

aetna[®]

AETNA BETTER HEALTH[®]

Medicaid, CHIP & STAR Kids Services

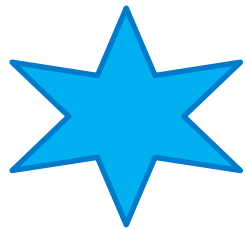
New STAR Kids Provider Orientation Training



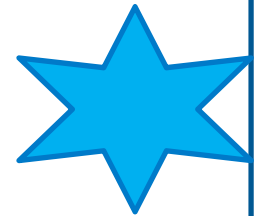
Objectives

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

- Describe features and benefits of the Aetna Better Health Medicaid, CHIP & STAR Kids programs
- Know how to identify Aetna Better Health Medicaid, CHIP & STAR Kids programs
- Understand the behavioral health, OB/GYN, vision, THSteps services, STAR Kids program features and services
- Know how to find the list of benefits on the Aetna Better Health website
- Locate additional resource information regarding the Aetna Better Health Medicaid, CHIP & STAR Kids programs
- Understand the differences between Medicaid managed care and traditional Medicaid, CHIP, and CHIP for the unborn child (perinatal).
 - CHIP offers health care benefits related to pregnancy. This is for pregnant women who cannot get Medicaid or other CHIP benefits because: (a) of their immigration status, or (b) they make too much money. There are no fees or co-pays for these benefits.



Welcome



STAR Kids

11/1/16

Overview

- Aetna contracts with the Texas Health and Human Services Commission (HHSC) to administer the Medicaid Managed Care, CHIP and STAR Kids programs in the Bexar and Tarrant service areas. **STAR Kids is administered in the Tarrant service area only.**
- Medicaid, CHIP and STAR Kids are three separate programs administered by HHSC with different eligibility requirements, benefits and oversight.
- Managed Care includes the member assignment to an in-network PCP to establish a medical home. The PCP coordinates the member's medical care and the health plan works with the PCP, specialists, etc. to ensure appropriate care.
- HHSC determines and provides member eligibility for the Medicaid and CHIP programs to Aetna Better Health.
- Aetna Better Health does not sell or market this program directly.
- All enrollment and disenrollment is handled through HHSC's CHIP and Medicaid enrollment broker (Maximus).

Aetna Better Health Service Areas

Bexar Service Area

- Atascosa
- Bexar
- Comal
- Guadalupe
- Kendall
- Medina
- Wilson
- Bandera



Tarrant Service Area

- Denton
- Hood
- Johnson
- Parker
- Tarrant
- Wise

Aetna Better Health of Texas Counties

STAR Kids coverage area includes the following counties in the Tarrant Service Area:

Counties:
Denton
Hood
Johnson
Parker
Tarrant
Wise

General Program Overview

Aetna Better Health – Medicaid and CHIP

PCP Selection

- Medicaid - required or member is “defaulted” to a PCP upon enrollment into a plan
- CHIP – not required but assigned by health plan
 - CHIP Perinate – not required
- Medicaid and CHIP - Most specialty care is coordinated through PCP. Please note that members do not need a referral from PCPs to get behavioral health care services.
- Medicaid and CHIP - Members access any Aetna Better Health in-network provider
- Medicaid - Members may see any Texas Health Steps (THSteps) provider for THSteps-covered services.

General Program Overview

Aetna Better Health – Medicaid and CHIP

Copayments

- **Medicaid** – does not apply
- **CHIP**
 - Applies based on the federal poverty level (FPL) until cost sharing maximum is met by family.
 - Does not apply for pregnancy-related or preventive services
 - Does not apply for services rendered to American Indian and Alaskan Native Members.
 - Does not apply to ER visits for emergency services related to an emergency diagnosis.
 - Does not apply to value added services.
- **CHIP Perinate Newborn** – copayments do not apply
- **CHIP Perinate** – copayments do not apply

****Please reference to the CHIP Cost Sharing Chart located within the Quick Reference Guide****

General Program Overview (continued) - Medicaid and CHIP

- Lab Services
 - Quest Labs
- Use of contracted radiology facilities
- Precertification required for all inpatient hospitalizations and selected outpatient services
- Prescription drugs – coordinated through CVS Caremark
- Direct Access (self-referral):
 - Ob/Gyn
 - Vision services – coordinated through Superior Vision
 - Therapeutic optometry – in-network providers only; excludes surgery
 - Behavioral Health
 - THSteps exams (***Medicaid benefit only***)
 - Family planning (***Medicaid benefit only***)

General Program Overview (continued)

– Medicaid and CHIP

Durable Medical Equipment (DME)

- Eligible to obtain DME/Medical Supplies when ordered by a network provider.
- For equipment/supplies costing < \$1000 the provider must complete the appropriate Home Health DME/Medical Supplies Physician Order Form.
- Prior authorization is required where the cost of the medical equipment and/or supplies is over \$1000.

****Refer to Aetna Better Health Provider Manual for more information on DME.***

STAR Kids Program Overview

- PCP Selection
 - Required or member is “defaulted” to a PCP upon enrollment into a plan
 - Specialty care is coordinated through PCP. Please note that members do not need a referral from PCPs to get behavioral health care services.
 - Members may access any Aetna Better Health in-network provider
 - Members may see any Texas Health Steps (THSteps) provider for THSteps covered services
- Lab Services
 - Quest Labs
- Use of contracted radiology facilities
- Precertification required for all inpatient hospitalizations and selected outpatient services

Individuals excluded from participating in STAR Kids include:

- Adults age 21 years or older.
- Children and young adults age 20 and younger enrolled in STAR Health.
- Children and young adults age 20 and younger who reside in the Truman Smith Children's Care Center or a state veteran's home.

STAR Kids Service Coordination

- Aetna Better Health must provide sufficient levels of service coordination to meet the unique needs of members.
- Service coordination are provided by Aetna Better Health nurses and other professionals with necessary skills to coordinate care, and includes but is not limited to:
 - Identification of needs (e.g., physical health, mental health, long-term services and supports).
 - Development of a service plan to address identified needs.
 - Assistance to ensure timeliness and coordinated access to services and providers.
 - Attention to addressing the unique needs of members.
 - Coordinating with other (non-capitated) services as necessary and appropriate.

Service Coordination and Transition Planning

- Transition planning, a special feature of STAR Kids, is the process of helping teens and young adults prepare for changes following their 21st birthday.

- Aetna Better Health will begin STAR Kids transition planning when their members turn 15:
 - The Aetna Better Health service coordinator and transition specialist will work closely together to ensure a smooth transition.

General Program Overview (continued)

– Medicaid & STAR Kids

Medical Transportation Program (MTP)

- The Medical Transportation Program (MTP) provides free rides to the doctor, dentist, or other covered services (such as to a drug store) for program eligible clients with Medicaid, Children with Special Health Care Needs (CSHCN) and Transportation for Indigent Cancer Patients (TICP) with means of transportation.
 - The MTP provides a variety of transportation services for clients based on health care needs and distance traveled, including but not limited to: bus, taxi, van service, or airplane.
 - The MTP may pay for an attendant with a documented request demonstrating medical need, if the client has mobility issues or a language barrier exists. Minors through age 17 must be accompanied by an attendant.
 - The MTP may reimburse gas costs to/from healthcare **services** if the member has a car but no fuel funds. If member does not have a car but someone can drive them, the driver may be reimbursed for mileage to/from the healthcare service.
 - To arrange for transportation services or get information, please contact MTP at 1-877-633-8747 (Bexar Service Area) or Logisticare at 1-855-687-3255 (Tarrant Service Area), Monday – Friday 8:00 a.m. to 5:00 p.m.

General Program Overview (continued)

– Medicaid, CHIP & STAR Kids

- CHIP and Children’s Medicaid both offer many benefits:
 - Dentist visits, cleanings, and fillings
 - Eye exams and glasses
 - Choice of doctors, regular checkups, and office visits
 - Prescription drugs and vaccines
 - Access to medical specialists and mental health care
 - Hospital care and services
 - Medical supplies, X-rays, and lab tests
 - Treatment of special health needs
 - Treatment of pre-existing conditions

For a full listing of CHIP benefit limitations, please refer to www.chipmedicaid.org or the Aetna Better Health Provider Manual

Texas Agency-Administered Programs and Case Management Services (Additional Resources)

Medicaid and CHIP

- Essential Public Health Services
- Early Childhood Intervention (ECI) Case Management/Service Coordination
- Department of State Health Services (DSHS) Targeted Case Management
- DSHS Mental Health Rehabilitation (Behavioral Health)
- DSHS Case Management for Children and Pregnant Women
- Women, Infants, and Children (WIC) Program
- Department of Assistive and Rehabilitative Services (DARS) Case Management for the Visually Impaired
- Tuberculosis Services Provided by DSHS-Approved Providers
- Department of Aging and Disability (DADS) Hospice Services

Medicaid

- Texas Department of Family and Protective Services (TDFPS)
- School Health and Related Services (SHARS)
- THSteps Medical Case Management
- THSteps Dental (Including Orthodontia)
- THSteps Environmental Lead Investigation (ELI)
- Medical Transportation Program (MTP)

*****Refer to Aetna Better Health Provider Manual for more information about these programs.***

Texas Provider Marketing Guidelines

- Purpose
- The purpose of the Texas Provider Marketing Guidelines is to provide guidance to the State of Texas Medicaid fee-for-service, Medicaid Managed Care, Children's Health Insurance Program (CHIP), Children's Medicaid Dental, CHIP Dental Providers and the STAR Kids program as to what is permissible and prohibited provider marketing.
- The information provided is not intended to be comprehensive, or to identify all applicable state and federal laws and regulations. Providers remain responsible for and must comply with all applicable requirements of state and federal laws and regulations.

Texas Provider Marketing Guidelines

■ Examples of Permissible and Prohibited Marketing Activities

	Permissible	Prohibited
1	Sending Marketing Materials to every person within a specific zip code, without specifically targeting Medicaid clients.	Unsolicited personal contact such as direct mail, telephone, and door-to-door solicitation.
2	Sending an appointment reminder to a Medicaid client.	Offering gifts or other inducements designed to influence a client's choice of Provider.
3	Participation at a health awareness education event And making available branded giveaways valued of No more than 10 dollars, individually.	Providing giveaways or incentives Valued at over 10 dollars, individually, or passing out materials.
4	General dissemination of Marketing Materials via television, radio, newspaper, Internet, or billboard advertisement.	Dissemination of material or any other attempts to communicate intended to influence the Client's choice of Provider.
5	Provider marketing conducted at: <ul style="list-style-type: none"> • Community-sponsored educational event • Health fair • Outreach activity or • Other similar community or nonprofit event And which does not involve unsolicited personal contact or promotion of the provider's practice that is not intended as health education.	Sending Marketing Materials to a client to offer inducements or incentives.
6	Provider marketing for the purpose of: <ul style="list-style-type: none"> • Providing appointment reminder • Distributing promotional health materials • Providing information about the types of services offered by the provider • Coordination of care 	Unsolicited personal contact at a child care facility or any other type of facility; or targeting clients solely because the client receives Medicaid/CHIP benefits.

Adoption Assistance and Permanency Care Assistance

Effective September 2017

Aetna Better Health, Texas
Provider Relations Department

Overview: Adoption Assistance and Permanency Care Assistance

What is AAPCA?

- The Adoption Assistance program provides help for certain children who are adopted from foster care.
- The Permanency Care Assistance program gives financial support to family members who provide a permanent home to children who were in foster care but could not be reunited with their parents.

Background

- The 83rd Texas Legislature directed HHSC to move remaining Medicaid fee-for-service clients to Medicaid managed care.
- Currently, Adoption Assistance and Permanency Care Assistance clients receive Medicaid services through Medicaid fee-for-service
- Most of these clients will move to Medicaid managed care September 1, 2017

Managed Care Programs in Texas

- STAR
- STAR Kids

The Adoption Assistance and Permanency Care Assistance program may provide: Medicaid coverage for the child (2) Monthly cash assistance from Department of Family and Protective Services (DFPS); (3) A one-time reimbursement from DFPS for some legal expenses that come with adopting or becoming the managing conservator of a child

What is STAR?

- STAR is a managed care program for most people on Medicaid.
- STAR serves:
 - Children,
 - Low-income families,
 - Former foster care children
 - Pregnant women
- As of Sept. 1, 2017, most children and youth in Adoption Assistance and Permanency Care Assistance will get services through STAR

Which AA/PCA Members Will Be in STAR?

- Adoption Assistance and Permanency Care Assistance clients who meet the following criteria have moved to STAR on September 1, 2017.
- Don't get:
 - Supplemental Security Income (SSI)
 - Medicare
 - 1915 (c) waiver services
- Don't have a disability as determined by the U.S. Social Security Administration or the State of Texas.
- Don't live in:
 - A nursing facility
 - An intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID).

What are STAR Benefits?

• Same Medicaid benefits you have today	• Unlimited prescriptions
• Unlimited necessary days in a hospital	• A primary care provider (main doctor, nurse or clinic) to serve as a medical home
• Value-added services	• Service management for certain members, including Adoption Assistance and Permanency Care Assistance

What is STAR Service Management?

- A service performed by the health plan to do all of the following:
 - Develop a service plan, which includes a summary of current needs, a list of services required, and a description of who will provide those services.
 - Coordinate services among a member's primary care provider, specialty providers and non-medical providers.
- All Adoption Assistance and Permanency Care Assistance managed care members get service management.

What is STAR Kids?

- STAR Kids is a managed care program for children and young adults 20 and younger who meet at least once of the following criteria:
 - Get Supplemental Security Income (SSI) or SSI-related Medicaid
 - Are enrolled in Medicare
 - Get services through a 1915 (c) waiver program
- As of September 1, 2017, children and youth in Adoption Assistance and Permanency Care Assistance who meet the above criteria will get services through STAR Kids.

Which AA/PCA Members Will Be in STAR Kids?

Adoption Assistance and Permanency Care Assistance clients who meet the following criteria have moved to STAR Kids on September 1, 2017.

- Get Supplemental Security Income (SSI)
- Have a disability as determined by the U.S. Social Security Administration or the State of Texas

What are STAR Kids Benefits?

• Same Medicaid benefits you have today	• Unlimited prescriptions
• Unlimited necessary days in a hospital	• Extra services
• Service Coordination	• A primary care provider (main doctor, nurse or clinic) to serve as a medical home
	• State Plan long-term services and supports, such as private duty nursing and personal care services

What is STAR Kids Service Coordination?

- Specialized care service provided by health plan nurses and other professionals with necessary skills to coordinate care, including:
 - Identification of needs, such as, physical health, mental health,, long-term services and supports.
 - Development of a person-centered service plan to address identified needs
 - Making sure clients get the services they need when they need them
 - Attention to addressing members' unique needs
 - Coordinating with other services when necessary

Continuity of Care

- The state requires STAR and STAR Kids health plans to provide “Continuity of Care.”
 - Authorizations for basic care such as specialist visits and medical supplies are honored for 90 days, until the authorization expires or until the health plan issues a new one
 - Authorizations for long-term services and supports are honored for six months or until a new assessment is completed
 - During the transition period, members can keep seeing current providers, even if they are out of the health plan’s network
 - Providers don’t need to resubmit authorization requests to the health plans if an authorization is already in place

How Will I Know What Plan My Patients Are In?

- All STAR and STAR Kids members get a health plan ID card, in addition to a Your Texas Benefits Medicaid card from the state.
- The health plan ID card includes:
 - Member's name and Medicaid ID number
 - Medicaid program (e.g. STAR, STAR Kids)
 - Health plan name
 - Primary care provider name and phone number
 - Toll-free phone numbers for member services, service coordination, and behavioral health services hotline
 - Other information may be provided (e.g. date of birth, service area, Primary Care Provider address)

Will Current Services Be Covered in Managed Care?

- Approved and active prior authorizations for covered services have been forwarded to the STAR or STAR Kids health plans before September 1, 2017.
- These prior authorizations are subject to the ongoing care requirements.
- Providers don't need to resubmit authorization requests to the health plans if an authorization is already in place.

Value-Added Services - Medicaid

- Vital Savings (age 21 and older & all pregnant members)
 - Discounts on dental services
 - Discounts for Alternative Health Care, such as chiropractic, acupuncture, nutritional counseling, etc.
 - Discounts for fitness services
 - Discounts for over the counter medications, vitamins, etc.
- 24 Hour Nurse Line
- Sports Physicals (ages < 19)
- Extended Vision Services (ages 12 and older)
- Weight Management (ages 12 - 19)
- Smoking Cessation (ages 12 and older)
- PROMISE Program (all pregnant members)
 - Free package of diapers upon completion of 10 prenatal and 1 postpartum visit

Value-Added Services - CHIP

- 24 Hour Nurse Line
- Sports Physicals
- Extended Vision Services (ages 12 and older)
- Weight Management (ages 12 and older)
- Smoking Cessation (ages 12 and older)
- PROMISE program (pregnant members)

STAR Kids Covered Services

STAR Kids Covered Services

- STAR Kids benefits are governed by the Aetna Better Health of Texas contract with the Health and Human Services Commission (HHSC), and include: medical, vision, behavioral health, pharmacy and long term services and supports (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP.
- The following chart details the Member benefit package available to Aetna Better Health of Texas STAR Kids Members. Please refer to the current Texas Medicaid Provider Procedures Manual, found at www.tmhp.com at www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx for the listing of limitations and exclusions

STAR Kids Value Added Services

- Aetna Better Health of Texas STAR Kids has developed several value-added services and extra benefits to provide our members.
 - Extra help getting a ride
 - Vision services
 - Well-child exam \$15 gift card
 - Additional hours of respite care
 - Help with members with asthma

STAR Kids MDCP Service Array

■ STAR Kids MDCP Waiver

- Adaptive aids
- Minor home modifications
- Transition assistance services
 - Employment Assistance*
 - Flexible family support services*
 - Financial Management Services*
 - Respite services*
 - Supported employment*

- *These services are available through the Consumer Directed Services (CDS) option

Assessments and Authorizations

- Aetna Better Health (ABH) will assess the need for PCS, PDN, CFC, and MDCP.
- •ABH is responsible for functional and medical assessments.
- •Existing authorizations for LTSS are honored for 6 months, until the end of the current authorization, or until ABH does a new assessment.
- •Existing authorizations for acute care services are honored for 90 days, until the end of the current authorization, or until ABH does a new assessment.
- Please visit our website for additional information surrounding our continuity of care guidelines (STAR Kids)

Covered Services

- The benefits in the Provider Manual show what services Aetna Better Health of Texas and Medicaid Fee-for-Service (FFS) covers.
- STAR Kids integrates the delivery of state plan services, behavioral health services, and LTSS benefits for children and young adults age 20 and younger with disabilities.
- Main features include service coordination, a comprehensive needs assessment, and client-centered planning and service design.

Covered Services

- Aetna Better Health is responsible for authorizing, arranging, coordinating, and providing services including:
 - Medically necessary covered services
 - Functionally necessary covered services

- Aetna Better Health will provide full coverage for necessary covered services beginning on the date of the member's enrollment and without regard to the member's:
 - Pre-existing conditions
 - Prior diagnosis
 - Health status; or
 - Any other factor

Long-Term Supports and Services

- LTSS available under the state plan for STAR Kids members includes:
 - Private duty nursing (PDN)
 - Personal care services (PCS)
 - Community First Choice (CFC)

- MDCP waiver services, available to members who meet income, resource, and medical necessity requirements for nursing facility level of care, include:
 - Services unavailable under the state plan, as a cost-effective alternative to living in a nursing facility.

Long-Term Supports and Services

- PDN services include nursing and caregiver training and education, and must be available to all members determined eligible through the STAR Kids Screening and Assessment Instrument (SK-SAI).
- PCS must be available to members who require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities (HMAs) because of a physical, cognitive, or behavioral limitation related to the members disability or chronic health condition, and PCS services must be authorized through the SK-SAI.
- Aetna Better Health will ensure members who receive PDN, PCS, or both, have access to appropriate providers .

Long-Term Supports and Services

- Aetna Better Health will provide functionally necessary CFC services for qualifying members, which include:
 - » Personal care services (attendant care)
 - » Acquisition, maintenance, and enhancement of skills (habilitation)
 - » Emergency response services
 - » Support management

- All CFC services are provided in a community-based setting.

- MDCP provides services to:
 - Support families caring for children and young adults who are medically dependent.
 - Encourage de-institutionalization of children in nursing facilities.

Long-Term Supports and Services

- STAR Kids MDCP Waiver
 - Adaptive aids
 - Minor home modifications
 - Transition assistance services
 - Employment Assistance*
 - Flexible family support services
 - Financial Management Services*
 - Respite services*
 - Supported employment*

- *These services are available through the Consumer Directed Services (CDS) option

Long-Term Supports and Services

Assessments and Authorizations

- Aetna Better Health will assess the need for PCS, PDN, CFC, and MDCP.
- Aetna Better Health is responsible for functional and medical assessments.
- Existing authorizations for LTSS are honored for 6 months, until the end of the current authorization, or until Aetna Better Health does a new assessment.
- Existing authorizations for acute care services are honored for 90 days, until the end of the current authorization, or until Aetna Better Health does a new assessment.

Service Coordination and Transition Planning

- Transition planning, a special feature of STAR Kids, is the process of helping teens and young adults prepare for changes following their 21st birthday.
- Aetna Better Health will begin STAR Kids transition planning when their members turn 15:
 - The Aetna Better Health service coordinator and transition specialist will work closely together to ensure a smooth transition.

Electronic Visit Verification (EVV)

- What is EVV?
 - EVV is a telephone and computer-based system that:
 - Electronically verifies that service visits occur; and
 - Documents the precise time the service provision begins and ends

EVV (cont.)

What Does EVV Do?

- EVV replaces paper timesheets
- EVV electronically documents the:
 - Individual or member receiving services
 - Attendant or *private duty nurse providing services
 - Provider agency information
 - Precise time the attendant or private duty nurse begins and ends service delivery
- * HHSC STAR Kids EVV implementation is November 1, 2016 for:
 - Personal Care Services
 - In-home Respite Services provided by an attendant
 - Flexible Family Support Services provided by an attendant
 - Community First Choice (CFC) personal assistance services and habilitation (PAS/HAB)
- The HHSC EVV Initiative implementation has been delayed for private duty nursing (PDN) services.

EVV (cont.)

How Does EVV Work?

Home Landline Telephone Calls

- The attendant or *private duty nurse must use the individual's or member's home landline telephone to document the times service begins and service ends.
- An individual's or member's cell phone can not be used in place of his or her home landline.
- It is the provider's responsibility to train their employees (attendants, private duty nurses, and administrative staff) to use the EVV system and follow the EVV requirements.

–* The HHSC EVV Initiative implementation has been delayed for private duty nursing (PDN) services.

EVV (cont.)

What Is a Home Landline Telephone?

- **A home landline telephone is a phone line that:**
 - Is provided only at a single specified address (the individual's or member's home), and
 - Cannot be used away from that location without contacting a third party to transfer the service to a new specified location.
- **Home landline telephone service may be provided through:**
 - Traditional copper or coaxial cables, including digital subscriber lines (DSL);
 - Fiber optic lines; or
 - Other transmission methods physically connected to the individual's or member's home.

EVV (cont.)

How Does EVV Work? Small Alternative Devices

- If the home landline is unavailable, the individual or member must complete, sign, and date the Medicaid EVV Small Alternative Device Agreement Form to request a small alternative device to be installed in the individual's or member's home.
- The attendant or private duty nurse will be required to use the small alternative device to document the times service begins and service ends.

EVV (cont.)

How Does EVV Work? Small Alternative Devices

- When the attendant or *private duty nurse uses a small alternative device, it generates unique numbers on the screen that represents a specific date and time. This is called the small alternative device value.
- The attendant or private duty nurse must enter the small alternative device values into the EVV system.

* The HHSC EVV Initiative implementation has been delayed for private duty nursing (PDN) services.

EVV (cont.)

How Does EVV Work? Small Alternative Devices

- All small alternative device values must be entered into the EVV system before they expire.
- Contact your EVV vendor for details on their small alternative device and instructions on entering small alternative device values.

EVV (cont.)

How Does EVV Work? Optional Mobile Applications

- Some EVV vendors offer an optional mobile application that may be used on a *voluntary* basis by an attendant or private duty nurse on his or her personal smartphone.
 - The attendant or *private duty nurse *cannot be required* to use the mobile application.
 - The attendant or private duty nurse will not be reimbursed for any costs associated with using the mobile application and assumes all liability for installing the mobile application on his or her personal smartphone.

* The HHSC EVV Initiative implementation has been delayed for private duty nursing (PDN) services.

EVV (cont.)

How Does EVV Work? Optional Mobile Applications

- **These optional mobile applications:**
 - Must be approved by HHSC.
 - May only be used in the event that both the individual's or member's home landline phone and the small alternative device cannot be used.
 - Require a written agreement between the provider agency and the attendant or *private duty nurse who is allowing the EVV mobile application to be installed and used on his or her personal smartphone.
- Contact your EVV vendor to find out more about any available optional mobile applications.

* The HHSC EVV Initiative implementation has been delayed for private duty nursing (PDN) services.

EVV (cont.)

Visit Maintenance

- Visit maintenance allows designated staff in a provider agency to edit records of EVV visits by reviewing, modifying, and correcting visit information.
- If the EVV system cannot automatically verify an attendant or private duty nurse's visit, the visit information must be corrected in visit maintenance to accurately reflect the time worked, and an exception is generated for each part of the visit that could not be verified.

EVV (cont.)

Visit Maintenance Exceptions

- Exceptions can occur when the attendant or private duty nurse:
 - Calls from a phone number not registered to any individual or member in the EVV system (e.g., a cell phone)
 - Forgets to call-in or call-out
 - Delivers service outside the home
- Exceptions are indicated in the EVV system.

EVV (cont.)

Visit Maintenance Exceptions

- Correcting exceptions in visit maintenance is similar to correcting an attendant or private duty nurse's paper time sheet.
- For a single visit, there may be more than one exception.
- Providers must enter the *most appropriate* reason code(s) and any required free text in the comment field in order to explain and clear each exception.

EVV (cont.)

Visit Maintenance Requirements

- All visit maintenance must be completed *within 60 calendar days* of the date of service.
- All situations that require documentation must be documented according to program policy.

EVV (cont.)

Visit Maintenance and Billing Deadlines

- A visit may not be billed until all exceptions have been cleared in the EVV system and visit maintenance is complete.
- Billing deadlines remain the same.
 - MCO providers have up to 95 days from date of service to bill for a visit.

EVV (Cont.)

Rounding Rules in EVV

The EVV system applies rounding rules to the total actual hours for every visit per program rule and policy.

- Provider agencies should bill in quarter-hour increments (0, 15, 30 or 45 minutes past the hour) based on the actual hours.
- Within each quarter-hour increment, provider agencies must round up to the next quarter-hour when the actual time worked is 8 minutes or more, and round down to the previous quarter hour when the actual time worked is 7 minutes or less.

EVV (cont.)

EVV Reason Codes

- Reason codes are used in visit maintenance when making corrections to a visit.
- Reason code explain the specific reason a change was made to the visit.
- In addition to the reason code, the provider can enter free text in the EVV system.
- Providers must associate the *most appropriate* reason code with each change made in visit maintenance and enter any required free text in the comment field.

EVV (cont.)

Reason Codes

- As of April 16, 2015, there are a total of 25 reason codes in the HHSC-approved EVV systems.
 - 20 Preferred Reason Codes
 - » Any reason code with a number less than 900 is a preferred reason code.
 - 5 Non-preferred Reason Codes
 - » Any reason codes with a number greater than or equal to 900 is a non-preferred reason code.

EVV (cont.)

Reason Codes and Verification

- Some reason codes include the requirement to verify that services were delivered.
- Other reason codes list specific information to be verified, such as the identity of the attendant or private duty nurse providing the services.
- Provider agencies must follow program policies and procedures to verify the required service delivery information for each visit as part of the visit maintenance process.

EVV (cont.)

Best Practices

- Become familiar with the EVV system and operations and develop a relationship with your selected EVV vendor.
- Call your EVV vendor for issues concerning EVV system problems, not DADS, MCOs, or TMHP. However, if you do not receive a response or the issue is not fixed, please call the entity you are contracted with.
- Set a date prior to the 60 day deadline to complete any required visit maintenance.

EVV (cont.)

Best Practices

- Become familiar with rules and program policies regarding EVV requirements.
- Learn the different categories of reason codes and their descriptions.
- Ensure your attendants and private duty nurses are trained and understand the importance of using the EVV system.
- Always document according to program policy.

Member Eligibility Verification

- Use the Aetna website at www.aetnabetterhealth.com/texas
- Aetna Better Health Member Services

Service Area	Medicaid	CHIP
Bexar	1-800-248-7767	1-866-818-0959
Tarrant – Medicaid Tarrant – STAR Kids	1-800-306-8612 1-844-STRKIDS (844-787-5437)	1-800-245-5380

*These numbers provide access to a **Behavioral Health Hotline** that operates **24 hours a day / 7 days a week.***

STAR Kids Eligibility

To be eligible for Texas Medicaid, a person must:

- Be a resident of Texas, be a U.S. Citizen, or qualified alien (most immigrants who arrive after August 22, 1996 are barred from Medicaid for five years, but could be eligible for Texas FamilyCare and certain programs for pregnant women)
- Meet specific standards for financial income and resources

In addition, a person must fall into one of the following categories to participate in STAR Kids:

- Children and young adults age 20 or younger.
- Who receive Supplemental Security Income (SSI) and SSI-related Medicaid.
- Who receive SSI and Medicare.
- Who receive Medically Dependent Children Program (MDCP) waiver services.

Texas Benefits Medicaid Card

The Texas Health and Human Services Commission now uses digital technology to streamline verifying eligibility and accessing a member's Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card.
- An online website where Medicaid providers can get up-to-date information on a patient's eligibility and history of services and treatments paid by Medicaid.

Texas Benefits Medicaid Card (continued)

The diagram shows a sample Medicaid ID Card from the Texas Health and Human Services Commission. The card is titled "Your Texas Benefits" and "Medicaid ID Card". It contains the following information:

- Member name: Your name goes here
- Member ID (Medicaid ID): 999999999
- Issuer ID: (00040) 999999999
- RxBIN: 001111
- RxPCN: ADV
- RxGRP: RX1234
- Date card sent: 09/01/2011
- Your Health Plan goes here: []

Callouts explain the following fields:

- Member name:** This is where your name appears.
- Member ID (Medicaid ID):** This is your Medicaid ID number.
- Issuer ID:** This is HHSC's agency ID number. Doctors and other providers need this number.
- RxBIN, RxPCN, RxGRP:** Drug stores use these numbers.
- Date card sent:** This is the date your card was sent to you.
- Your Health Plan goes here:** If you have a health plan, its name and phone number will be listed here. Call this number if you have questions about your doctor or services.

Member ID Cards – Medicaid, CHIP & STAR Kids

Aetna Medicaid members should present:

- Your Texas Benefits Card

AND

- Aetna Medicaid ID card

Aetna Better Health

Identification Cards

- All Aetna Better Health members receive an ID card, in addition to a Your Texas Benefits Medicaid card from the State.

- The plan ID card contains the following information:
 - Member's name and Medicaid ID number

 - Medicaid program (e.g., STAR, CHIP or STAR Kids)

 - Aetna Better Health name


 - PCP name and phone number

 - Toll-free phone numbers for member services and behavioral health services hotline



Sample ID Cards

Front →

AETNA BETTER HEALTH®		
Member ID# 000000000-00	Date of Birth 00/00/0000	
Member Name Last Name, First Name	Sex X	
PCP Last Name, First Name	No Copay	
PCP Phone 000-000-0000	Effective Date 00/00/0000	
.....		
RxBIN 000000	RxPCN 00	RxGRP 0000
Pharmacist Use Only 1-000-000-0000		
www.aetnabetterhealth.com		
THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.		
To verify member eligibility please call 1-000-000-0000.		
Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call 1-000-000-0000.		
Send Medical Claims To	Aetna Better Health	
Aetna Better Health	Payer ID 0000	
PO Box 0000	Provider Claims Questions	
Phoenix, AZ 00000-0000	1-000-000-0000	
Member Services	1-000-000-0000 (24 hours/7 days a week)	
Behavioral Health Services	1-000-000-0000	
Dental Services	1-000-000-0000	
Hearing Impaired	(state) Relay 7-1-1	
Transportation Services	1-000-000-0000	
Vision Services	1-000-000-0000	

← **Back**

Clearinghouse & Clean Claims

- We accept both paper and electronic claims
- Change Healthcare (formerly Emdeon) is preferred clearinghouse for electronic claims
 - EDI claims received directly from Change Healthcare
 - Processed through pre-import edits to:
 - Evaluate data validity
 - Ensure HIPAA compliance
 - Validate member enrollment
 - Facilitate daily upload to Aetna Better Health system



Aetna Better Health Claim Submission

- Aetna Better Health encourages participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). You can submit claims by visiting Change Healthcare at <https://www.changehealthcare.com/> . Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare.

- Please use the following Payer ID when submitting claims to Aetna Better Health:
 - Change Healthcare (formerly Emdeon) – Use Payer ID 38692

 - If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054. If using this payer ID, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

Claim Submission (cont.)

- Providers must file claims within 95 days of the date of service (DOS)
- If your electronic billing vendor can convert to 38692, but doesn't submit directly to Change Healthcare, we recommend that you use "MC" prior to the member number to make sure the claims are processed correctly.

Paper Claims:

Aetna Better Health of Texas
Attention: Claims Department
P.O. Box 60938
Phoenix, AZ 85082



Clearinghouse & Clean Claims (cont.)

- 98% of all claims filed within 30 days of receipt
- 99% of all clean claims within 90 days of receipt.

A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Claim Submission

Please note that we follow Texas billing practices, (i.e., required diagnosis codes, CPT, HCPCs and associated modifiers), and Texas' fee schedule methodologies. We also follow Texas' timely filing requirements along with the claim dispute processes and timeframes.



- Common Barriers

- 5010 Requirements (*Rendering NPI and pay-to NPI; Both are required*)
- NDC Codes Missing or Incomplete
- Lack of Prior Authorization

- Resubmissions

- Electronic and paper resubmitted claims are accepted, however, we prefer electronic claims. Resubmitted claims must be labeled appropriately.

Claim Submission

– 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.

- How to fill out a CMS 1500 Form:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>

- Sample CMS 1500 Form:

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf>

- How to fill out a CMS UB-04/1450 Form:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf>



Claim Submission (HIPAA 5010 & ICD0)

- Our website includes detailed information about HIPAA and ICD10 resource

HIPAA 5010 and ICD10

On January 15, 2009 the US Department of Health & Human Services issued two final rules for adoption:

- An updated HIPAA X12 standard version 5010 for electronic transactions, with a compliance date of January 1, 2012. The updated format has more than 1300 changes to the 4010 standard (with 600+ just for claims).
- Adoption of the ICD-10 Code Sets with a compliance date in October 2015 (version 5010 accommodates the ICD-10 code structure; 4010 does not).

Aetna Better Health met the compliance requirements for the federally mandated HIPAA 5010 version transactions for 1/1/2012 and is on track to be able to accept ICD-10-CM & PCS Codes for dates of service for October 2015.

Online ICD-10 Resources

- [Road to 10](#): The Centers for Medicare and Medicaid Services (CMS) has created a website that's a great resource for small physician practices and specialty practices.
- [Crosswalks for the Top 50 Codes by Specialty](#) at the AAPC website
- [100 Tips for ICD-10-PCS Coding](#) at icd10monitor.com
- [Free code conversion tool](#) from icd10monitor.com

For your convenience, Aetna Better Health has added additional information, updates and links available for 5010 in the document library.

Claims Appeals

Medicaid, CHIP & STAR Kids

Definitions:

▪ **Original Claim:** *A submitted request for payment (on the appropriate form and with the appropriate information) based on services rendered.*

▪ **Corrected Claim:** *A claim request that has been corrected OR contains additional information than what was sent on a previous submission.*

▪ **Appeal:** *A written reconsideration that has been reviewed previously (at the original, clean claim level and at the reconsideration level) and that is now requesting further consideration based on previously submitted information. The document submitted by the provider must include verbiage including the word “appeal”.*

**These definitions are important, because they can assist providers in routing claims, corrected claims, reconsiderations and appeals to the proper area – to ensure the fastest and most appropriate possible processing of submitted claims

▪ *For more information on the claims appeal process, please refer to the Aetna Better Health Provider Manual located at www.aetnabetterhealth.com/texas*

Claims Appeals (cont.)

Appeals:

1. Appeals should be sent with the Appeal Form. Clearly defined requests will ensure that appeals are reviewed in the most appropriate way. Please include claim forms, EOB (or copy) , appropriate documentation and *specifically* indicate what services are being appealed.
2. Appeal requests must be received within 120 calendar days from the resolution date on the most recently reviewed claim's EOB.
3. Appeal requests should be mailed to the following address:

Aetna Better Health
Appeals and Correspondence
PO Box 569150
Dallas, TX 75356

Claims Appeals cont'd and Reconsiderations Medicaid, CHIP & STAR Kids

A written request from a provider to reconsider or grant an exception on a previously processed claim determination/payment due to medical necessity.

The documentation must include the word “Appeal” for consideration as an exception to standard payment/denial, and be submitted on the appropriate Appeal form.

*Providers will often identify Reconsiderations as Appeals.

**These definitions are important, because they can assist providers in routing claims, corrected claims, reconsiderations and appeals to the proper area – to ensure the fastest and most appropriate possible processing of submitted claims.

Claims Appeals cont'd and Reconsiderations Medicaid, CHIP & STAR Kids

Reconsiderations:

Reconsiderations should be sent with at least the following info.:

1. Claim form for each reconsideration.
2. EOB (or copy) for each resubmitted claim, with indications of which claim is being resubmitted
3. Any information that was previously requested from the Health Plan.

Reconsiderations requests (other than Coordination of Benefits (COB) related resubmissions) must be received within 120 days of the resolution date on the original (clean) claim's EOB.

1. COB related resubmission:
 - Are identified as claims previously denied for other insurance information, or originally paid as primary without coordination of benefits.

Appeals and Fair Hearings

- Members may appeal to the Aetna Better Health and/or file a fair hearing request with the State if services are denied, reduced, or terminated.
- Services may continue during the review if the appeal or fair hearing is requested within the adverse action period and the member requests continued services pending the appeal.

Provider Complaints

- Providers are to contact Aetna Better Health to file a complaint and must exhaust the health plan resolution process before filing a complaint with HHSC.
- •Appeals, grievances, or dispute resolution is the responsibility of the Aetna Better Health.
- •Providers may file complaints with HHSC if they did not receive full due process from the Aetna Better Health .

Complaints and Appeals

- Aetna Better Health use appropriately trained pediatric providers for the purposes of reviewing all medically-based member complaints and appeals, such as:
 - Member appeals regarding a benefit denial or limitation.
 - Member complaints about the:
 - Quality of care or services
 - Accessibility or availability of services
 - Claims processing

Billing Members – Medicaid

- **Providers may not bill or require payment from Members for Medicaid covered services.**

Providers may not bill, or take recourse against Members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to the current Texas Medicaid Provider Procedure's Manual found on the TMHP website at www.tmhp.com

Electronic Remittance Advice and Electronic Funds Transfer Enrollment – Medicaid, CHIP & STAR Kids

- **Forms for requesting an Electronic Funds Transfer and/or an Electronic Remittance Advice can be found on the Aetna Better Health Plan website at: www.aetnabetterhealth.com/texas**
- **When filling out these forms please:**
 - **Submit one enrollment form per Tax ID**
 - **Include your NPI #**
 - **Attach a voided check or bank letter**
 - **Obtain signatures by two authorized individuals**
 - **A healthcare professional – MD, CFO, CEO, etc**
 - **A supervisor-level authorized office or billing manager**
 - **Complete all sections marked with an asterisk and Fax the form to 1-855-596-8401.**
- **Please allow 10-15 business days for processing.**

Referral Process for Aetna Better Health – Medicaid and CHIP

In-network referrals are no longer required for most procedures.

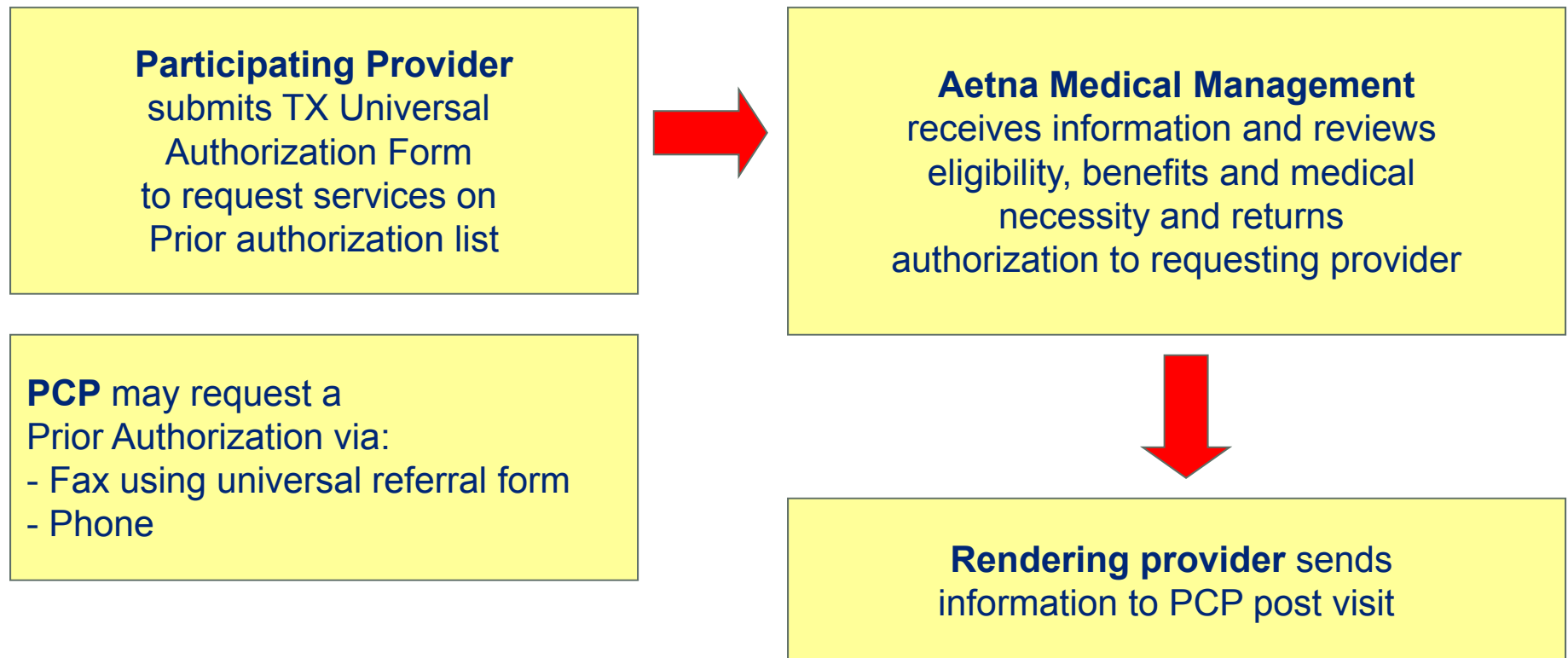
Exceptions for PCP other than PCP of record.

PCP sends universal referral form to specialist with all pertinent information, including test results, etc., if available
Refer to the Prior Authorization list for exceptions for specific specialty care requirements



Specialist provides follow-up information to PCP post visit.
Refer to Prior Authorization list for procedures that require precertification.

Prior Authorization Process for Aetna Better Health – Medicaid and CHIP



Prior Authorization Decision Timeframes

Decision	Decision/Notification Timeframe	Notification to	Notification Method
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner / Provider	Telephone and in writing
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision	Practitioner / Provider	Telephone and in writing
Continued / extended services approval (non-ED/acute inpatient)	1 business day of receipt of necessary information	Practitioner / Provider	Telephone and in writing
Post-service approval of a service for which no pre-service request was received.	30 calendar days from receipt of the necessary information	Practitioner / Provider	Telephone and in writing

Medicaid, CHIP & STAR Kids Medical Prior Authorization

- You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:
- **Medicaid and CHIP Prior Authorization FAX only**
 - Fax - Acute/DME: fax requests to **1-866-835-9589**
Concurrent review: Fax requests to **1-866-706-0529**
- **STAR Kids Prior Authorization FAX only**
 - Fax – Acute/DME: fax requests to **1-866-835-9589**
 - Fax - Long Term Services and Supports (LTSS): **844-275-5728**
- 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

STAR Kids Referrals

- Referrals are not needed in-network.
- Members should still let their PCP know they are going to another provider so the PCP can coordinate their care.
- Some services may need to be preauthorized.

Behavioral Health Services – Medicaid and CHIP

- Direct Access
 - Members may access BH benefits, without a referral from their PCP.
 - Member Services available 24/7

- PCP involvement
 - Provide screening, evaluation, treatment and/or referrals (as medically appropriate) for any behavioral health problem/disorder
 - Treat for mental health and/or substance abuse disorders with their scope of practice
 - Inform members how and where to obtain behavioral health services

Behavioral Health Services (continued) – Medicaid and CHIP

- Members have direct access to behavioral health providers.
- BH providers must send initial and quarterly (or more frequently if clinically indicated) summary reports to the PCP, with the member or member's legal guardian's consent.
- BH providers must refer members with known or suspected and untreated physical health problems to their PCP for examination and treatment.
- BH providers must be licensed to provide physical health care services.
- Clinical decision making is based on LOCUS, CALOCUS and TCADA standards
- Routine care must be offered within 14 days of request, urgent care within 24 hours and emergency situations must be responded to immediately
- Following an inpatient stay, members should be offered an outpatient follow up appointment within 7 days of discharge
- Screening, brief intervention, and referral to treatment (SBIRT) for substance use related issues is a benefit of Texas Medicaid. ***See Aetna Better Health Provider Manual for further detail.***

Behavioral Health Services (continued) – Medicaid and CHIP

- Prior authorization is not required for routine outpatient therapy.
- Prior authorization is required for these services.
 - Inpatient admissions
 - Residential admission
 - Partial hospitalization admissions
 - Psychological and neurological testing
 - Outpatient ECT
 - Biofeedback
 - Outpatient detoxification
 - Psychiatric home care services
 - Amytal interviews
 - Applied Behavioral Analysis (ABA)
- Prior authorization requests for behavioral health may be faxed into Aetna Better Health. Aetna Behavioral Health Prior Authorization (PA) toll free FAX number is 855-841-8355.
- Aetna Behavioral Health Concurrent Review (CCR) toll free FAX number is 855-857-9932.

Mental Health/Substance Abuse (MH/SA) STAR Kids

In order to meet the behavioral health needs of our members, we will provide a continuum of services to members at risk of or suffering from mental, addictive, or other behavioral disorders.

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 primary care providers' scope of practice
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to an in-network behavioral health care provider without a referral from the member's PCP.

Whenever a PCP is concerned about an member who may have a MH/SA problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. Please refer to the Provider Manual about the tools we use to screen members with possible MH/SA concerns.

Behavioral Health

Is defined as those services provided for the assessment and treatment of problems related to mental health and substance abuse.

These services include but are not limited to: assessment and treatment planning, substance abuse services , medication management , inpatient services, intensive outpatient services, case management services and outpatient therapy.

For more detail on the behavioral health benefits , please refer to the Covered services section in our provider manual (see provider website).

List of Behavioral Health Covered services (not all-inclusive)

Medicaid STAR Kids covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, Fee-For-Service (FFS) Medicaid coverage.

The services may be subject to the Aetna Better Health of Texas' non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including but not limited to:

- Inpatient mental health services including in Freestanding Psychiatric Facilities for children
- Outpatient mental health services
- Psychiatry services

Vision Services – Medicaid, CHIP & STAR Kids

Vision Services coordinated through Superior Vision 1-800-879-6901

- Direct access
 - Members may access routine vision services, without a referral from their PCP, provided they are coordinated through Superior Vision
- Non-routine vision services
 - PCP can refer directly to a participating ophthalmologist for non-routine vision services
 - In-network ophthalmologists and optometrists may perform non-surgical services within the scope of their licenses without a referral from the member's PCP or an authorization from Aetna Better Health Plan

Pharmacy Coverage



CVS Caremark administers the prescription drug benefit for our members.

- Please review the Provider Manual for copay information
- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications.
- The following documents are available online:
 - Preferred Drug List (PDL)
 - Over-the-Counter Drug List
 - Prior Authorization Form
 - Mail Order Form



Digital image. CVS Pharmacy. © Copyright 1999 - 2015 CVS.com, n.d. Web.

Pharmacy Coverage – Medicaid, CHIP & STAR Kids

- Aetna Better Health covers prescription medications as of March 1, 2012
- Pharmacy Benefits are coordinated through CVS Caremark
- Our members can get their prescriptions at no cost (Medicaid) or at low co-pays (CHIP) when:
 - They get their prescriptions filled at a network pharmacy
 - Their prescriptions are on the Preferred Drug List (Medicaid) or formulary (CHIP).
- It is important that you as the provider know about other prescriptions your patient is already taking. Also, ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.

Pharmacy Coverage - Medicaid

- **Preferred Drug List (PDL)**

- You can find out if a medication is on the preferred drug list. Many preferred drugs are available without prior authorization (PA). Check the list of covered drugs on our website at www.aetnabetterhealth.com/texas
- The Texas **Medicaid** Preferred Drug List is now available on the [Epocrates drug information system](https://online.epocrates.com/home) at <https://online.epocrates.com/home>.
- The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm, Pocket PC handheld device, or SmartPhone.

Pharmacy Coverage – Medicaid and CHIP

- **Formulary Drug List**

- The Texas Drug Code Formulary (<http://www.txvendordrug.com/formulary/formulary-information.shtml>) covers more than 32,000 line items of drugs including single source and multi source (generic) products. You can check to see if a medication is on the state's formulary list. Remember before prescribing these medications to your patient that it may require prior authorization.
- If you want to request that a drug be added to the formulary please contact an Aetna Better Health Provider Representative for assistance at:

Medicaid	1-800-248-7767 (Bexar)	1-800-306-8612 (Tarrant)
CHIP	1-866-818-0950 (Bexar)	1-800-245-5380 (Tarrant)

Pharmacy Coverage – Medicaid and CHIP

- **Over the Counter Drugs (OTC)**

- Aetna Better Health also covers certain over-the-counter drugs if they are on the list. Some of these may have rules about whether they will be covered. If the rules for that drug are met, Aetna Better Health will cover the drug. Check the list of covered drugs at www.txvendordrug.com/pdl/
- All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Pharmacy Coverage

Medicaid, CHIP & STAR Kids

- **E-prescribing**

- Electronic Prescribing (e-prescribing, or eRx), supports a physician's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy
- Aetna Better Health Plan and CVS Caremark provide for the submission of both paper and electronic prescriptions.
- Providers engaged in E-prescribing must do so in accordance with all applicable State and Federal laws

- **Mail order form for your members**

- While mail order is an option, the use of pharmacy mail order delivery is not required. If you are prescribing a maintenance medication you can assist your patient in completing the MOD form that is available on www.aetnabetterhealth.com/texas

Pharmacy Coverage – Medicaid and CHIP

- **Obtaining Pharmacy Prior Authorization**

- To obtain a Prior Authorization providers can call CVS Caremark at 1-855-656-0363 or fax an authorization form designed specifically for pharmacy requests. You can download that form at www.aetnabetterhealth.com/texas and fax the request to 1-866-255-7534.
- Please also include any supporting medical records that will assist with the review of the prior authorization request. For all requests allow 24 hours to complete the authorization process.

Pharmacy Coverage - Medicaid

- **Obtaining a 72 Hour Emergency Fill**

- Federal and Texas law require pharmacies to dispense a 72-hour emergency supply of a prescribed drug to a Medicaid client when the medication is needed without delay and the prescriber is not available to complete the prior authorization
- Applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical PA needing prescriber's prior approval
- The pharmacy will submit an emergency 72-hour prescription when warranted; this procedure will not be used for routine and continuous overrides
- For further details on the 72 hour emergency supply requests, please use this link to the State VDP website
http://www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf

Supplemental Pharmacy Services

- **Comprehensive Care Program (CCP) - Medicaid**

- The Medicaid Comprehensive Care Program (CCP) can cover medically necessary drugs and supplies that are not covered by the Vendor Drug Program for members from birth through 20 years of age. Your patients can call TMHP at 1-800-335-8957 to locate a participating CCP pharmacy provider.

- **Durable Medical Equipment – Medicaid and CHIP**

- Pharmacies are encouraged to provide some limited Durable Medical Equipment (DME) and medical supplies to Medicaid (STAR) and CHIP plan members. Participating pharmacies are eligible to provide the limited approved DME and medical supplies that are covered under the state of Texas Medicaid (STAR) and CHIP programs.

Pharmacy Contact Information – Medicaid and CHIP

Reason	Phone Number	Website
Prior Authorization	Call 1-855-656-0363 Fax 1-866-255-7534	www.aetnabetterhealth.com/texas (for form)
Caremark Pharmacy Help Desk (Point of service/ adjudication issues)	1-877-874-3317	www.caremark.com/pharminfo
Aetna Better Health (eligibility verification)	1-800-248-7767 Bexar Medicaid 1-800-306-8612 Tarrant Medicaid 1-866-818-0950 Bexar CHIP 1-800-245-5380 Tarrant CHIP 1-844-STRKIDS or 844-787-5437	www.aetnabetterhealth.com/texas
Texas Vendor Drug Program (for pharmacies only)	1-800-435-4165	www.txvendordrug.com

Ob/Gyn Services - Medicaid

- Female patients have direct access to in-network Ob/Gyn specialists.
- If an Ob/Gyn needs to refer for out-of-network specialty care for related services, the physician must initiate the referral through Aetna Better Health Medical Management unit.
- Aetna Better Health allows Pregnant Members past the 24th week of pregnancy to remain under the care of their current Ob/Gyn through the Member's postpartum checkup, even if the provider is out-of-network. Member may select an Ob/Gyn within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

CHIP Perinatal Services

- CHIP perinatal provides care to unborn children of pregnant women with household income up to 200% of the federal poverty level (FPL) and who are not eligible for Medicaid. Once born, the child will receive benefits that are similar to the traditional CHIP benefits for the duration of the 12-month coverage period.
- Coverage begins on the first day of the month in which eligibility is determined. For example, if an application was submitted Feb. 23, 2009, and eligibility was determined March 13, 2009, coverage would start March 1, 2009.
- **Who is eligible?**
 - Unborn children of pregnant women who:
 - Have a household income greater than 185% FPL and at or below 200% FPL.
 - Have a household income at or below 200% FPL but do not qualify for Medicaid because of immigration status.
 - Women who are U.S. citizens or qualified immigrants with household income at or below 185% FPL may be eligible for coverage under Medicaid's pregnant women program.

CHIP Perinatal Services Continued...

- CHIP perinatal coverage includes:
- Up to 20 prenatal visits.
 - First 28 weeks of pregnancy — one visit every four weeks.
 - 28 to 36 weeks of pregnancy — one visit every two to three weeks.
 - 36 weeks to delivery — one visit per week.
 - Additional prenatal visits allowed if medically necessary.
- Some laboratory testing, assessments, planning services, education and counseling.
- Prescription drug coverage based on the current CHIP formulary.
- Hospital facility charges and professional services charges related to the delivery. Preterm labor that does not result in a birth and false labor are not covered benefits.
 - For women with income from 186-200% of the FPL:
 - Hospital facility charges paid through the CHIP perinatal health plan.
 - Professional service charges paid through the CHIP perinatal health plan.
 - For women with income at or below 185% FPL (The majority of CHIP perinatal clients are at or below 185% FPL):
 - Professional service charges paid through CHIP.
 - Hospital facility charges paid through Emergency Medicaid.

CHIP Perinatal Services Continued...

Benefits Once the Child is Born

- Two postpartum visits for the mother.
- Depending on the family's income level, hospital facility charges for labor with delivery and the newborn's first hospital admission may or may not be covered by CHIP perinatal. The covered services available before the child is discharged from the hospital are explained in more detail in the health plan provider manuals.
- Once a child is discharged from the initial hospital admission, the child receives the traditional CHIP benefit package. A full list of covered benefits is available at www.chipmedicaid.com/english/cover.htm.

CHIP Perinatal Services Continued...

Reimbursement

- Women with CHIP perinatal coverage who have income at or below 185% of the FPL no longer need to apply for Medicaid at the time of delivery to cover their hospital stay. Instead, the hospital will need to fill out and send HHSC the mother's bar-coded Emergency Medical Services Certification (Form H3038). This form asks for the dates the woman received emergency medical services (labor with delivery). Once HHSC receives the completed Form H3038, Emergency Medicaid coverage will be established for the mother for the period of time reflected on the form.
- In these situations, facility charges are billed to TMHP. All professional charges are always billed to the CHIP perinatal health plan.

****Please find a Copy of the H3038 Form at www.hhsc.state.tx.us****

CHIP Perinatal Services Continued...

- A CHIP perinatal provider can be an obstetrician/gynecologist (OB/GYN), a family practice doctor or another qualified health care provider that provides prenatal care.
- Covered services for CHIP Perinate Members must meet the CHIP Perinatal definition of "Medically Necessary."
- ***Please refer to the Aetna Better Health Provider Manual (located on our website) for complete information on CHIP Perinate and CHIP Perinate Newborn Covered Services***

The Texas Vaccines for Children Program (TVFC) – Medicaid and CHIP

Texas leads the nation in the number of uninsured and underinsured children. The TVFC program helps to ensure that our children receive the complete series of immunizations required to protect them from vaccine-preventable diseases.

- Benefits of Participation
 - The TVFC program allows at-risk children to more easily access immunizations
 - The program eliminates the financial barriers to full immunization
 - Children receive vaccines from their PCP and other “medical home” providers

- Enrollment and participation is easy
 - More program information and an enrollment application can be found at: <http://www.dshs.state.tx.us/immunize/tvfc/default.shtm>.

ImmTrac – the Texas Vaccine Registry

- *ImmTrac* is an important component of Texas' strategy to improve vaccine coverage rates.
- The *ImmTrac* Registry serves to consolidate immunization records from multiple sources into a single registry
- Texas law states that health care providers must report to ***ImmTrac*** all vaccines administered to a child under 18 years of age within 30 days of administration.
- *ImmTrac* allows providers Internet access to immunization histories on and also supports reminder and recall capability.
- *ImmTrac* is available free of charge to authorized health care providers.

More information about the Texas Immunization Registry is available at <http://www.dshs.state.tx.us/immunize/providers.shtm>.

Preventive Health Care – Medicaid, CHIP & STAR Kids

- **Medicaid & STAR Kids**

- Texas Health Steps (THSteps) – use periodicity schedule in provider manual for members ages 0 – 20
- Medicaid members 21 and older – uses the U.S. Preventive Services Task Force, American Cancer Society and CDC recommendations published in the provider manual

- **CHIP**

- Well child visits - use the American Academy of Pediatrics preventive health guidelines

Texas Health Steps (THSteps) - Medicaid

- Also known as the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services
- Eligibility includes Medicaid recipients from birth to age 21
- Members may see any THSteps provider (self-referral)
- Covered services:
 - Periodic comprehensive physical examinations
 - Periodic dental checkups
 - Hearing and vision screening
 - Immunizations and lab work
 - Case management

THSteps Complete Checkup - Medicaid

- Document all components of the checkup that were performed during the visit. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for a list of the necessary elements that make up a complete check-up. The TMPPM can be found on the TMHP website at www.tmhp.com.
 - Patients' medical records need to support diagnosis and procedures billed
 - Charts are subject to review for claims and quality of care
- Billing for THSteps checkup
 - Only complete medical checkups will be considered for reimbursement under the Medicaid managed care program
 - All components of the checkup are included in the reimbursement code for the comprehensive medical exam (*Refer to the Texas Medicaid Provider Procedures Manual for the correct billing codes*)
 - A provider must bill for THSteps services in accordance with state standards

THSteps Immunizations - Medicaid

- Immunizations and medical checkup should be administered according to the periodicity schedule. An updated periodicity schedule is available via the Aetna Better Health Provider Manual which can be found on the ABH website at www.aetnabetterhealth.com/texas
- Vaccines are supplied free of charge to THSteps providers for Medicaid clients
 - Call 1-800 SHOTS 4 U (1-800-746-8748)
 - www.immunizetexas.org
- Report immunization data to
 - www.ImmTrac.com or call 1-800-348-9158

Oral Evaluation and Fluoride Varnish - Medicaid

- THSteps providers can become certified by the Department of State Health Services to provide oral evaluation fluoride varnish
- For certification requirements, please access www.dshs.state.tx.us/thsteps
- THSteps providers can bill for oral evaluation fluoride varnish when performed on the same day as the THSteps medical checkup

THSteps and the Frew Settlement - Medicaid

- Frew vs Smith-- a lawsuit filed against the state, on behalf of children in the Texas Medicaid program, alleging these clients were unable to access appropriate healthcare services based on the federally mandated Early and Periodic Screening and Diagnostic Treatment (EPSDT) benefit for children under age 21.
- Results of settlement
 - Enhanced rates for pediatricians and subspecialists, such as neurologists
 - Investments that will enhance medical care for children in rural and inner urban areas
 - Improved state call centers to help Medicaid patients better understand treatment options
- For more information, please refer to www.aetnabetterhealth.com/texas

THSteps and Frew (continued)...

What does the Frew settlement agreement mean for providers?

- Increased fees for the provision of services
- Provide a complete checkup within 90 days of patient's enrollment in a Medicaid HMO and educate patient's parent or guardian regarding the benefits of preventive healthcare
- Ensure provision of medical and dental checkups according to periodicity schedule
- Document complete checkups and patient refusal of services
- Provide accelerated services to children of migrant farm workers
- Cooperate with compliance monitoring of medical records documentation

THSteps and Frew (continued)...

Your responsibility as the child's provider

- Educate the child's parent or guardian regarding the health benefits of preventive care
- Schedule complete checkups in a timely manner according to the periodicity schedule
- Perform complete exam and document all components of THSteps exam within 90 days of member enrollment
- Perform timely complete exam and document all components of THSteps exam according to periodicity schedule
- Cooperate with compliance monitoring of medical records documentation

THSteps and Children of Migrant Farm Workers- Medicaid

- Children of a migrant farm worker (MFW) who are due for a THSteps medical checkup may receive their checkup on an accelerated basis before leaving the area
- Please allow these children of MFW to obtain THSteps services expeditiously
- Performing a make-up exam for a late THSteps medical checkup is not considered an accelerated service; it is considered a “late checkup”

Quality Assessment and Performance Improvement – Medicaid, CHIP & STAR Kids

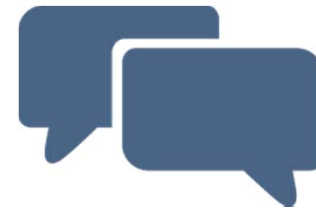
- Aetna Better Health Plan has an ongoing Quality Assessment and Performance Improvement (QAPI) Program that is comprehensive in scope, including both the quality of clinical care and service for all aspects of our health care delivery system. The ABH QAPI program is:
 - Tailored to the unique needs of the membership in terms of age groups, disease categories and special risk status.
 - Compliant with all State and federal requirements for Quality Improvement (QI).
 - Directed by a multidisciplinary committee whose members bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program.

Cultural Competency – Medicaid, CHIP & STAR Kids

- Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. The Aetna Better Health Cultural competency program is geared toward:
 - **Improving health care access and utilization**
 - **Enhancing the quality of services within culturally diverse and underserved communities**
 - **Promoting cultural and linguistic competence as essential approaches in the elimination of health disparities.**
- Additional provider-focused Cultural Competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at: <http://www.hrsa.gov/culturalcompetence/index.html>

Member Rights & Responsibilities

- It is our policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities in the Provider Manual. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.
-
- In the event that we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.
- For a complete list of member's right and responsibilities, please review the Provider Manual.



Americans with Disabilities Act (ADA)

- The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.
- Our providers are obligated to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities (e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible)
- Offer waiting room and exam room furniture must meet needs the needs of all members, including those with physical and non-physical disabilities.
- Be accessible along public transportation routes and/or provides enough parking.
- Have clear signage and “way” finding (e.g., color and symbol signage) throughout doctors offices/facilities.
- Resources:
 - <http://www.ada.gov/reg3a.html>



Access to Care Standards & Availability

Primary Care Providers provide covered services in their offices during normal business hours and are available and accessible to Members, including telephone access, 24-hours-a-day, 7 days per week, to advise Members requiring urgent or emergency services. If the Primary Care Provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating physicians must be arranged.

If a member is referred to another Primary Care Provider who is not on record as a covering provider, a referral must be submitted to the Aetna Better Health Prior Authorization unit to prevent a delay in payment.

- PCP's must be accessible to Covered Persons 24 hours a day, 7 days a week, via one of the following methods:

(1) office phone answered by answering service, with calls returned by PCP within 30 minutes;

(2) office phone answered by recording in each language of the major population groups served by the PCP, with a recording giving the PCP's or another Participating Provider's direct number, which must be answered (referring the Covered Person to another recording is not acceptable);

(3) office phone transferred to another location that answers and contacts the PCP or another designated Participating Provider, with the call to be returned within 30 minutes. PCP's may not have a phone message that directs the Covered Person to simply leave a message or to go to the emergency room for any service needed, although direction to go to the emergency room for Emergency Care is appropriate.

Access and Availability Requirements

- All Participating Providers must make Covered Services available and accessible to Covered Persons during normal business hours. All Participating Providers must provide telephone access to Covered Persons 24 hours a day, 7 days per week, regarding urgent or Emergency Care questions, and must meet the following standards:

Service	Standard
Referrals	Routine Specialist care referrals must be provided within 30 calendar days of the referral
After-hours	Coverage must be available after normal posted business hours 7 days a week, 365 days a year
After-hours calls returned	≤ 30 minutes
In-office wait time	≤ 30 minutes

Provider Appointment Standards

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Same day	Within 24 hours	Within 72 hours	Within 14 days	No more than 30 minutes
Specialty Referral	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 4 weeks	No more than 30 minutes
Dental Care	Within 48 hours (2)	Within 3 days of referral		Within 30 days of referral	No more than 45 minutes
Mental Health/ Substance Abuse (MH/SA)	Same day	Within 24 hours		Within 14 days	No more than 45 minutes
Lab and Radiology Services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

Provider Appointment Standards Cont.

Physicals:	
Baseline Physicals for New Adult Members:	Within 180 calendar days of initial enrollment.
Baseline Physicals for New Children Members and Adult Clients of DDD:	Within 90 days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine Physicals:	Within 4 weeks for routine physicals needed for school, camp, work, or similar.

Provider Appointment Standards Cont.

Prenatal Care: Members shall be seen within the following timeframes:

3 weeks of a positive pregnancy test (home or laboratory)

3 days of identification of high-risk

7 days of request in first and second trimester

3 days of first request in third trimester

State Mandated Appointment Standards

Level/Type of Care	Time to Treatment (Calendar Days)
Low-Risk Pregnancies	Within 14 calendar days
High-Risk Pregnancies	Within 5 calendar days
New Members in the Third Trimester	Within 5 calendar days

Provider Appointment Standards Cont.

Initial:	
Initial Pediatric Appointments:	Within 3 months of enrollment
Supplemental Security Income (SSI) and Texas Care (ABD & Disabled Members):	Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.

Maximum number of Intermediate/Limited Patient Encounters. 4 per hour for adults and 4 per hour for children.

After-Hours Coverage

- Primary Care Physicians must be accessible to members 24 hours a day, 7 days a week.
- The following are acceptable and unacceptable after-hours coverage.

After-Hours Coverage (Cont.)

Acceptable After-Hours Coverage:

- The office telephone is answered after hours by an answering service, which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.
- The office telephone is answered after normal business hours by language appropriate recording directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the covering provider's phone. Another recording is not acceptable; and
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

After-Hours Coverage (Cont.)

Unacceptable after-hours coverage:

- The office telephone is only answered during office hours;
- The office telephone is answered after hours by a recording, which tells the patients to leave a message;
- The office telephone is answered after hours by a recording which directs patients to go to an emergency room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

Aetna Better Health Fraud and Abuse Policy – Medicaid, CHIP & STAR Kids

- Aetna Better Health (Aetna) recognizes its responsibility and commitment to detecting, preventing, investigating and reporting of waste, abuse, and fraud for all services pertaining to the Medicaid and CHIP programs, including services provided by subcontractors (vision services).
- Aetna Better Health also recognizes that it is responsible for investigating and reporting waste, abuse or fraud related to the filing of false claims against the United States Government or failure of an MCO to provide services required under contract with the state of Texas, enrollment/marketing violations and wrongful denial of claims.
- Aetna Better Health employees must adhere to the Corporate Code of Conduct to ensure ethical behavior and actions of all employees, and participate in annual training regarding corporate policies and procedures.

Fraud vs. Abuse

Fraud	Abuse
<p>The intent to abuse the system.</p> <p>The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit.</p>	<p>The misuse of the Medicaid and/or CHIP program without the intent to commit fraud.</p> <p>Business, medical or recipient practices that result in unnecessary reimbursement/cost to the program.</p>

- ❖ Fraud and Abuse program overview is available in Aetna Better Health Provider Manual.
- ❖ Aetna Better Health Provider Manual is located at www.aetnabetterhealth.com/texas

What is waste?

- Less than fraud and less than abuse
- Involves practices that are not cost efficient such as ordering medical services or supplies beyond a patient's needs.

- ❖ Reporting Provider/Clients Waste, Abuse and Fraud is available in the Aetna Better Health Provider Manual.
- ❖ Aetna Better Health Provider Manual is located at www.aetnabetterhealth.com/texas

PROVIDER FRAUD, WASTE, AND ABUSE TRAINING

Welcome!

We designed this training to assist you in helping Aetna Better Health of Texas detect, report, and prevent fraud, waste, and abuse.

Following these requirements protects our members from harm and helps to keep health care costs down.

Definitions

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

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

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

First you are required to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.

Second you have a duty to the program to report any violations of laws that you may be aware of.

Third you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

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

- ◆ Develop a compliance program
- ◆ Monitor claims for accuracy - ensure coding reflects services provided
- ◆ Monitor medical records – ensure documentation supports services rendered
- ◆ Perform regular internal audits
- ◆ Establish effective lines of communication with colleagues and members

Member Abuse and Neglect

IDENTIFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION OF A MEMBER

Aetna Better Health's policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

Definitions

Neglect means intentional or unintentional failure to fulfill a caregiver's obligation or duty to an elderly person. "Self neglect" can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

Abuse constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Aggravating circumstances (such as cruelty, recklessness, and malice in causing injury to others) are often considered by the courts in imposing more severe penalties than a typical sentence for similar offenses.

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

Abuse

Examples of Abuse

- ◆ Bruises (old and new)

Reporting Waste, Abuse and Fraud by a Provider or Client – Medicaid & CHIP

Please contact the following:

Aetna Better Health
Attention: SIU Coordinator
PO Box 569150
Dallas, TX 75356-9150
1-888-761-5440

- ❖ Provider manual is located on the Aetna website
www.aetnabetterhealth.com/texas
- ❖ Fraud and Abuse reporting information is found on page 124 on the provider manual.

To report providers:

Office of Inspector General
Medicaid Provider Integrity/Mail Code 1361
PO Box 85200
Austin, TX 78708-5200

To report clients:

Office of Inspector General
General Investigations/Mail Code 1362
PO Box 85200
Austin, TX 78708-5200

- ❖ If you do not have internet access, call the HHSC Office of Inspector General Fraud Hotline at 1-800-436-6184.

Fraud, Waste & Abuse – STAR Kids

Do you want to report Waste, Abuse, or Fraud?

- Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:
 - Getting paid for services that weren't given or necessary.
 - Not telling the truth about a medical condition to get medical treatment.
 - Letting someone else use their Medicaid ID.
 - Using someone else's Medicaid or CHIP ID.
 - Not telling the truth about the amount of money or resources he or she has to get benefits.

Fraud, Waste & Abuse cont'd – STAR Kids

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **<https://oig.hhsc.state.tx.us/>** Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:
 - MCO's name
 - MCO's office/director address
 - MCO's toll free phone number

Fraud, Waste & Abuse cont'd – STAR Kids

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Provider Complaints, Grievance & Appeals

Provider Payment Disputes:

- Network providers may file a payment dispute verbally or in writing direct to Aetna Better Health of Texas to resolve billing, payment and other administrative disputes.

Provider Complaints:

- Both network and out-of-network providers may file a verbal complaint with Aetna Better Health of Texas. Provider complaints are an expression of dissatisfaction filed with Aetna Better Health of Texas that can be resolved outside of the formal appeal and grievance process.

Provider Grievances:

- Both network and out-of-network providers may file a formal grievance in writing directly with Aetna Better Health of Texas in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action.

Provider Appeal:

- A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with Aetna Better Health of Texas within 90 calendar days from the Aetna Better Health of Texas Notice of Action.

Medical Records - Standards

Laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a members or their contract with Aetna Better Health of Texas for inspection, evaluation, and audit for the longer of:

- A period of 5 years from the date of service; or 3 years after final payment is made under the provider contract/subcontract and all pending matters are closed.

Additional Information:

- Providers must maintain member records in either a paper or electronic format.
- Providers must also comply with HIPAA security and confidentiality of records standards.

Our standards for medical records have been adopted from NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.

Additional Information & Important Requirements

- 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).
- Accommodating members with special needs, which includes but is not limited to: offering extend office hours to include night and weekend appointments, promoting practices offering extended hours, and offering flexible appointment scheduling systems
- Ensuring that hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals) All services are available 24 hours a day, 7 days a week when medically necessary

Maintaining Contact Information

- Network providers must inform Aetna Better Health and

HHSC's administrative services contractor of any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:

- The production of an accurate provider directory
- The support of an accurate online provider lookup function
- The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member's PCP
- The guarantee of accurate claim payment delivery information

Provider Services Call Center

- Medicaid STAR **1-800-248-7767** (Bexar)
- **1-800-306-8612** (Tarrant)
- Medicaid STAR Kids **1-844-STRKIDS (1-844-787-5437)**
- CHIP or CHIP Perinate **1-866-818-0959** (Bexar), **1-800-245-5380** (Tarrant)

Aetna Better Health Medicaid and CHIP website

www.aetnabetterhealth.com/texas

- Provider manuals
- https://www.aetnabetterhealth.com/texas/assets/pdf/provider/Provider%20Manual_2015_TX-12-08-06_0915_FINAL.pdf
- <https://www.aetnabetterhealth.com/texas/assets/pdf/provider/STARKids-ProviderManual.pdf>

- Provider directory/Provider search
- Member handbook

- Member eligibility with Aetna Medicaid or CHIP

- Links to subcontractors (Superior Vision)

- Complaints and appeals process

New Provider Orientation - Handouts

- Medical Record Criteria
- ABH Provider Newsletter
- ABH/PCHP EFT/ERA forms
- Member Acknowledgement Form
- Private Pay Agreement
- ABH Demographic Form
- ABH Prior Authorization List
- TX Standard Prior Authorization Form
- Evicore/Med Solutions
- Provider Claims Appeal Form
- Claims Appeal process
- Complaint Form
- Texas Health Steps QRG
- THS Screening Updates
- After Hours Access Survey standards
- Aetna Behavioral Health services
- THS Outpatient Lab Services
- ICD 10 FAQ
- ABH Provider Advisory Committee
- Sport Physicals
- ABH Important Phone Numbers
- Emdeon Virtual Card Payment Notice
- Helpful resource links
- Billing information
- HHA/DME Medical Supplies Form
- Migrant Farm Worker
- Availability & Accessibility
- Provider Complaints & Appeals
- THS Periodicity Schedule
- Medicaid Benefits FAQ

These handouts will be mailed separately!!!

Questions?