Aetna Better Health® of Oklahoma

Provider Manual

Provider Services Department:

AetnaBetterHealth.com/Oklahoma

Volume 4 – March 1, 2025

TABLE OF CONTENTS

Chapter 1: Introduction to Aetna Better Health® of Oklahoma

Back to Table of Contents

Welcome

Welcome to Aetna Better Health® of Oklahoma, a SoonerSelect Managed Care Plan. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Oklahomans who need us most. For the purpose of this manual, "provider" refers to practitioners (licensed health care professionals who provide health care services) and providers (institutions or organizations that provide services) that have agreed to provide covered services to health plan members pursuant to a participating health provider agreement ("contract").

Our Aetna Better Health Provider-Led Entity (PLE) is comprised of a majority of key Local Oklahoma Provider Organizations (LOPOs) that reflect a fully integrated behavioral health, physical health, Tribal, foster care, urban and rural model. This Governing Body will have the ultimate responsibility and authority to oversee the Aetna Better Health PLE SoonerSelect contract with OHCA. Aetna Better Health recognizes the diversity of needs and barriers presented by a statewide contract in Oklahoma. Building a health plan to serve all of Oklahoma requires a flexible, field-based approach that adapts to address the unique needs, expectations, and requirements of our members Aetna Better Health provides a Governing Body alongside Clinical and Quality Committees, focused on the needs of every Oklahoma member. Our PLE's Governing Body structure will ensure comprehensive oversight of our clinically integrated health plan, member benefit delivery, access to care, and improved quality and accountability in care delivery. With deep roots in the Oklahoma health care system, they will advise on implementation strategy and conduct outreach with Oklahoma providers on the benefits of health care transformation to managed care.

Experience and innovation

Aetna Better Health Medicaid has more than 30 years' experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and maximum cost outcomes.

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

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Today, Aetna Better Health Medicaid owns and administers Medicaid managed health care plans for more than three million members across 17 state markets. In addition, we provide care management services to hundreds of thousands of high-costs, high-need Medicaid members.

Meeting the promise of managed care
Our state partners chose us because of our expertise in effectively managing integrated health models for Medicaid that provide quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their status, their quality of life, the environmental conditions in which they live and their behavioral health risks. Aetna Better Health Medicaid has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

We have expertise in successfully serving children with special health care needs, children in foster care, persons with developmental and physical disabilities, women with high-risk pregnancies, and people with behavioral health needs.

Aetna Better Health distinguishes itself by:

- More than 30 years' experience managing the care and costs of the Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD) (both physical and behavioral) populations.
- More than 30 years' experience managing the care and costs of the developmentally disabled population, including over 9,000 members served today through the Mercy Care Plan in Arizona
- 20 years' experience managing the care and costs of children and youth in foster care or other alternative living arrangements
- Operation of several capitated managed care plans
- Participation on the Center for Health Care Strategies (CHCS) Advisory Committee, as well as specific programs and grants, since CHCS' inception in 1995
- Local approach – recruiting and hiring staff in the communities we serve

About the Oklahoma Medicaid managed care program
OHCA administers the state and federally funded SoonerSelect Medicaid program for certain groups of low to moderate-income adults and children.

About the Medicaid managed care program
Aetna Better Health was chosen by OHCA to be one of the SoonerSelect managed care health plans to arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

Aetna Better Health is offered statewide.

Disclaimer
Providers are contractually obligated to adhere to and comply with all terms of the plan and your Aetna Better Health Provider Agreement, including all requirements described in this manual, in addition to all federal and state regulations governing a provider. While this manual contains basic information about Aetna Better Health OHCA requires that providers fully understand and apply OHCA requirements when administering covered services.

Please refer to **Oklahoma.gov/OHCA** for further information on OHCA.

Aetna Better Health policies and procedures
Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to verify all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and updates are made as needed. All updates are communicated to both OHCA, and providers/practitioners as needed via paper and/or electronic methods, such as but not limited to provider newsletter, website or secure provider portal.

Eligibility
OHCA has sole authority for determining eligibility for SoonerSelect and for determining whether a member can be enrolled in the SoonerSelect Program. The following populations are eligible for SoonerSelect Program:

- Children (newborn up to 19 years of age)
- Pregnant women (women of childbearing age)
- Low-income non-disabled adults with children (under age 19)
- Individuals seeking family planning services (19 years of age and older)
- Individuals seeking behavioral health services (no age limit)
- Adults, not eligible for Medicare, age 19-64
- Individuals who are employed by a company enrolled in Insure Oklahoma
- Individuals who were enrolled in Medicaid and who aged out of foster care (at 18 years old) in another state, on or after January 1, 2023

Determination
OHCA uses a specific method to determine the income and household size for someone applying for SoonerSelect, Insure Oklahoma, or other programs. This method is called Modified Adjusted Gross Income (MAGI). MAGI is the method required by the Affordable Care Act (ACA) to determine eligibility for income-based Medicaid and subsidized health insurance through the exchanges. MAGI is found by taking your household's current adjusted gross income and adding back certain deductions. See below chart:

Adjusted Gross Income (AGI)	
Include: • Wages, salaries, tips, etc. • Taxable interest • Taxable amount of pension, annuity or IRA • Business income, farm income, capital gain, other gains (or loss) • Unemployment compensation • Ordinary dividends • Alimony received • Rental real estate, royalties, partnerships, corporations, trusts, etc. • Taxable refunds, credits, or offsets of state and local income taxes • Other income • Lotto and gambling winnings	**Deduct:** • Certain self-employed expenses[4] • Student loan interest deductions • Educator expenses • IRA deduction • Moving expenses for Active Duty Military • Penalty on early withdrawal of savings • Health savings account deduction • Alimony payments prior to Dec. 31, 2018 • Certain business expenses of reservists, performing artists, and fee-based government officials

Choosing a PCP

- Members need to select a PCP that is in the Plan's provider network.
- Each eligible family member does not have to have the same PCP.
- If a member does not select a PCP, we will assign one for the member.
- Providers must verify eligibility via the provider portal for every visit with the member.

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services.

When a member first enrolls in our plan, we will do our best to make sure the member gets to keep their current PCP they chose. Sometimes we cannot assign the member to the PCP they choose. When this happens, we will choose a PCP for the member. The PCP's name and phone number will be on the member's ID card. The member can call us at anytime to change PCPs. We might choose a PCP for the member if:

- They did not choose a PCP when enrolled
- The PCP they chose is not accepting new members
- The PCP they chose only sees certain members, such as Pediatricians or Specialists

If we must choose a PCP for a member, we will try to find a PCP that is close to the member's residence and best fits their needs. We look for:

- The member's recent PCP
- The member's family member's PCP
- The member's zip code
- The member's age

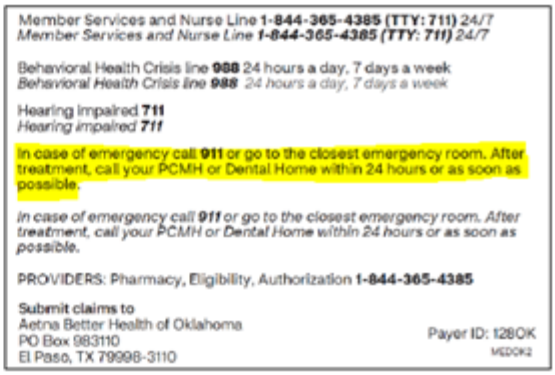
ID Card

Members should present their ID card at the time of service. The member ID card contains the following information:

- Member name
- Member ID number
- Member date of birth
- Member's gender
- PCP name
- PCP phone number
- Effective date of eligibility
- Claims address
- Health plan name
- Aetna Better Health website
- Rx bin number
- Rx PCN number
- Rx group number
- CVS Caremark® number (for pharmacists use only)

Sample ID card

Front and back:



Model of care

Integrated care management

Our integrated care management (ICM) model is built upon a foundation of multidisciplinary physical health, behavioral health, and social services experts, both within our organization and throughout our provider network. Our care management activities seek the input of members/guardians as well as our multidisciplinary provider partners. Our ICM model utilizes an interdisciplinary approach to support member's unique health care needs. The team meets as a group or individually with a member to stress the importance of routinely addressing specialized health care needs. Members of this team, including the member's provider if requested by the member, provide education, identify gaps, and address barriers to care, such as transportation. The interdisciplinary care team collaboratively develops a person-centered individualized care plan

and updates the plan, as needed, to support the member and their journey to better health. Members are educated through the planning process and empowered to work with the team to establish and meet established health goals.

Aetna Better Health integrated care management program (ICM) objective:

- An integrated approach to physical and behavioral health conditions, that also addresses bio-psychosocial circumstances, is critical to proactively identifying and intervening with our most vulnerable, high-risk members to structure an integrative, person-centered care management approach. Our approach is to partner with both the member and providers to enhance care outcomes and prioritize whole person healthcare. Work collaboratively as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage bio-psycho-social complexity, expand community supports for both members and their families, and quickly identify and resolve social determinant of health (SDoH) needs.
- Focuses on member health and well-being using behavioral change strategies, relationship building and engaging community and social systems to wrap around the member, to enhance resiliency and self-efficacy. Includes building partnerships within the member's community to promote a more robust system of social & natural supports.
- Starts with assessing members as they are identified, evaluating them holistically and elucidating both strengths and needs. Includes all elements surrounding them that may impact their health status.
- Assigns to an appropriate level of intervention intensity and staff will collaborate with them in managing their care addressing coordination needs, and linkage to integrative services.
- Resolve provider access issues and remove barriers to receiving high quality behavioral health care.
- Tools and services assist in decreasing the need for invasive care and increasing self-management to improve health and well-being.
- Establish a collaborative working relationship with providers in each county.
- Identify strengths: assure we neither duplicate nor disrupt what is working well.
- Identify and prioritize gaps in the local array of services and support each member's needs and conditions in general and priority populations in particular.
- Identify and respond to opportunities for training and technical assistance to support providers.

The ICM interventions and services are detailed below:

Health promotion and wellness (Tier 1)	Supportive care management (Tier 2)	Complex care management (Tier 3)
• Monitoring and education • Basic educational outreach • Individualized services to members who	All interventions in Tier 1 plus: • Standard care coordination and planning • Coaching on managing conditions and self-	All interventions in Tier 2 plus: • Complex clinical and psycho-social care coordinating and planning, included covered and wrap

require routine screening, monitoring and follow-up • Deployment of additional staff, such as CHWs or peer support specialists • Community based education, events, resources • Screening every trimester for low risk pregnant mothers • Bi-annual condition specific newsletter • Annual reassessments, or sooner as appropriate	care • Gaps in care resolution, treatment adherence support • Encouraging members to communicate and follow-up with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Community based referrals for SDoH services • Care plan reviews every 90 days or sooner when a change in status or triggering event occurs • Reassessments including HR S and condition specific assessments at least annually	around services • Chronic condition management education • Education on accessing care • Monthly contract • Quarterly face to face visits offered as clinically indicated • Frequent contact during acute or transitional episodes • Care plan reviews every 30 days or sooner when a change in status or triggering event occurs • Comprehensive assessments at least annually

About this Provider Manual

This manual serves as a resource and outlines operations the Aetna Better Health SoonerSelect Health program. Through the provider manual, providers should be able to identify information on most of responsibilities and expectations that may affect working with Aetna Better Health, medical and other procedures are denoted within the Manual.

The Aetna Better Health provider manual is updated and made available to providers via the Aetna Better Health website at **AetnaBetterHealth.com/Oklahoma/Providers**

Aetna Better Health annually notifies all new and existing participating providers in writing that the provider manual is available on the Aetna Better Health website via provider newsletter and email. The provider manual is available in hard copy by contacting our provider services department at or via email at **ABHOKProviderEngagement@Aetna.com**

Otherwise, for your convenience Aetna Better Health will make the provider manual available on

our website at **AetnaBetterHealth.com/Oklahoma/Providers**

This manual is intended to be used as an extension of the participating health provider agreement, a communication tool and reference guide for providers and their office staff.

About patient-centered medical homes (PCMH)
PCMH is a care-delivery model designed to provide patient-oriented, primary care driven by an on-going partnership between the provider, the patient and the patient's family. PCMH incorporates accessibility, care coordination, self-care and planning, and health information technology to help ensure practices provide health care services through all stages of life that meet certain quality and safety standards. Practices that wish to demonstrate that they meet these standards may seek formal recognition/certification through a variety of state and national organizations.

Chapter 2: Contact information

Back to Table of Contents

Providers who have additional questions can refer to the following phone numbers:

Important contacts	Phone number	Facsimile	Hours and days of operation (excluding state holidays)
Aetna Better Health	**1-844-365-4385** (TTY 711) (Benefits, education, grievances) **AetnaBetterHealth.com/Oklahoma/Providers**		8 AM - 5 PM CST Monday - Friday 24 hours / 7 days per week Providers have access to member services staff and UM staff during normal business hours as well as after hours.
Language line	**1-844-365-4385 (TTY 711)** Follow the prompts to the member services department for assistance with translation services for our members		Members have access to services for hearing impaired (TTY) Oklahoma relay services for hearing-impaired members as well a language line if the member needs a translator.

Important contacts	Phone number	Facsimile	Hours and days of operation (excluding state holidays)
Aetna Better Health care management (CM)	**1-844-365-4385 (TTY 711)** Follow the prompts or ask to be connected to the CM department		
Aetna Better Health medical prior authorization department	**1-844-365-4385 (TTY 711)** Follow the prompts or ask to be connected to the prior authorization department		24 hours / 7 days per week

Aetna Better Health compliance hotline (reporting fraud, waste or abuse) Providers may remain anonymous.	**1-833-898-1441**	N/A	24 hours / 7 days per weekthrough voicemail inbox
Aetna Better Health special investigations unit (SIU) (reporting fraud, waste or abuse) Providers may remain anonymous.	**1-800-338-6361**	N/A	24 hours / 7 days per week

Aetna Better Health department	**Fax number**
Care management	**1-833-898-6542**
Medical prior authorization	**1-833-923-0831**
Concurrent review	**1-833-923-0780**
Behavioral health	**1-833-923-0829**
Pharmacy prior authorization	**1-888-601-8461**

Community resource	**Contact information**
Oklahoma tobacco quit line	**1-800-QUIT NOW (1-800-784-8669)** Website: **OKHelpline.com**
Member REACH team	**1-833-316-7010**

Contractors	**Phone number**	**Facsimile**	**Hours and days of operation (excluding state holidays)**
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired.	Please contact Member Services at **1 -844-365-4385**	N/A	24 hours / 7 days per week
EyeMed	**1-844-844-0908**	N/A	8 AM - 5 PM CST Monday - Friday
Lab – Quest Diagnostics (preferred lab)	Please visit the website for additional information. **QuestDiagnostics.com**	Please visit the website for additional information.	Please visit the website for additional information.

Durable medical equipment – DME **AetnaBetterHealth.com/Oklahoma/Providers**	Please see our online provider search tool for details regarding DME providers. (Follow the prompts to reach the appropriate departments)	N/A	N/A

Agency contacts & important contacts	**Phone number**	**Facsimile**	**Hours and days of operation (excluding state holidays)**
Oklahoma Department of Health Care Services OHCA – SoonerSelect	**1-800-522-0114**	NA	Monday through Friday from 6:30 AM - 5 PM
Office Ally	**1-360-975-7000** Website: **CMS.OfficeAlly.com/Form-Contact-Form-New**	N/A	24 hours / 7 days per week
Relay Oklahoma	The toll-free access numbers are: **1-800-722-0353** or **1-800-522-8506 (TTY/TDD/Voice)**	N/A	24 hours / 7 days per week
Reporting suspected abuse, neglect or fraud			
The Oklahoma Department of Human Services (adult and child abuse/neglect reporting)	Abuse and neglect hotline at **1-800-522-3511**	NA	24 hours / 7 days per week
The Oklahoma Domestic Violence Hotline	**1-800-522-SAFE (7233)**	N/A	24 hours / 7 days per week
The Oklahoma Medicaid Fraud Division of the Oklahoma Department of Human Services	**1-855-817-3728**		

The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**		

In addition to the telephone numbers above, participating providers may access the Aetna Better Health website 24 hours a day, 7 days a week at: **AetnaBetterHealth.com/Oklahoma/Providers** for up-to-date information, forms and other resources such as:

- Provider quick reference guide
- Member rights and responsibilities
- Searchable provider directory
- Credentialing information
- Prior authorization requirements
- Clinical practice guidelines
- Adult and child preventive health guidelines
- Member handbook and benefits
- Appeals Information and forms
- Provider newsletters
- Pharmacy formulary and prior authorization guidelines and forms
- Health and wellness materials and resources
- Provider education

Chapter 3: Provider experience department

Back to Table of Contents

Provider experience department overview

Our provider experience department serves as a liaison between the health plan and the provider community. Our staff is comprised of provider experience representatives and network specialists. Our provider experience representatives conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our provider experience representatives and network specialists are available by phone or email to provide support to all providers. Below are some of the areas where we may be able to provide assistance:

- Advise of an address change
- View recent updates
- Locate Forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- How to submit prior authorizations
- Review or search the preferred drug list
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Advise of a tax ID or national provider identification (NPI) number change
- Obtain a secure web portal or member care login ID
- Review claims or remittance advice
- Policy explanation

Provider orientation

Aetna Better Health is required to provide initial orientation to newly contracted providers **prior** to being placed on active status with Aetna Better Health and before you provide service members. To view our orientation information, it can be found on our website, or a digital version can be faxed or emailed to you if requested.

As a follow up to initial orientation, Aetna Better Health provides a variety of provider educational forums for ongoing provider training and education, such as routine provider office visits, group or individualized training sessions on select topics (i.e. appointment time requirements, claims coding, appointment availability standards, member benefits, Aetna Better Health website navigation), distribution of periodic provider newsletters and bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/Oklahoma/Providers**

Provider inquiries

Providers may contact us at **1-844-365-4385,** option 2, between the hours of 8 AM and 5 PM, Monday through Friday, email us at **ABHOKProviderEngagement@Aetna.com** or access our secure provider web portal (Availity) for questions including checking on the status of an inquiry, claim, complaint, grievance and/or appeal. Our provider experience team will respond within 48 business hours.

Interested providers

If you are interested in applying for participation in our Aetna Better Health network, please visit our website at **AetnaBetterHealth.com/Oklahoma/Providers**, and complete the provider application (directions will be available online). If you would like to speak to a representative about the application process or the status of your application, please contact our Network Contracting team at **1-844-365-4385**.

Please send paper applications to:

Aetna Better Health of Oklahoma
Attention: Network Management
777 NW 63rd Street, Suite 100
Oklahoma City, OK 73116

Please note this is for all medical type of providers including HCBS, LTC, ancillary, hospital, etc.

Chapter 4: Provider responsibilities & important information

Back to Table of Contents

Provider responsibilities overview

This section outlines general provider responsibilities; however, additional responsibilities are included throughout the provider manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the SoonerSelect program, the request for proposal (RFP) between OHCA and Aetna Better Health, and your provider agreement, and requirements outlined in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than your provider agreement and this manual.

Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to OHCA, the Oklahoma Medicaid Fraud Division of the Department of Health Care Services, Health and Human Services – Office of the Inspector General (HHS OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Aetna Better Health enforces strict adherence to the 2022 Oklahoma Statutes Title 21, particularly §21-1247. This statute prohibits smoking in designated public areas, indoor workplaces, and educational facilities. To meet this requirement, it is imperative for all providers to establish and enforce smoke-free policies within their offices. Failure to comply may result in penalties. We strongly encourage our providers to collaborate with patients in promoting smoking cessation and offer assistance as needed. For support, please refer patients to the Oklahoma cessation line.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Providers must also assure the use of the most current diagnosis and treatment protocols and standards. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

In addition, participating providers are required to ensure the following:

- When providing inpatient psychiatric services to members, that the member is scheduled for outpatient follow-up care **prior to discharge** from the inpatient setting with the outpatient treatment occurring **within seven (7) calendar days** from the date of discharge.
- That treatment to pregnant members who are intravenous drug users and all other pregnant substance users is provided **within 24 hours** of assessment.

If you have any questions, please contact the Aetna Better Health Provider Experience Department at **1-844-365-4385** or email at **ABHOKProviderEngagement@Aetna.com**

Sub-contractual relationship and delegation of responsibilities
Regardless of the relationship that Aetna Better Health has with a subcontracted, IPAs, or delegates,whether direct or indirect through additional layers of contracting, Aetna Better Health hold ultimate responsibility for adhering to, and fully complying with all terms and conditions of the contract with the OHCA.

Unique identifier/national provider identifier
Providers who provide services to Aetna Better Health members must obtain and maintain unique identifiers. Qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by CMS.

Appointment availability standards
Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. our provider experience department will routinely monitor compliance and seek corrective action plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the OHCA and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

In accordance with 42 C.F.R. § 438.206(b)(1), Aetna Better Health shall maintain and monitor a network of appropriate participating providers, supported by a signed provider agreement that is sufficient to provide adequate access and availability to all services covered under this contract for all members, including those with LEP or physical or mental disabilities. Aetna Better Health and it's providers shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for emergency medical conditions and shall make arrangements with, or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under its contract can be furnished promptly and without compromising the quality of care, in accordance with 42 C.F.R. §§ 438.3(q)(1) and (q)(3). In developing an adequate network of participating providers, Aetna Better Health shall:

a. Meet and require its participating providers to meet state standards for timely access to care and services, as specified in its contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i);
b. Ensure that its participating providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to other SoonerSelect populations, if the participating provider serves only SoonerSelect members, in accordance with 42 C.F.R. § 438.206(c)(1)(ii);
c. Make services included in its contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary, in accordance with 42 C.F.R. § 438.206(c)(1)(iii);
d. Establish mechanisms to ensure compliance of with timely access requirements by participating providers, in accordance with 42 C.F.R. § 438.206(c)(1)(iv);
e. Monitor participating providers regularly to determine compliance with timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(v); and

f. Take corrective action if Aetna Better Health, or its participating providers, fail to comply with the timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(vi).

Aetna Better Health shall be able to demonstrate the ongoing activities and efforts to comply with these standards. OHCA shall monitor and review Aetna Better Health compliance with these standards as part of its ongoing oversight activities.

"Time and distance and appointment access standards" provides a listing of the minimum required components of network access standards. This is not meant to be an all-inclusive listing of provider types and components of the participating provider network. The participating provider network for other service providers must be adequate to ensure that care is available timely and geographically accessible. In addition, Aetna Better Health shall add additional participating providers based on the needs of members or due to changes in state or federal requirements.

In accordance with 42 C.F.R. § 438.206(b)(4), if Aetna Better Health is unable to provide necessary medical services covered under its contract to a particular member, Aetna Better Health shall adequately and timely cover the services provided out-of-network by a non-participating provider, for as long as the Aetna Better Health is unable to provide the services within the network. Aetna Better Health shall coordinate payment with Non-Participating Providers and ensure that the cost to the member is no greater than it would be if the services were furnished by a Participating Provider, in accordance with 42 C.F.R. § 438.206(b)(5).

If a female members designated PCP is not a women's health specialist, Aetna Better Health shall provide the member with direct access to a women's health specialist within the participating provider network for covered routine and preventive women's health care services, in accordance with 42 C.F.R. § 438.206(b)(2).

Aetna Better Health shall provide for a second opinion from a participating provider or arrange for the member to obtain a second opinion outside the participating provider network, at no cost to the member, in accordance with 42 C.F.R. § 438.206(b)(3).

Please note: Pursuant to Health & Safety Code 42 C.F.R. § 438.68, if a provider who is not accepting new patients is contacted by a member or potential member seeking to become a new patient, the provider shall direct the member or potential member to Aetna Better Health for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

The tables below outline appointment wait time standards for primary care providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), and high-volume participating specialist providers (PSPs).

Emergency services:

Emergency appointments and services, including crisis services, must be made available immediately upon the member's request.
Routine primary care services:
a. Not to exceed thirty (30) days from date of the member's request for routine appointment b. Within seventy-two (72) hours for non-urgent sick visits c. Within twenty-four (24) hours for urgent care d. Each PCP shall allow for at least some same-day appointments to meet acute care needs
OB/GYN:
Not to exceed thirty (30) days from the date of the member's request for routine appointment
Within seventy-two (72) hours for non-urgent sick visits
Within twenty-four (24) hours for urgent care
Maternity care:
Prenatal care appointments must be made available to pregnant members as follows:
First trimester – not to exceed fourteen (14) calendar days
Second trimester – not to exceed seven (7) calendar days
Third trimester – not to exceed three (3) business days
High-risk pregnancy - within three (3) business days of identification of high-risk to the contractor or maternity provider, or immediately if an emergency exists
Adult and pediatric specialty
Not to exceed sixty (60) days from date of the member's request for routine appointments
Within twenty-four (24) hours for urgent care
Adult and pediatric mental health & substance use
Not to exceed thirty (30) days from date of the members request for routine appointment
Within seven (7) days for residential care and hospitalization
Within twenty-four (24) hours for urgent care

Please note that follow-up to ED visits must be in accordance with ED attending provider discharge instructions.

Aetna Better Health offers a 24-hour nurse line and BH crisis services hotline (**988**) and is also always available to members.

Updates to contact information

Network providers must inform Aetna Better Health and OHCA 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

Aetna Better Health requires providers to use the OHCA online provider portal for demographic

updates. Aetna Better Health will receive a daily file feed from the state and will load these

changes within 3 days of receipt. To keep other requests in an easy and quick submission format Aetna Better Health has built a simple online form for providers to complete. The online form can accept any changes that are not able to be shared via the OHCA portal, such as updates, or terminations; new provider adds to existing group contracts; terming providers due to office closures, retirement, and leaving a medical group; large add/change/termination files; and W-9 submissions. Once the request is submitted an email confirmation is generated to the provider. All cases are assigned to an Aetna Better Health staff member within 48 hours. It is our goal to handle all demographic changes in a timely manner our goal is to have all requests handled within 30 days of submission. We will share a completion notification to the requester once the task is complete.

Telephone accessibility standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available, or having on-call arrangements in place withother qualified participating Aetna Better Health providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care, and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and emergent health care issues are held to the same accessibility standards regardless of if after hours coverage is managed by the PCP, current service provider, or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via email) between members, their PCPs, and practice staff.

Providers must return calls within 30 minutes. We will routinely measure the PCP's compliance with these standards as follows:

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

Providers must comply with telephone protocols for all the following situations:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and

interpretivelinguistic needs)
- Triage for medical conditions and special behavioral needs for individuals who are experiencing intellectual, cognitive or developmental concerns. Triage is defined as a process for assessing a member's needs and determining the appropriate level and type of service.

A telephone response should be considered acceptable/unacceptable based on the following criteria:
Acceptable – an active provider response, such as:
- Telephone is answered by provider, office staff, answering service, or voice mail
- The answering service either:
  - Connects the caller directly to the provider
  - Contacts the provider on behalf of the caller and the provider returns the call
  - Provides a telephone number where the provider/covering provider can be reached
- The provider's answering machine message provides a telephone number to contact the provider/covering provider

Unacceptable:
- The answering service:
  - Leaves a message for the provider on the PCP's/covering provider's answering machine
  - Responds in an unprofessional manner
- The provider's answering machine message:
  - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation for care without enabling the caller to speak with the provider for non-emergent situations
  - Instructs the caller to leave a message for the provider
- No answer
- Listed number no longer in service
- Provider no longer participating in the contractor's network
- On hold for longer than ten (10) minutes
- Telephone lines persistently busy despite multiple attempts to contact the provider

Providers must make certain that their 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.

If a provider fails to meet telephone accessibility standards, a provider services representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and workto correct the barrier to care.

Annual network certification
Federal and state laws and regulations require that Aetna Better Health has the capacity to serve our members. As part of that certification, Aetna Better Health shall demonstrate that we are contracted with the required number and mix of primary and specialty care providers, and that we are able to provide medically necessary services needed for 100% of anticipated membership and

utilization. Specifically, Aetna Better Health will ensure we and our subcontractor IPA's network includes the following:

- Adult and pediatric PCPs. Including non-physician medical practitioners
- Obstetrician-gynecologists (OB/GYN)
- Adult and pediatric specialists
- Adult and pediatric mental health providers
- Adult and pediatric SUD providers
- Hospitals
- Pharmacies
- Federally Qualified Health Centers (FQHC) and/or Rural Health Center (RHC)

Aetna Better Health is required to have a network with the capacity to serve 100% of eligible members in each county and will adjust the number of network providers proportionally to accommodate any changes in enrollment. At a minimum, Aetna Better Health must meet the full time equivalent (FTE) ratios. Additionally, Aetna Better Health will provide specialty mental health services in compliance with mental health parity requirements.

Aetna Better Health will ensure providers comply with time and distance standards and service availability, physical accessibility, out of network access, timely access, continuity of care and language assistance requirements. Provider education and/or a corrective action plan will be issued to any providers who do not meet the requirements. In the case that Aetna Better Health is unable to meet time and distance standards and has exhausted all reasonable contracting options with nearer providers, alternative access providers will be identified to meet the specific needs of the member(s).

Covering providers

Our provider services department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health. This notification must occur in advance of providing authorized services. Depending on the program, reimbursement to a covering provider is based on the fee schedule. If members have other insurance coverage, providers must submit a paper or electronic bill and primary carrier EOB for reimbursement. Medicaid is always the payor of last resort. Failure to notify our provider services department of covering provider affiliations or other insurance coverage may result in claim denials and the provider may beresponsible for reimbursing the covering provider.

Verifying member eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non- emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to members who lost eligibility or who were not assigned to the primary care provider's panel (unless she/he is a physician covering for the provider).

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

- **Secure website portal:** Contact our provider services department for additional information about securing a confidential password to access the site.
- **Monthly roster:** Monthly rosters are found on the secure website portal.

— Note: rosters are only updated once a month.

- **Telephone verification:** Call our member services department to verify eligibility at **1-844-365-4385**. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as the member's identification number, date of birth and address beforeany eligibility information can be released.

Provider secure web portal

The secure web portal is a web-based platform that allows us to communicate member healthcare information directly with providers. Providers can perform panel roster to view the list of members currently assigned to the provider as the PCP.

Preventive or screening services

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

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations
- Woman's health care services (female members may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral)
- Age and risk appropriate health screenings

Health education

Several health education tools, resources and materials are available at no cost for providers to share with and educate members about including:

- The MyActiveHealth tool can be accessed by members through their patient portal or the Aetna Better Health website and provides members with interactive tools about several different health issues and conditions. The Aetna Better Health health educator can provide an orientation about MyActiveHealth to providers and their staff and members upon request.
- Member newsletters are provided to all members on a quarterly basis and are mailed to their homes and contain health tips and information about a variety of health topics. Aetna Better Health has extra copies of newsletters that can be provided upon request. Members diagnosed with certain chronic conditions will also receive information specific to that condition.
- The Aetna Better Health website Health and Wellness section contains information about specific health topics, links to Krames Health Sheets, and information about the latest Aetna Better Health health education classes and resources available in the community.

Educating members on their own health care

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

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his or her behavioral health care,

including the right to refuse treatment, and to express preferences about future treatment decisions

Practitioners/providers may freely communicate with members on items such as these regardless of benefit including limitations.

Emergency services
Authorization is not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest in-network urgent care or emergency department.

Urgent care services
As the provider, you must serve the medical needs of our members; you are required to adhere to all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the "find a provider" link on our website and select an "urgent care facility" in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna Better Health will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Primary care providers (PCPs)
The primary role and responsibilities of PCPs include, but are not limited to:

- Provide or arrange for urgent covered services as defined in your contract, including emergency medical services, to members on 24 hours per day, seven days per week basis
- Arrange and direct specialty care
- Medication reconciliation
- Identify behavioral health conditions and needs and refer or treat as appropriate
- Providing primary and preventive care and acting as the member's advocate
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult member from pediatric to adult providers
- Maintaining the member's medical record
- Providing to members:
  - Office visits during regular office hours
  - Office visits or other services during non-office hours as determined to be medically necessary
  - Response to phone calls within a reasonable time and on an on-call basis 24 hours per day, seven days per week
  - Facilitating use of open scheduling and same day appointments, where possible

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

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

- Referring members to behavioral health providers, or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers
- Coordinating with our prior authorization department about prior authorizationprocedures for members
- Conducting follow-up (including maintaining records of services provided) for referral servicesthat are rendered to their assigned members by other providers, specialty providers and hospitals
- Coordinating the medical care for the programs the member is assigned to, including at a minimum:
  - Oversight of drug regimens to prevent negative interactive effects
  - Follow-up for all emergency services
  - Coordination of inpatient care
  - Coordination of services provided on a referral basis
  - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs
  - Care Coordination in accordance with member's care plan, as applicable based on the Aetna Better Health Risk Stratification Level Framework, and in cooperation with the member's care team

Aetna Better Health prefers for primary care providers (PCPs) to establish and maintain hospital admitting privileges that are sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members. This includes:

- Arranging for coverage during leave of absence periods with an in-network provider with admitting privileges
- Utilizing and practicing evidence-based clinical decision supports
- Screening members for behavioral health disorders and conditions
- Using health information technology to support care delivery
- Engaging active participation by the member and the member's family, authorized representative, or personal support, when appropriate, in health care decision-making and feedback and care plan development
- Participating in continuous quality improvement and voluntary performance measures as established by Aetna Better Health and/or OHCA

Specialty providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna Better Health participating specialist. Specialists are required to coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

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

Specialty providers acting as PCPs

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

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

The Aetna Better Health Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as PCP. The CMO will have the authority to make the final decision to grant PCP status taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in Chapter 2. This includes arraigning for coverage 24 hours a day, 7 days a week.

Self-referrals/direct access

Members may self-refer/directly access some services without a referral from their PCP. We encourage all members to discuss specialty care with their PCP, who can coordinate needed services. Members have direct access to behavioral health care, vision care, minor consent services, and services provided by women's health care providers (WHCPs). Members have the right to select their own WHCP,including nurse midwives who participate in the Aetna Better Health network, and can obtain maternity and gynecological care without prior approval from a PCP. The member must obtain these self-referred services from an Aetna Better Health provider.

Family planning services

Our members have direct access for family planning services without a referral and may also seek family planning services at the practitioner or provider of their choice (in- or out-of-network). The following services are included:

- Annual gynecological exam;
- Annual pap smear;
- Lab services;
- Contraceptive supplies, devices, and medications for specific treatment; and
- Contraceptive counseling.

Nursing facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-

IDD) providers

The health plan covers sixty (60) days of care in a nursing facility or ICF-IDD facility while a level of care determination is completed. If the level of care determination indicates that the member requires long-term care in a nursing facility of ICF-IID, the member shall be disenrolled from the health plan.

State plan personal care services [1]

Eligibility for personal care services, and corresponding nurse supervision, is contingent upon an individual requiring one (1) or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping, or errands or specified special tasks to meet activities of daily living (ADLs) or instrumental activities of daily living (IADLs) assessed needs. Eligibility is determined utilizing the uniform comprehensive assessment tool (UCAT) administered by the Aetna Better Health care manager.

To be eligible for personal care services, the member must meet the following conditions:

- Have adequate informal supports that contribute to care or decision-making ability, as documented on the UCAT, to remain in the home without risk to health, safety, and well-being:
    - The individual must have the decision-making ability to respond appropriately to situations that jeopardize health and safety or available supports that compensate for lack of ability as documented on the UCAT or
    - The individual who has decision-making ability but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and has been informed by the Aetna Better Health care manager of potential risks and consequences may be eligible

- Require a care plan involving the planning and administration of services delivered under the supervision of professional personnel
- Have a physical impairment or combination of physical and mental impairments as documented on the UCAT. An individual who poses a threat to self or others as supported by professional documentation may not be approved for personal care services
- Not have members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors
- Lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others
- Require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration
- If it is determined that the member meets criteria for personal care services, based on the UCAT, Aetna Better Health will authorize these services[2]

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for the member. While services may have been authorized for caregivers and agencies, providers should not be billing for any days that fall

1 2023 Oklahoma SoonerSelect Draft Contract, Section 1.21.2
2 2023 Oklahoma SoonerSelect Draft Contract, Section 1.21.2

between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Example:
Member is authorized to receive 20 hours of personal care services per week over a 5-day period. The member is receiving 4 hours of care a day. The member is admitted into the hospital on January 1 and is discharged from the hospital on January 3. There should be no billable hours for January 2, as no services were provided on that date since the member was hospital confined for a full 24 hours.

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

Personal assistants and community agencies are responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the personal assistants and agencies will be required to pay back any monies paid by Aetna Better Health. Aetna Better Health will conduct periodic audits to verify this is not occurring.

Electronic visit verification (EVV) requirements[3]
Participating providers providing State Plan Personal Care and home health services subject to EVV requirements to SoonerSelect members, must participate in the contracted EVV system unless granted an approved written exception from the State.

In addition, providers of EVV services must monitor and use information from the EVV system to verify that services are provided as specified in the member's care plan; in accordance with schedule, amount, frequency, duration and scope of services and that service gaps are identified and immediately addressed (including but not limited to late and missed visits) with the established back up plan. This monitoring is required any time a member is receiving services, including after normal business hours.

Out of network providers
When a member with a special need for services is not able to be served through a contracted provider, Aetna Better Health will authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through the medical transportation vendor when there are no providers that can meet the member's special need available in a nearby location. If needed, our provider services department will negotiate a single case agreement (SCA) for the service and refer the provider to our network development team for recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

Second opinions
A member may request a second opinion from a qualified health care professional within our network any time a member wants to confirm a recommended treatment. Providers should refer the member to another network health care professional within an applicable specialty for the

3 2023 Oklahoma SoonerSelect Draft Contract, Section 1.21.2

second opinion. If an in-network provider is used, no prior authorization or referral is required to obtain a second opinion. Out-of-network practitioners/providers may be used if the network is limited in the specialty for which the opinion is requested. The member will incur no more cost for an out-of-network second opinion than they would if the service was obtained in-network.

Medical records review

Aetna Better Health standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health provider network. Below is a list of Aetna Better Health medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health members immediately and completely available for review and copying by the department and federal officials at the provider's place of business, or forward copies of records to the department upon written request without charge.

Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record (i.e., name, Medicaid identification number)
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Medicaid identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, operations, illnesses, accidents, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant while the member)Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received
- Immunization records
- Dental history

- Current problem list (the record will contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition,significant illness, medical conditions, and health maintenance concerns are identified in the medical record)
- Patient visit data - documentation of individual encounters must provide adequate evidence of, at aminimum:
  - History and physical examination - appropriate subjective and objective information is obtained for the presenting complaints
  - Plan of treatment
  - Diagnostic tests
  - Therapies and other prescribed regimens
  - Follow-up - encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits
  - Referrals, recommendations for specialty, behavioral health, and vision care, and results thereof
  - Other aspects of patient care, including ancillary services
- Fiscal records - providers will retain fiscal records relating to services they have rendered to members,regardless of whether the records have been produced manually or by computer
- Recommendations for specialty care, as well as behavioral health, vision care and results thereof
- Current medications (therapies, medications, and other prescribed regimens - drugs prescribed as part of the treatment, including quantities and dosages, will be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record will have a notation to the effect.)
- Documentation, initialed by the member's PCP, to signify review of:
  - Diagnostic information including:
    - Laboratory tests and screenings
    - Radiology reports
    - Physical examination notes
    - Other pertinent data
- Reports from referrals, consultations, and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health and (2) prior admissions, as necessary)
- Behavioral health referrals and services provided; if applicable, including notification of behavioral health providers. If known, document when a member's health status changes, new medications are prescribed, and behavioral health history
- Documentation as to whether an adult member has completed advance directives and location of thedocument. Oklahoma advance directives include Advance Directive for Health Care, Durable Power of Attorney (Health Care Powers Only) and Psychiatric Advance Directive (PAD). A psychiatric advance directive (PAD) is a legal document that documents a person's preferences for future mental health treatment and allows appointment of a health proxy to interpret those preferences during a crisis

- Documentation related to requests for release of information and subsequent releases
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care
- Entries - entries will be signed and dated by the responsible licensed provider. The responsible licensed provider will counter sign care rendered by ancillary personnel. Alterations of the record will be signed and dated
- Provider identification - entries are identified as to author
- Legibility – again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer

Medical record audits

Aetna Better Health, OHCA or its appointed authority, or CMS may conduct routine medical record audits to assess compliance with established standards including the completion of the initial health assessment (IHA) within 120 days of member's enrollment. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities, or quality of care issues. Providers must respond to these requests promptly within thirty (30) days of request. Medical records must be made available to OHCA or designee for quality review upon request and free of charge.

Access to facilities and records

Providers are required to retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of seven (7) years from the date of service; or
- Seven (7) years after final payment is made under the provider's agreement and all pending matters are closed.

Documenting member appointments

When scheduling an appointment with a member over the telephone or in person (i.e., when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record. You may access our website to electronically verify member eligibility or call the member services department at **1-844-365-4385**.

Missed or cancelled appointments

- Providers must: Document in the member's medical record, and follow-up on missed or canceled appointments, including missed EPSDT appointments
- Conduct an affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member to bring the member's care into compliance with the standards
- Notify our member services department when a member continually misses appointments

Documenting referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists within our network. Providers must follow the respective practicesfor emergency room care, second opinion, and noncompliant members.

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

Specifically, our network providers must:

- Maintain accurate medical records and other health information
- Help verify timely access by members to their medical records and other health information

Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and member information. Providers must follow both required and voluntary provision of medical records and must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations.

Health Insurance Portability and Accountability Act of 1997 (HIPAA)
HIPAA has many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, visit **HHS.gov/HIPAA/For-Professionals/Privacy**
In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA
- Keep patient records, papers and computer monitors out of view
- Have electric shredder or locked shred bins available

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information Protected Health Information (PHI). The privacy rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

- “Individually identifiable health information” is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health, or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- Individually identifiable health information includes many common identifiers (e.g., name,address, birth date, social security number)
- Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of **Aetna Better Health®**
- Release of data to third parties requires advance written approval from the department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law

Additional privacy requirements are located throughout this Manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records. For additional training or Q&A, please visit:
Aspe.Hhs.gov/Standards-Privacy-Individually-Identifiable-Health-Information

Member privacy rights

Aetna Better Health® privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements.

Our privacy policy conforms with 45 C.F.R. (Code of federal regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists **Aetna Better Health®** personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about **Aetna Better Health®** practices regarding their PHI
- Maintaining a process for members to request access to, changes to, or restrictions on, disclosure of their PHI. Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken

Member privacy requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI

- Receive confidential communications
- Receive a notice of privacy practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan notice of privacy practices, requests from members or a member's representative must be submitted to **Aetna Better Health®** in writing.

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

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability topay or ability to speak English. **Aetna Better Health®** expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health® has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter,and we develop and implement proven methods for responding to those challenges.

Providers receive education about such important topics as:
- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment

  The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices)
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care

Health literacy – limited English proficiency (LEP) or reading skills
In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, **Aetna Better Health®** is

required to verify that limited English proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members,including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- Those experiencing homelessness
- Individuals with physical and mental disabilities
- Individuals who identify as gay, lesbian, bisexual, transgender or gender nonconforming

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, **Aetna Better Health®** makes its telephonic and face to face language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible to associated costs. Our language interpreter vendor provides interpreter services at no cost to providers and members.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, **Aetna Better Health®** member services representatives will assist the member via a three-way call to communicate in the member's native language
- Members and providers should contact the member services call center via phone to request face-to-face interpretive services. **Aetna Better Health®** requires at least 48 hours advance notice of the appointment
- When providers need interpreter services and cannot access them from their office, they can call **Aetna Better Health®** to link with an interpreter

Aetna Better Health® provides alternative methods/auxiliary aids to assist with communication for members who are visually impaired, including large print and other formats. Contact our member services department for alternative formats.

The use of professional interpreters is required for linguistic interpretive services. It is never appropriate to ask family members or friends of members to interpret. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Aetna Better Health® offers sign language, face-to-face and over-the-phone interpreter services at no cost to the provider or member. When applicable, participating providers are required to accommodate the presence of interpreters. Please contact **Aetna Better Health®** at for more

information on how to schedule these services in advance of an appointment.

Individuals with disabilities
Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office visits will be conducted by our provider services staff to verify that network providers are compliant.

Office administration changes and training
Providers are responsible to notify our provider experience department of any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners) as soon as possible. Administrative changes in office staff may result in the need for additional training. Contact our provider services department to schedule staff training.

Credentialing/re-credentialing
Oklahoma uses current NCQA standards and guidelines for the review, credentialing leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

Providers are re-credentialed every three (3) years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required.

Aetna Better Health® will verify during the credentialing and re-credentialing process that a home-like environment and community integration exists in facilities they intend to contract with as well as in existing network ALFs.

Licensure and accreditation
Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at leastannually or as indicated.

Discrimination laws
Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law

- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164

In addition, our network providers must comply with all applicable laws, rules, and regulations, and as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member based on health status.

Financial liability for payment for services
In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a network provider may collect monies from members in accordance with the terms of the member's Handbook (if applicable). Providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna Better Health to service such members, as long as the member follows Aetna Better Health rules for accessing services described in the approved Member Handbook
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member'sresponsibility to pay the full cost of the services
- Agreeing that when referring a member to another provider for a non-covered service to verify thatthe member is aware of his or her obligation to pay in full for such non-covered services

Continuity of care
Providers terminating their contracts are required to provide a notice before terminating with Aetna Better Health. Providers must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost.

Aetna Better Health® notifies members affected by the termination of a practitioner or practice group in general, family, or internal medicine or pediatrics at least thirty (30) calendar days prior to the effective termination date, and helps the members select a new practitioner. If a practitioner notifies **Aetna Better Health®** of termination less than thirty (30) days prior to the effective date, **Aetna Better Health®** notifies the affected members as soon as possible, but no later than thirty (30) calendar days after receipt of the notification.

Aetna Better Health® is not responsible for payment of services rendered to members who are not eligible. You may contact our utilization management Department for assistance.

Members should be held harmless by the provider for the costs of medically necessary core

benefits and services.

Continuity of care for pregnant women
Authorizations not withstanding the foregoing requirement to honor existing prior authorizations for a minimum of one hundred twenty (120) days, Aetna Better Health will have additional procedures in place that address the continuity of care needs of at least the following populations:

- **Aetna Better Health®** will be responsible for the costs of pregnant women for continuation of medically necessary prenatal care services, delivery, and post-natal care, through follow-up checkup within six (6) weeks of delivery, without any form of prior approval and without regard to whether such services are being provided by a participating or non-participating provider.

Continuity for behavioral health care
The PCP will provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services. Referrals to a behavioral health provider/practitioner do not require prior authorization.

Provider marketing
All health care providers delivering services to **Aetna Better Health®** members enrolled in SoonerSelect are welcome to inform their patients of the SoonerSelect plan they have chosen to participate with, but SoonerSelect has strict prohibitions against patient steering, which all providers must observe. The requirements below must be strictly observed by all SoonerSelect providers.

Marketing allowable and prohibited activities
Allowable marketing activities
Aetna Better Health® and its subcontractors are allowed to perform the following marketing activities (either written or verbal):

a. Distributing general information through mass media (e.g., newspapers, magazines and other periodicals, radio, television, internet, public transportation advertising and any other media outlets). General material without OHCA, SoonerSelect, or other State logo may be distributed without approval
b. Responding to verbal or written requests for CE-specific information made by a member
c. Organizing or attending activities/events that are designed to benefit the entire community, such as health fairs or other health education and promotion activities which have been prior approved by OHCA
d. Attending events at the request of OHCA to disseminate or share information about **Aetna Better Health®**, its services, and outcomes; and
e. Offering eligibles, and members tokens or gifts of nominal value

Prohibited marketing activities

a. Distributing marketing materials or attending/organizing marketing events that have not received prior approval from OHCA
b. Engaging in direct or indirect door-to-door, telephone, email, texting, or other cold-call marketing techniques or activities
c. Influencing enrollment in conjunction with the sale or offering of any private insurance

d. Distributing plans and materials or making any statement that OHCA determines to be inaccurate, false, misleading, or intended to defraud members, eligibles, or OHCA. This includes, but is not limited to, statements that mislead or falsely describe covered services, membership or availability of participating providers or participating providers' qualifications or skills. The contractor and subcontractors must ensure this to OHCA.
e. Asserting that an eligible must enroll in **Aetna Better Health®** to obtain benefits or to not lose benefits
f. Asserting that **Aetna Better Health®** is endorsed by the CMS, the State, or federal government or similar entity, including any other governmental entity
g. Assisting with enrollment or improperly influencing CE selection
h. Designing a marketing plan that discourages or encourages CE selection based on health status or risk (however, this provision does not preclude **Aetna Better Health®** from proclaiming expertise or excellence with a specific subpopulation enrolled in the SoonerSelect program)
i. Conducting any other marketing activity prohibited by OHCA during the term of the contract. OHCA reserves the right to prohibit additional marketing activities at its discretion

Database screening and criminal background check of employees

Participating providers are required to comply with all state and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with members and/or access to member's protected health information. Providers are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid, or any federal health care program. Participating providers are required to conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with state and federal law. The participating provider must immediately report to **Aetna Better Health®** any exclusion information discovered. OHCA reserves the right to deny enrollment to terminate a provider agreement with a participating provider as provided under state and federal law.

Chapter 5: Covered and non-covered services

Back to Table of Contents

Services covered by **Aetna Better Health®** are listed below. Some limitations and prior authorization requirements may apply.

All services must be medically necessary. If you have questions about covered services, call member services at **1-844-365-4385 (TTY: 711).**

Covered services

Outpatient (ambulatory) services

- Physician services
- Advanced Practice Registered Nurse (APRN)
- Hospital outpatient & outpatient clinic services
- Outpatient surgery (Includes anesthesiologist services)
- Podiatry
- Chiropractic
- Allergy testing
- Treatment therapies (chemotherapy, radiation therapy, etc.)
- Dialysis/hemodialysis
- Alternative treatment for pain management
- Hospice care covered for members with a life expectancy of (6) months or less

Emergency services

- Emergency room services
- All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider.
- Ambulance or emergency transportation services

Hospitalization

- Inpatient hospital services
- Anesthesiologist services
- Surgical services (bariatric, reconstructive surgery, etc.)
- Organ & tissue transplantation (kidney transplant, liver transplant, etc.)

Maternity and newborn care

- Prenatal care
- Delivery and postpartum care
- Breastfeeding education
- Donor human breast milk in the first year of life
- Abortion is a covered benefit regardless of the gestational age of the fetus and only to save the life of a pregnant woman in a medical emergency[4]
  - Medical justification is required and must be submitted with the claim

[4] 2023 Oklahoma SoonerSelect Contract, Section 1.7.18

Mental health and substance use disorder (SUD) services, including behavioral health treatment

- Outpatient mental health services
- Outpatient substance use disorder services
  - Residential treatment services
- Voluntary inpatient detoxification

Prescription drugs

- Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class

  Beneficiaries may receive up to a 90-day supply of many medications

Programs such as physical and occupational therapy (known as rehabilitative & habilitative services) and devices

- Physical therapy
- Speech therapy
- Occupational therapy
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Medical supplies, equipment, and appliances
- Durable medical equipment
- Orthotics/prostheses
- Hearing services – under 21 years of age
- Home health care services
- Infusion therapy

Laboratory services

- Outpatient laboratory and X-ray services
  - Various advanced imaging procedures are covered based on medical necessity
- Diagnostic testing entities

Preventive and wellness services and chronic disease management

- United States Preventive Services Task Force A & B recommended preventive services
- Advisory committee for immunization practices recommended vaccines
- Health resources and service administration's bright futures recommendations
- Preventive services for women recommended by the Institute of Medicine
- Family planning services
- Tobacco cessation services
- Diabetes education
- Genetic counseling and testing – covered for pregnant members and members meeting medically necessity criteria

State plan personal care services

State plan personal care is a Medicaid service that helps individuals, from children through adults, with daily living activities at home. A personal care attendant helps the individual with things like bathing, grooming, transferring, toileting, meals, eating, laundry tasks, shopping/errand tasks and light housekeeping.

Pediatric services including oral and vision care

Early and periodic screening, diagnostic, and treatment (EPSDT) is a SoonerSelect benefit for individuals under the ageof 21 who have full-scope SoonerSelect eligibility. EPSDT provides periodic screenings to determine health care needs and, in addition to the standard SoonerSelect benefits, a beneficiary under the age of 21 may receive extended services as medically necessary.

Vision

Members do not need a referral to see an in-network vision provider. Members can find a vision provider through our vision vendor EyeMed.

Aetna Better Health uses EyeMed for vision services. Members can call EyeMed at **1-844-844-0908 (TTY: 711)**, Monday – Friday from 8 AM to 5 PM CT.
EyeMed also provides adult vision to members over the age of 21 that includes:

- $150 every two (2) years to cover glasses or contacts
- $75 towards an annual exam

Non-emergency medical transportation services (NEMT)

Aetna Better Health provides NEMT to members to access all SoonerSelect covered services. Aetna Better Health is also required to ensure necessary transportation and to use the most appropriate form of transportation for the member and provide assistance with transportation to children and their families as part of Medicaid's EPSDT benefit. This includes all benefits for which Aetna Better Health is responsible, as well as benefits which are covered by SoonerSelect but not the responsibility of Aetna Better Health will operate a reservation system for members to schedule NEMT services via the following modes, at minimum:

a. Toll-free telephone line
b. Email
c. Website

NEMT will be available from 8 AM to 6 PM CT, Monday through Saturday. These services are provided by our transportation vendor, ModivCare, and they can be reached at **1-877-718-4208**. Ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contraindicated and transportation is required for obtaining needed medical care for a SoonerSelect benefit.

Nurse line
Access to a nurse is available 24-hours a day, 7 days a week at **1-844-365-4385 (TTY: 711).**

Care4Life diabetes coaching program
Provides personalized text messages with appointment and medication reminders,exercise, and weight goal setting and tracking, education, and personal care manager support **Care4Life.com**

Help to stop smoking
Provides smoking cessation medications for up to six months and health coaching **OkHelpline.com**

Community resource support
The Aetna Better Health REACH team is dedicated to understanding and assisting members' needs and can connect them to local programs that may be able to offer food, housing, transportation, financial assistance and more. Call **1-833-316-7010**, Monday through Friday, 8 AM-5 PM CT to talk to a Member REACH Coordinator.

Interpretation services
Telephone interpretive services are provided at no cost to members, potential members, or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling the Aetna Better Health member services department at **1-844-365-4385**.

Telehealth services
Telehealth services are provided at no cost to members or providers. Providers must be licensed (or equivalent) and be enrolled in FFS Medicaid (if there is a path of enrollment) and will be reimbursed at the same rate as a standard office visit if the service is the same, regardless of modality of delivery. In order to offer telehealth services, providers must comply with the following:

- Maintain documentation of either verbal or written consent for the use of telehealth from the patient
- Comply with all state and federal laws regarding the confidentiality of health care information
- Patient's rights to own medical information applies to telehealth interactions
- The patient is not precluded from receiving in-person healthcare services after agreeing to receive telehealth services

Certain types of services cannot be appropriately delivered via telehealth. Providers must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service.

Medicaid covered services
Some services are covered by Medicaid but not by Aetna Better Health. Since these services are not covered by our plan, you do not have to use our network providers to obtain these services.

Service	How to access
ICF/DD Services	Contact the Office for Citizens with Developmental Disabilities at **1-800-349-9173**
All home & community-based waiver services	Contact the Office for Citizens with Developmental Disabilities at **1-800-349-9173**
Targeted case management services	Contact the Office for Citizens with Developmental Disabilities at **1-800-349-9173**
Individualized Education Plan (IEP)services provided by a school district	Contact the Oklahoma Department of Education at **1-405-521-3351**
SoonerCare Dental	SoonerCare Helpline **1-800-987-7767**

Cost for services

Aetna Better Health has a contract with SoonerSelect to provide health care services to all members. However, some members will be required to pay a co-pay for certain covered services. Please check the members ID card or call member services with questions.

Non-covered services

There are some services that Aetna Better Health does not cover, these include:

- All non-medically necessary services
- Services or items used only for cosmetic purposes
- Duplicative services
- Treatment for infertility
- Weight loss programs
- Service codes determined by Oklahoma Health Care Authority as not covered
- Health services prohibited by law or regulation
- Reversal of sterilization procedures for the purpose of conception
- Services from a provider who is not part of Aetna Better Health unless Aetna Better Health has approved for the member to consult with that provider
- Services from a provider who is located greater than fifty (50) miles from the Oklahoma border that has not been approved in advance by Aetna Better Health
- Services which require a prior authorization, and the provider did not get authorization
- Services provided in a skilled nursing or swing bed
- Medical services provided out of the country
- Tattoo removal
- Experimental/investigational procedures, drugs and equipment (Phase I & II clinical trials are considered experimental)
- Hearing services for adults over the age of 21

Women, infants, and children supplemental nutrition program (WIC)

WIC services are not covered under Aetna Better Health contract with the OHCA. However, Aetna Better Health can assist in identifying and referring eligible members. As a part of the referral process, Aetna Better Health will provide the WIC program with a current hemoglobin or

hematocrit laboratory result. Provider must document the laboratory result and the referral in the member's medical record as a part of the member's initial health assessment (IHA), or as a part of the initial evaluation of pregnant members, and refer and document the referral of pregnant, breastfeeding, or postpartum members or a parent and/or guardian of children under the age of 5 as mandated by 42 CFR 431.635.

Medical necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Medical necessity, as established under OAC 317:30-3-1, is established through these considerations:

a. Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability
b. Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the members need for the service
c. Treatment of the members condition, disease, or injury must be based on reasonable and predictable health outcomes
d. Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical Provider
e. Services must be delivered in the most cost-effective manner and most appropriate setting
f. Services must be appropriate for the members age and health status and developed for the member to achieve, maintain, or promote functional capacity or age-appropriate growth and development

Also aligning with federal standards, "medically necessary services" are no more restrictive than the state Medicaid program including quantitative and non-quantitative treatment limits (NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures. The contractor shall cover medically necessary services related to the ability for a member to attain, maintain, or regain functional capacity.

A current list of the services that require a prior authorization is available on our website at **AetnaBetterHealth.com/Oklahoma/Providers**. If you are not already registered for the secure web portal, download an application from the Oklahoma providers section of the site. If you have questions or would like to get training on the secure provider web portal and the prior authorization requirement search tool, please contact our provider call center at **1-844-365-4385**.

Mental health/substance use services

Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Further, this encompasses the care coordination, care management, and linkage to providers and services to assess and treat mental health and substance use disorders. Substance use disorders include problematic use and misuse of alcohol and both licit and illicit drugs.

Primary care provider referral

We promote early intervention and health screening for identification of behavioral health problems and patienteducation. To that end, Aetna Better Health providers are expected to:

- Screen, evaluate, treat, and refer (as medically appropriate), any behavioral health problem/disorder
- Treat mental health and substance use disorders within the scope of their practice and make appropriate referrals
- Inform members how and where to obtain behavioral health services

Coordination between behavioral health and physical health services

We are committed to coordinating medical and behavioral care for members who will be appropriately screened,evaluated, treated, and referred for physical health, behavioral health or substance use disorder, dual or multiple diagnoses or developmental disabilities. With the member's permission, our care management staff can facilitate coordination of care management related substance use screening, evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, conduct an individual health education behavioral assessment, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers are screened for co-existing medical issues.

Behavioral health providers will refer members with known or suspected and untreated physical health problems ordisorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. Mental health/substance use (MH/SUD) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care with the Aetna Better Health care management staff to promote coordination and integration.

Information is shared between Aetna Better Health, behavioral health, and medical providers to verify interactions with the member result in appropriate coordination between medical and behavioral health care.

The primary care provider and behavioral health provider are asked to share pertinent history and test results within 24 hours of receipt of results in urgent or emergency cases, and notification within 10 business days of receipts of results for non-urgent or non-emergency lab results.

Behavioral health coverage for members under 21 years of age

In accordance with federal early and periodic screening, diagnostic and treatment requirements,

Aetna Better Health will provide coverage for all medically necessary behavioral health services for members under 21 years of age. This applies to children diagnosed with autism spectrum disorder and children for whom a licensed physician, surgeon, licensed mental health professional or psychologist determines that behavioral health services are medically necessary. There are no treatment limitations for behavioral health services for members under 21 years of age.

Medical records standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on medical records standards can be found in chapter 4 of this manual.

Mental Health Parity and Addition Equality Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to verify "parity" or fairness between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a Managed Care Organization (MCO) such as Aetna Better Health. Enacted in 2008, MHPAEA does not require an MCO to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor, and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. On Friday, November 8, 2013, the Departments issued a final rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist. However, while the premise of the law seems simple; the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help providers understand the law and the rights it affords them. Aetna Better Health will not impose more restrictive limitations for mental health services as compared to medical-surgical services. Further, Aetna Better Health has standards for medically necessary determinations for both mental health and medical-surgical benefits and these standards will be provided to members and providers upon request. This includes reasons for any denial of mental health or medical-surgical services.

Links to key materials

- Final regulation, available at **FederalRegister.gov/Documents/2013/11/13/2013-27086/Final-Rules-Under-The-Paul-Wellstone-And-Pete-Domenici-Mental-Health-Parity-And-Addiction-Equity-Act**
- Interim final regulation, available at **FederalRegister.gov/Documents/2010/02/02/2010-2167/Interim-Final-Rules-Under-The-Paul-Wellstone-And-Pete-Domenici-Mental-Health-Parity-And-Addiction**
- FAQs about ACA implementation Part XVII and mental health parity implementation, available at **DOL.gov/Agencies/EBSA/Laws-And-Regulations/Laws/Mental-Health-And-**

Substance-Use-Disorder-Parity/Tools-And-Resources

- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at **GovInfo.gov/Content/pkg/FR-2013-11-13/pdf/2013-27086.pdf**
- News release, available at **DOL.gov/Agencies/EBSA/Laws-And-Regulations/Laws/Mental-Health-And-Substance-Use-Disorder-Parity/News-And-Updates**
- CMS January 16, 2013, letter to State Health Officials and Medicaid Directors, available at **Medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf**
- CMS overview document **CMS.gov/Marketplace/Private-Health-Insurance/Mental-Health-Parity-Addiction-Equity**

Chapter 7: Member rights and responsibilities

Back to Table of Contents

Aetna Better Health is committed to treating members with respect and dignity. Member rights and responsibilities are shared with staff, providers, and members each year through our web site, secure web portal, and provider newsletter.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member' rights and responsibilities are important because you can help members to better understand their role in and improve their compliance with treatment plans.

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 below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

If Aetna Better Health is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health will initiate an investigation into the matter and further peer review action may be necessary.

In the event Aetna Better Health is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health will make good faith efforts to address the issue with the member and educate the member on their responsibilities.

Member rights

Members, their families, and guardians have the right to information related to Aetna Better Health, its services, its providers, and member rights and responsibilities in a language they can understand.

Members have the following rights:

- Receive information on the SoonerSelect program and Aetna Better Health.
- Be treated with respect and with due consideration for their dignity and their privacy.
- Receive information on available treatment options and alternatives, in a way they understand.
- Participate in decisions regarding their health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of their medical records, and to request that they be amended or corrected.
- Obtain available and accessible health care services covered by Aetna Better Health.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the Aetna Better Health and the care provided.

- Make recommendations regarding Aetna Better Health member rights and responsibilities policy.
- File a grievance and appeal.

Member responsibilities

Aetna Better Health encourages members to be responsible for their own health care by becoming informed and active participants in their care. Aetna Better Health members, their families, or guardians agree to the following responsibilities:

- Check OHCA and Aetna Better Health information, correct inaccuracies and allow government agencies, employers and providers to release records to OHCA orAetna Better Health.
- Notify OHCA or Aetna Better Health within 10 days if there are changes in income, the number of people living in the home, address or mailbox changes, or health insurance changes.
- Transfer, assign, and authorize to OHCA all claims the member may have against health insurance, liability insurance companies, or other third parties. This includes payments for medical services made by OHCA for the member's dependents.
- Respond to requests from the Oklahoma Human Services (OHS) Office of Child Support Services.
- Allow SoonerCare to collect payments from anyone who is required to pay for medical care.
- Share necessary medical information with any insurance company, person or entity who is responsible for paying the bill.
- Inspect any medical records to see if claims for services can be paid.
- Obtain permission for Oklahoma Human Services or OHCA to make payment or overpayment decisions.
- Keep their identification card and know their social security number to receive health care services or prescriptions.
- Confirm that any care received is covered.
- Understand how and when to request non-emergency medical transport (NEMT) services.
- Cost sharing.
- Ensure all information provided to OHCA or Aetna Better Health is complete and true upon penalty of fraud or perjury.
- Follow plans and instructions for care that they have already agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

For questions or concerns, please contact our provider services department at **1-844-365-4385**.

Member Rights Under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizationsthat receive financial assistance from any federal department or agency, including hospitals, nursing homes,mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunityto receive benefits and services. Qualified individuals with disabilities have the right to participate in, and access, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals withdisabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, based on disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits, or opportunities to participate as a result of physical barriers

Chapter 8: Early periodic screening, diagnosis, and treatment (EPSDT)

Back to Table of Contents

The early and periodic screening, diagnostic, and treatment (EPSDT) service is Medicaid's comprehensive and retentive health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905®(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT Program consists of two mutually supportive, operational components: **(1) assuring the availability and accessibility of required health care resources; and (2) helping members and their responsible parties/guardians effectively use these resources.** These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations, and to see that the health problems found are diagnosed and treated early before they become more complex and their treatment more costly. (Adapted from CMS website at **CMS.gov/Regulations-And-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/cms021927**

Periodicity schedule
The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at **BrightFutures.AAP.org/clinical_practice.html**

Identifying barriers to care
Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. To address this, Aetna Better Health trains its' member services and care management staff to identify potential obstacles to careduring communications with members, their family/caregivers, primary care providers (PCPs) and other relevant entities and works to maintain access to services.

Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities

- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventiveservices, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Linking members with other needed community-based support services

Aetna Better Health closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. Aetna Better Health also notifies members annually of their eligibility for EPSDT services and encourages the use of the services.

Educating members about EPSDT services

Aetna Better Health informs members about the availability and importance of EPSDT services, including information regarding wellness promotion programs that Aetna Better Health offers. The information process includes:

- Member handbook & evidence of coverage
- Member newsletters and bulletins
- The Aetna Better Health website
- Educational flyers
- Reminder postcards
- Care plan interventions for high-risk members enrolled in care management

Provider responsibilities in providing EPSDT services

Participating providers will be contractually required to do the following in providing EPSDT services:

- Provide EPSDT screenings and immunizations to children aged birth to twenty-one (21) years of age in accordance with Oklahoma's periodicity schedule, including federal and state laws standards and national guidelines (i.e., **American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care: BrightFutures.AAP.org/Clinical_Practice.html**) and as federally mandated.
- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization, or screening during a visit for a mild acute illness or injury or during a sibling's visit).
- Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities on the state-required standard encounter documentation form and verify that the record is completed and readable.
- Comply with the Aetna Better Health minimum medical record standards for quality management, EPSDT guidelines and other requirements under the law.
- Cooperate with the Aetna Better Health periodic reviews of EPSDT services, which will include chart reviews to assess compliance with standards. Report members' EPSDT visits by recording the applicable current procedural terminology (CPT)preventive codes on the required claim submission form.

- Contact members or their parents/guardians after a missed EPSDT appointment so that it can be rescheduled.
- Have systems in place to document and track referrals including those resulting from an EPSDT visit. The system should document the date of the referral, date of the appointment and date information is received documenting that the appointment occurred.
- Oklahoma law requires laboratories and health care providers performing blood lead analysis on blood specimens drawn in Oklahoma to electronically report all results to OCLPPP.

Aetna Better Health requires participating providers to make the following recommended and covered services available to EPSDT-eligible children at the ages recommended on the state Medicaid regulators' periodicity schedule:

- Immunizations, education, and screening services, provided at recommended ages in the child's development, including all of the following:
  - Comprehensive health and developmental history (including assessment of both physical and mental health development)
  - Comprehensive unclothed physical exam
  - Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines)
  - Laboratory test
  - Health education/anticipatory guidance - Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical exams provide the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention
  - Vision services, including periodic screening and treatment for defects in vision, including eyeglasses
  - Hearing services, including, at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids
  - Lead toxicity screening consists of two components, verbal risk assessment and blood lead testing in accordance with CMS and Oklahoma state requirements. Other necessary health care to correct or ameliorate physical and mental illnesses and conditions discovered by the screening process
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services

For questions or concerns, please contact our provider experience department at **1-844-365-4385**.

PCP notification

On at least a quarterly basis Aetna Better Health will provide all PCPs with a list of members who have not had an encounter and who have not complied with the EPSDT periodicity and immunization

schedules for children.

Direct-access immunizations
Member may receive influenza and pneumococcal vaccines from any network provider without a referral, and there is no cost to the member if it is the only service provided at that visit.

Palliative care
Palliative care consists of patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care is not based on the member's life expectancy and may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if the member meets the hospice eligibilitycriteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

Eligibility criteria:
- The member has started to or is likely to use the hospital or emergency department as a means to manage an advanced disease (not including elective procedures)
- The member's death within a year would not be unexpected based on clinical status
- The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective
- The member agrees to attempt, as medically/clinically appropriate, in-home or outpatient disease management/palliative care instead of first going to the emergency department and agrees to participate in advance care planning discussions

Some of the conditions that may qualify for palliative care for members age 21 years and older are congestiveheart failure, chronic obstructive pulmonary disease, advanced cancer, such as stage III or IV solid organ cancer, lymphoma or leukemia, liver disease.

Members under the age of 21 may be eligible for palliative care if the family and/or legal guardian agree to the provision of pediatric palliative care services and there is documentation of a life-threatening diagnosis. This can include, but is not limited to conditions for which curative treatment is possible but may fail such as advanced or progressive cancer or complex and severe heart disease, conditions requiring long-term treatment aimed at maintaining quality of life, such as HIV, cystic fibrosis or muscular dystrophy or progressive conditions for which treatment is exclusively palliative after diagnosis, such as progressive metabolic disorders or severe forms of osteogenesis imperfecta, or conditions involving severe, non-progressive disability or causing extreme vulnerability to health complications such as extreme prematurity, severe neurologic sequelae of infectious disease or trauma or severe cerebral palsy with recurrent infection or difficult to control symptoms.

Palliative care may be provided by Aetna Better Health providers in a variety of settings, including but notlimited to, inpatient, outpatient, or community-based settings.

Chapter 9: Members with special needs

Back to Table of Contents

Adults with special needs include our members with complex and chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders, and developmental disabilities. Members may be identified as having special needs because they are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who require health and related services of a type or amount beyond that generally required by children.

Aetna Better Health providers are required to refer members with developmental disabilities to services for the developmentally disabled for evaluation and treatment of non-medical services. These services consist of services such as but not limited to, respite, out-of-home placement and supportive living. Aetna Better Health will monitor medical services, which includes identification of all appropriate services including medically necessary outpatient mental health services, which may need to be provided to the member.

Screening, brief interventions, and referral to treatment (SBIRT)
Effective January 1, 2014, the state of Oklahoma started offering the SBIRT benefit to SoonerSelect beneficiaries. This benefit aligns with the U.S. Preventative Services Task Force recommendation and is offered annually to all SoonerSelect beneficiaries 18 years and older in primary care settings. In accordance with the Bright Futures/American Academy of Pediatrics recommendation, adolescent SoonerSelect beneficiaries, ages 11 -17, are to be given an alcohol and drug use assessment annually in primary care settings using the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) tool for screening.

As part of SBIRT, Aetna Better Health will provide at least one alcohol misuse screening per year, as medically necessary. Aetna Better Health will also offer behavioral counseling interventions for alcohol misuse and/or refer any member identified as being engaged in risky or hazardous drinking to mental health and/or alcohol use disorder services as specified by OHCA. PCPs must maintain documentation of the alcohol misuse screening of their members.

Aetna Better Health will develop care plans that address the member's service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. Our care management and utilization management teams collaborate closely so that all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out of our network.

Outreach and enrollment staff are trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members and potential members who prefer not to or are unable to communicate in English and use a relay system and American Sign Language interpreters, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a contracted specialist or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member's PCP and may authorize such referrals, procedures, tests, and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no cost to the member. If our network does not have a provider orcenter with the expertise the member requires, we will authorize care out of network.

After-hours protocol for members with special needs is addressed during initial provider trainings, in our provider manual. Providers must be aware that non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Aetna Better Health nurse line is available 24 hours a day 7 days a week for members with an urgent or crisis situation.

Aetna Better Health requires our contacted providers to use the most current diagnosis and treatment protocols and standards established by the medical community in conjunction with OHCA. During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

Provider monitoring

The methods we utilize to monitor our providers and members compliance/success in obtaining the appropriatecare associated with EPSDT include a multi-pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

1. Analysis and evaluation of provider utilization
    - EPSDT audit and other provider office visits
    - EPSDT compliance report
2. Tracking and trending provider data
    - Evaluation of performance measures and outcome data including Healthcare Effectiveness Data and Information Set (HEDIS®) and EPSDT results (monitoring results on a monthly basis) to ensure compliance with contractually required performance levels or the most recent national 50th percentile rate published by NCQA specifications
    - Tracking emergency rooms utilization by members
3. Review and tracking of member grievances and appeals and provider complaints to identify trends
    - Peer review of quality, safety, utilization, and risk management referrals
    - Re-credentialing review activities
    - Review of gaps in care reports and analysis of data from PCP profiles and performance reports
    - Review of sentinel events
4. Monitoring network capacity and availability and accessibility to care delivery systems, re-

credentialing review activities

Our provider services department educates providers about EPSDT program requirements and monitors theadequacy of our EPSDT network. Provider services staff may take referrals from a provider to have a member outreached by care management staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Providers Services Staff may also take referrals from providers who identify problems through EPSDT exams.

Back to Table of Contents

Identify and track at-risk members

Aetna Better Health uses data-driven tools to provide early detection of members who are at risk of becoming high cost, who have actionable gaps or errors in care and who may benefit from care management. These tools have two main components. The first is our predictive modeling tool known as the CORE™ model, or Consolidated Outreach and Risk Evaluation, which uses predictive modeling based the integration of multiple sources of internal and external data to assess member's physical, behavioral, and SDoH risks using claims data, pharmacy data, and diagnoses along with predictive modeling that indicates each member's risk of ED utilization and inpatient admission over the next twelve (12) months. We supplement this information with data collected from health risk screeners. We track member information in a web-based care management tracking application.

These tools, described below, enable us to work closely with providers, members and their families or caregiversto help improve clinical outcomes and enhance the quality of members' lives.

Predictive modeling

Our predictive modeling software is used to prioritize outreach to members to complete the HRS or other assessments, with the highest-risk members prioritized first. CORE™ algorithm predicts the likelihood of a member's inpatient stay within the next 12 months (IP risk) and predicted future medical costs based on diagnoses and prescribed medications using the combined Chronic Illness and Disability Payment System and Medicaid Rx (CDPS+Rx) model.

CORE™ also incorporates clinical impact factors, which are physical, mental, or social health care needs where care management interventions are most likely to have a positive impact (e.g., ED risk, multiple chronic conditions, medication non-adherence, and SDoH risk). These can be customized based on aid categories and population cohort demographics. CORE™ calculates a baseline risk score using the first two scores (IP risk and CDPS+Rx), then adds additional weights based on the clinical impact factors to create a final predictive modeling risk score for each member.

To augment CORE™, we use SDoH risk stratification tools, which compile both community-level and member-specific data from hundreds of sources to assign risk scores on food, housing, economic risk, transportation, health literacy, and social connectedness. We can map risk down to 200 meters (or within one city block) and overlay multiple data sets, such as member addresses, provider offices, grocery stores, existing community resources, and more. In addition to the scoring methodology of predictive modeling, our Care Management system also creates "alerts" to notify care managers to potential risk factors, including:

- Members with new hospital authorizations (currently inpatient)
- Notification of ER services through HIE data feeds
- Calls received by the Aetna Better Health member services department

Health risk screener/health related social needs screening tool (HRS/HRSN)

Aetna Better Health uses the combined HRS/HRSN tool to systematically identify and address the health-related social needs of our members. Aetna Better Health staff review the HRS/HRSN tool

with the member or caregiver during a telephone call made to each member to welcome them to the health plan. The results of the HRS/HRSN screening tool are used to inform member treatment plans and make referrals to community resources for services. At a minimum, the Health Risk Screening tool includes questions about the following:

- Demographic information for verification purposes
- Current and past physical health and behavioral health conditions
- Identifying members with special health care needs and specialized treatment or equipment
- Services or treatment the member is currently receiving, including from out-of-state providers
- Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another CE
- Most recent ER visit, hospitalization, physical exam, and medical appointments
- Current medications
- Questions to address SDoH, including food, shelter, transportation, utilities, and personal safety

Care management (CM) business application systems

Our care management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses all screening tools, comprehensive assessment, condition-specific questionnaires and care plans/service plans and allows care management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use of the information in future cases. The system interfaces with our predictive modeling software, the inpatient census tool and allows documents to be linked to each member's unique case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in care management.

Referrals to care management

In addition to the tools and referrals to Care Management identified above, providers can refer members to Care Management directly, by filling and sending the following form securely to **AetnaBetterHealthOKCM@aetna.com** (**ICM Referral Form OK**)

Members can be referred to the complex case management program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers. For a member referral into case management, call **1-844-365-4385 (TTY: 711)** or visit our website at **AetnaBetterHealth.com/Oklahoma**

Chapter 11: Concurrent review

Back to Table of Contents

Concurrent review overview

Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including freestanding specialty hospitals. The UM clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to members, complies with the requirements of this section. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for admission, and appropriateness of the level of care, using the MCG Guidelines or ASAM Criteria. Admission certification is conducted within twenty-four (24) hours of receiving notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician areresponsible for developing a discharge plan for the member and for involving the member and family inimplementing the plan.

Our concurrent review nurse (CRN) works with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring discharge planning begins on the day of admission
- Facilitating or attending discharge planning meetings for members with complex and multipledischarge needs
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, Durable medical equipment (DME)/medical supply companies, other outpatient providers)
- Informing hospital staff and attending physician of covered benefits as indicated

Chapter 12: Prior authorization

Back to Table of Contents

PCPs or treating providers are responsible for initiating and coordinating a members request for authorization. However, specialists, PCPs and other providers may need to contact the prior authorization department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with the Aetna Better Health prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provisionof sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Services requiring prior authorization

Our secure web portal located on our website, lists the services that require prior authorization, consistent with our Aetna Better Health policies and governing regulations. The list is updated at least annually and updated periodically as appropriate. In addition to the list, you will find a link that will allow you to access ProPAT, which is an easy tool in which you enter codes to see if a prior authorization is needed or not. For additional information regarding the secure web portal, please access the secure web portal navigation guide located on our website. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized. All services provided by out-of-state providers/practitioners greater than 50 miles from the state border require prior authorization.

Exceptions to prior authorizations

- Access to family planning services
- Well-woman services by an in-network provider
- Minor consent services
- Basic prenatal care
- Preventive services
- STD and HIV testing and services
- Behavioral health crisis services
- Medication assisted treatment (MAT)
- Programs for assertive community treatment (PACTs)
- Behavioral health urgent services

Emergency services

Aetna Better Health covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. Aetna Better Health will not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. Aetna Better Health will cover emergency services provided outside of the

contracting area except in the following circumstances:

- When care is required because of circumstances that could reasonably have been foreseen prior to the members departure from the contracting area
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy are covered.

Aetna Better Health will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Payment will not be withheld from providers in or out of network. However, notification is encouraged for appropriate coordination of care and discharge planning. The notification will be documented by the prior authorization department or concurrent review clinician. Additionally, emergency medical services include at least a 72-hour supply of medically necessary discharge drugs when needed.

Post-stabilization services

Aetna Better Health will cover post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by an Aetna Better Health network provider:

- When Aetna Better Health authorized the services
- The provider requested prior approval for the post-stabilization services, but Aetna Better Health did not respond within one (1) hour of the request
- The provider could not reach Aetna Better Health to request prior approval for the services
- The Aetna Better Health representative and the treating provider could not reach an agreement concerning the member's care, and an Aetna Better Health medical director was not available for consultation
    - Note: In such cases, the treating provider will be allowed an opportunity to consult with an Aetna Better Health medical director; therefore, the treating provider may continue with the member's care until a medical director is reached or any of the following criteria are met
        - An Aetna Better Health provider with privileges at the treating hospital assumes responsibility for the member's care
        - An Aetna Better Health provider assumes responsibility for the member's care through transfer
        - Aetna Better Health and the treating provider reach an agreement concerning the member's care
        - The member is discharged

Provider requirements

Generally, a member's PCP, or treating provider is responsible for initiating and coordinating a request for authorization. However, specialists and other providers may need to contact the prior authorization department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with the Aetna Better Health prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current procedural terminology (CPT)
  - International classification of diseases, 10th Edition (ICD-10)
  - CMS healthcare common procedure coding system (HCPCS) codes
  - National drug code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring or provider
- Name, address, phone, and fax number of the consulting provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory andimaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

How to request prior authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 secure provider web portal located on the Aetna Better Health website at **AetnaBetterHealth.com/Oklahoma/Providers**
- Fax the request form to the appropriate fax number below. Please use a cover sheet with the practice's correct phone and fax numbersto safeguard the protected health information and facilitate processing. Aetna Better Health's prior authorization forms can be accessed on the website at **AetnaBetterHealth.com/Oklahoma/Providers**
  - Care management **1-833-898-6542**
  - Medical prior authorization **1-833-923-0831**
  - Concurrent review **1-833-923-0780**
  - Behavioral health **1-833-923-0829**
  - Pharmacy prior authorization **1-888-601-8461**
  - Through our toll-free number **1-844-365-4385**

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the provider secure web portal at **AetnaBetterHealth.com/Oklahoma/Providers** or call us at **1-844-365-4385**. The portal will allow you to check status, view history, and email a care manager for further clarification if needed.

For further information about the secure web portal, please review **Chapter 4** of this manual.

Medical necessity criteria

To support prior authorization decisions, Aetna Better Health uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health policies and procedures.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care; or provide financial incentives of any kind to individuals toencourage decisions that result in underutilization.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health provider experience representative. These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- **Oklahoma.gov/OHCA/Providers/Types/Pharmacy/Prior-Authorization/2023**
- Applicable MCG Guidelines as the primary decision support for most medical diagnoses and conditions
- American Society of Addiction Medicine Criteria (ASAM) – substance use disorder services
- Aetna Better Health clinical policy bulletins (CPBs)
- Aetna Better Health policy council review

If MCG states "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health CPBs, should be consulted and utilized. Medical and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon requestand, upon request, to members and potential members.

MCG (Milliman Care Guidelines)
Aetna Better Health uses MCG guidelines to verify consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating commonconditions. MCG guidelines are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

American Society of Addiction Medicine (ASAM)
Aetna Better Health uses ASAM criteria for authorizing substance use disorder (SUD) services. ASAM is a nationally recognized, evidence-based criteria which are applied based on the needs of the individual member.

A copy of individual guidelines pertaining to a specific case is available for review upon request. To request a copy of the clinical review criteria used in an adverse benefit determination, call Member Services at **1-844-365-4385 (TTY: 711)**

Timeliness of decisions and notifications to providers, and members
Aetna Better Health makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the OHCA, Aetna Better Health adheres

to the following decision/notification time standards. For standard requests, notice will be provided as expeditiously as the member's health condition requires, but in a timeframe not to exceed 72 hours following receipt of the request for service, in accordance with Oklahoma Statute Title 56 § 4002.6. For urgent requests, notice will be provided as expeditiously as the member's health condition requires, but in a timeframe not to exceed 24 hours following receipt of request, in accordance with Oklahoma Statute Title 56 § 4002.6. Aetna Better Health ensures the availability of appropriate staff twenty-four (24) hours, seven (7) days per week to respond to authorization requests within the established time frames for urgent requests. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/notification requirements

Decision	Notification timeframe	Extension
Urgent pre-service decision (approvals and denials)*	Within 24 hours of the initial request	Up to 48 hours if member requests** Up to 48 hours if health plan requests and State approves**
Non-urgent preservice decision (approvals and denials)	Within 72 hours of the initial request	Up to 14 days if member requests** Up to 14 days if provider requests** Up to 14 days if health plan requests and State approves**
Urgent concurrent request (approvals and denials)	Within 24 hours of the initial request	Up to 48 hours if member requests** Up to 48 hours if health plan requests and State approves**

*Note: Includes DME requests within 5 days of discharge from acute.
*Note: Includes member transfer from acute to post-acute level of care (LTAC, rehab.)

Prior authorization period of validation

Prior authorization numbers are valid for the date of service authorized. The member must be enrolled and eligible on each date of service.

Out-of-network providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by case basis in consultation with the Aetna Better Health medical director.

Out-of-state providers

Members may travel to a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico or Texas) within fifty (50) miles of the Oklahoma state border to receive covered services. Reimbursement for covered services in another state is available to the extent that reimbursement for covered services are furnished within Oklahoma boundaries.

The services rendered must be provided by a provider who is contracted with Aetna Better Health.

On occasion, a member may need services that are out of state and greater than the fifty (50) miles from the Oklahoma state border due to unavailability of the in-state service. All requests for a service by a provider out-of-state greater than the fifty (50) mile Oklahoma border require prior authorization review. These are reviewed on a case-by-case basis and require detailed verification of unavailability within Oklahoma.

American Indian/Alaska Native (AI/AN)

AI/AN members can access out-of-network Indian Health Care Providers (IHCP) for services that are covered benefits.

Notice of action (NOA) requirements

To deny, reduce, suspend, or terminate a prior authorization request, limits, or to authorize a service in the amount duration or scope that is less than requested or denies payment, in whole or part for a service, a NOA must be completed.

The notice will include:

- The action that Aetna Better Health has or intends to take
- The specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which thedenial decision was based
- The name and contact information for the physician that reviewed and denied the service
- Notification that, upon request and at no cost, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that the provider has the opportunity to discuss medical and behavioral healthcare UM denial decisions with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member or provider (with written permission of the member) right to request a Medicaid state fair hearing and instructions about how to request a Medicaid state fair hearing
- A description of the expedited appeals processes for urgent preservice or urgent concurrent denials
- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or

pending a Medicaid fair hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits

Continuation of benefits

Aetna Better Health will continue member's benefits during the appeal process if:

- The member or the provider files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e., a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice wasgiven to allow a member a timely appeal

Aetna Better Health will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal
- A state fair hearing office issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met

Prior authorization and coordination of benefits

Aetna Better Health will coordinate benefits with other providers, any subcontractors and OHCA's contractors. If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Self-referrals

Aetna Better Health does not require referrals from PCP or treating providers. Members may self-refer and access some services without an authorization from their PCP. These services include vision care, family planning, minor consent services, and women's healthcare services. The member must obtain these self-referred services from Aetna Better Health provider network, except in the case of family planning.

Members may access family planning services from any qualified provider. Members also have direct access toWomen's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including nurse midwives participating in Aetna Better Health network, and can obtain maternity and gynecological care without prior approval from a PCP.

Behavioral health prior authorization process

- Inpatient behavioral health – Acute. A determination will be made and issue notice to the provider within 24 hours of receipt of request.
- Inpatient behavioral health – Acute II/Psychiatric Residential Treatment Facility. A determination will be made and issue notice to the provider within 24 hours of receipt of request.
- Inpatient medical – A determination will be made and issue notice to the provider within 24 hours of receipt of request.
- Inpatient Medical Out of State (OOS) – A determination will be made and issue notice to the provider within 24 hours of receipt of request.

- Standard prior authorization to include outpatient services – A determination will be made and issue notice to the provider within 72 hours of receipt of request.

Behavioral health prior authorization extensions
For all inpatient acute, post-acute services, and inpatient behavioral services Acute II/ Psychiatric Residential Treatment Facility. The provider may be granted an extension period of up to 72 hours from the receipt of request to obtain the necessary documentation. Inpatient Acute behavioral health, no extension is granted.

For all Out of State (OOS) services for Aetna Better Health and providers, an extension period will be granted. This allows Aetna Better Health up to 14 calendar days from receipt of request for due diligence on unavailability of in-state services, to obtain the necessary documentation, and to issue notice to the provider.

Standard prior authorization an extension period is granted to allow the Aetna Better Health up to 14 calendar days from receipt of the request to obtain the necessary documentation and to issue notice of determination to provider.

Behavioral health prior authorization – peer to peer
Provider will be provided an opportunity for peer-to-peer conversations with Oklahoma-licensed clinical staff with the relevant specialty within 24 hours of adverse determination. There are no extension periods available for peer-to-peer conversations.

Chapter 13: Quality management

Back to Table of Contents

Overview

Our quality management (QM) program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. Aetna Better Health uses this approach to measure conformance with desired medical standards and develop activities designed to improve patient outcomes. Our approach for the Oklahoma Quality Assurance and Performance Improvement (QAPI) builds on the State's successes to help propel Oklahoma toward improved physical and behavioral health (BH) outcomes.

Aetna Better Health performs QM through a QAPI program with the involvement of multiple organizational components and committees. The primary goal of the QM program is to improve the health status of members or maintain current health status when the member's condition is not amenable to improvement. The QM program description, QM evaluation and performance are available upon request.

The Aetna Better Health QM program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously andproactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM process enables us to:

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

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

The Aetna Better Health QM program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization and committees from the board of directors to the member / community advisory committee. This structure allows members and providers to offer input into our quality improvement activities. Our medical director oversees the QM program. The medical director is supported inthis effort by our QM department and the quality management oversight committee (QMOC) and subcommittees.

The primary purpose of the QAPI program is to provide the structure and processes necessary to identify and improveclinical quality, maximize safe clinical practices, and enhance member and provider satisfaction across the various settings of care within the care delivery system.

The QAPI program strives to ensure that the services provided to Aetna Better Health members conform to the standards and requirements of regulatory and accrediting agencies, including OHCA, and the National Committee for Quality Assurance (NCQA).

Further, the purpose of the QAPI program is to establish standards and criteria and provide processes, procedures, and structures to review and monitor the care and service delivered, including accessibility, availability, and continuity of care. In accordance with 28 CCR 1300.70(a), the QAPI program is directed by providers and there is a process to document that the quality of care provided is being reviewed, that problems are being identified, that effective action istaken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Aetna Better Health strives to achieve the following primary goals:

- Implement a QM program that effectively promotes and builds quality into the organizational structure and processes of the health plan
- Conduct continual monitoring and assessment of patient care and services striving to provide health care and services to health plan members that meet accepted and appropriate medical practice standards and the needs of the health plan members and health care professionals
- Identify and analyze opportunities for improvement with implementation of actions and follow-up
- Encourage patient safety
- Maintain compliance with local, state, and federal regulatory requirements and accreditation standards

Provider representation on the Quality Improvement Committee (QIC) is integrated into our local structure and led by our local Oklahoma-based chief medical officer (CMO) and our QM director. This committee plays an integral role and advises and makes recommendations to the governing body, Aetna Better Health leadership, vendors, providers, and community partners on the quality of care and service provided to members, including the oversight and maintenance of the QAPI and utilization management programs. Additional committees such as service improvement committee (SIC), credentialing and performance, appeals/grievance, and quality management/utilization management further support our QAPI Program. Aetna Better Health encourages provider participation on key medical committees. Providers may contact the medical director or inform their provider services representative if they wish to participate. Aetna Better Health can be reached by calling **1-844-365-4385**.

The Aetna Better Health QM staff develops and implements an annual work plan, which specifies projected QM activities. Based on the work plan, we conduct an annual QM Program evaluation, which assesses the impact and effectiveness of QM activities.

The Aetna Better Health QM department is an integral part of the health plan. The focus of our QM staff isto review and trend services and procedures for compliance with nationally recognized standards and recommendand promote improvements in the delivery of care and service to our members. Our QM and medical management departments maintain ongoing coordination and collaboration regarding quality initiatives, care management, anddisease management activities involving the care of our members.

Aetna Better Health QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, Aetna Better Health, in collaboration with providers, is able to monitor and reassess the quality of servicesprovided to our members. Providers are obligated to support and meet the Aetna Better Health QAPI and Utilization Management program standards. Contracted participating providers are required by contract to:

- Cooperate with QI activities
- Maintain the confidentiality of member information and records
- Allow the plan to use practitioner performance data

Note: Providers must also participate in the CMS and OHCA quality improvement initiatives. Any information providedmust be reliable and complete.

Identifying opportunities for improvement

Aetna Better Health identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data Aetna Better Health monitors to identify opportunities for quality improvements include:

- **Formal feedback from external stakeholder groups**: Aetna Better Health takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (Consumer assessment of healthcare providers and systems (CAHPS), provider satisfaction survey), or focus groups with individuals, such as members and families, providers, and state and community agencies.
- **Findings from external program monitoring and formal reviews***:* Externally initiated review activities,such as an annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process assists Aetna Better Health in identifying specific programactivities/processes needing improvement.
- **Internal review of individual member or provider issues**: In addition to receiving grievances and appeals from members, providers, and other external sources, Aetna Better Health proactively identifies potential quality of service or care issues for review through daily operations (i.e. member services, prior authorization, and care management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services, and quality of care), Aetna Better Health is able to identify specific opportunities for improving care delivered to individual members.
- **Findings from internal program assessments**: Aetna Better Health conducts several formal assessments/reviews of program operations and providers that are used to identify opportunities for improvement. This includes but is not limited to record reviews of contracted providers, credentialing/ recredentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment, and assessment of provider accessibility and availability.
- **Clinical and non-clinical performance measure results**: Aetna Better Health uses an array of clinical and non-clinical performance standards (e.g., call center response times,

and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, Aetna Better Health can identify opportunities for improvement in clinical and operational functions. These measures include:

  - Adherence to nationally recognized best practice guidelines and protocols
  - Prior authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals)
  - Provider availability and accessibility, including:
    - Length of time to respond to requests for referrals
    - Timeliness of receipt of covered services
    - Timeliness of the implementation of members' care plans - availability of 24/7 telephonic assistance to members and caregivers receiving home care services

- **Data trending and pattern analysis**: With our innovative information management systems and data mining tools, Aetna Better Health makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- **Other service performance monitoring strategies**: Aetna Better Health uses a myriad of monitoring processes to confirm effective delivery of services to all our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health monitors include, but are not limited to:
  - High-cost, high-volume, and problem prone aspects of the long-term care services our members receive
  - Effectiveness of the assessment and service planning process, including its effectiveness in assessing a member's informal supports and treatment goals, planned interventions, and theadequacy and appropriateness of service utilization
  - Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services

Potential quality of care (PQoC) concerns

Aetna Better Health has a process for identifying PQoC concerns related to our provider network including home and community-based services (HCBS), researching, and resolving these care concerns in an expeditious manner, and following up to make sure needed interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna Better Health tracks and trends PQoC cases and prepares trend reports that we organize according to provider, issue category, referral source, number of verified issues, and closure levels. Aetna Better Health will use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Better Health credentialing and performance committee or identify the need for possible quality improvement initiatives.

Performance improvement projects (PIPs)

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

- Target improvement in areas that will address a broad spectrum of key aspects of members' care andservices over time, including behavioral health follow-up services
- Address clinical or non-clinical topics, such as SDoH and health disparities
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Better Health enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM department prepares PIP proposals by collaborating with providers and stakeholders. PIP proposals are reviewed and approved by our medical director, quality management/utilization management committee, and the quality management oversight committee (QMOC) prior to submission to OHCA for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health, as well as from network providers who are members of our quality management/utilization management committee.

The QM department conducts ongoing evaluation of the study indicator measures throughout the length of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvementor even a decline in performance, Aetna Better Health immediately conducts an analysis to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Peer review
Peer review activities are evaluated by the credentialing and performance committee. This committee may act if a quality issue is identified. Such actions may include, but are not limited to, development of a corrective action plan (CAP) with time frames for improvement, evidence of education, counseling, development of policies and procedures, monitoring and trending of data, limitations, or discontinuation of the provider's contract with the plan. The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, and health provider credentials, as well as other quality issues.

The health plans peer review process adheres to Aetna Better Health policies, is conducted under applicable state and federal laws, and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in the Aetna Better Health network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions mayinclude the restriction, reduction, suspension, or termination of a contract under specific circumstances.

Performance measures
Aetna Better Health collects and reports clinical and administrative performance measure data to OHCA.The data enables Aetna Better Health and OHCA to evaluate our adherence to practice

guidelines as applicable, and improvement in member outcomes.

Satisfaction survey
Aetna Better Health conducts member and provider satisfaction surveys to gain feedback regarding members and providers' experiences with quality of care, access to care, and service/operations. Aetna Better Health uses member and provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

Member satisfaction surveys
Consumer assessment of healthcare providers and systems (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (adult and children) are subsets of HEDIS reporting. Aetna Better Health contracts with a National Committee for Quality Assurance (NCQA)-certified vendor to administer the survey according to HEDIS survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience. We use CAHPS survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow up on survey findings, and develop an action plan, which includes implementation steps and a timeline for completion.

Provider satisfaction surveys
Aetna Better Health conducts an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and our response to inquiries.

External quality review (EQR)
EQR is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.S.C. 1396u–2] for states to contract with an independent external review body to perform an annual review of the quality ofservices furnished under State contracts with the SoonerSelect Plans, including the evaluation of quality outcomes, timeliness, and access to services. External Quality Review (EQR) refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

Aetna Better Health cooperates fully with external clinical record reviews assessing our network's qualityof services, access to services, and timeliness of services, as well as any other studies determined necessary by OHCA. Aetna Better Health assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. Aetna Better Health also provides complete records to the external quality review organization (EQRO) in the time frame allowed by the EQRO. Our contracted providers are required to provide any records that the EQRO may need for its review within thirty (30) days of request.

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

Provider profiles
To promote the provision of quality care, Aetna Better Health profiles providers who meet the

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

The provider profiling program is designed to share standardized utilization data with physicians in an effort to improve clinical outcomes. Our profiling program is intended to support clinical decision-making and patient engagement as providers often have little access to information about how they are managing their members or about how practice patterns compare to those of their peers. Additional goals of the provider profiling program are to improve the provider-patient relationship to reduce unwanted variation in careand improve efficacy of patient care. We use key quality and efficiency indicators and use these reports to collaborate with providers to identify opportunities to improve the member experience.

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

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

Aetna Better Health distributes profile reports to providers so they can evaluate:

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

The Aetna Better Health CMO and medical directors regularly visit individual network providers to interpretprofile results, review quality data, and discuss any new medical guidelines. Our CMO and medical directors investigate potential utilization or quality of care issues that may be identified through profiles. Our medical leadership is committed to collaborating with providers to find ways to improve patient care.

Clinical practice guidelines

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

Clinical guidelines are made available to providers on the Aetna Better Health website; providers are informed of the availability of new guidelines and updates in the provider newsletter. Providers may

request a copy of aguideline at any time by contacting their provider services representative or the Aetna Better Health office of the chief medical officer.

Clinical guidelines: **AetnaBetterHealth.com/Oklahoma/providers/guidelines**

Shared decision-making aids are communication tools used as a way for providers and patients to make informed health care decisions based on what is important to the member. They do not replace physician guidance but are intended to help complement the discussions between members and physicians on treatment decisions. Evidence-based aids that provide information about treatment options, lifestyle changes, and outcomes can be found on the provider website.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. Aetna Better Health collects this data annually.

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by CMS. Accrediting bodies such as the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS data. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes, and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

Why does the plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data.

Typically, a plan employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the practitioner or provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan may ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers

to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the plan?
The HIPAA Privacy Rule permits a practitioner or provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506 (c) (4). Thus, a practitioner or provider may disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the practitioner or provider bill the plan for providing copies of records for HEDIS?
According to the terms of their contract, practitioners and providers may not bill either the plan or the member for copies of medical records related to HEDIS.

How can practitioners and providers reduce the burden of the HEDIS data collection process?
We recognize that it is in the best interest of both the practitioner/provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to electronic medical records (EMRs) and setting up electronic data exchange from the practitioner/provider EMP to the plan. Please contact a provider relations representative or the QM department for more information. Complete and accurate coding as well as submitting secondary payer claims can significantly reduce the number of charts needed to review.

How can practitioners or providers obtain the results of medical record reviews?
The plan's QM department can share the results of the medical record reviews performed at practitioner or provider offices and show how results compare to that of the plan overall. Please contact a provider relations representative or the QM department for more information.

Chapter 14: Advance directives (The Patient Self Determination Act)

Back to Table of Contents

Providers are required to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life SustainingTreatment Act (POLST) and the Oklahoma Advance Directive rules Title 63 OK Stat § 3101.4 (2022), including all other State and federal laws regarding advance directives for adult members.

Advance directives

Aetna Better Health defines Advance Directives as a legal document through which a person may provide directions or express preferences concerning his/her medical care and/or to appoint someone to act on his/her behalf. Physicians and others use advance directives when a person is unable to make or communicate decisions about his/her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes someone to be unable to actively make a decision about his/her medical care. A health care advance directive may include a living will (advance directive for health care), a durable power of attorney for health care[5] as well as a psychiatric advance directive.

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

- Providing written information to adult member regarding each individual's rights under State law to make decisions regarding medical care and any provider written policies concerning advance directives (includingany conscientious objections)
- Documenting in the member's medical record whether or not the adult member has been provided theinformation and whether an advance directive has been executed
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care
- Educating staff on issues related to advance directives as well as communicating the member's wishes to attending staff at hospitals or other facilities
- Educate members on advance directives (durable power of attorney, advance directive for health care and psychiatric advance directive)

For additional information about medical record requirements, please visit chapter 3 of this manual.

Patient Self-Determination Act (PSDA)

The patient self-determination act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept, or refuse should they become unable to make those decisions due to illness.

The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receivingMedicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health requires our providers to comply

[5] CMS Glossary 3/2022

with this act.

For additional information about the PSDA, visit **Gapna.org**

Physician orders for life sustaining treatment (POLST) act
Aetna Better Health requires providers to comply with the physician orders for life sustaining treatment act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the Physician's Order for Life-Sustaining Treatment (POLST)program. The POLST protocol requires a health care professional to discuss available treatment options with seriously ill members (or their advocate/family member), and these preferences are then documented on a standardized medical form that the member keeps with them.

The form must be signed by a member's attending provider or advanced practice nurse. This form then must become part of a member's medical record, as this form will follow the member from one healthcare setting to another, including hospital, home, nursing home, or hospice.

Concerns
Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health as a grievance or complaint, or with the State/SoonerSelect at **1-405-426-8030.**

Chapter 15: Encounters, billing and claims

Back to Table of Contents

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable State and federal laws, rules, and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in any SoonerSelect Programs, or any program under federal law, or is not in good standing with the OHCA.

Aetna Better Health uses our claims processing system to process and adjudicate claims. Both electronic and manual claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately, and timely, Aetna Better Health encourages providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health has developed a business relationship with Office Ally. Aetna Better Health receives electronic data interchange (EDI) claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, and member enrollment, and then uploads them into our claims processing system each business day. Within twenty-four (24) hours of file receipt, Aetna Better Health provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Encounters, billing and claims overview
Aetna Better Health is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM)codes, and code to the highest level of specificity. Complete and accurate use of the CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in our claims processing system. Important notes: The ICD10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four- digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification forthat subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

CMS risk adjustment data validation
Risk adjustment data validation (RADV) is an audit process to verify the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to support randomly selected claims to verify the accuracyof diagnosis codes submitted.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because wemay request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no laterthan January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Better Health by CMS based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the hierarchical condition category (HCC) payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are basedon predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete, and truthful risk adjustment data to us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna Better Health and payments made by Aetna Better Health to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for a member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services areas follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as "probable," suspected," "questionable," rule out" or "working" diagnosis. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted byAetna Better Health medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses

submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and thediagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules, and regulations. CMS may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the CMS website at **CsscOperations.com**

When to bill a member

All providers must adhere to federal financial protection laws (§ 1932(b)(6) of The Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). Providers are prohibited from billing the member for the cost of covered services except for any applicable Co-payment amount allowed by OHCA.

A member may be billed **ONLY** when the member knowingly agrees to receive non-covered services under the SoonerSelect Program:

- Provider MUST notify the member in advance that the charges will not be covered under the program.
- Provider MUST have the member sign and date a statement agreeing to pay for the services, letting the member know how much they will have to pay, why they are not covered for the service(s), and place the document in the member's medical record.

When to file a claim

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

Timely filing of claim submissions

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

- **New claim submissions** – Claims must be filed on a valid claim form within six (6) months 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 member.
- **Claim resubmission** – Claims to be resubmitted, when applicable, within an additional six (6) months from the date of service. The only exceptions to the resubmission deadline are the following: a. administrative correction or action by Aetna Better Health taken to resolve a dispute; b. reversal of eligibility determination; c. investigation for fraud or abuse of the provider; or d. court order or hearing decision.

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

How to file a claim

Instructions on how to fill out the claim forms can be found on our website at **AetnaBetterHealth.com/Oklahoma/providers**

Claims filing formats

Providers can elect to file claims with Aetna Better Health in either an electronic or a hard copy format. Claims must be submitted using either the CM 1500 or UB 04 formats, based on your provider type as detailed below.

Service	Claim form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**CMS UB-04 Form**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**

Paper claims submission

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

Aetna Better Health of Oklahoma
Attn: Claims
PO Box 983110
El Paso, TX 79998-3110

- Providers must file claims within 6 months from the date of service, unless there is a contractual exception. For inpatient claims, the date of service refers to the member's discharge date. Providers has 180 days from the paid date to resubmit a revised version of a processed claim.
- Providers can file claims for retro members through the normal claims process. These are members who are retroactively eligible for coverage.
    - Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
    - The claim form may be returned unprocessed if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

Electronic claims submission

In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health encourages providers to electronically submit claims, through Office Ally.

Please use the Payer ID number 128OK when submitting claims to Aetna Better Health for both CMS 1500 and UB 04 forms. Claims can be submitted by visiting Office Ally at **CMS.OfficeAlly.com**. Prior to submitting a claim through your preferred clearinghouse, please verify that your clearinghouse is compatible with Office Ally.

Claims	Mail to	Electronic submission
Medical	Aetna Better Health of Oklahoma PO Box 983110 El Paso, TX 79998-3110	Claims can be submitted by visiting **Office Ally** at **CMS.OfficeAlly.com**

Important points to remember

- Aetna Better Health does not accept direct EDI submissions from its providers.
- Aetna Better Health does not perform any 837 testing directly with its providers but performs such testing with Office Ally.

Billing and rendering provider requirements

To ensure complete encounters submission as per Aetna Better Health requirements, the below fields are required in both billing and rendering provider sections:

- NPI (Typical Providers) – Uses for all instances that require provider identification
- SoonerSelect Provider Number (Atypical Providers) – SoonerSelect Provider ID or Tax ID used for atypical providers
- Taxonomy

About Office Ally

Aetna Better Health uses Office Ally which is a web-based solution set that simplifies the everyday tasks for provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. There are no provider costs for specialized software or per-transaction fees, even providers who previously only interfaced by submitting claims manually may utilize Office Ally for automated payer interaction.

Features

- Secure personalized web portal for submitting providers
- Automated electronic batch claim submission & real-time patient eligibility, benefit verification, referrals, pre certs, authorizations, claim inquiry and more
- Fast implementation
- Real-time provider enrollment offers immediate electronic capability

Benefits

- Improves auto-adjudication rates
- Increases automation and improves efficiency
- Reduces call center volumes and associated expenses
- Eliminates requirement for capital investments in IT and staffing related to internal portal development andmaintenance
- Drives providers directly to payers' websites
- Improves provider satisfaction

Please visit Office Ally to gain access for automated payer interaction: **CMS.OfficeAlly.com**

Correct Coding Initiative
Aetna Better Health follows the same standards as NCCI's Medicaid performs edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit **CMS.gov/Medicare-Medicaid-Coordination/National-Correct-Coding-Initiative-Ncci/Ncci-Medicaid**

Aetna Better Health utilizes ClaimXten and Cotiviti as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct coding initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through clear claim connection.

Clear claim connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimXten and Cotiviti. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimXten and Cotiviti.

Providers will have access to clear claim connection through our website through a secure login. Clear claim connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct coding
Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive codewhen those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect coding
Examples of incorrect coding include:

- "Unbundling" - fragmenting one service into components and coding each as if it were a separate service
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

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

- **Modifier 59 – distinct procedural services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the

same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

- **Modifier 25 – significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and wasnot part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with evaluation and management codes and cannot be billed with surgical codes.
- **Modifier 50 – bilateral procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57 – decision for surgery** – must be attached to an evaluation and management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the CMS claims processing manual, **CMS.gov/Files/Document/Medicare-Ncci-Policy-Manual-2023-Chapter-1.pdf**

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

Please refer to your current procedural terminology (CPT) manual for further detail on all modifier usage.

HCPCS codes

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

Instructions for specific claim types

Aetna Better Health general claims payment information

Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from non-participating health providers will be paid in accordance with original CMS claim processing rules.

Skilled nursing facilities (SNF)

Providers submitting claims for SNFs should use CMS UB-04 Form. Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health, following consolidated billing. For additional information regarding CMS consolidated billing, please refer to the following CMS website address: **CMS.gov/SNFPPS/05_ConsolidatedBilling.asp**

Home health claims

Providers submitting claims for home health should use UB forms not a CMS 1500 for skilled nursing codes as partof home health. Providers must bill in accordance with contract. Non-participating health providers must bill according to CMS HHPPS requirement rules for Aetna Better Health. For additional information regarding CMS home health prospective payment system (HHPPS), please refer to the following CMS website address: **CMS.gov/HomeHealthPPS**

Durable medical equipment (DME) rental claims

Providers submitting claims for durable medical equipment (DME) rental should use CMS 1500 Form. DME rental claims are only paid up to the purchase price of the durable medical equipment.

Units billed for the program equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental.Medicaid will calculate the amount of days needed for the claim based on the date span.

Same day readmission

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

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

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

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

Hospice claims

Aetna Better Health will cover and ensure the provision of hospice care services as defined in Sections 1905(o)(1) of the Social Security Act. Aetna Better Health will ensure that members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. Services shall be limited to individuals who have been certified as terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified. However, for a member under age 21, a voluntary election of hospice care shall not constitute a waiver of any rights of that member to be provided with, or to have payment made for covered services that are related to the treatment of that member's condition for which a diagnosis of terminal illness has been made. For members who have elected hospice care, Aetna Better Health will arrange for continuity of medical care, including maintaining established patient-provider experience is, to the greatest extent possible. Aetna Better Health will cover the cost of all hospice care provided. Aetna Better Health is also responsible for all medical care not related to the terminal condition. Admission to a nursing facility of a member who has elected covered hospice services as described in 22 CCR 51349, does not affect the member's eligibility for enrollment under the GMC Contract. Hospice services are covered services under the

GMC and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility HCPCS codes. There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare billing requirement rules, which could result in separate billing for claims under Aetna Better Health. While most claims can be processed under both Medicare and Medicaid, there may be instances where separate billing may be required.

Prompt pay requirements

- Ninety percent (90%) of all clean claims must be paid within fourteen (14) days of the date of receipt.
- Ninety-nine percent (99%) of all clean claims must be paid within ninety (90) days of the date of receipt.

Online status through the Aetna Better Health secure website

Aetna Better Health encourages providers to take advantage of using our online provider secure web portal at **AetnaBetterHealth.com/Oklahoma/providers/portal** as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The provider secure web portal is located on the Aetna Better Health website.

Providers who already use the Availity Provider Portal must contact the administrator on the account to request a username. If provider does not know who the administrator on the account is, the provider must reach out to Availity at 1-800-282-4548. If the practice is new to the Availity Provider Portal, the provider can register at **Availity.com/Essentials-Portal-Registration.** Please see **https://www.aetnabetterhealth.com/oklahoma/providers/portal.html** website for additional details surrounding the provider secure web portal.

Checking status of claims

Providers may check the status of a claim by accessing our secure web portal or by calling the claims inquiry claims research (CICR) department.

Aetna Better Health Claims Inquiry Claims Research (CICR) Department is responsible for claims adjudication; resubmissions and claims inquiry/research.

Calling the claims inquiry claims research department

The claims inquiry claims research (CICR) department is also available to:

- Answer questions about claims
- Assist in resolving problems or issues with a claim
- Provide an explanation of the claim adjudication process
- Help track the disposition of a particular claim
- Please be prepared to give the service representative the following information:
  - Provider name and national provider identification (NPI) number or TIN (tax identification number) with applicable suffix if appropriate
  - Member identification number, member name and full date of birth
  - Date of service
  - Claim number and billed amount from the remittance advice on which you have received payment or denial of the claim

Claim resubmission

Providers have six (6) months from date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not a constitute reconsideration or claim dispute.

Providers may resubmit a claim that:

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

Include the following information when filing a resubmission:

- Use the resubmission form located on our website
- An updated copy of the claim
- All lines must be rebilled
- A copy of the original claim (reprint or copy is acceptable)
- A copy of the remittance advice on which the claim was denied or incorrectly paid
- Any additional documentation required
- A brief note describing requested correction
- Complete box 22 with the resubmission code and the previous claim number

Providers can submit resubmissions electronically if no additional documentation is required. For electronic resubmissions, providers must submit a 7 or 8 in the indicator field for a resubmission claim. Any claims with a frequency code of 5 will not be paid.

Resubmissions with additional documentation may not be submitted electronically. Failure to mail and accurately label the resubmission to thecorrect address will cause the claim to deny as a duplicate.

Aetna Better Health via mail to the following address:

Aetna Better Health of Oklahoma
Attn: Reconsiderations
PO Box 983110
El Paso, TX 79998-3110

Please note: Providers will receive an EOB when their resubmitted claim has been processed. Providers can review our secure web portal to check the status of a resubmitted/reprocessed and adjusted claim. These claims will be noted as “paid” in the portal. To view our portal, please click on the portal tab, which is located under the provider page, which can be found on the following website: **AetnaBetterHealth.com/Oklahoma/index.html**

Providers may also call our CICR department during regular office hours to speak with a representative about their claim. The CICR department will be able to verbally acknowledge receipt of the resubmission, reconsideration, and the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status.

Remittance Advice

Provider remittance advice

Remittance advice provider remittance advice Aetna Better Health generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid,

denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission.

Aetna Better Health partners with ECHO to offer providers a single platform to register for EFT/ERA service across all Aetna Better Health plans. Provider enrollment in EERS is required for electronic payment service. For providers who utilize ECHO as a clearing house, additional enrollment is required for EERS. To enroll in EERS, visit. **Enrollments.EchoHealthInc.com/EFTERAInvitation**
For FAQs, go to "how does it work" page **Enrollments.EchoHealthInc.com/EFTERAInvitation**
To contact ECHO regarding the EERS system, call **1-888-834-3511.**

The provider remittance advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The summary box found at the top right of the first page of the remit summarizes the amounts processed forthis payment cycle. The remit date represents the end of the payment cycle.
- The beginning balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- The processed amount is the total of the amount processed for each claim represented on the remit.
- The discount penalty is the amount deducted from, or added to, the processed amount due to late or earlypayment depending on the terms of the provider contract.
- The net amount is the sum of the processed amount and the discount/penalty. The amount paid is the total of the net amount, plus the refund amount, minus the amount recouped.
- The ending balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative amount paid.
- The check # and check amount are listed if there is a check associated with the remit. If payment is made electronically then the electronic funds transfer (EFT) reference # and EFT amount is listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The benefit plan refers to the line of business applicable for this remit. Tax identification number (TIN) refers to the tax identification number.
- The claim header area of the remit lists information pertinent to the entire claim. This includes:
    - Member name
    - ID
    - Birth date
    - Account number
    - Authorization ID, if obtained

- Provider name
- Claim status EERS
- Claim number
- Refund amount, if applicable
- The claim totals are totals of the amounts listed for each line item of that claim
- The code/description area lists the processing messages for the claim
- The remit totals are the total amounts of all claims processed during this payment cycle
- The message at the end of the remit contains claims inquiry and resubmission information as well asgrievance rights information

An electronic version of the Remittance Advice can be attained. To qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Aetna Better Health partners with ECHO to offer providers a single platform to register for EFT/ERA service across all Aetna Better Health plans. Provider enrollment in EERS is required for electronic payment service. For providers who utilize Office Ally as a clearing house, additional enrollment is required for EERS. To enroll in EERS, visit **PayerEnrollServices.com**
For FAQs, visit **PayerEnrollServices.com/faq**

To contact Office Ally regarding the EERS system, call **1-360-975-7000** or live chat is available at **CMS.OfficeAlly.com/form-contact-form-new** to connect with live support.

Encounter management system (EMS)
Aetna Better Health uses an encounter management system (EMS) that warehouses claim data and formats encounter data to OHCA requirements. The EMS also warehouses encounter data from vendors,and formats it for submission to OHCA. We use our state-of-the-art EMS to monitor data for accuracy, timeliness, completeness, and we then submit encounter data to OHCA. Our EMS processes CMS1500, UB04 (or UB92), dental, pharmacy and long-term care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II). Our provider contracts require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements.

Part of our encounter protocol is the requirement for providers to utilize NDC coding in accordance with the Department's requirements. Encounter formats must meet the requirements of the Affordable Care Act and 42 C.F.R. 438.3(s). Medications administered by the provider undergo multiple checks to ensure a valid 11-digit national drug code (NDC) is present, the units and number of billable units are accurate (milliliters (ML), units (UN), grams (GR)), the NDC's effective date is valid for the date of service, and other necessary information such as healthcare common procedure coding system codes are present.

The EMS has top-of-the-line functionality to track encounters accurately, and consistently throughout the submission continuum including collection, validation, reporting, and correction. Our EMS can electronically accept a HIPAA-compliant 837 (I and P) electronic claim transaction,

835 Claim Payment/Advice transaction and the NCPDP D.O. or PAH transaction in standard format and we require our providers and their clearinghouses to send electronic claims in these formats.

We collect claims information from multiple data sources into the EMS for processing, including data from our Claims Processing System as well as data from third-party vendors under contract to process various claims, such as vision, transportation, and pharmacy. Our EMS accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EMS, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Claims processing
Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EMS. Our encounter management unit carries out reconciliation of all claims data received into EMS, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Encounter management system (EMS) edits
This EMS feature allows the encounter management unit to apply OHCA edit profiles to identify records that may be unacceptable to the OHCA. Our encounter management unit is able to customize our EMS edits to match the edit standards and other requirements of the OHCA. This means that we can align our encounter edit configuration with the OHCA's configuration to improve encounter acceptance rates. When an encounter is edited due to incomplete or invalid data submitted by the provider, it might result in claim recoupment. This is implemented to maintain encounters accuracy.

To ensure complete encounters submission as per OHCA requirements, the below fields are required in both billing and rendering provider sections:

- NPI (Typical Providers) – Uses for all instances that require provider identification
- SoonerSelect provider number (atypical providers) – SoonerSelect provider ID or tax ID
- Taxonomy

Encounter tracking reports
Encounter tracking reports are custom tailored for Aetna Better Health. Our encounter management unit uses a series of customized management reports to monitor, identify, track, and resolve problems in the EMS or issues with an encounter file. Using these reports our encounter management unit is able to identify the status of each encounter in EMS by claim adjudication date and date of service. Using these highly responsive and functional reports, our encounter management unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into EMS, submission to and acceptance by the department. Reports are run to verify that all appropriate claims have been extracted from the claims processing system.

Data correction

As described above, the encounter management unit is responsible for the EMS. This responsibility includes managing the data correction process should it be necessary to resubmit an encounter due to rejection of the encounter by the department.

Our encounter management unit uses two processes to manage encounter correction activities:

1. Encounters requiring re-adjudication and those where re-adjudication is unnecessary. If re-adjudication is unnecessary, the encounter management unit will execute corrections to allow resubmission of encountererrors in accordance with the department encounter correction protocol.
2. Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system, the adjusted claim is imported into the EMS for resubmission to the department in accordance with the encounter correction protocol, which is tailored to the department's requirements. The EMS generates, as required, the appropriate void, replacement, and corrected records.

Although our data correction procedures enable the encounter management unit to identify and correct encountersthat failed the department's acceptance process, we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EMS edit describedabove. In this way, we will expand our EMS edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

Our encounter management unit is important to the timely, accurate, and complete processing and submission of encounter data to the OHCA. Our encounter management unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and are responsible for oversight and monitoring of encounter files submissions to the OHCA. The team includes a technicalsupervisor and a project manager to monitor the program.

Another critical step in our encounter data correction process is the encounter error report. We generate this reportupon receipt of response files from the department and give our encounter management unit critical information toidentify and quantify encounter errors by type and age. These data facilitate the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

Chapter 16: Appeal and grievance system

Back to Table of Contents

Member appeal and grievance system overview

Members or their designated representative can file an appeal or express dissatisfaction with Aetna Better Health orally or in writing. Requests that disagree with an action Aetna Better Health has taken or intends to take are classified as an appeal; see "standard appeal" and "expedited appeal." All other expressions of dissatisfaction are classified as a grievance; see"standard grievance" and "expedited grievance".

A representative is someone who acts on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing. A network provider, acting on behalf of a member, and with the member's written consent, may file a grievance or appeal with Aetna Better Health. Members' and their representatives including providers with written consent may also file an External Medical Review and/or a State Fair Hearing as appropriate. When a provider acts on behalf of a member the request follows the member appeal and grievance processes and timeframes.

Aetna Better Health informs members and providers of the grievance system processes for grievances, appeals, external medical review and/or a state fair hearings. This information is also contained in the member handbook and is available on the Aetna Better Health website. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, large font, braille, providing oral interpreter services including Spanish and other prevalent non-English languages, and toll-free numbers that have adequate TTY/TTD and oral interpreter capability at no cost to the member/potential member.

Aetna Better Health will ensure that no punitive action is taken in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member'sappeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing a grievance or appeal with Aetna Better Health.

Our processes for resolving member grievances and appeals are described below.

Standard grievance

Standard grievances are defined as written or oral expressions of dissatisfaction regarding Aetna Better Health and/or a provider, including quality of care concerns. Standard grievances may be submitted by telephone, facsimile, email, or online through the Aetna Better Health website at any time. Standard grievances are resolved within thirty (30) calendar days following receipt.

Members, providers, or their designated representatives, may submit a grievance either in writing or by calling our MemberServices line or other health plan staff. Providers can also advise and advocate on behalf of member.

We will acknowledge verbal standard grievances verbally at the time of receipt and all grievances in writing within ten (10) calendar days of receipt that informs the grievant of the following:

- The grievance has been received
- Date of receipt
- The name and telephone number and address of the Aetna Better Health representative who may be contacted about the grievance

Our goal is to resolve grievances a quickly as possible and notify the member or representative of the resolution in writing within two (2) business days from the resolution and within the thirty (30) calendar day timeframe. Aetna Better Health will notify the member in writing if the grievance has not been resolved within thirty (30) days and provide an estimated completion date.

Expedited grievance
Expedited grievances are defined as a grievance as a result of Aetna Better Health denying expedited processing of an appeal or prior authorization or when Aetna Better Health takes an extension on the processing time of an appeal or prior authorization.

Members, providers, or their designated representatives, may submit an expedited grievance either in writing through facsimile, email, United States postal mail, online through the Aetna Better Health website or by calling our member services line or other health plan staff.

We will acknowledge expedited grievances verbally at the time of receipt and in writing within 72 hours of receipt. Verbal acknowledgements will be documented and will include notification to the member that the member may immediately submit a grievance to the department. The acknowledgment will be followed by a written statement on the decision or the pending status of the expedited appeal to both the member and the department, 72 hours of receipt.

Standard appeal
A standard appeal is defined a request for reconsideration of an adverse determination for a health care service, supply, or device for a member.

Members or their designated representatives including a provider can file an appeal directly with us either in writing or verbally by calling into member services, provider services, or by calling any other health plan staff. Providers can also advise and advocate on behalf of member. The date of the verbal appeal establishes the filing date for the appeal. Members have 60 days from the date of the notice of adverse benefit determination letter to file an appeal.

The notice of adverse benefit determination letter from the initial denial describes the member's appeal rights and includes a request foradditional clinical documentation that could assist in verifying the medical necessity of the desired services.
The member or their designated representative may present supporting evidence in person or in writing, either on orbefore the appeal meeting date. During this time, the member or their designated representative may contact us to request a copy of the member's file or clinical records that will be reviewed during the appeals process. There is no cost to the member.

Appeals will be reviewed and decided by an appropriately licensed clinical peer reviewer with expertise in the same or similar specialty as the service that is the subject of the appeal, who were not involved in the initial determination, and are not a subordinate of any person who rendered the

initial decision. An appeal maybe reviewed by the appeal committee. When reviewed by the committee an appropriately licensed clinical peer reviewer with expertise in the same or similar specialty as the service that is the subject of the appeal, who were not involved in the initial determination, and are not a subordinate of any person who rendered the initial decision will approve and sign the decision.

We execute the appeal process with the utmost regard to protecting the confidentiality of protected health information in compliance with our privacy policies and HIPAA requirements. In most cases, we decide the appeal within 30 calendar days.

Expedited appeal

An expedited appeal is defined as a request for reconsideration of an adverse benefit determination for a health care service, supply, or device for a member that involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Members, providers, or their designated representatives including a provider can file an expedited appeal for all pre-service or continued care services within 60 calendar days of the initial adverse benefit determination directly with us either in writing or verbally by calling into member services, provider services, or by calling any other health plan staff. Providers can also advise and advocate on behalf of member. Expedited appeals requested by the provider that meet criteria do not require written consent from the member.

While most appeals will follow the standard process and are resolved within the 30-calendar day requirement, there are times when we expedite appeals. Some situations may require a faster decision. In those cases, we expedite the decision-making process. This may include situations where:

- A member's life, health, or ability to attain, maintain, or regain maximum function may be at risk
- The treating provider's opinion is that the member's condition cannot be adequately managed without urgent care or services

If a request meets the expedited criteria listed above, expedited appeals are reviewed and decided by an appropriate licensed clinical reviewer who was not involvedin initial determination and is not a subordinate of the person who rendered the initial decision as quickly as the member's health requires. This reviewer will have clinical expertise in the same or a similar specialty, and typically treat the medical condition or perform the procedure.

We immediately initiate the appeals process upon receipt of the expedited appeal request. For requests made by telephone, we acknowledge the request verbally at the time of the initial telephone call from the member, their designated representative, including their provider. If we receive a written request, we will acknowledge in writing within the 72-hour processing timeframe.

We will make a decision and provide a written statement on the decision or the pending status of the expedited appeal to both the member or their designated representative, no later than seventy-

two (72) hours from receipt of the request.

Providing prompt notification when denying expedited processing of an appeal
We conduct an initial review of the issue to determine if the issue meets the criteria of an expedited appeal as documented in policy and procedure documents. If the issue fails to meet the expedited appeal criteria, we transition it to the standard appeal process and maintain the original received date. We verbally notify the member of the denial of their request for expedited processing. We will follow the verbal notification with a written notification within two (2) calendar days of the decision. The member may file a grievance inresponse to a denial of expedited resolution.

External medical review
Members or their designated representative including a provider acting on their behalf with written consent mayrequest an external medical review after the Aetna Better Health appeal decision. Additionally, if Aetna Better Health fails to adhere to the notice and timing requirements set forth for processing an appeal, the member is deemed to have exhausted the appeals process, and may initiate request for an external medical review. This request must be completed within one hundred twenty (120) calendar days from the day afterthe date of the NOA Letter. Information on how to submit an external medical review is included in Aetna Better Health appeal adverse benefit determination decision letters.

State fair hearing
Members or their designated representative including a provider acting on their behalf with written consent mayrequest a state fair hearing through OHCA after the Aetna Better Health appeal decision.

Additionally, if Aetna Better Health fails to adhere to the notice and timing requirements set forth for processing an appeal, the member is deemed to have exhausted the appeals process, and may initiate request for a state fair hearing. This request must be completed within one hundred twenty (120) calendar days from the day afterthe date of the NOA letter.

Information on how to submit a state fair hearing is included in Aetna Better Health appeal adverse benefit determination decision letters. Requests should be sent to: OHCA.

Provider complaint system
Provider or their designated representative can file a complaint reconsideration orally or in writing, or an appeal in writing. Requests that disagree with an action Aetna Better Health has taken or intends to take are classified as a reconsideration or appeal; see “provider appeal” and “provider reconsideration.” All other expressions of dissatisfaction are classified as a grievance; see “provider complaint.”

Provider complaints
Both network and out-of-network providers may file a complaint verbally or in writing directly with Aetna Better Health regarding our policies, procedures, or any aspect of our administrative within 60 calendar days from when they became aware of the issue. Providers can also file a verbal complaint with Aetna Better Health when it is related to Aetna Better Health staff or contracted vendor behavior by calling **1-844-365-4385**. To file a complaint in writing, providers can submit through the provider portal, website or to:

Aetna Better Health of Oklahoma
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Email: **OKAppealAndGrievance@Aetna.com**
Fax: **833-805-3310**

The appeals and grievance manager assumes primary responsibility for coordinating and managing provider complaints, and for disseminating information to the Provider about the status of the complaint.

Provider complaints will be acknowledged within five (5) business days. If the complaint requires research or input by another department, the appeals and grievance manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions as appropriate collecting pertinent facts from all parties applying the Aetna Better Health written policies and procedures. If the complaint be resolved within the appeal and grievance department, the case will be escalated to the complaint committee for resolution. The complaint committee will include a provider with same or similar specialty if the complaint is related to a clinical issue. The complaint committee will also include an officer of the plan who has the authority to require corrective action. Aetna Better Health will resolve all provider grievances within thirty (30) calendar days of receipt of thegrievance and will notify the provider of the resolution within five (5) calendar days of the decision.

Provider reconsiderations
A provider may file a reconsideration verbally or in writing, with Aetna Better Health within 30 calendar days Aetna Better Health remittance advice. Written reconsiderations can be sent through the provider portal, website or to:

Aetna Better Health of Oklahoma
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Email: **OKAppealAndGrievance@Aetna.com**
Fax: **833-805-3310**

The appeals and grievance manager assumes primary responsibility for coordinating and managing providerreconsiderations, and for disseminating information to the provider about the status of the reconsideration.

Provider reconsiderations will be acknowledged within five (5) business days.

If the reconsideration requires research or input by another department, the appeals and grievance manager will forward the information to the affected department and coordinate with the affected

department to thoroughly research each reconsideration using applicable statutory, regulatory, and contractual provisions as appropriate collecting pertinent facts from all parties applying the Aetna Better Health written policies and procedures. Reconsiderations that require medical necessity review will be reviewed and decided by an Aetna Better Health appropriately licensed medical director who was not involved in the initial determination and are not a subordinate of any person who rendered the initial decision. The reconsideration decision letter will include the right to file an appeal and the timeframe to do so. Aetna Better Health will inform providers through the provider manual and other methods, including periodic provider newsletters, training, provider orientation, the website and by the provider calling their provider services representative about the provider reconsideration process.

Provider appeal
A provider may file a formal appeal in writing, following the reconsideration process within 30 calendar days from the Aetna Better Health notice of reconsideration decision letter. The expiration date to file an appeal is included in the Reconsideration decision letter. Written appeals can be sent through the provider portal, website or to:

Aetna Better Health of Oklahoma
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Email: **OkAppealAndGrievance@Aetna.com**
Fax: **833-805-3310**

The appeals and grievance manager assumes primary responsibility for coordinating and managing provider appeals, and for disseminating information to the provider about the status of the appeal.

Provider appeals will be acknowledged within five (5) business days. The appeal with all research will be presented to the appeal committee for decision. The appeal committee will include a provider with same or similar specialty. The appeal committee will consider the additional information and will issue an appeal decision. The reconsideration decision letter will include the right to file an administrative appeal with OHCA and the timeframe to do so.

Aetna Better Health will inform providers through the provider manual and other methods, including periodic provider newsletters, training, provider orientation, the website and by the provider calling their provider services representative about the provider appeal process.

Provider administrative appeal
A provider may file an administrative appeal in writing with OHCA, following the appeal process within 30 calendar days from the Aetna Better Health notice of appeal decision letter. The expiration date to file an administrative appeal is included in the appeal decision letter. Providers should complete the OHCA LD2 form along with any additional documentation to:

Oklahoma Health Care Authority
Legal Docket Clerk Legal Division
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
405-530-3444 (Fax)
405-522-7217 (Phone)

The appeals and grievance manager assumes primary responsibility for coordinating and managing provideradministrative appeals.

Aetna Better Health furnish a litigation summary to OHCA including all information related to the item or service being appealed within 15 calendar days of the providers request for administrative appeal. OHCA's decision is final and if overturned will be effectuated within ten calendars from receipt of the decision.

Aetna Better Health will inform providers through the provider manual and other methods, including periodic provider newsletters, training, provider orientation, the website and by the provider calling their provider services representative about the provider administrative appeal process.

Oversight of the grievance and appeal processes
The appeal and grievance department staff reports to the Aetna Better Health Medicaid administrators director of appeal and grievance with a dotted line to the Aetna Better Health chief operating officer (COO). the appeal and grievance manager has overall responsibility for management of the appeal and grievance processes This includes:

- Documenting individual complaints, grievances, and appeals
- Coordinating resolutions
- Maintaining the appeals and grievance database
- Tracking and reviewing complaint, grievance, and appeal data for trends in quality of care or other service-related issues
- Reporting all data to the service improvement committee (SIC) and quality management oversight committee (QMOC)

The Aetna Better Health grievance and appeals process is integrated into our quality improvement program. All data collected is reported to the appeal and grievance committees, service improvement committee (SIC) and quality management oversight committee (QMOC) at least quarterly (more frequently if appropriate) summarizing the frequency and resolution of all appeals and grievances for identification of opportunities for improvement as well as follow up on identified actions to address those opportunities. In addition, our quality management (QM) responsibilities include:

- Review of individual quality of care grievances
- Use of the data for quality improvement activities including collaboration with credentialing and recredentialing processes, as required
- Participation in the identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

The Aetna Better Health appeal and grievance manager will serve as the primary contact person for

appeal and grievance processes with the Aetna Better Health with our Medicaid administrators director of appeal and grievance as the back-up contact person. The member services department, in collaboration with the QM department and provider services department, is responsible for informing and educating members and providers about a member's right to file a grievance, appeal, state fair hearing and for assisting members in filing a grievance, or appeal.

Members are advised of their grievance and appeal and, state fair hearing rights and processes at thetime of enrollment and at least annually thereafter. Providers receive this information in this manual, during provider orientations, within the provider agreement and on the Aetna Better Health website.

Website and electronic appeal or grievance submission

The Aetna Better Health site is updated as necessary to ensure information is current, including the online form that members can use to file a grievance or appeal. The Aetna Better Health website is designedfor easy access by members, and the online appeal or grievance submission procedure:

- Is accessible through the member services portal and is clearly identified as "appeal or grievance form."
- The form is in HTML format and allows the user to enter required information directly into the form.
- All information submitted through this process is processed through a secure server.
- Allows the member to preview and edit the form prior to submitting.
- Includes a current hyperlink to the Oklahoma department of managed health care website.
- Includes a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the required department paragraph as noted in the section above entitled "telephone numbers and required paragraph."

Aetna Better Health also includes the following information on its internet website:

- Telephone number that members or provider scan call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have beenexhausted, in-network provider access information, and claims processing information.
- A link to prescription drug formularies or instructions on how to obtain the formulary
- A detailed summary that describes the process by which Aetna Better Health reviews and authorizes orapproves, modifies, or denies requests for health care services.
- Lists of providers or instructions on how to obtain the provider list.
- A detailed description of how a member may request continuity of care
- Information concerning the right, and applicable procedure, of a member to request an independent medicalreview (IMR)

Aetna Better Health ensures the information available to its members on the website is current by conducting monthly and quarterly reviews and updates. All information provided on the Aetna Better Health website is madeavailable to members in hard copy format upon request.

Chapter 17: Fraud, waste, and abuse

Back to Table of Contents

Aetna Better Health has an aggressive, proactive fraud, waste, and abuse program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A special investigations unit (SIU) is a key element of theprogram. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste or abuse to appropriate state and federal agencies as mandated by Oklahoma administrative code. During the investigation process, the confidentiality of the patient and people referring the potential fraud and abuse case is maintained.

Aetna Better Health uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including claims, provider experience, member services, medical management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of providerservice patterns, hotline reporting, claim review, data validation, and data analysis.

Special investigations unit (SIU)
Our special investigations unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and isresponsible 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, seek information, or want to reportpotential 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.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoringthe huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantlyfrom those of their peers. If it identifies a case of suspected fraud, the SIU's information technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Reporting suspected fraud and abuse
Participating providers are required to report to Aetna Better Health all cases of suspected fraud, wasteand 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 **1-833-898-1441**
- 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.

Provider fraud should be reported to OHCA, at **1-800-784-5887** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS or** (**1-800-447-8477**).

The OHCA program integrity unit was created to preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for all state agencies responsible for services funded by Medicaid.

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

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

Fraud, waste, and abuse defined

- **Fraud**: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
- **Waste**: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse**: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includesbeneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of fraud, waste, and abuse

Examples of fraud, waste, and abuse include:

- Charging in excess for services or supplier
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health due to improper payments to providers, or overpayments
- Physical or sexual abuse of members

Fraud, waste, and abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions

- Switching a member's prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing logininformation
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members, a cash payment as an inducement to enroll in a specific plan
- Selecting or denying members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for twenty (20) nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health and the member, or billing Aetna Better Health and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-coveredservice that was rendered.

Fraud, waste and abuse can incur risk to members as well:

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

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another members ID)
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults a number of doctors for obtaining multiple prescriptions for narcotics painkillers or other drugs doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Elements to a compliance plan

An effective compliance plan includes seven core elements:

1. Written standards of conduct: Development and distribution of written policies and procedures that promote Aetna Better Health to compliance and that address specific areas of potential fraud, waste, and abuse.
2. Designation of a compliance officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. Effective compliance training: Development and implementation of regular, effective education, and training.
4. Internal monitoring and auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. Disciplinary mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
6. Effective lines of communication: Between the compliance officer and the organization's employees,managers, and directors and members of the compliance committee, as well as related entities.
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential oractual non-compliance, will maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health.
7. Procedures for responding to detected offenses and corrective action: Policies to respond to and initiatecorrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant laws

There are several relevant laws that apply to fraud, waste, and abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits,among other things:
    - Knowingly presenting a false or fraudulent claim for payment or approval
    - Knowingly making or using, or causing to be made or used, a false record or statement in order tohave a false or fraudulent claim paid or approved by the government
    - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

  "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

  Providers contracted with Aetna Better Health must agree to be bound by and comply with allapplicable State and federal laws and regulations.

- 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 federalhealth 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'simmediate family member has a financial relationship unless an exception applies.
- Red flag rule (identity theft protection)
  - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, orspecific activities that could indicate identity theft.
- HIPAA requires:
  - Transaction standards
  - Minimum security requirements
  - Minimum privacy protections for protected health information
  - National provider identification (NPIs) numbers

- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which thegovernment makes a payment. The amount of the false claim penalty is to be adjusted periodically for inflation in accordance with a federal formula.

- Under the federal anti-kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly, or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health services through SoonerSelect.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health providers will follow federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health services through SoonerSelect.

- The Oklahoma False Claims Act (CAFCA), Section 12650-12656 of the Oklahoma government code, which wasenacted in 1987 intends any office, employee or agent of the state or of a political subdivision to have the ability, authority and resources to pursue civil monetary penalties, liquidating damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth herein, to obtain payments to which these health care providers or persons are not entitled. Cal. Gov't Code §12650.
- Office of the Inspector General (OIG) and General Services Administration (GSA) exclusion program prohibits identified entities and providers excluded by the OIG or GSA from

conducting business or receiving payment from any federal health care program.

Administrative sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG list of excluded individuals/entities database
- License suspension or revocation

Remediation

Remediation may include any or all the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
  - Automatic disbarment
  - Prison time

Children

Providers must report suspected or known child abuse, and neglect to the Oklahoma Department of Human Services (OKDHS) **Statewide 24-hour Child Abuse and Neglect Hotline at 1-800-522-3511** or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child'swelfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following State agencies:

- The Oklahoma Domestic Violence Hotline at **1-800-522-SAFE** (**7233**)
- Reporting Agencies
  - Oklahoma Department of Human Services (OKDHS)
  - **1-800-522-3511**

Critical incidents

Aetna Better Health has developed and implemented a critical incident (CI) reporting and tracking system for behavioral health adverse or critical incidents and requires participating providers to report adverse or critical incidents to Aetna Better Health, Oklahoma Human Services (OHS), and the member's parent or legal guardian. Aetna Better Health will provide appropriate training and take corrective action as needed to ensure its staff and participating providers, as applicable, comply with critical incident requirements, in the manner and format required in the State's reporting manual.

Aetna Better Health staff and participating providers will immediately, but not to exceed twenty-four (24) hours, take steps to prevent further harm to any and all members and respond to any emergency needs of members. Participating providers will conduct an internal CI investigation and submit a response on the investigation as soon as possible, based on the severity of the CI, to Aetna Better Health, OHS, and the member's parent or legal guardian. Participating providers will disclose to Aetna Better Health by phone no later than 5 PM CT on the business day following a serious occurrence and disclose, at a minimum:

a. The name of the member involved in the serious occurrence
b. A description of the occurrence
c. The name, street address, and telephone number of the facility

Within three (3) days of the serious occurrence, a participating provider must also submit a written facility critical incident report to Aetna Better Health containing specific information regarding the incident including any available follow-up information regarding the member's condition, debriefings, and programmatic changes implemented, if applicable. A copy of this report must be

maintained in the member's record, along with the names of the person(s) at Aetna Better Health and OHS to whom the occurrence was reported. A copy of the report must also be maintained in the incident and accident report logs kept by the facility. Aetna Better Health will review the participating provider's report and follow up with the participating provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.

Critical Incidents will include, but not be limited to the following when the member is in the care of a behavioral health inpatient, Psychiatric Residential Treatment Facility (PRTF), or crisis stabilization unit:

a. Suicide death
b. non-suicide death
c. Death-cause unknown
d. Homicide
e. Homicide attempt with significant medical intervention
f. Suicide attempt with significant medical intervention
g. Allegation of physical, sexual, or verbal abuse or neglect
h. Accidental injury with significant medical intervention

Reporting identifying information
Any provider who suspects that a member may be in need of protective services should contact the appropriate stateagencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information)

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify the Aetna Better Health compliance hotline at **1-833-898-1441.**

Our providers must fully cooperate with the investigating agency and will make related information, records and reports available to the investigating agency unless such disclosure violates the federal family educational rights andprivacy act (20 U.S.C. § 1232g).

Examinations to determine abuse or neglect
When a state agency notifies Aetna Better Health of a potential case of neglect and abuse of a member, our care managers will work with the agency and the PCP to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health also notifies the appropriate regulatory agency of the report.

Depending on the situation, Aetna Better Health care managers will provide the member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, behaviors and signs

Abuse

Examples of abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (bed sores)
- Missing teeth
- Broken bones / sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behavior indicators of a child wary of adult contacts:

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
- Reports injury by parents

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

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
- Un-kept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Financial exploitation

Examples of financial exploitation:

- Caregiver, family 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

Communicable diseases

Title 63 Oklahoma Statute (O.S.) 1981 §1-503 mandates the reporting of cases of diseases and conditions by Oklahoma healthcare providers and laboratories to the OSDH. **https://url.usb.m.mimecastprotect.com/s/elwMCGwN7ohAZQp9WrgUKCBwa?domain=oklahoma.gov**

The secure, web-based Public Health Investigation and Disease Detection of Oklahoma (PHIDDO) is the preferred method of reporting diseases and conditions to the OSDH, aside from the 2019 Novel Coronavirus (COVID-19). COVID-19 lab reporting occurs through the Spring ML web portal and COVID-19 case reporting occurs via the OSDH Case Investigation (OSDHCI) application.

The Acute Disease Service Epi-on-call is available 24 hours/7 days a week at **405-426-8710** for communicable disease consultations and reporting of diseases or outbreaks.

Chapter 19: Pharmacy management

Back to Table of Contents

Pharmacy management overview

Aetna Better Health covers prescription medications and certain over-the-counter medicines when you write a prescription for a member. We use CVS/Caremark® for pharmacy benefit management services. CVS/Caremark® provides members access to a retail pharmacy network and other services including claims processing and mail order pharmacy program.

E-Prescribing

E-prescribing is the transmission, using electronic media, of a prescription or prescription-related information, between a prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network such as Surescripts. We provide member eligibility and coverage status, medication history, and formulary information to providers who use e-prescribing tools.

Preferred drug list (PDL)

Aetna Better Health adheres to the OHCA universal Preferred Drug List (PDL) and clinical criteria. You can use our online formulary search tool to validate drug coverage information, such as preferred status, prior authorization (PA), and quantity level limits (QLL). You can also download a print version of our PDL from the website. When prescribing medications and over the counter drugs, check the coverage status of the drug to identify any restrictions or limitations. For drugs on the PDL that require prior approval, there are pharmacy PA request forms available on our website. If you do not have access to the internet, you may contact us telephonically, through member services, or by fax to submit a PA request or have a PA form mailed to your office. If a drug is not listed on our PDL, a pharmacy PA request form must be completed before an exception to the PDL is considered. Please include supporting medical records that assist with the review of the exception and PA request.

We update the PDL posted to our website monthly or more frequently as applicable. Please visit the Aetna Better Health website at **AetnaBetterHealth.com/Oklahoma** pharmacy page to view the most recent PDL updates and access our up-to-date PDL search tool.

Quantity level limits (QLL)

Quantity level limits (QLL) apply for certain medications to promote the safe and appropriate use of these medications. QLLs are developed based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat. Aetna Better Health uses quantity limits established by OHCA. Review the PDL online search tool to determine if a prescribed medication has a QLL. To request an exception to the QLLs, submit a PA request by calling our Pharmacy PA team at **1-844-365-4385**, faxing the request to **1-888-601-8461**, or by submitting an electronic PA request through the health plan website, **AetnaBetterHealth.com/Oklahoma**

Prior authorization process

Certain medications listed on the PDL require PA to make sure they are utilized appropriately prior to the dispensing of those medications. There may also be a need for a prescribed drug that is not listed on the PDL. In those instances, a provider may make an exception request for coverage of a non-preferred drug. Typically, we require providers to obtain PA/exception approval prior to prescribing or dispensing for the following drugs:

- Select specialty medications, including injectables and oral medications
- Non-formulary/non-preferred drugs not excluded under a State's Medicaid program
- Prescriptions that do not conform to our evidence-based utilization practices (e.g., QLLs, age restrictions, or ST)
- Brand name drug requests, when an "A" rated generic equivalent is available

To request a PA, the prescribing provider can contact Aetna Better Health pharmacy prior authorization department, at **1-844-365-4385**, submit a fax request to **1-888-601-8461**, or submit an electronic PA through the health plan website **AetnaBetterHealth.com/Oklahoma** 24 hours per day; calls should be placed from 8 AM – 7 PM CT, Monday through Friday, 9 AM to 5 PM CT Saturday, and 11 AM to 4 PM CT Sunday, except for state holidays.

Prescribing providers can download the drug specific PA form or general pharmacy PA forms from the health plan website. To support the timely review of a PA request, prescribers are asked to supply the following information:

- Member's name, date of birth, and identification number
- Prescribing practitioner's/provider's name, and telephone and fax numbers
- Medication name, strength, frequency, quantity, and duration
- Diagnosis for which medication is prescribed
- Other medications tried for the same indication
- Medical records to support the necessity for the authorization (e.g., non-formulary drug, age limit, QLL, or ST override, generic override, or vacation override)

The prescribing provider and member are notified of all decisions in accordance with regulatory requirements and timelines. Prior to making a final decision, we may contact the prescriber to discuss the case or consult with a board-certified physician from an appropriate specialty area such as a psychiatrist. In the event that a PA or exception request has an adverse determination, the prescribing provider may contact the issuing medical director/pharmacist to discuss the decision by calling our pharmacy prior authorization at **1-844-365-4385**.

Decision and notification standards

Aetna Better Health makes pharmacy PA and/or exception (if applicable) decisions and notifies practitioners/providers, and/or members in a timely manner, according to the standards defined below:

- Decision of approval, denial, or request for information for pharmacy prior authorization requests are completed within twenty-four (24) calendar hours of receipt
- Aetna Better Health notifies requesting practitioners/providers by fax, phone, or electronic communication of the approved decision within twenty-four (24) calendar

hours of receiving all necessary information

- If an authorization is denied, Aetna Better Health gives requesting practitioners/providers and members electronic or written confirmation of the reason for the decision with information about their appeal rights and appeal process including how to initiate an expedited appeal
- Aetna Better Health will fill qualifying prescriptions for a seventy-two (72) hour supply if the member's prescription has not been filled due to a pending prior authorization decision and the prescribing provider is unreachable, if dispensing pharmacists deems appropriate

Mail order prescriptions

Aetna Better Health offers mail order program for non-specialty maintenance medications through CVS/Caremark mail service. This program allows members to receive a 90-day supply of certain prescription medications. If you have a member who may benefit from our mail order program and would like more information on our program, visit our health plan website at

Pharmacy & Prescription Drug Benefits | Aetna Medicaid Oklahoma (aetnabetterhealth.com)

English: CVS MailOrderForm_English (aetnabetterhealth.com)

Spanish: CVS MailOrderForm_unauth_spanish (aetnabetterhealth.com)

Chapter 20: Forms

Back to Table of Contents

The following forms can be found online at **AetnaBetterHealth.com/Oklahoma**

- **Consent to sterilization**
  Consent to sterilization must be signed by both the member and the provider performing the sterilization.

- **Acknowledgment of hysterectomy information**
  An acknowledgment of information provided related to hysterectomy to be signed by both the member and provider

- **Provider claims dispute form**
  To be completed by a provider who needs to file a claim dispute.

- **Pharmacy coverage determination request form**
- **Prior authorization request forms**

Chapter 21: Provider's bill of rights

Each provider who contracts with a SoonerSelect plan to furnish services to the members will be assured of the following rights:

- A health care professional, acting within the lawful scope of practice, will not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatmentthat may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his/her health care, including the right torefuse treatment, and to express preferences about future treatment decisions.
- To receive information on the grievance, appeal and state fair hearing procedures.
- To have access to the SoonerSelect plan's policies and procedures covering the authorization of services.
- To be notified of any decision by the SoonerSelect plan to deny a service authorization request, or to authorize aservice in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, orpayment for, medical assistance.
- The SoonerSelect plan's provider selection policies and procedures must not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who isacting within the scope of his/her license or certification under applicable State law, solely based on that license or certification.