

**New York State Managed
Long Term Care
Provider Training**



Aetna Better Health



Introduction

- Aetna Better Health of New York Leadership
 - ✓ Introduce Staff
 - ✓ Training Overview
 - ✓ Q&A



Training Objectives

As a result of this training session, you will be able to:

- Describe features and services offered to Aetna Better Health Managed Long Term Care (“MLTC”) member’s.
- Describe the eligibility and enrollment process.
- Understand the Care Manager’s relationship between the member and the provider.
- Understand your role as the provider.
- Locate additional information regarding Aetna Better Health online.

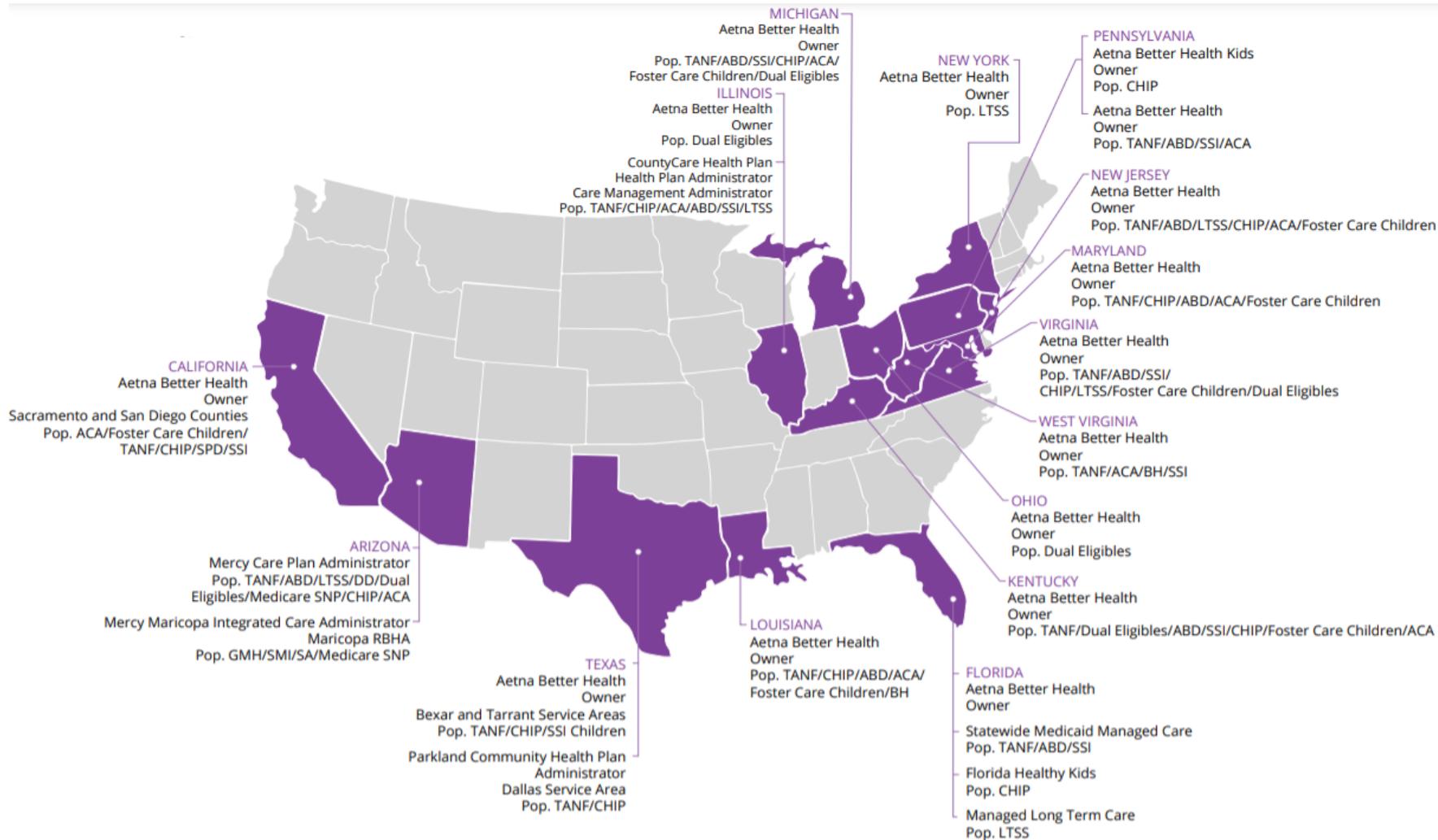


Aetna Better Health

- Aetna Better Health is a Managed Long Term Care Plan (MLTCP) and a subsidiary of Aetna, Inc.
- Together, Aetna and its affiliates have more than 150 years of experience in meeting members' health care needs with over 25 years of experience in Medicaid managed care.



Aetna Medicaid Programs



Service Areas



- *Manhattan*
- *Brooklyn*
- *Queens*
- *Nassau County*
- *Suffolk County*
- *Bronx*



Eligibility Verification Options

- You can check member's eligibility status 24/7 using the following Aetna Better Health options:
 - ✓ By calling **1-855-456-9126**
 - ✓ Accessing our secure web portal at **[AetnaBetterHealth.com/New York](https://www.aetnabetterhealth.com/new-york)**



Sample NY ID Card

Aetna Better Health® of New York 

Member ID# 00004545640 **Date of Birth** 06/21/1933

Member BRUCKMEI, NATASHA

Sex M **Effective Date** 01/01/2014

Member Services 1-855-456-9126

Hearing Impaired NY-Relay 7-1-1

Vision Services 1-855-873-1282

Dental Services 1-855-225-1727 (TTY 1-877-855-8039)

AetnaBetterHealth.com/NewYork

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

MENYMLTC1

1327-NY-2A8B (C/NY 1013) OMAKHP08890-C03734337-LAN0086--MUD0VU0
20211022T6B Sh: 0 Bin 1
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Urgent Care: Call your primary care physician (PCP).

Emergency Care: Call 911 or go to the nearest emergency room when your medical situation is very serious - when it may be life or death. Call your PCP as soon as you can.

Verify member eligibility at AetnaBetterHealth.com/NewYork or call 1-855-456-9126.

Prior authorization required for selected outpatient services. To notify of an admission, please call 1-855-456-9126.

Send Medical Claims To:
Aetna Better Health (NY)
PO Box 982972
El Paso TX 79998-2972

Electronic Claims:
Payer ID# 34734

NYMLTC1

1327-NY-2A8B (C/NY 1013) OMAKHP08890-C03734337-LAN0086--MUD0VU0
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J023 Env [1] Csets 1 of 1



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Availity Secure Web Portal

The Availity web portal allows users to perform a variety of tasks such as:

- ✓ Verify eligibility
- ✓ Download various forms used to submit authorization requests
- ✓ Download the Provider Manual
- ✓ Search the directory for list of participating providers
- ✓ Submit and verify service authorization requests
- ✓ Check claims status

[AetnaBetterHealth.com/NY/providers/secure-portal](https://www.aetna.com/betterhealth/ny/providers/secure-portal)



Cultural Competency

- Aetna Better Health promotes cultural competency and offers sensitivity education and training in an effort to help eliminate health care inequalities. We offer free online cultural competency courses that providers' and their staff can take advantage of to help with daily interactions with members'.
 - ✓ Bridge cultures & build stronger patient relationships

Course Information:

Closing the Health Care Gap Video	Quality Interactions® Refresher Course featuring a Geriatric Orthopedic Case
Reducing Health Care Disparities	Quality Interactions® for Health Care Employees

- To access the online cultural competency courses, please visit:
<https://www.aetna.com/health-care-professionals.html>
- Additional provider-focused cultural competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at:
www.hrsa.gov/culturalcompetence/index.html



Reporting Suspected Maltreatment of Members

- Part of Aetna Better Health's mission is to assist members who are at a high risk for abuse, neglect, exploitation and unusual incidents.
- Providers and their staff are required to report member incident's when they suspect, witness, or have been told of an incident of: physical, sexual, mental abuse; financial exploitation; neglect or death of a member.



Reporting Fraud or Suspected Abuse

- Aetna Better Health recognizes that we have a responsibility and commitment to detect, prevent, investigate and report fraud and abuse. Aetna Better Health encourages providers and members to contact our Special Investigations Unit (SIU) or our Compliance hotline to report concerns.
- Reporting
 - Aetna Better Health Special Investigations Unit (SIU) Fraud Hotline (National Aetna Compliance)
1-800-338-6361
 - Aetna Better Health Plan Compliance Hotline (Health Plan Compliance)
1-855-456-9125



Fraud vs. Abuse

Fraud	Abuse
<p>Any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state laws, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee or other person(s). A "provider" includes any individual or entity that receives funds in exchange for the provision, or arranging for the provision, of health care services to an MCO enrollee.</p>	<p>Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor or provider. Provider includes any individual or entity that receives funds in exchange for providing, or arranging for the provision of a service.</p>



Member Rights & Responsibilities

- Aetna Better Health educates members on their rights and responsibilities.
- Refer to the Member & Provider Handbooks for information on:
 - ✓ Rights and responsibilities
 - ✓ Grievances and appeals
 - ✓ Policies and procedures
 - ✓ Member's and Provider's "roles"
- Member & Provider Handbooks are available at:

[AetnaBetterHealth.com/NewYork](https://www.aetnabetterhealth.com/newyork)



What is Aetna Medicaid's Long-Term Care Management Model?

Member-Centered Approach

Home & Community-Based Care (HCBS) services:

- *Full array of home & community-based support*

Support services

- *Home modifications*
- *Assistive equipment*
- *Durable Medical Equipment (DME)*



Adult-day care

- *Congregate meals*

Institutional care in Nursing Facility (NF)

- *Custodial*
- *Subacute*

Identifying Members' Needs

- Aetna Better Health focuses on relationship building; promoting choice among members and caregivers; and assisting in the coordination of the full continuum of physical, behavioral, social, financial, and environmental care and services.

SAAM Instrument

- Once Aetna Better Health identifies a candidate or potential candidate for services, a clinically licensed and experienced Assessment Registered Nurse (RN) will conduct an initial face-to-face home visit to explain services in detail and obtain an Enrollment agreement and complete a comprehensive evaluation of the individual in the community using the state-mandated SAAM instrument to determine eligibility
 - The Assessment RN completes a provisional service plan in collaboration with the candidate, his / her family, and caregivers.
- If the individual is determined eligible for the MLTC Program and is enrolled with Aetna Better Health, the Assessment RN meets with the Care Management team to transition into the member-centric care/service planning process. The member will be assigned to a Care Management team that will utilize communication techniques and assessment tools to gain a perspective of the member's status.



Care Management Team

- Aetna Better Health's Care Management teams will be responsible for coordinating members' care throughout the continuum of covered and non-covered services. They will employ a number of strategies to accomplish this objective, including:
 - ✓ Communicating with Members and their Informal Support Systems
 - ✓ Communicating with Providers
 - ✓ Telephonic or In-Person Visits



Service Authorization Responsibilities

Authorization Requests from Members and Providers

- Once a care and service plan has been implemented, members and providers may submit a request to the member's Care Management team to add a new service or support or to modify existing services and supports.
- If the request is to modify an existing service or support, the Care Management team will work with the member, the member's informal supports, and other stakeholders (e.g., requesting provider) to evaluate the medical necessity and appropriateness of the request.
 - ✓ As needed and appropriate, Care Management teams may also consult with a Care Management Supervisor or Manager during this process.



Service Authorization Process

- Submit service authorization requests to Aetna Better Health via one of the options below:
 - ✓ Care Management Team
 - ✓ Secure web-portal
 - ✓ Fax
 - ✓ Phone
- Please submit the following with each authorization request:
 - ✓ Member Information, e.g., correct and legible spelling of name, ID number, date of birth, etc.
 - ✓ Diagnosis Code(s)
 - ✓ Treatment or Procedure Codes
 - ✓ Anticipated start and end dates of service(s) if known
 - ✓ All supporting relevant clinical documentation to support the medical necessity
- Include an office/department contact name, telephone and fax number



Service Authorization Decision Timeframes

Decision	Decision/notification timeframe	Notification to	Notification method
Expedited / Service Authorization	3 business days from request for service	Member- Provider if indicated-	Telephonic and Written Electronic or Written
Standard Service Authorization	Within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services	Member- Provider if indicated-	Telephonic and Written Electronic or Written
Standard Concurrent Review	Within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services	Member- Provider if indicated-	Telephonic and Written Electronic or Written
Expedited Concurrent Review	Within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services	Member- Provider if indicated-	Telephonic and Written Electronic or Written
Post-service	30 calendar days from receipt of the request.	Member- Provider if indicated-	Oral and Written Electronic or Written
Termination, Suspension, or Reduction of Service Authorization	At least ten (10) Calendar Days before the date of the action.	Member- Provider if indicated-	Oral and Written Electronic or Written



Care Management Program

- Aetna Better Health members' are each assigned to an Aetna Better Health Care Management Team (CMT).
 - ✓ Every CMT is comprised of a registered nurse (RN), social worker (SW), and care management associate (CMA).
 - ✓ The CMT works closely with members to facilitate and communicate the delivery of physical health, behavioral health and substance abuse services/treatment.
- Members can opt out of the care management program.
- The CMTs are responsible for reaching out and communicating with the member's community based service provider(s) in an effort to promote continuity of care and to avoid duplication of services.
 - ✓ Upon enrollment, the CMT will send the member's PCP a notice of the members enrollment in Aetna Better Health Care Management. The member's Care Manager will be identified in the notice
- Providers can refer member's for ad hoc care management support by contacting the member's CMT or the Care Coordination Department directly.



Quality Management

- Our Quality Management (QM) Department is an integral part of our medical management processes and internal operations.
- The primary goal of our QM program is to improve the health status of members' or maintain current health status when the member's condition is not amenable to improvement.
- Our experienced quality management staff review and trend services to determine compliance with nationally recognized standards, as well as recommend and/or promote improvements in the delivery of care and service to our members.



Quality Management

- 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
- Aetna Better Health's QM activities include but are not limited to:
 - ✓ Medical record reviews
 - ✓ Peer reviews
 - ✓ Satisfaction surveys
 - ✓ Performance improvement projects
 - ✓ Provider profiling



Claims Information

- Aetna Better Health's Provider Manual has detailed information on the processes and timeframes required to submit initial and corrected claims, how to submit electronic claims; and how to check the status of claims via the web portal.
- Aetna Better Health accepts claims submitted on CMS 1500 and UB-04 forms.
- Change Healthcare Payer ID: 34734
- Important Requirements for Billing
 - Personal Emergency Response System
 - All bills for Personal Emergency Response Systems shall contain a dated certification by the provider that the care, services, and supplies itemized have in fact been furnished.
 - 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 member.
 - Additional Billing Requirements as noted in Title 18, Section 540.7
w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/0fe0d9931726c4f48525672200769_1a2?OpenDocument

AetnaBetterHealth.com/NewYork



Claims Submission Tips

- Providers have a maximum of 120 days from the date of service for initial submission of a claim and a maximum of 180 days from the date of remittance to file a dispute and/or a claim resubmission, and 365 days from the date of the EOB for Coordination of Benefits.
- Providers are required to submit valid, current HIPAA compliant codes that most accurately identify the member's condition or service(s) rendered

- Claims & Resubmissions address:

Aetna Better Health (NY) PO
Box 982972
El Paso, TX 79998

- Provider Dispute address:

Aetna Better Health
Provider Relations Manager
Attention: Provider Dispute
55 West 125th Street,
Suite 1300
New York City, NY 10027



Provider Complaints (Dispute)

- The provider complaint process permits both network and out-of-network providers to file a complaint verbally or in writing directly with Aetna Better Health in regard to our policies, procedures or any aspect of our administrative functions.
- The Provider must complete and submit the Reconsideration Form and any appropriate supporting documentation to Aetna Better Health's Manager of Provider Services. The Reconsideration Form is accessible on Aetna Better Health's website via fax or by mail.



Provider Complaints (Dispute)

- The Provider Services Manager assigns the Reconsideration Form to a Provider Services Representative to research, analyze and review. In the event of a claim dispute it is delegated to Claims Inquiry Claims Research (CICR) for research, analysis and review. Aetna Better Health will notify the Provider of its decision by phone, email, fax or in writing.
- In the event the Provider remains dissatisfied with the dispute determination, the Provider is notified in the written notice that a grievance may be initiated. Aetna Better Health's Provider Manual includes the process a provider can use to submit a grievance.



Subcontractors

Transportation

- Non-emergent transportation services are offered to Aetna Better Health member's. If a member has questions about transportation services, please instruct them to call our Member Services Department at **1-855-456-9126**.

Dental

- Dental services are provided through LIBERTY Dental. If a member has questions about their dental care benefits, please instruct them to call LIBERTY Dental at **1-855-225-1727**.

Vision

- Vision services are provided through EyeQuest. If a member has questions about their vision care benefits, please instruct them to call EyeQuest at **1-888-696-9551**.



Questions, Concerns or Issues?

- Aetna Better Health wants to work with you and your team to answer your questions about the program, our processes, or to help you with a difficult case.
- Your Provider Relations Representative can assist you in answering questions and/or to research a concern or issue you may have. Please call **1-855-456-9126** to speak to a representative.
- Aetna Better Health has a Claims Inquiry Department to assist you with questions about your remittance or can provide instructions on how to submit an initial or corrected claim.



Questions?

