WELCOME TO THE

Aetna Better Health of Ohio

Ohio Provider LTSS Overview

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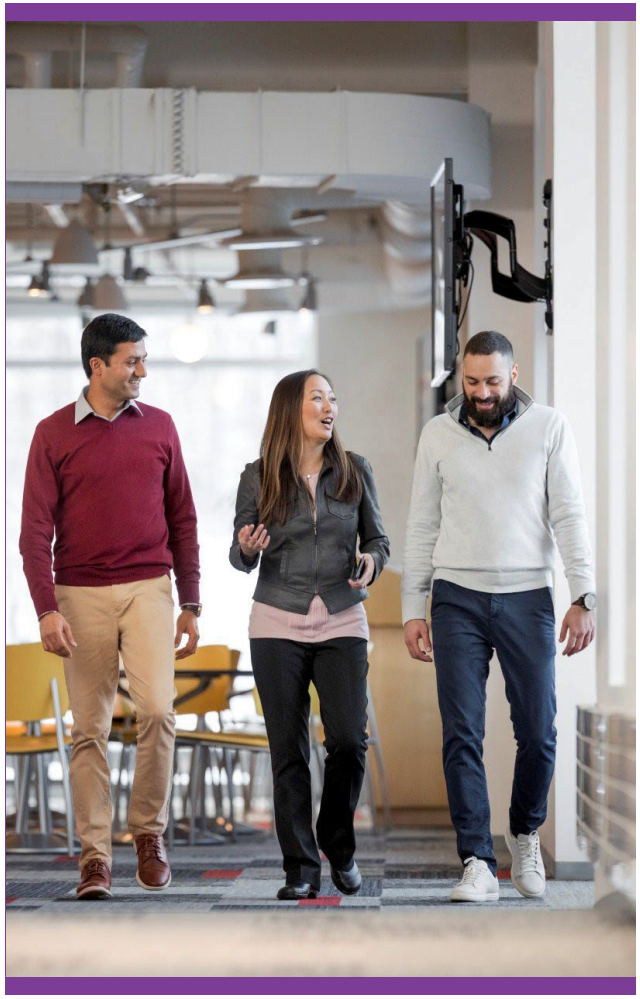
Aetna Better Health of Ohio Orientation for Providers

Agenda

- Aetna Better Health of Ohio Plan Design Overview
- Enrollment & Eligibility
- Covered Benefits
- Provider Contracts
- Claims Submissions
- Secure Provider Portal
- Provider Resources



Aetna Better Health of Ohio Overview

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Medicare and Medicaid Alignment

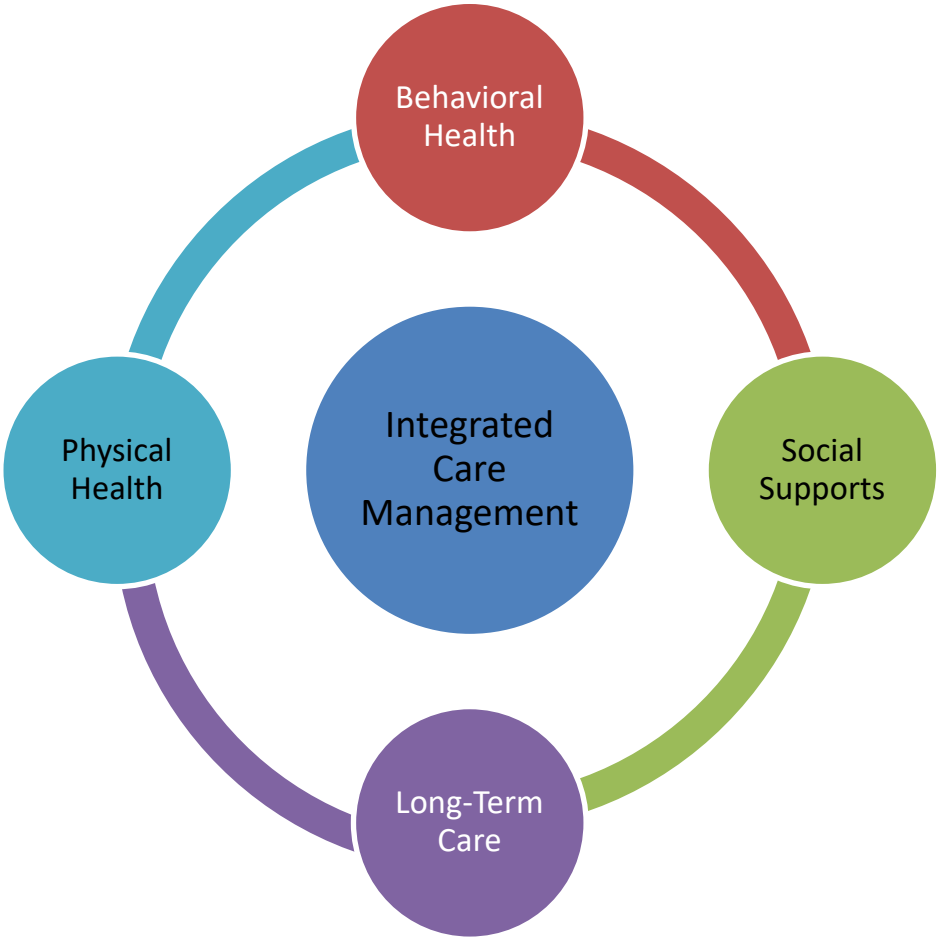
- Integrated plan for people who are eligible for Medicare and full Medicaid medical benefits (known as full benefit duals)
- Aetna Better Health of Ohio can provide both Medicare and Medicaid benefits to enrollees
- Care coordination without the barriers that exists between the two programs in order to improve the quality of care for our members
- Aetna Better Health of Ohio providers must have a valid Medicaid ID by registering as a provider through the Ohio Department of Medicaid

Enrollment options for individuals who qualify for ABH of Ohio

- Select and enroll with the MCO of their choice
- If selection is not made by the individual, they will be passively enrolled and assigned to an MCO
- Ability to “opt out” of the program

Aetna Better Health of Ohio members can change Managed Care Organization (MCOs) or may opt out on a monthly basis. This is unlike the Integrated Care Plan (ICP) program where members may only change MCOs within the first 90 days and are then locked into the plan until the anniversary date.

Medicare Medicaid Plan (MMP)



As an Integrated Care Management model, Aetna Better Health of Ohio is designed to address enrollees'

- Physical Health
- Behavioral Health
- Long-term Care
- Social Supports

Enrollment & Eligibility

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Enrollment Qualifications

Aetna Better Health of Ohio serves members living in Central, Northwest and Southwest counties. Our members have complex care needs through an integrated delivery model across the full continuum of care. This includes individuals who are...

- Age 18 and older
- Entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receive full Medicaid benefits
- Reside in a MyCare Ohio Plan County
- Our plan also services waiver members (e.g. LTSS).
- To receive waiver services, an individual must be eligible for Medicaid, have a developmental disability, and have a limitation in one or more of the major life activities such as self care, learning, mobility, self-direction and capacity to live alone.

ID Cards

Members have only one ID card for Medicare, Medicaid and Pharmacy benefits

**This is a sample version of the ID card

Covered Benefits

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Basic Aetna Better Health of Ohio

- 24/7 nurse line
- Behavioral health services
- Doctor services
- Eyecare services
- Hearing services
- Home health care
- Hospital services
- Lab tests and x-rays
- Medical supplies
- Prescriptions
- Therapy
- Dental Services
- Transportation to medically necessary appointments

Aetna Better Health of Ohio

Value Added Benefits

- $105 OTC pharmacy benefit
  - Per quarter, per member, no rollover
  - Some restrictions on use
- Dental: Preventive, 2 visits per year
- Expanded Podiatry (3 visits per year)
- Vision Services (1-2 visits per year, depending on age)
- Health Education and Nutrition
- Smoking cessation

Copays

- No copays for any benefits, including pharmacy

Transition of Care

Transition of care coverage allows the member to continue to receive services for specified medical and/or behavioral health conditions for a defined period of time with designated health care professionals.

- 90 days TOC begins for first time members that enroll in a Medicare-Medicaid plan
- 90 days TOC for members that change to Aetna Better Health of Ohio from a different Medicare-Medicaid plan.

Primary Care Physician (PCP)

- All members are required to have a PCP
- PCPs may participate only with the Aetna Better Health of Ohio.
- Find a Provider tool on Aetna Better Health of Ohio website
- PCP changes are effective immediately
- Members will need to call into Member Services and request a new ID card anytime a PCP change is made

Provider Appointment & Access Standards

Provider Appointment Standards

Aetna Better Health of Ohio monitors provider compliance to the Ohio Integrated Care Program appointment availability standards

- Routine, preventive care available within 28 days for most providers from request
- Urgent care appointments, not deemed an emergency medical condition, triaged, and if deemed necessary, provided within 24 hours
- Appointment not deemed serious (non-urgent complaints) within 28 days
- Post-hospitalization or emergency department visits within 7 days of discharge

Provider Access Standards

- Aetna Better Health of Ohio requires access to their medical home/PCP, including after hours and on weekends (with a “live person” and no answering machines). Provider voicemail messages should direct members to the emergency room in cases of emergency
- Aetna Better Health of Ohio will monitor the availability of 24/7 access and the processes that support after hours availability and response
- Providers are encouraged to use alternative options for communication, such as scheduling appointments via the web, communicating via secure email and expanded office hours or open access scheduling
- This membership necessitates that providers make their practices accessible to accommodate the full range of disabilities that may exist with the population

Provider Type	Emergency Appointment	Urgent Appointment	Routine Appointment	Wait Time in the Office
Primary Care	Immediate	Within 24 Hours	Within 28 Days	No more than 45 minutes
Specialist	Immediate	Within 24 Hours Of Referral	Within 28 Days	No more than 45 minutes
OB/GYN	Immediate	Within 24 Hours	1st Trimester: Within 3 Weeks 2nd Trimester: Within 7 Calendar Days 3rd Trimester: Within 3 Calendar Days High Risk: Within 3 Calendar Days Routine Care: Within 3 Weeks Postpartum: Within 6weeks	No more than 45 minutes
Behavioral Health	Immediate	Within 24 Hours	Within 10 Days	No more than 45 minutes

In addition to the standards above, Behavioral Health providers are contractually required to offer:

- Follow-up Behavioral Health Medical Management within 3 months of the first appointment
- Follow-up Behavioral Health Therapy within 10 business days of the first appointment
- Next Follow-up Behavioral Health Therapy within 30 business days of the first appointment

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Pharmacy

- CVS Caremark is the Pharmacy Benefit Manager (PBM)
- Formulary/Preferred Drug List
  - Indications for Medicare drugs
- For more information on pharmacy benefits and materials see the provider prescription drug page at:

https://www.aetnabetterhealth.com/ohio/providers/premier/partd

- Additional information is available on the Aetna Better Health of Ohio website under:

https://www.aetnabetterhealth.com/ohio/find-provider

- Pharmacy: CVS Caremark
  - Pharmacy network contracting and network point-of-sale (POS) claim processing and mail order delivery
  - Call Aetna Better Health of Ohio Pharmacy Services at **1-855-364-0974**

Aetna Better Health of Ohio

- Dental – DentaQuest
  - Coverage for routine and specialty dental services
  - 1-800-416-9185
  - 8:00am – 6:00pm CST, Monday – Friday
  - Website: DentaQuest Log In
- Vision: VSP
  - Coverage for routine eye exams, prescription frames and lenses
  - Contact VSP directly at **800-877-7195**
  - 8:00am – 5:00pm CST, Monday – Friday
  - Website: https://www.vsp.com/eye-doctor
- Transportation: MTM
  - 30 round trips or 60 one-way trips
  - Three days advance notice required for non-emergent transportation – including non- emergent ambulance transportation
  - MTM can be reached at **888-889-0094**
  - Trips are scheduled through Aetna customer service at **1-855-364-0974**
- Interpreter Services: Language Line can be used by calling Aetna provider services at **1-855-364-0974**

Provider Contracts

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Provider Contracts

Providers are eligible to join the Aetna Better Health of Ohio network by having an...

- Active ODM Medicaid ID
- A valid National Provider ID (NPI)

If you wish to join the MMP network, please contact our Provider Services department to request a contract packet

- **1-855-364-0974**
- COEProviderServices@Aetna.com
- https://www.aetnabetterhealth.com/ohio/providers/join

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Claim Submissions

Electronic claims through Provider's own clearinghouse

- Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with ECHO Health, Inc. using the 837 file format
- Please use Submitter ID #50023 when submitting electronic claims

Electronic claims through Aetna Better Health of Ohio Provider Portal or Availity

- We encourage participating providers to electronically submit claims through our portal. Information can be found at https://www.aetnabetterhealth.com/ohio/providers/portal

Paper Claims:
Aetna Better Health of Ohio
P.O. Box 982966
El Paso, TX 79998-2966

Claim form

Tips for Submitting Claims

- Confirm member's eligibility before rendering services.
- To best ensure timely and accurate payment of your claim, submit a "clean claim"
- A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party

  - It does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity

- Clean claims are processed according to the following timeframes:

  - 90% of clean EDI claims adjudicated within 30 days of receipt

  - 90% of clean paper claims adjudicated within 90 days of receipt

- If providers have an approved authorization for a claim, include the authorization number on all claim lines pertaining to the authorization.

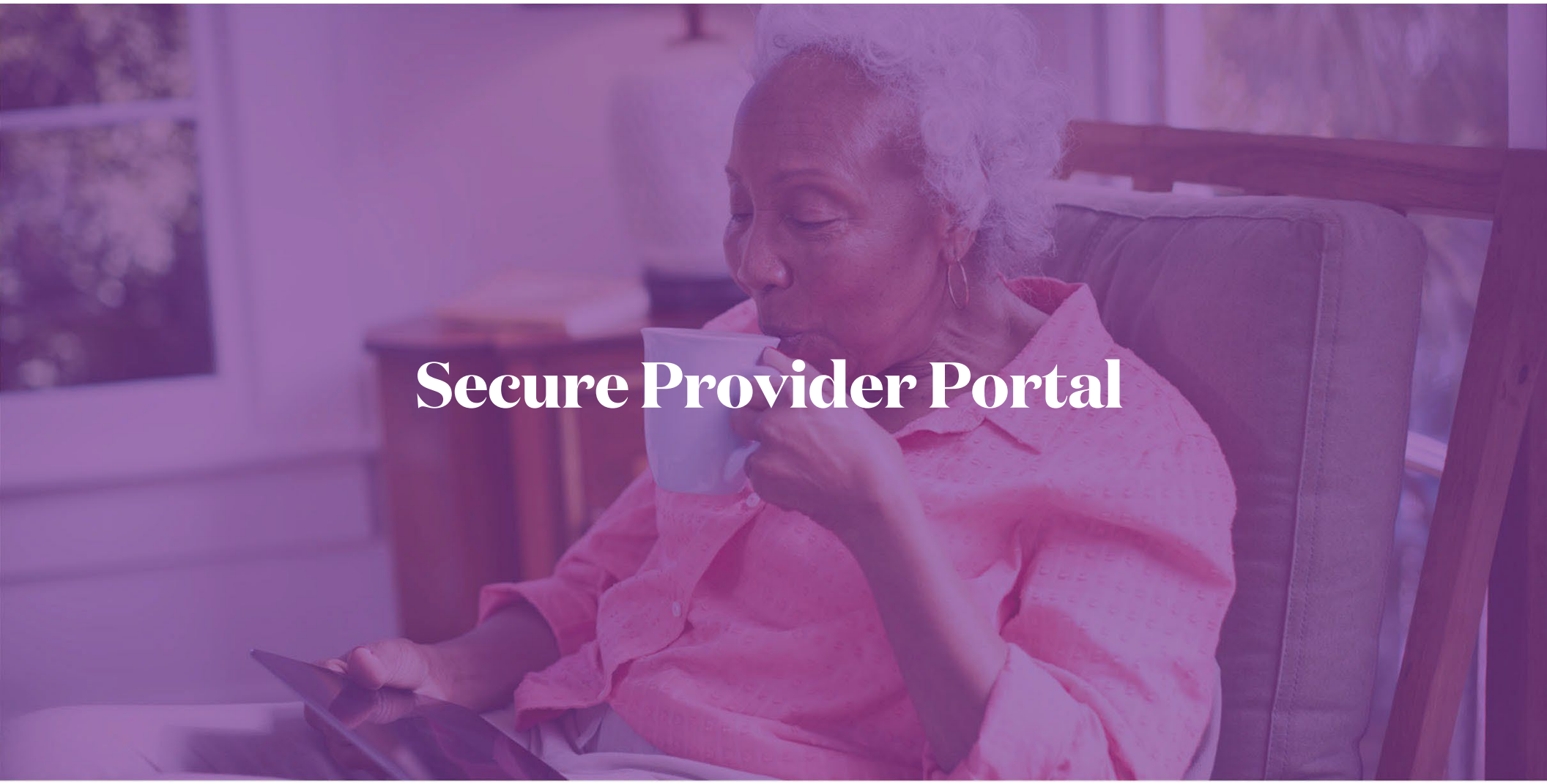
Timely Filing

In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:

- New claim submissions – Claims must be filed on a valid claim form within your contracted TF timeframe. This is from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.

- Claim Resubmission – Claim resubmissions must be filed within your contracted TF period. The only exception to this is if a claim is recouped, the provider is given an additional contracted days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

- Previous waivers on timely filing were provided for the Covid Health Emergency. Waivers to timely filing deadlines are expiring May 11, 2023



Secure Provider Portal

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Secure Provider Portal

The Aetna Better Health Availity Portal allows providers to:

- Request portal access
- Verify eligibility
- Access the Provider Handbook
- Search the directory for a list of participating providers
- Submit and verify prior authorization requests
- Verify which codes require Prior Authorization
- Check claim status
- Retrieve PCP roster of assigned members
- Access to evidence-based clinical practice guidelines
- File a dispute/submit supporting documentation

https://www.aetnabetterhealth.com/ohio/providers/portal

Secure Provider Portal

- If you are already registered with Availity, you will simply select Aetna Better Health from your list of payers to begin accessing the portal and all the features
- If you are not registered, we recommend that you do so immediately
- Please visit the “Portal” tab under the “For Providers” section of the Aetna Better Health Premier Plan MMAI website

  Click here to learn more about **Availity Portal Registration**

- For registration assistance, please call Availity Client Services at 1-800-282-4548 between the hours of 8:00am and 8:00pm Eastern, Monday – Friday (excluding holidays)

Provider Resources

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Provider Resources

Eligibility Verification Options

- Aetna Better Health of Ohio 24/7 options:

  - Call **1-855-364-0974 (TTY: 711)**

  - Secure Provider Portal at https://www.aetnabetterhealth.com/ohio/login

Providers may continue to use the existing Medicaid eligibility verification methods set up by the State

Medicaid Web Portal

EFT & ERA Setup

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

What is EERS?

EERS offers providers a standardized method of electronic payment and remittance. Providers will be able to use the
ECHO tool to manage ETF and ERA enrollments with multiple payers on a single platform.

How does it work?

Please complete the ERA/EFT **enrollment form**. Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process. If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 888.834.3511.To validate your account, please make sure you have an ECHO Health draft number and payment amount so they can validate your enrollment request. A draft number is listed as the EPC draft # on ECHO Health explanation of payments. If you do not have an ECHO draft number available please dial 888.834.3511.

How do I enroll?

To enroll in EERS, please visit **ECHO Portal Guide.**

Provider Disputes

If you are a Contracted Provider, you may use the Dispute Form found online to have your claim reconsidered. Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

Aetna Better Health of Ohio
P.O. Box 982966
El Paso, TX 79998-2966

For faster processing, you may also submit a dispute through the Availity Provider Web Portal.

You must select the appropriate reason for your Dispute (Incomplete or missing information may cause Dispute decision to be upheld or returned to Provider) including but not limited to:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed

Provider Relations

Our provider Relations staff is available to you Monday - Friday 8 AM - 5 PM to assist you on any facets of your relationship with Aetna Better Health of Ohio.
You can reach Provider Relations via:

Aetna Better of Ohio Phone Number: **1-855-676-5772**

Email: **COEProviderServices@aetna.com**

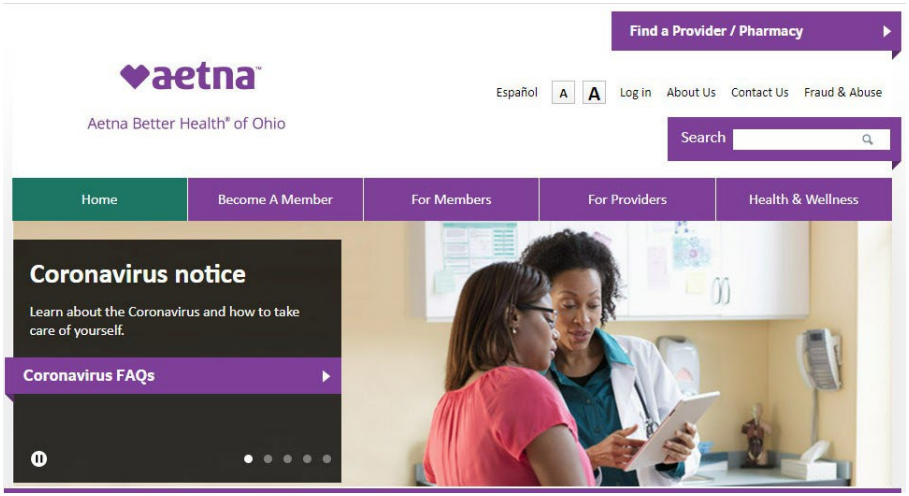
Each participating provider group is also assigned a Provider Relations Liaison who can assist with any escalated claim questions or other concerns.

Visit Our Website

Providers can access the Aetna Better Health of Ohio Plan website at **https://www.aetnabetterhealth.com/ohio/** There you'll find tools and resources to make doing business with us quick and simple.

We've listed a few of the tools and resources found on the "For Providers" tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Document Library
- Provider Education



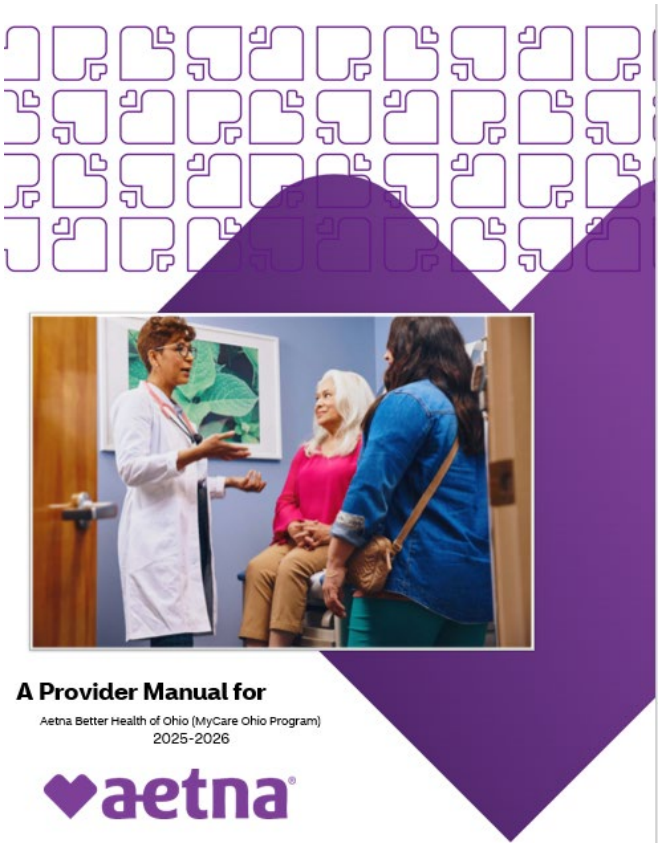
Provider Manual

The provider manual contains plan policies, procedures and benefits. You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available **here** on our website.

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department.

Email: **COEProviderServices@aetna.com**



Provider Responsibilities

- Enrollee Privacy Rights
- Enrollee Privacy Requests
- Advanced Directives
- Provider Marketing
- Cultural Competency
- Health Literacy
- Alternative Formats
- Americans with Disabilities Act
- Abuse and Neglect
- Fraud, Waste, and Abuse

Provider Responsibilities (continued)

1. **Enrollee Privacy Rights and Requests**
   - Privacy requirements of HIPAA when members exercise privacy rights through privacy request,
   - Making information available about Aetna Better Health of Ohio's practices regarding their PHI
   - Maintaining a process to request access to, changes, or restrictions on disclosure of their PHI
   - Consistency in review, disposition, and response to privacy requests within required time standards
   - Documenting requests and actions taken

2. **Advanced Directives**

   The advance directive must be prominently displayed in medical records.

   Must include:

   Providing written information on individual's rights under state law to make medical decisions

   Written policies about advance directives (including any conscientious objections).

   Documenting whether or not member's advance directive has been executed.

   Not discriminating because of advance directive decisions and not making it conditional for care.

3. **Provider Marketing**
   - Aetna may not conduct sales activities in healthcare settings.
   - Providers may discuss MyCare Ohio plan in response to an inquiry.
   - Providers are encouraged to display enrollee materials participating plans.
   - Refer patients to 1-800-MEDICARE, Enrollment Broker, or CMS's website

   Providers may:

   Educate on plan benefits and policies

   Refer to sources within Aetna

   Discuss participating status

   Providers may not:

   Accept applications

   Induce enrollments

   Accept direct marketing compensation

Provider Responsibilities (continued)

4. **Cultural Competency and Health Literacy**
   - Care without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.
   - Treat all enrollees with dignity and respect as required by federal law.
   - Participating providers are required to identify language needs and provide translation, oral interpretation, and sign language services.
     Aetna makes its language interpretation and sign language services available for free to the enrollee and to the provider. Contact 1-855-364-0974 to access services
   - Culturally and Linguistically Appropriate Services (CLAS) available at https://thinkculturalhealth.hhs.gov/education/physicians

4. **Alternative Formats**
   - Large print, Braille, and alternative media for plan materials
   - Contact Provider Services at 1-855-364-0974

5. **Americans with Disabilities Act**
   - Obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities
   - Waiting room and exam room furniture meets needs of all enrollees, including those with disabilities.
   - Accessibility by public transportation routes
   - Clear signage
   - Appropriate accommodations such as large print materials
   - Additional Resources at http://www.ada.gov/

6. **Abuse and Neglect**
   All providers are "Mandated Reporters"
   Immediately report suspected abuse, neglect (including self-neglect), or exploitation to the County Departments of Job and Family Services.

8. **Fraud, Waste and Abuse (FWA)**
   - Aetna complies with state and federal regulations.
   - Aetna targets fraud and abuse including internal, electronic data, and external fraud.
   - Special Investigations Unit (SIU) detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to the appropriate agencies. During the investigation process, confidentiality of patients referring the potential fraud and abuse case is maintained.

Thank You

Aetna policy statement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