the IRE or ALJ and the State Fair Hearing officer, the decision that is most favorable to the enrollee will be the one that counts. Enrollees or their representative may request an Administrative Law Judge (ALJ) if the total of the item/services appealed meets the AIC established dollar amount, then Medicare Appeals Council (MAC), or Judicial Review in successive order.

We inform enrollees and providers of the grievance, appeal, State Fair Hearing and PRIRA procedures. This information is contained in the enrollee's Summary of Benefits, Member Handbook within this Provider Manual on our website and in the Member Handbook. When requested, we provide enrollees reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, provider interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Grievances

A grievance may be filed with us either orally, or in writing, by the enrollee or the enrollee's authorized representative at any time. With written consent of the member, a provider may file a grievance on behalf of a member. We will send the enrollee or the enrollee's representative an acknowledgment letter in a timely manner. If we are unable to resolve a grievance within the specified time frame of thirty (30) days, we may ask to extend the grievance decision date by 14 days. In these cases, we will provide information describing the reason for the delay in writing to the enrollee and, upon request, to the Centers of Medicare and Medicaid Services (CMS) and as required by the MDHHS.

Enrollees are advised in writing of the outcome of the grievance investigation when we make our decision on your grievance but not later than the expiration of the grievance time frame plus the extensions (44 days). The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the enrollee can speak with someone regarding the decision.

Expedited Grievance Resolution

We resolve grievances effectively and efficiently, as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where we have:

- Taken an extension on prior authorization or appeal decision making timeframe; or
- Determined that an enrollee's request for expedited prior authorization, or for an expedited appeal decision

making, does not meet the criteria and has transferred the request to a standard request.
- Waiting the standard timeframe could seriously jeopardize the life or health of the enrollee

Enrollees and their representative, if designated, are informed of their right to request an expedited grievance in the EOC and in the extension and denial of expedited processing prior authorization and appeal letters.

In most cases, a decision on the outcome of an expedited grievance is reached within twenty-four (24) hours of the date the grievance was filed. Enrollees are advised orally of the resolution within the twenty-four (24) hours, followed by a written notification of resolution. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the enrollee can speak with someone regarding the decision.

Quality Improvement Organization - Quality of Care Grievances

An enrollee may file a grievance, regarding concerns of the quality of care received, with us directly. For items or services covered by Medicare, an enrollee or their authorized representative may also file a quality of care concern with CMS's contracted Quality Improvement Organization (QIO). In Michigan, the QIO, which is located at:

Livanta LLC
BFCC-QIO
10820 Guilford Road, Suite 202 Annapolis
Junction, MD 20701-1105 Phone 1-888-
524-9900
TTY: MI Relay 1-888-985-8775 Fax
248-465-7428
https://www.livantaqio.cms.gov/en/appeal-initiation

Regulatory Complaints

For items/services covered by Medicaid, only an enrollee or their designated representative may submit complaints direct to the State, primarily through the Long Term Care Ombudsman's office at **1-866-485-9393.**

For items/services covered by Medicare only, an enrollee or their designated representative may submit complaints direct to CMS through **1-800-MEDICARE (1-800-633-4227**).

For items/services covered by both Medicaid and Medicare, an enrollee or their designated representative may submit complaints direct to the State, primarily through the Long-Term Care Ombudsman's office at **1-866-485-9393**, or to CMS through **1-800-MEDICARE (1-800-633-4227).**

Appeals

An enrollee may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with us. Authorized enrollee representatives, including providers, may also file an appeal on the enrollee's behalf with the written consent of the enrollee. Appeals must be filed no later than sixty (60) calendar days from the postmark on the Aetna Better Health Premier Plan Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

The Notice of Action informs the enrollee of the following:

- Our decision and the reasons for our decision
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the enrollee can use to file an appeal by phone
- The procedures for exercising their rights to appeal and/or a State Fair Hearing
- That the enrollee may represent himself or designate legal counsel, a relative, a friend, a provider or other spokesperson to represent them
- The specific regulations that support, or the change in Federal or State law, that requires the action
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or requests a State Fair Hearing within the timeframes specified for filing

Appeals may be filed either verbally, by contacting our Member Services Department, or by submitting a request in writing.

Enrollees may appeal the decision and request a further review of our actions. Examples of appeals include:

- The denial or limited approval of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously approved service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to respond to an appeal in a timely manner
- The denial of an enrollee's request to obtain services outside of the contracting area when Aetna Better Health Premier Plan is the only health plan servicing a rural area.
- Enrollees may file an appeal by:
- Calling our Member Services Department at **1-855-676-5772** /TTD MI Relay 7-1-1
- Writing Aetna Better Health Premier Plan at:

  Aetna Better Health Premier Plan
  Grievance & Appeals Department
  P.O. Box 818070
  Cleveland, OH 44181
  Phone: 1-855-676-5772
  Fax: 1-855-883-9555

If the enrollee requests services to continue while the appeal is reviewed, the appeal must be filed no later than ten (10) calendar days from the date of the Notice of Action letter to suspend or reduce previously authorized services or prior to the intended effective date of the action, whichever is later. We will also provide enrollees with access to necessary medical records and information to file their appeals.

A brief overview of the appeals process follows:

- An enrollee may file an appeal either verbally or in writing. An enrollee, an enrollee’s appointed representative, or the enrollee’s provider with the written consent of the enrollee may request a standard or expedited "fast" appeal on behalf of the enrollee.
- Aetna Better Health Premier Plan acknowledges appeals in writing in a timely manner within three (3) business days.
- Enrollees are advised of their, or their authorized representative's, rights to provide more information and document for their appeal either in person or in writing.
- Enrollees are advised of their, or their authorized representative's right, to view their appeal file.
- Enrollees or their authorized representative may be present either onsite, or via telephone, when the Appeal Committee reviews their appeal.
- Appeals will be resolved within thirty (30) days or forty-four (44) calendar days if an extension is granted and we provide a reason for the extension, or the enrollee or their authorized representative requests the extension) after Aetna Better Health Premier Plan receives the appeal.
- If we do not agree with the enrollee's appeal, and the item or service is standardly covered by Medicaid only the decision letter includes information that the enrollee or their authorized representative can ask for a State Fair Hearing or a PRIRA review and request to receive benefits while the hearing is pending. If we do not agree with the enrollee's appeal, and the item or service is standardly covered by Medicare only or is covered by both Medicare and Medicaid, the decision letter includes notification that the appeal has been forwarded to the IRE for review.
- If we do not agree with the enrollee's appeal, and if the item or service is standardly covered by both Medicare and Medicaid, the enrollee or their authorized representative can ask for a State Fair Hearing at the same time as the IRE.
- If Aetna Better Health Premier Plan, the State Fair Hearing officer, or the IRE reverses the original decision and approves the appeal, the plan authorizes or provides the disputed services promptly and as expeditiously as the member’s health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

If an enrollee or their authorized representative shows good cause in writing, we may extend the time frame for filing an appeal. The enrollee or their authorized representative must request the appeal in writing and include the reason for good cause. The circumstances considered when making the decision to extend the timeframe for appeal include, but are not limited to:

- The enrollee did not personally receive the adverse Notice of Action, or he/she received it late;
- The enrollee was seriously ill, which prevented a timely appeal of the decision;

- There was a death or serious illness in the enrollee's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the appeal process; or
- The enrollee lacked capacity to understand the time frame for filing a request for an appeal.

If we deny an enrollee's request for a good cause extension, the enrollee will be notified of the case dismissal. The enrollee has a right to file a grievance with the plan for the denial of a good cause extension.

Expedited Appeal Resolution

We resolve appeals effectively and efficiently, as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where an enrollee's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the enrollee's condition cannot be adequately managed without urgent care or services. If the enrollee's ability to attain, maintain, or regain maximum function is not at risk, the request to process the appeal in an expedited time frame may be denied and the appeal processed within the normal thirty (30) day time frame. An enrollee or their authorized representative, including providers with written consent from the enrollee, may request an expedited appeal either verbally, or in writing, within sixty(60) days from the day of the decision or event in question.

Upon receipt of an expedited appeal and all necessary supporting documentation, we begin the appeal process immediately. We attempt to acknowledge expedited appeals by telephone or in writing on the day the expedited request is received. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue is transferred to the standard appeal process. We make reasonable efforts to give the enrollee prompt verbal notice of the denial of expedited processing and follow up in writing within two (2) business days of receipt of the expedited appeal request.

In cases where the health plan determines an enrollee's request meets expedited urgency, or a provider supports the enrollee's request, our Medical Director will render a decision as expeditiously as the enrollee's health requires, but no later than seventy-two (72) hours from the receipt of the expedited appeal. We will make reasonable efforts to give the enrollee prompt verbal notice and we will send written notice of the appeal decision within the seventy-two (72) hours from the receipt of the expedited appeal request.

If enrollees wish for services to continue while their appeal is reviewed, they must request the appeal within ten(10) calendar days from the date of the Notice of Action letter or prior to the intended effective date of the action, whichever is later. If we reverse our original decision and approve the appeal, services will begin immediately.

If we are unable to resolve an expedited appeal within the specified timeframe, we may extend the period by up to fourteen (14) calendar days. In these cases, we will attempt to provide prompt oral notice of the delay and provide written notification describing the reason for the delay in writing to the enrollee within two (2) calendar days and, upon request, to CMS and as required to the MDHHS.

The Michigan Department of Health and Human Services (MDHHS State Fair Hearing)

For items/services covered by Medicaid only, the enrollee and/or the enrollee's representative acting on behalf of the enrollee may request a State Fair Hearing through the MDHHS within one hundred and twenty (120) days from Aetna Better Health's Notice of Action (NOA) Letter or the Appeal Decision Letter.

For items/services covered by both Medicaid and Medicare, the enrollee and/or the enrollee's representative acting on behalf of the enrollee may request a State Fair Hearing through the MDHHS within one hundred and twenty (120) days from the Independent Review Entity (IRE) decision letter.

If enrollees wish services to continue receiving services while their State Fair Hearing is reviewed, they must request a State Fair Hearing within ten (10) days from the date of the Notice of Action Letter or the Appeal Decision Letter. At the State Fair Hearing, enrollees may represent themselves or be represented by a lawyer, their provider or other authorized representative, with the enrollee's written permission. To request a State Fair Hearing, enrollees must call (877)
833-0870, write or email **administrativetribunal@michigan.gov** MDHHS with their request. To submit a request in writing, enrollees should write to:

Michigan Department of Health and Human Services Bureau
of State Hearings
P.O. Box 30763
Lansing, MI 48909

The State Fair Hearing officer reverses our decision we will approve the appeal, services will begin immediately.

The Patient Right to Independent Review Act (PRIRA)

For items/services that are covered by Medicaid only an enrollee or a representative acting on their behalf may request an PRIRA Review within one hundred and twenty (120) calendar days from the health plan's Appeal Decision Letter in the event of a denial, termination, suspension or reduction of services for medical necessity. An enrollee or their representative must request an PRIRA Review in writing to the Commissioner.

The Commissioner will:

- Review the request for completeness and acceptance or denial. Acceptance criteria includes:
  - Review of enrollee eligibility at the time of service
  - Review of whether the item/service reasonably appears to be covered
  - Review of whether the enrollee completed the Aetna Better Health Premier Plan appeal process
  - Review of whether the item/service involves issues of medical necessity or clinical review criteria
- Will immediately send written notification of its decision to accept or deny with information that the enrollee may submit additional information for consideration within 7 calendar days of the notification.
- If accepted the Commissioner will assign the case to an independent review organization approved by the State
- Provide written notice of decision within 7 calendar days of receiving the independent review organization or within 14 calendar days of the decision if the Commissioner decided the case.

If the enrollee requested both an PRIRA review and a State Fair Hearing, the decision most favorable to the enrollee will be the one that counts.

The enrollee may contact Aetna Better Health Premier Plan at **1-855-676-5772 (TTY: 711)** for further assistance during the hearing process. Information on how to request an PRIRA Review will be the Medicaid only Appeal Decision Letter.

Aetna Better Health Premier Plan will devote the necessary staffing resources necessary to address enrollee appeals at the External Review level.

Independent Review Entity (IRE)

For items/services covered by Medicare only or by both Medicare and Medicaid, if the decision is upheld at appeal in whole or in part, we will submit a case summary to the Independent Review Entity (IRE). We will then notify the enrollee that we forwarded the case to the IRE for review in the Appeal Decision Letter. The notice will include contact information for the IRE and the enrollee's right to submit additional evidence that may be relevant to the case direct to the IRE.

The Independent Review Entity (IRE) will conduct the review as expeditiously as the enrollee's health condition requires, will notify all parties of the determination, and will include the right to an ALJ hearing and the procedure to request one if the total dollar amount of the items/services being appealed meets or exceeds the established AIC threshold of $180.00[3] and for items or services that are standardly covered by both Medicare and Medicaid it will also include the right to request a State Fair Hearing at the same time as or instead of an ALJ request.

Administrative Law Judge (ALJ)

The enrollee or their authorized representative may file a request, for an ALJ hearing in writing within sixty (60) calendar days of the IRE notice of determination, to the entity specified in the IRE's reconsideration notice. If we receive a written request for an ALJ hearing from the enrollee, we will forward the enrollee's request to the IRE. The IRE will compile the reconsideration file and forward it to the appropriate ALJ hearing office.

The ALJ will conduct its review as expeditiously as the enrollee's health condition requires, not to exceed ninety (90) days for a standard request, or ten (10) days for an expedited request and will notify all parties of their decision. The notification will include information about the right to a MAC review and the procedure to request one.

Medicare Appeals Council (MAC)

The enrollee or their authorized representative may request a MAC review in writing through a letter to the MAC within sixty (60) calendar days of the Administrative Law Judge (ALJ) decision. The request should be submitted directly to the MAC at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6127 Medicare
Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

The MAC will review the appeal and render a decision within ninety (90) calendar days for a standard request, and within ten (10) calendar days for an expedited request and will notify all parties of determination appeal. If the decision is upheld in whole or in part, notification will include the right and the time frames to request a Judicial Review.

Judicial Review

Any party, the enrollee, their representative, if designated, or Aetna Better Health Premier Plan, may request judicial review upon completion of the MAC review process when the total dollar amount of the items/services meets or exceeds the Amount in Controversy (AIC) threshold of $1,840.00[4]. The party may combine claims to meet the amount in controversy requirement. To meet the requirement:

- All claims must belong to the same enrolle;
- The MAC must have acted on all the claims;
- The enrollee must meet the 60-day filing time limit for all claims; and
- The request must identify all claims.

To request a Judicial Review any party, must file a civil action in a district court of the United States. The action should be initiated in the judicial district in which the enrollee lives, or where the health plan has its principal place of business. If neither the organization, nor the enrollee, is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

Contracting Provider Disputes

Aetna Better Health Premier Plan and our contracted providers are responsible for timely resolution of any disputes between both parties. Disputes will be settled according to the terms of our contractual agreement and there will be no disruption or interference with the provision of services to enrollees as a result of disputes.

We will inform providers through the Provider Manual and other methods including Periodic Provider Newsletters, training, provider orientation, the website and by the provider calling their Provider Relations Representative about the provider dispute process. Our Provider Relations Representatives are available to discuss a provider's dissatisfaction with a decision based on this policy and contractual provisions, inclusive of claim disputes.

In the case of a claim dispute, the provider may be required to complete and submit the Provider Dispute Form and any appropriate supporting documentation to our Provider Relations Manager. The Provider Dispute Form is accessible on our website, via fax or by mail.

Our Provider Relations Manager assigns the Provider Dispute Form to a Provider Relations Representative to review research and analyze. Claims disputes are delegated to Claims Investigation Claims Research Department to review research and analyze. We will contact the provider by email, fax, and telephone or in writing of the decision.

In the event the provider remains dissatisfied with the dispute determination, the Provider is notified that a complaint may be initiated. Our Complaint System policy, as well as the Provider Manual, includes the process by which the provider can submit a grievance.

Non-Contracting Provider Claim Appeals

Upon denial of payment on a claim for an item/service that is covered by Medicare only, or by both Medicare and Medicaid, non-contracted providers have the right to request a Non-Contracting Provider Claim Appeal. Non-

contracting provider claim appeals must be submitted in writing with a completed Waiver of Liability (WOL) form within sixty (60) calendar days of the remittance advice.

Non-Contracting Provider Payment Disputes

Upon disagreement with a payment on a submitted claim for an item/service that is covered by Medicare only or by both Medicare and Medicaid, non-participating providers have the right to request Non-Contracting Provider Payment Dispute. Non-Participating Provider Payment Disputes must be submitted in writing with the supporting documentation that they should receive a different payment under original Medicare within sixty (60) calendar days of the remittance advice.

If the provider remains in disagreement with the Non-Participating Provider Payment Dispute decision, the provider can submit a request in writing for an Independent Review Entity (IRE) review through CMS within one-hundred-eighty (180) calendar days of the remittance advice. The IRE will process the request within sixty (60) calendar days of receipt and will notify all parties to the appeal of their decision. If the decision is overturned, we will effectuate the decision within thirty (30) calendar days of receipt of IRE's notification of decision.

Provider Grievances

Both, network and out-of-network providers, may file a complaint verbally or in writing, directly with us in regard to our policies, procedures or any aspect of our administrative functions. Providers can file a verbal grievance with us by calling **1-855-676-5772**. To file a grievance in writing, providers should write to:

Aetna Better Health Premier Plan
Grievance & Appeals Department
P.O. Box 818070
Cleveland, OH 44181
Phone: 1-855-676-5772
Fax: 1-855-883-955

Aetna Better Health Premier Plan Grievance & Appeals Department assumes primary responsibility for coordinating and managing provider grievances and for disseminating information to the Provider about the status of the grievance. Aetna Better Health will not seek punitive action against any provider who files a grievance. If the grievance requires research or input by another department, the Grievance & Appeals Department will forward the information to the affected department and coordinate with the affected department to thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health Premier Plan's written policies and procedures, collecting pertinent facts from all parties. The grievance, with all research, will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with the same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the grievance within thirty (30) calendar days. The Grievance & Appeals Department will notify the provider of the resolution by phone, email or fax.

Provider Appeals

A provider may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, within sixty (60) calendar days from the postmark on the Aetna Better Health Notice of Action or the remittance advice. Providers can file a verbal appeal with us by calling 1-855-676-5772. Providers must submit an Authorization of Representative form or valid member written consent when requesting an appeal on behalf of the member (pre-service). All written appeals should be sent to the following:

Aetna Better Health Premier Plan
Grievance & Appeals Department
P.O. Box 818070
Cleveland, OH 44181
Phone: 1-855-676-5772
Fax: 1-855-883-955

Management of the Process

The Grievance & Appeals Department has overall responsibility for the management of the enrollee Grievance System process and reports to the Director of Complaints and Appeals. This includes:

- Documenting individual grievances, appeals, State Fair Hearings and PRIRA reviews
- Coordinating resolutions of grievances and appeals
- Tracking, trending and reporting data
- Identification of opportunities for improvement
- Maintaining the appeals and grievance database and records of the grievance and appeals

The Compliance Department has oversight responsibility of the grievance and appeals process. This includes:

- Review of individual grievances and appeals
- Monitoring for compliance with contractual obligations
- Monitoring for compliance with state and federal regulatory requirements

Our Grievance & Appeals Department Director will serve as the primary contact person for the grievance and appeals process, with the Aetna Better Health Premier Plan Quality Management (QM) Coordinator in the QM Department serving as the back-up contact person.

Our Member Services Department, in collaboration with the QM Department and Provider Relations Department, is responsible for informing and educating enrollees and providers about an enrollee's right to file a grievance, appeal, MDHHS State Fair Hearing or PRIRA review and for assisting enrollees throughout the grievance or appeal process.

Enrollees are advised of their grievance, appeal, MDHHS State Fair Hearing, PRIRA, Independent Review Entity (IRE), Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review rights and processes, as applicable, at the time of enrollment and at least annually thereafter. Providers receive this information via the Provider Manual, during initial provider orientation, within the Provider Agreement, and on our website.

Fraudand Abuse

Aetna Better Health Premier Plan has an aggressive, proactive Fraud, Waste, and Abuse (FWA) Program that complies 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. Our Special Investigations Unit (SIU) is a key element of the program. The SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to the appropriate state and federal agencies as mandated by Michigan Administrative Code. During the investigation process, the confidentiality of the patient and or people referring the potential fraud and abuse case is maintained.

We use a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and enrollees, share 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.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste and abuse, and is responsible to investigate cases of alleged fraud, waste and abuse. With a total staff of over 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 been acknowledged as an effective tool, and we encourage 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'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 enrollee 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.

Reporting Suspected Fraud and Abuse

Participating providers are required to report all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies they become aware within the MI Health Link Program, to Aetna Better Health Premier Plan.

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

- By phone to the confidential Aetna Better Health Premier Plan Compliance Hotline at **1-855-676-5280**; or
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**.

Note: If you provide your contact information, your identity will be kept confidential.

You can also report fraud to the State of Michigan Office of the Inspector General at **1-800-222-8558**, or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services (HHS) at **1-800-HHS-TIPS (1-800-447-8477).**

CMS requires us to have a compliance plan that guards against potential fraud, waste and abuse under 42 C.F.R. § 422.503 (b) (4) (vi), and 42 C.F.R §423.504(b) (4) (vi).

CMS combats fraud by:

- Close coordination with contractors, providers, and law enforcement agencies
- Developing MI Health Link Program compliance requirements that protect stakeholders
- Early detection through medical review and dataanalysis

- Effective education of providers, suppliers, andenrollees

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

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 or Medicare 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 and or Medicare 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 the MI Health Link Program
- 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 Premier Plan due to improper payments to providers or overpayments.
- Physical or sexual abuse of enrollees Fraud,

Waste and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions.
- Switching an enrollee'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 enrollees, a cash payment as an inducement to enroll in a specific plan.
- Selecting or denying enrollees 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 (e.g., by not referring an enrollee to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., 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 enrollees 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 enrollees.
- Double billing such as billing both the enrollee, or billing Aetna Better Health Premier Plan and another enrollee.

- Misrepresenting the date services were rendered or the identity of the enrollee 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 enrollees as well:

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

addition, enrollee fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit.
- Attempting to use an enrollee's ID card to obtain prescriptions when the enrollee is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another enrollees ID).
- Forging and altering prescriptions.
- Doctor shopping (i.e., when an enrollee consults a number of doctors for the purpose of 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.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of Michigan's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. 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.
3. Effective Compliance Training: Development and implementation of regular, effective education, and training.
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and address individuals or entities that are excluded from participating in the MI Health Link Program.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, directors, and enrollees of the compliance committee, as well as related entities.
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non- compliance, while maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health Premier Plan.
7. 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 that Apply to Fraud, Waste, and Abuse

Providers contracted with us must agree to be bound by, and comply with, all applicable state and federal laws and regulations. There are several relevant laws that apply to Fraud, Waste, and Abuse:

The False Claims Act (FCA)

- The Federal False Claims Act 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 in order 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.

- Self-Referral Prohibition Statute (Stark Law)
  - Prohibits providers from referring enrollees to an entity with which the provider or provider's immediate family enrollee 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 thefederal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims' 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's Premier Plan services through the MI Health Link Program.
- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health Premier Plan providers must follow state and federal 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's Premier Plan services through the MI Health Link 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 database
- License suspension or revocation

Potential Civil and Criminal Penalties

- False Claims Act – For each false claim, the penalty could range from $5,500.00 - $11,000.00. If the government proves it suffered a loss, the provider is liable for three times the loss.
- Anti-Kickback Statute – Up to five years in prison and fines of up to $25,000.00 for violations of the Anti- Kickback Statute. If an enrollee suffers bodily injury as a result of the scheme, the prison sentence may be 20+ years.

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

By law, we are required to check providers against the Office of the Inspector General's (OIG) Exclusion Database, 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 Michigan Department of Community Health (MDHHS) may prescribe.

We do 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/or who have been terminated from Medicaid or any programs by the MDHHS for fraud, waste, or abuse. The provider must agree to assist us as necessary in meeting our obligations under the contract with the MDHHS to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 C.F.R. § 455.2) in the provision of health care services.

CHAPTER 18: ABUSE, NEGLECT, EXPLOITATION & MISAPPROPRIATION OF ENROLLEE PROPERTY

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Mandated Reporters

As mandated by Mich. Comp. Laws § 400.11a(1) and (4) – (5) , all providers who work or have any contact with an Aetna Better Health Premier Plan enrollee are required, as "mandated reporters", to report any suspected incidences of abuse, neglect, exploitation and misappropriation of an adult enrollee's property, to the appropriate state agency. A full version of the MI revised code can be found on the Michigan General Assembly website at:
https://www.legislature.mi.gov/(S(iitqlwzqzziorquf1eybj4rz))/mileg.aspx?page=home

Adults (Over 60

Adult Protective Services (APS), under the Department of Human Services, are responsible for investigating reports of suspected abuse, neglect, or exploitation of Michiganders aged eighteen (18) and older. Adult Protective Services (APS) follows the Michigan Model Vulnerable Adult Protocol when investigating these reports.

Adult Protective Services provide to the elderly who are in danger of harm, unable to protect themselves, and/or have no one else to assist them. Investigators are mandated to investigate and evaluate all reports of suspected abuse, neglect, and exploitation of vulnerable adults age 18 and over.

Investigations of reports alleging abuse, neglect, and exploitation are mandated to be initiated within 24 hours if any emergency exists, or within 24 hours after the report is received. Upon completion of the investigation, the investigator determines whether or not the adult, who is the subject of the investigation, is in need of protective services.

Social, medical, and mental health care professionals are mandated by law to immediately report suspected abuse, neglect (including self-neglect), or exploitation (see grid below). Other mandated reporters include attorneys, peace officers, senior service providers, coroners, clergymen, and professional counselors.

CMS Guidance–Nursing Home / Long-Term Care Facilities

The Centers for Medicare and Medicaid Services (CMS) issued guidance on the reporting requirements for nursing homes when there are alleged violations related to mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property. Federal regulations (42 C.F.R. § 483.13 & 42 U.S.C. § 1320b–25) and state regulations [Mich. Comp. Laws § 400.11a(1) and (4) – (5)] require the reporting of alleged violations of abuse, mistreatment and neglect, including injuries of unknown origin, immediately to the facility administrator and in accordance with state law, to the Department of Health. Additionally, Federal regulations require that alleged violations of misappropriation of resident property be reported immediately.

Reporting timeframes are as follows:

- *Serious Bodily Injury* – two (2) Hour Limit: If the incident and/or events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual must report the suspicion immediately, but not later than two (2) hours after forming the suspicion.
- *All Others* – Within twenty-four (24) Hours: If the incident and/or events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual must report the suspicion not later than twenty-four (24) hours after forming the suspicion.

The Office of Services to the Aging in Michigan

Long Term Care Ombudsman program was created to help address the quality of care and quality of life experienced by residents who reside in licensed long-term care facilities such as nursing homes, homes for the aged, and adult foster care facilities. Please see the below grid for additional information.

Information to Report

When reporting the incident, please be prepared to provide the following information if applicable:

- The identity of the person making the report and where he/she can be found

- The name and address of the health care facility
- The names of the operator and administrator of the facility, if known
- The name of the subject of the alleged physical abuse, mistreatment or neglect, if known
- The nature and extent of the physical abuse, mistreatment or neglect
- The date, time and specific location of the occurrence
- The names of next of kin or sponsors of the subject of the alleged physical abuse, mistreatment or neglect, ifknown
- Any other information which the person making the report believes would be helpful to further the purposes of this section

Reporting Agency	Suggested Reporting Timeframes	CMS Required Reporting Timeframes	MI Attorney General's Office
Adults Michigan Department of Human Services Centralized Intake for Abuse and Neglect Hotline: **1-855- 444-3911**	Anytime Day or Night	N/A	Report abuse either online at **www.michigan.gov/ag** or call the "HOTLINE" at **1-800-24-ABUSE (22873)**
Nursing Home / Long- Term Care Facilities Office of Services to the Aging The Long-Term Care Ombudsman Program (LTC Ombudsman): **1-866-485-9393**	Anytime Day or Night	Serious Bodily Injury – immediately, but not later than two (2) hours after forming the suspicion All Others –twenty-four (24) hours after forming the suspicion	Report abuse either online at **www.michigan.gov/ag** or call the "HOTLINE" at **1-800-24-ABUSE (22873)**

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Michigan's Compliance hotline at **1-855-676-5280**.

Examinations to Determine Abuse or Neglect

When a State agency notifies us of a potential case of neglect and/or abuse of an enrollee, our Case managers will work with the agency and the Primary Care Provider (PCP) to help the enrollee receive timely physical examinations for determination of abuse or neglect. In addition, we also notify the appropriate regulatory agency of the report.

Definitions

- Reasonable Cause means that, based on your observations, training and experience, you have a suspicion that a vulnerable person has been subject to abuse or neglect as described below. Significant incidents that may place a vulnerable person at risk of harm must also be reported. Reasonable cause can be as simple as doubting the explanation given for an injury.
- Immediately means "*right-away";* however, reporting may be delayed to prevent harm (e.g., for as long as it takes to call emergency responders and/or address the need to maintain supervision.)
- Discovery comes from witnessing the situation, or when the vulnerable person or another individual comes to you and the available information indicates reasonable cause.

The Social Welfare Act, MCL 400.11, provides the following definitions:

- **Abuse** means harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes, but is not limited to, nonaccidental physical or mental injury, sexual abuse, or maltreatment.

- **Adult in need of protective services or "adult"** means a vulnerable adult not less than 18 years of age who is suspected of being or believed to be abused, neglected or exploited.
- **Exploitation** means an action that involves the misuse of an adult's funds, property, or personal dignity by another person.
- **Neglect** means harm to an adult's health or welfare caused by the inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care. A person shall not be considered to be abused, neglected or in need of emergency or protective services for the sole reason that the person is receiving or relying upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, and this act shall not require any medical care or treatment in contravention of the stated or implied objection of that person.
- **Protective Services** includes, but is not limited to, remedial, social, legal, health, mental health, and referral services provided in response to a report of alleged harm or threatened harm because of abuse, neglect or exploitation.
- **Vulnerable** means a condition in which the adult is unable to protect himself or herself from abuse, neglect or exploitation because of a mental or physical impairment or because of advanced age.

Examples, Behaviors and Signs

Abuse

Examples 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

Behaviors of Abusers (Caregiver and /or Family Enrollee)

- 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 basic necessities and care because of lack of experience, information, or ability Signs of

Neglect

- Malnutrition or dehydration
- Unkempt 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 enrollee, or professional expresses excessive interest in the amount of money being spent

on the enrollee

- Forcing enrollee to give away property or possessions
- Forcing enrollee to change a will or sign over control of assets

Additional Resources:

- **http://www.michigan.gov/dhs/0,4562,7-124-7119---,00.html**
- **https://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_7193---,00.html**

CHAPTER 19: FORMS

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The Following forms are located on our website at

AetnaBetterHealth.com/Michigan/providers/forms

Abortion Certification Form

To be completed by the provider attesting to the need for an abortion based on the criteria indicated in the form.

Consent to Sterilization

A consent to sterilization to be signed by both the enrollee and the provider performing the sterilization.

Acknowledgment of Hysterectomy Information

An acknowledgment of information provided related to hysterectomy to be signed by both the enrollee and provider.

Waiver of Liability Form

To be completed by non-contracted providers who file a claim appeal.

Provider Claims Dispute Forms (Par/Non-Par Providers)

To be completed by a provider who needs to file a claim dispute.

Pharmacy Coverage Determination Request Form

To be completed by a provider who needs to obtain an authorization for an enrollee.

Medical Coverage Determination/Prior Auth Request Form

To be completed by a provider who needs to obtain an authorization for an enrollee.

EFT/ERA Forms

To be completed by a provider who requests electronic funds transfer.

AetnaBetterHealth.com/Michigan

86.05.805.1-MI

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Linking Medicare and Medicaid for you