Aetna Better Health® of Kansas

Welcome

Aetna Better Health is proud to have been chosen by the Kansas Department of Health and Environment (KDHE) to participate in the State of Kansas KanCare Program. Aetna Better Health will arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

The goals of the Aetna Better Health plan are to:

- Create a person-centered care management approach to improve the quality of care members receive
- Comprehensively manage benefits across the continuum of care, including social and community services
- Integrate services for all physical, behavioral, long-term care, and social needs

Our network in these areas is made up of doctors, hospitals, pharmacies, and providers of long-term and community-based services and supports. Service coordinators and care teams will help members receive the services that they need.

Our ability to serve our members well is dependent upon the quality of our provider network. Our providers are the cornerstone of our service delivery approach. By joining our network you help us achieve our goal of providing our members with access to high quality health care services.

We have assembled the enclosed Provider Orientation Kit to help acquaint you and your staff with our plan. We hope you find this information to be useful. Should you have any questions or concerns, please contact us directly at **1-855-221-5656** or via email at: **ProviderExperience_KS@aetna.com**.

Thank you,

Provider Experience Staff
Aetna Better Health of Kansas

Aetna Better Health® of Kansas

Contact Information Sheet

Aetna Better Health of Kansas Address	9401 Indian Creek Parkway, Ste. 1300 Overland Park, KS 66210

Important Contact Information	**Phone Number**	**Hours and Days of Operation**
Aetna Better Health Provider Experience Email: **ProviderExperience_KS@aetna.com**	**1-855-221-5656** (TTY: **711**) Toll-free Fax: **1-855-215-8760** Non toll-free Fax: **959-282-8865** You can locate your assigned Provider Liaison by visiting our territory map at: **aetnabetterhealth.com/kansas** **The map will outline your assigned Provider Liaison and contact information.**	Live agents available: Monday through Friday 8 a.m. - 5 p.m. Central Time, excluding State holidays Interactive voice response (IVR) system available: 24 hours per day/7 days per week Secure Web Portal available: 24 hours per day/7 days per week
Aetna Better Health Behavior Health Services	**1-855-221-5656** (TTY: **711**)	Live agents available: 24 hours per day/7 days per week Interactive voice response (IVR) system available: 24 hours per day/7 days per week
Aetna Better Health Member Services	**1-855-221-5656** (TTY: **711**) Fax: **1-866-499-9343**	Representatives available 24 hours per day/7 days per week Interactive voice response

		(IVR) system available: 24 hours per day/7 days per week Interpreter services available for members
Aetna Better Health Service Coordination	**1-855-221-5656** (TTY: **711**)	Service Coordinators available: Monday through Friday 8 a.m.-5 p.m. Central Standard Time, excluding State holidays Interactive voice response (IVR) system available: 24 hours per day/7 days per week For urgent issues at all other times, call our after-hours area through the IVR system
Aetna Better Health Utilization Management	**1-855-221-5656** (TTY: **711**) Prior Authorization Fax: **1-855-225-4102** Concurrent Review Fax: **1-855-225-4113**	UM clinician available: Monday through Friday 8 a.m.-5 p.m. Central Standard Time, excluding State holidays Interactive voice response (IVR) system available: 24 hours per day/7 days per week For urgent issues at all other times, call our after-hours area through the IVR system
Aetna Better Health Compliance Hotline (Reporting Fraud, Waste, or Abuse)	**1-855-221-5656** (TTY: **711**)	24 hours per day/7 days per week through Voice Mail inbox

Aetna Better Health Special Investigations Unit (SIU) (Reporting Fraud, Waste, or Abuse)	**1-800-338-6361** (TTY: **711**)	24 hours per day/7 days per week

Aetna Better Health Partners	**Phone Number & Website**
Dental - SkyGen	**1-855-918-2256** (Providers) **1-855-918-2257** (Members) **www.skygenusa.com**
Vision - SkyGen	**1-855-918-2258** (Providers) **1-855-918-2259** (Members) **www.skygenusa.com**
Radiology and Pain Management – Evicore	**1-888-693-3211** **www.evicore.com**
Clearing House: Change Healthcare	**1-866-371-9066** **www.changehealthcare.com**

State & Federal Contact Information	**Phone Number & Website**
Kansas, The Department of Health and Environment (KDHE)	**785-296-1500** KDHE: **www.kdheks.gov** KanCare: **www.kancare.ks.gov**
Kansas Department for Aging and Disability Services (KDADS)	**1-785-296-4986** (KDADS)**: www.kdads.ks.gov**
Kansas Medical Assistance Program (KMAP)	**1-800-933-6593** Monday through Friday, 8 a.m.-5 p.m. Central time, excluding State holidays **www.kmap-state-ks.us/PROVIDER/SECURITY/logon.asp**
Kansas Relay (TTY)	**711**
Kansas Tobacco Quitline “KanQuit”	**1-800-QUIT-NOW (784-8669)** **www.KSquit.org**

Aetna Better Health® of Kansas

Provider Fraud, Waste and Abuse Training

Welcome

We designed this training to assist you in helping Aetna Better Health 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.

Criminal fraud: knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 United States Code § 1347).

What does that mean?

Fraud

Intentionally submitted false information to the government or a government contractor in order to get money or a benefit.

Waste and abuse

Requesting payment for items and services when there is no legal entitlement to payment. Unlike fraud, the provider has not knowingly and intentionally misrepresented facts to obtain payment.

Differences between fraud, waste and abuse

There are differences between fraud, waste and abuse. One of the primary differences is intent and knowledge.

Fraud requires the person to have intent and obtain payment and knowledge that their actions are wrong.

Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

What are my responsibilities as a provider?
You are a vital part of our effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

First, you are required to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program including billing for services accordingly to what was provided and to follow proper coding and guidelines etc.

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.

Your responsible for preventing fraud, waste, and abuse by (also applies to laboratories as mandated by 42 CFR 493):

- Developing a compliance program
- Monitoring claims for accuracy - ensure coding reflects services provided
- Monitoring medical records – ensure documentation supports services rendered
- Performing regular internal audits
- Establishing effective lines of communication with colleagues and members
- Asking about potential compliance issues in exit interviews
- Taking action if you identify a problem

Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote commitment to compliance and address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee responsible for and with authority for operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of a regular, effective education and training program.
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities excluded from participating in the Medicaid program.
6. Effective Lines of Communication: Between the Compliance Officer and employees, managers, directors, and members of the compliance committee, as well as related entities.

7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

How can I prevent fraud, waste and abuse?

- Make sure you are up to date with laws, regulations, and polices.
- Ensure data/billing is both accurate and timely.
  - Monitor claims for accuracy, ensuring coding reflects services provided.
- Verify information provided by you.
  - Monitor medical records, ensuring documentation supports services rendered.
  - Perform regular internal audits.
  - Be on the lookout for suspicious activity.
  - Establish effective lines of communication with colleagues and staff members.
- Make sure you understand and follow Aetna Better Health's policies and procedures.
- Comply with Aetna Better Health's compliance program.
- Ensure policies and procedures are in place at your facility to address fraud, waste, and abuse.

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Special Investigations Unit (SIU)

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

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

Examples of fraud, waste and abuse

- Billing for services and supplies that were never performed or provided.
- Billing for a higher-level treatment than was actually provided.
- Billing separately for services that are already included in the primary procedure.
- Health care provider not providing enough care or delaying needed care. This is done in order to maximize the health care provider's service funds.
- Billing for services or procedures that are not needed.
- Utilizing false or inflated diagnosis codes for encounter information to increase premiums.
- Writing scripts from brand name pharmaceuticals even though generic is

stated in the plan formulary.
- Use of medical benefits by an unauthorized individual.

Reporting fraud, waste and abuse
Participating providers are required to report to Aetna Better Health all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

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

- By phone to the confidential Aetna Better Health Compliance Hotline at **1-800-338-6361**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**

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

Laws you need to know about

The False Claim Act (FCA)
Prohibits:
- Knowingly presenting a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

Anti-Kickback Statute
The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Self-Referral Prohibition Statute (Stark Law)
Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

Exclusions
No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General. (42 U.S.C. § 1395(e0(1), 42 C.F.R. §1001.1901).

HIPAA
Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry. Safeguards to prevent unauthorized access to protected health care information. As a provider who has access to protected health care information, you are responsible for adhering to HIPAA.

Kansas Medicaid Fraud Control Act
As part of the federal Deficit Reduction Act of 2005, the State of Kansas has enacted the Kansas Medicaid Fraud Control Act, K.S.A. 21-3844, as a way to support the federal effort for reducing and eliminating false and fraudulent claims. This law prohibits knowingly making a false claim, statement or representations to Medicaid with intent to defraud.

The Kansas law broadly defines a false claim to include the following:

- Any false or fraudulent claim made to Medicaid
- False information for use in determining payments or amount of payments
- Fraudulent entries in records used to support claims to Medicaid
- Negligent or intentional failures to keep required records and creating any fraudulent documents for submittal to support a claim for payment from Medicaid

There are serious penalties for violations of the Kansas Fraud Control Act. These include criminal and civil money penalties and exclusion from participation in federal programs. These penalties may be in addition to FCA penalties.

Consequences of committing fraud, waste or abuse
The following are potential penalties. The actual consequences depend on the violation.

- Civil money penalties
- Criminal convictions/fines
- Imprisonment
- Loss of provider license
- Exclusion from Federal Health Care Program

Personal Care Service (PCS) Providers
The major reason for improper payments involves fraud, waste, and abuse. Simple, infrequent billing mistakes may not necessarily constitute fraud, waste, or abuse; they may more than likely be human errors. When billing errors occur, PCS providers, like all providers, are required to disclose the errors and return any payments received for them. Some PCS providers are offering medically unnecessary services or more services than necessary—such as more hours than authorized to meet the member's needs—thereby wasting resources. It is important that PCS providers only offer necessary and authorized services.

Five common types of improper PCS payment:

- Claims paid without supporting documentation
- Services provided and billed that are not eligible for reimbursement according to State Medicaid plans, demonstrations, or waivers
- Services provided without required supervision
- Services provided by unqualified PCAs or PCAs without verification and documentation of their required qualifications
- Payments made for care provided while a member was in an institution, such as a hospital (not including payments to a PCA to retain services or during a

period in which the individual is receiving covered respite care)

Improper Medicaid PCS payments costs taxpayers, strains state budgets, and could result in PCS waiver programs becoming limited and ultimately, discontinued.

KDADS Personal Care Services and Limitations Policy

For information about KDADS PCS policy, please review the following website at: **www.kdads.ks.gov/docs/default-source/CSP/HCBS/HCBS-Policies/draft-final-policies/general-policies/personal-care-services-e2016-006.pdf?sfvrsn=804b3aee_6**

In compliance with federal requirements to ensure health, safety and welfare and prevent fraud, waste and abuse, PCS workers for both agency-directed and self-directed employers shall use AuthentiCare® Kansas for electronic visit verification.

Additional References

- Aetna Better Health's Provider Manual
- Code of Federal Regulations (C.F.R.), Title 21
- National Conference of State Legislatures (NCSL): **www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx**
- **www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf**

Aetna Better Health® of Kansas

Identifying & Reporting Abuse, Neglect & Exploitation of a Member

Aetna Better Health 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 a member. "Self-neglect" can also occur when a member is unable or unwilling to make provision for proper care for them-selves.

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 a more severe sentence than is typical for similar offenses.

Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

Imminent danger is a condition which could cause serious or life-threatening injury or death.

Financial exploitation is when someone uses coercion, harassment, or deception to misuse or steal a person's money or property.

Mandated reporters are professionals who, in the ordinary course of their work and because they have regular contact with children, disabled persons, senior citizens, or other identified vulnerable populations, are required to report (or cause a report to be made) whenever financial, physical, sexual or other types of abuse have been observed or are suspected, or when there is evidence of neglect.

Major unusual incidents are defined as any alleged, suspected, or actual occurrence of an incident that adversely affects the health and safety of an individual.

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)
- Burns or bites
- Pressure ulcers (bed sores)
- Missing teeth
- Broken bones/sprains
- Spotty balding from pulled hair
- Marks from restraints

Behaviors of abusers (caregiver and/or family member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Financial exploitation

Examples of financial exploitation:

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

Reporting

The Kansas Department for Children and Families (DCF), Prevention and Protection Services website provides resource information about how abuse, neglect and exploitation can be reported online, tips on making a report and also includes information on who is a mandated reporter and their responsibilities. Please visit their website at:
www.dcf.ks.gov/services/PPS/Pages/KIPS/KIPSWebIntake.aspx

Providers must report all adverse incidents involving individuals receiving services by agencies licensed or funded by KDADS online through the Adverse Incident Reporting (AIR) system, which is located on the KDADS website, within 24 hours of becoming aware of the incident. To make a report through the open face AIR system, click on the below link and scroll down "Quick Links" and locate the Adverse Incident Reporting (AIR) link. **www.kdads.ks.gov**

Children

If the child is in immediate danger, call **911** as well as the following, as applicable:

- Kansas Protection and Report Center at **1-800-922-5330**

Vulnerable Adults

Report to one of the following state agencies:

- Kansas Protection and Report Center at **1-800-922-5330**
- The National Domestic Violence Hotline at **1-800-799-SAFE (7233)**
- The local county Police or Sheriff's Department

For members age 60 or older, providers may report verbally or in writing to the:

- Elder Abuse must be reported to the Kansas Department of Children and Families Adult Protective Services at **1-800-922-5330**
- Nursing Homes, Hospitals, Home Health Agency Abuse and Neglect: Report abuse to the Kansas Department of Aging and Disability Services at **1-800-842-0078**

Aetna Better Health of Kansas Compliance Hotline

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health at **1-800-338-6361**.

Additional Resources

- **www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf**

Aetna Better Health® of Kansas
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210

Date

Provider Organization Name
Address
City, State Zip

Dear Provider Organization Name,

Enclosed you will find an executed copy of the Participating Agreement or Amendment for your records.

We are here to help
If you have questions, do not hesitate to contact the Aetna Better Health of Kansas Provider Experience Team at **providerexperience_KS.com** or **1-855-221-5656**.

Additional tools (including the link to your area specific Aetna Better Health of Kansas Provider Representative) are available at **aetnabetterhealth.com/kansas.**

Thank you for your participation.

Sincerely,

Director of Provider Experience