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Welcome
Welcome to Aetna Better Health of Florida. 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 Floridians who need us most. As a Long Term Care (LTC) Professional, you play a very important role in the delivery of healthcare and support services to our members. The Provider Manual is intended to be used as an orientation tool and guideline for the provision of covered services to members. This manual contains policies, procedures, and general reference information including minimum standards of care which are required of Plan Providers. As a Network Provider, we hope this information will help you better understand Aetna Better Health of Florida. Should you or anyone on your staff have any questions about any information contained in this manual or anything else about Aetna Better Health of Florida, please feel free to contact Provider Relations department. We look forward to working with you and your staff to provide quality managed healthcare service to our members. Our vision is to benefit all stakeholders while considering consumer choice and outcomes, Provider qualifications, and Aetna Better Health of Florida’s requirements. “Agency” or “AHCA” may be used herein to reference the Florida Agency for Health Care Administration.

Experience and Innovation
We have more than 25 years’ experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and cost effective outcomes.

We are dedicated to enhancing member and Provider satisfaction, using tools such as predictive modeling, case 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 providers to achieve sustainable improvements in service delivery. We are committed to building on the significant improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Meeting the Promise of Managed Care
Our state partners chose us because of our expertise in effectively managing integrated health models for Medicaid that provides 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 health, their quality of life, and the environmental conditions in which they live. Aetna Better Health of Florida has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

Medicaid Program
Florida Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. The Florida Medicaid program is responsible for policies, procedures, and programs to promote access to quality acute and long-term medical, behavioral, therapeutic, and transportation services for Medicaid beneficiaries. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the families or individual’s income and assets.

Statewide Medicaid Managed Care Program
Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children,
seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for medical assistance (MMA) and one for Long-Term Care (LTC).

About the Florida LTC Program
The Agency for Health Care Administration (AHCA) administers the state- and federally- funded LTC program for certain groups of low- to moderate- income adults:

- FL LTC is a Medicaid program for eligible recipients age 18 or older, that have been determined by CARES to meet the nursing facility level of care.

Aetna Better Health of Florida was chosen by AHCA as a managed care organization to manage the LTC benefits for enrolled members. This includes coordination of services, member engagement and outreach, benefit education and community based care management.

Aetna Better Health of Florida offers the LTC Program in the following regions and counties:

- Region 6 – Hillsborough, Polk, Manatee, Hardee, Highlands
- Region 7 – Seminole, Orange, Osceola, Brevard
- Region 9 – Indian River, Okeechobee, St. Lucie, Martin, Palm Beach
- Region 11 – Monroe, Miami-Dade

Disclaimer
Providers are contractually obligated to adhere to and comply with all terms of the Plan and the Aetna Better Health of Florida Provider Agreement. This includes all requirements described in this manual and all federal and state regulations governing Providers and the provision of Medicaid services. While this manual contains basic information about Aetna Better Health of Florida, AHCA requires that Providers fully understand and apply AHCA requirements when administering covered services.

For further information please refer to the AHCA LTC program website:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml

Aetna Better Health of Florida Policies and Procedures
Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to ensure all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are completed as needed.

Eligibility
The Florida Department of Children and Family Services (DCF) and the federal Social Security Administration determine a person’s financial and categorical Medicaid eligibility. The Comprehensive Assessment and Review for Long Term Care Services (CARES) unit of DOEA (Department Of Elder Affairs) determines a person’s clinical eligibility for the FL LTC program. Applicants for the LTC program must be 18 years of age or older, meet ICP financial eligibility, and at risk of institutional placement per (701B and 3008) CARES assessment process.

Model of Care
**Integrated Care Management**
Aetna Better Health of Florida’s Integrated Care Management (ICM) Program uses a Bio-Psycho-Social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at highest risk of not doing well over the next 12 months, and offer them intensive case management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their Primary Care Practitioner (PCP). This relationship continues throughout the case management engagement. We offer members who are at lower risk supportive case management services. These include standard clinical case management and service coordination and support. Disease management is part of all case management services that we offer.

**Integrated Long Term Care Management**
Aetna Better Health of Florida’s Integrated Long Term Care Management (ILTCM) program uses a person-centered case management approach and will provide Long-Term Care (LTC) to our aging and disabled members in the most integrated and least restrictive care environment possible. Our ILTCM program recognizes the complex medical, psychological, and social issues which must be addressed for our members and we help coordinate the response to their needs and desires. Our model for LTC is driven by the unique needs of the member. Services and supports are integrated the fullest extent possible, including the coordinate of services and support not covered by Medicaid and community resources/referral networks.

**Case Management Role**
We will assign a case manager once a member enrolls in our plan. The case manager is your contact person. The case manager helps the member arrange their services. The case manager will contact the member within five (5) business days after they have joined our Plan. If the member lives in a nursing facility, the case manager will contact you and the member/representative within seven (7) business days after the member joins our Plan. The case manager and you or your representative will discuss which services are right for the member and will help choose a Provider for service deliverys.

**About this Provider Manual**
This Provider Manual serves as a resource and outlines operations for Aetna Better Health of Florida’s LTC Program. Through the Provider Manual, Providers should be able to obtain information on the majority of issues that may affect working with Aetna Better Health of Florida. Medical, dental, and other procedures are clearly denoted within the manual.

Aetna Better Health of Florida will update the Provider Manual at least annually and will distribute bulletins as needed to incorporate any changes. Please check our website at [www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida) for the most recent version of the Provider Manual and updates. The Aetna Better Health of Florida Provider Manual is available in hard copy or on CD-ROM at no charge by contacting our Provider Services department at 1-844-645-7371. For your convenience Aetna Better Health of Florida will make the Provider Manual available on our website at [www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida).

**CHAPTER 2: CONTACT INFORMATION**
Providers who have additional questions can refer to the following phone numbers:

<table>
<thead>
<tr>
<th>Important Contacts</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health of Florida</td>
<td>1-844-645-7371</td>
<td></td>
</tr>
<tr>
<td>Long Term Care Program</td>
<td>(follow the prompts in order to reach the appropriate departments)</td>
<td></td>
</tr>
<tr>
<td>1340 Concord Terrace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunrise, FL 33323</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Services department</td>
<td>1-844-645-7371</td>
<td>1-844-235-1340</td>
</tr>
<tr>
<td>Member Services department</td>
<td>1-844-645-7371</td>
<td>1-844-365-6502</td>
</tr>
<tr>
<td>Grievance and Appeals</td>
<td>1-844-645-7371</td>
<td>1-844-410-8655</td>
</tr>
<tr>
<td>Aetna Better Health of Florida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attn: LTC - Grievance &amp; Appeals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1340 Concord Terrace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunrise, FL 33323</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility Verifications</td>
<td><a href="http://www.aetnabetterhealth.com/florida">www.aetnabetterhealth.com/florida</a></td>
<td>N/A</td>
</tr>
<tr>
<td>Claims / CICR</td>
<td>1-844-645-7371 - prompt 2, then prompt 2 again</td>
<td>N/A</td>
</tr>
<tr>
<td>Case Management</td>
<td>1-844-645-7371</td>
<td></td>
</tr>
<tr>
<td>To report Fraud, Waste or Abuse:</td>
<td></td>
<td></td>
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<tr>
<td>Aetna Better Health of Florida Compliance Hotline</td>
<td>1-888-891-8910</td>
<td></td>
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<tr>
<td>Florida Medicaid Consumer Complaint Hotline</td>
<td></td>
<td></td>
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<tr>
<td>Agency for Health Care Administration</td>
<td>1-888-419-3456</td>
<td></td>
</tr>
<tr>
<td>Medicaid Program Integrity</td>
<td><a href="http://www.ahca.myflorida.com">www.ahca.myflorida.com</a></td>
<td></td>
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<tr>
<td>2727 Mahan Drive</td>
<td></td>
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<tr>
<td>MS #6</td>
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<tr>
<td>Tallahassee, FL 32308</td>
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<tr>
<td>Aetna Better Health of Florida Special Investigations Unit</td>
<td>1-844-806-7020</td>
<td></td>
</tr>
<tr>
<td>(SIU)</td>
<td>or 1-844-645-7371</td>
<td></td>
</tr>
<tr>
<td>Florida Attorney General</td>
<td>1-866-966-7226</td>
<td></td>
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<tr>
<td>Aging and Disability Resource Center</td>
<td>1-800-963-5337</td>
<td></td>
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<tr>
<td><a href="http://www.ElderAffairs.state.fl.us">www.ElderAffairs.state.fl.us</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida Department of Children and Families - ACCESS</td>
<td>1-866-762-2237</td>
<td>1-866-886-4342</td>
</tr>
<tr>
<td><a href="http://www.myflfamilies.com">www.myflfamilies.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida Department of Health (DOH)</td>
<td>1-850-245-4444</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.floridahealth.gov/">www.floridahealth.gov/</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To report abuse, neglect or exploitation of elder and disabled adults:</td>
<td></td>
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<tr>
<td>Florida Protective Services</td>
<td>1-800-96ABUSE or 1-800-962-2873</td>
<td></td>
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<tr>
<td>The National Domestic Violence Hotline</td>
<td>1-800-799-SAFE (7233)</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>Phone Number</td>
<td>Fax Number</td>
</tr>
<tr>
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</tr>
<tr>
<td>Dental: Managed Care of North America (MCNA) Dental</td>
<td>1-800-494-6262, TDD/TTY 1-800-955-8771 E-mail: <a href="mailto:contactus@mcna.net">contactus@mcna.net</a> <a href="http://www.mcnafl.net">www.mcnafl.net</a></td>
<td>N/A</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>1-844-645-7371 TTY 711</td>
<td>N/A</td>
</tr>
<tr>
<td>Hearing: Hear USA</td>
<td>1-800-731-3277 <a href="http://www.HearUSA.com">www.HearUSA.com</a></td>
<td>1-888-888-0099</td>
</tr>
<tr>
<td>Vision: Icare Health Solutions</td>
<td>1-855-373-7627</td>
<td>N/A</td>
</tr>
<tr>
<td>Non-Emergency Transportation: Logistarcare</td>
<td>1-866-799-4463</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment- DME:</td>
<td><a href="http://www.aetnabetterhealth.com/florida">www.aetnabetterhealth.com/florida</a></td>
<td>N/A</td>
</tr>
<tr>
<td>Emdeon Customer Service</td>
<td>1-800-845-6592</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Emergency Service Responsibilities**

Aetna Better Health of Florida has an emergency management plan that specifies what actions Aetna Better Health will take to ensure the ongoing provision of covered services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and attack-related...
emergencies. Aetna Better Health of Florida offers an after regular business hours provider services line that is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. This will not be construed to mean that the Provider must obtain verification before providing emergency services and care.

**Weather-related and emergency-related closings**

At times, emergencies such as severe weather, fires, or power failures can disrupt operations. In such instances, it is important Aetna Better Health of Florida be kept informed of your status. This is of real significance if you have an active authorization for a member. AHCA resources can be found at this link: [http://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml](http://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml)

**Emergency Status System** - Web-based system for reporting and tracking health care facility status before, during, and after an emergency [http://ahcaxnet.fdhc.state.fl.us/essweb/](http://ahcaxnet.fdhc.state.fl.us/essweb/).

You will need to register your facility. If you have an member and need assistance with this, please contact our Provider Relations department at **1-844-645-7371**.

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**CHAPTER 3: PROVIDER SERVICES DEPARTMENT**

**Provider Services Department overview**

Our Provider Services Department serves as a liaison between the Health Plan and the Provider community. Our staff is comprised of Provider Liaisons and Provider Service Representatives. Our Provider Liaisons conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Services Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Advise us of an address change
- View recent updates
- Locate forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- Submit a prior authorization
- 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

Any change in a Provider’s name, address, telephone number, or change of ownership, needs to be reported in writing immediately to Provider Relations.

Our Provider Services Department supports network development and contracting with multiple functions, including the evaluation of the Provider network and compliance with regulatory network capacity standards.
Our staff is responsible for the creation and development of provider communication materials, including the Provider Manual, periodic Provider Newsletters, Bulletins, Fax/Email blasts, website notices, and the Provider Orientation Kit.

Below are some time periods to note in regards to contracting:

- Applications must be completed within 180 days of Provider signature.
- If Letter of Agreement used, it will have an expiration date and need to be replaced by full application and agreement.
- Re-credentialing will occur every 3 years.
- Out of network or other authorizations are limited to the terms of the authorization.

Provider orientation
Aetna Better Health of Florida provides initial orientation for newly contracted providers within 30 days after they join our network. Orientation should occur prior to joining our network and before you see members. In follow up to initial orientation, Aetna Better Health of Florida 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 of Florida website navigation), distribution of periodic Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at [www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida).

Provider inquiries
Providers may contact us at [1-844-645-7371](tel:1-844-645-7371) between the hours of 8 a.m. and 7 p.m., Monday through Friday, or email us at [FLMedicaidProviderRelations@Aetna.com](mailto:FLMedicaidProviderRelations@Aetna.com) for all questions including checking on the status of an inquiry, complaint, grievance, and appeal. Our Provider Services staff will respond within 48 business hours.

Interested providers
If you are interested in applying for participation in our Aetna Better Health of Florida network, please visit our website at [www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida), and complete the provider application forms (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 Provider Services Department at [1-844-645-7371](tel:1-844-645-7371). To determine if Aetna Better Health of Florida is accepting new Providers in a specific region, please contact our Provider Services Department at the number located above.

If you would like to mail your application, please mail to:

Aetna Better Health of Florida  
Attention: Medicaid / LTC-Provider Services  
1340 Concord Terrace  
Sunrise, FL 33323

Please note this is for all medical service providers including (HCBS, LTC, Ancillary, Hospital etc.). Please contact MCNA if you are a dental provider and are interested in becoming part of their network.
CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

Provider responsibilities overview
This section outlines general provider responsibilities; however, additional responsibilities are included throughout the 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 FL LTC Program, your Provider Agreement, and requirements outlined in this manual. Aetna Better Health of Florida 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, the Agency for Health Care Administration (AHCA),; Department of Health (DOH), Medicaid Program Integrity Bureau (MPI), the Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of 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.

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 use of the most current diagnosis and treatment protocols and standards established by Agency for Health Care Administration (AHCA) and the medical community. 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).

Unique Identifier/National Provider Identifier
Providers who provide services to Aetna Better Health of Florida members must obtain identifiers. Each Provider is required to have a unique identifier, and qualified Providers much have a National Provider Identifier (NPI) on or after the compliance date established by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. You may apply for an NPI number online at https://nppes.cms.hhs.gov.

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. Providers are NOT reimbursed for services rendered to members who have lost eligibility.

Member eligibility can be verified through one of the following:

- **Telephone Verification**: Call our Member Services department at 1-844-645-7371. To protect member confidentiality, Providers are asked for at least three pieces of identifying information such as the members identification number, date of birth and address before any eligibility information can be released. Additional member eligibility requirements are noted in Chapter 08 of this manual.

- **Secure Web Portal**
The Secure Web Portal is a web-based platform that allows us to communicate member health care information directly with Providers. Providers can perform many functions within this web-based platform. The following information can be obtained from the Secure Web Portal:

- **Member Eligibility Search** – Verify current eligibility of one or more members.
- **Provider List** – Search for a specific Provider by name, specialty, or location.
- **Claims Status Search** – Search for Provider claims by member, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed.
- **Remittance Advice Search** – Search for Provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user’s account Provider ID will be displayed.
- **Provider Prior Authorization Look up Tool** – Search for Provider authorizations by member, Provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account Provider ID will be displayed. The tool will also allow Providers to:
  - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
  - Review Prior Authorization requirement by specific procedures or service groups
  - Receive immediate details as to whether the codes (s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
  - Export CPT/HCPCS code results and information to Excel
  - Verify staff is working with the most up-to-date information on current prior authorization requirements
- **Submit Authorizations** – Submit an authorization request on-line. Three types of authorization types are available:
  - Medical Inpatient
  - Outpatient
  - Durable Medical Equipment – Rental

- **Healthcare Effectiveness Data and Information Set (HEDIS)** – Check the status of the member’s compliance with any of the HEDIS measures. A “Yes” means the member has measures that they are not compliant; a “No” means that the member has met the requirements.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

**Educating members on their own health care**
Aetna Better Health of Florida 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 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 or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

**Specialty/long term care providers**
Specialty/long term care Providers are responsible for providing services in accordance with the accepted community standards of care and practices. The specialist/long term care provider is responsible for verifying member eligibility prior to providing services.

When a specialist/long term care Provider refers the member to a different specialist/long term care Provider, the original Provider must share the records, upon request, with the accepting provider or specialist/long term care Provider. The sharing of the documentation should occur at no cost to the member, other specialists/long term care Provider, or other Providers.

Referrals/direct access
Members may self-refer directly to access some services. These services include hearing care, vision care, and dental care. The member must obtain these self-referred services from an Aetna Better Health of Florida Provider.

Skilled Nursing Facility (SNF) providers
Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to members that need continuous care, but do not need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members.

For purposes of this section, the term “Direct Service Provider” means a person 18 years of age or older who, pursuant to a program to provide services to the elderly:
- Has direct, face-to-face contact with a client while providing services to the client or
- Has access to the client’s living areas or
- To the client’s funds or
- Personal property (which includes personal information)

This term includes coordinators, managers, and supervisors of residential facilities and volunteers.

Aetna Better Health of Florida has established and verified Provider credentialing and re-credentialing criteria that includes a determination of whether the Provider, or employee or volunteer of the Provider, meets the definition of “Direct Service Provider” and completion of a Level 2 criminal history background screening on each Direct Service Provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S. Any Provider, employee, or volunteer of the Provider meeting the definition of “Direct Service Provider” who has a disqualifying offense is prohibited from providing services to members.

No additional Level 2 screening is required if the individual is qualified for licensure or employment by AHCA pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.)
- Aetna Better Health of Florida must maintain a signed affidavit from each Provider attesting to its compliance with this requirement, or with the requirements of its licensing agency if the licensing agency requires Level 2 screening of Direct Service Providers.
- Aetna Better Health of Florida must include compliance with this requirement in its Provider contracts and subcontracts and verify compliance as part of its subcontractor and Provider monitoring activity.

Home and Community Based Services (HCBS)
Home and Community Based Providers are required to work with Aetna Better Health of Florida case managers. Case managers will complete face-to-face assessments with our members, in their residence, at least every 90 days. Based on the assessment, case managers will identify the appropriate services that meet the members functional needs, including determining which network Providers may be available to provide services to the member in a timely manner. The case managers will create authorizations for the selected Provider and fax/e-mail these authorizations accordingly. Case managers will also follow up with the member the day after services were to start to confirm that the selected Provider started the services as authorized.

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 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 40 hours of personal assistant per week over a 5-day period. The member is receiving 8 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 services 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 of Florida. Aetna Better Health of Florida will conduct periodic audits to verify this is not occurring.

**Home and Community Based Services (HCBS) in Assisted Living Facilities**

The OIG published this report in December 2012:

**HOME AND COMMUNITY-BASED SERVICES IN ASSISTED LIVING FACILITIES, OEI-09-08-00360**

OIG recommend that CMS issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver. CMS concurred with our recommendation. CMS has also published expectations regarding person-centered plans of care and to provide characteristics of settings that are not home and community-based to verify state compliance with the statutory provisions of section 1915(c) of the Act.

What this means for residential HCBS providers such as assisted living facilities is summarized as follows:

- A focus on quality of services provided
- An Individualized Person-Centered Care Plan
- A community integration goal planning process
- The right to receive home and community-based services in a home-like environment

As a result, Aetna Better Health of Florida may take interventions or remediation steps that the state would expect to see. Aetna Better Health of Florida will work with the Assisted Living Facilities (ALF) administrators
and staff to correct any identified deficiencies within a timeframe mandated by the state. The following are some examples of such interventions or remediation steps Aetna Better Health may implement upon discovery that an assisted living facility (ALF) is not maintaining a home-like environment:

- Aetna Better Health of Florida will not refer new Nursing Home Diversion members to the non-compliant ALF until outstanding deficiencies are resolved.
- Aetna Better Health of Florida will terminate from its network ALFs that consistently fail to exhibit home-like characteristics and that do not resolve outstanding issues.
- As a last resort, Aetna Better Health of Florida may counsel an member who is not residing in a home-like environment that he/she will not be able to continue to receive home and community-based waiver services in a non-compliant facility. If the individual wishes to remain in the ALF, he/she may face disenrollment.
- If Aetna Better Health of Florida terminates a contract with an ALF, and the member agrees to move to a different ALF, Aetna Better Health of Florida would facilitate transferring the member to an ALF that meets the home-like environment requirements.

Residential facility Providers agree to comply with the home-like environment and community integration language provided by the State. Such language is included in your provider agreement. All Providers must also comply with the applicable Resident Bill of Rights and attest to being in compliance as part of the monitoring and credentialing process. The verbatim wording used by Aetna Better Health of Florida in support of the Home and Community based Tool and the ALF and AFCH provider agreements is as follows:

Assisted Living Facilities (ALF) and Adult Family Care Homes (AFCH) must maintain Home-Like Environment (HLE) (also known as Home and Community Based or HCB) characteristics according to mandates. Notwithstanding anything to the contrary in this agreement, the following will apply.

Additionally, waiver member residing in ALFs and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:
- Private or semi-private rooms
- Roommate for semi-private rooms
- Locking door to living unit
- Access to telephone and unlimited length of use
- Eating schedule
- Activities schedule
- Participation in facility and community activities

Ability to have:
- Unrestricted visitations
- Snack as desired

Ability to:
- Prepare snacks as desired; and
- Maintain personal sleeping schedule
Home delivered nutrition program providers

All home delivered nutrition programs Providers must verify compliance with Florida Standards for the Home Delivered Meals program otherwise known as “Meals On Wheels”. All food handling must comply with s. 381.0072 F.S., “Food Service Protection”. Additionally, the State Department of Health, AHCA, Department of Business and Professional Regulation, the Department of Agriculture and Consumer Services and the Department of Children and Families personnel will conduct routine unannounced operational inspections of all caterers, kitchens, and sites involved in the program annually or as often as deemed necessary. Follow-up inspections are conducted and legal action may be initiated when conditions warrant.

Note – Home and Community Based Services (HCBS) providers may not submit claims when the member has been admitted to a hospital or nursing home. The day of admission or discharge is allowed, but the days in between are not. Providers submitting claims for the days in between may be subject to Corrective Action Plan (CAP).

Out-of-network providers

When a member with a special need or service is not able to obtain services through a contracted Provider in a nearby location, Aetna Better Health of Florida 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 Aetna Better Health of Florida’s medical transportation Provider. 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.

Provider requested member transfer

When persistent problems prevent an effective Provider-patient relationship, a participating Provider may ask a Aetna Better Health of Florida member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law. The following steps must be taken when requesting a specific Provider-patient relationship termination:

1. The Provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:

   Aetna Better Health of Florida
   Attn: Medicaid/ LTC-Provider Services Manager
   1340 Concord Terrace
   Sunrise, FL 33323

2. The Provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.

3. Upon request, the Provider will provide resources or recommendations to the member to help locate another participating Provider and offer to transfer records to the new Provider upon receipt of a signed patient authorization.
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.

Medical records review
Below is a list of Aetna Better Health of Florida medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health of Florida 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 of Florida 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
• 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 (recommended for adult members if available)
• Dental history if available, and current dental needs and services
• 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.)
• 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 dental and 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.)
• Reports from referrals, consultations and specialists
• 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 of Florida
  2. Prior admissions as necessary
• Documentation as to whether or not an adult member has completed advance directives and location of the document (Florida advance directives include Living Will, Health Care Power Of Attorney or Health Care Surrogate, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
• Documentation related to requests for release of information and subsequent releases, and
• Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the member’s 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 countersign 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 clinical reviewer

Medical record audits
Aetna Better Health of Florida or AHCA may conduct routine medical record audits to assess compliance with established standards. 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 30 days of request. Medical records must be made available to AHCA 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 members or their contract with Aetna Better Health of Florida for inspection, evaluation, and audit for the longer of:
  • A period of five years from the date of service; or
  • Three years after final payment is made under the Provider’s agreement and all pending matters are closed.

Confidentiality and accuracy of member records
Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a Aetna Better Health of Florida 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.

Provider must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations. (www.hhs.gov/ocr/privacy/).

**Health Insurance Portability and Accountability Act of 1997 (HIPAA)**
The Health Insurance Portability and Accountability Act of 1997 (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, please visit www.hhs.gov/ocr/hipaa/. 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
• Consider the patient sign-n sheet
• 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:
  o The individual’s past, present or future physical or mental health, or condition.
  o The provision of health care to the individual
  o 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.
  o Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
  o 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 of Florida.
  o 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 the following site at http://aspe.hhs.gov/admnsimp/final/pvguide1.htm

Member privacy rights
Aetna Better Health of Florida’s 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 of Florida 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 of Florida’s 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 of Florida in writing.

Cultural competency
Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand 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 to pay or ability to speak English. Aetna Better Health of Florida 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 on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health of Florida has developed a Cultural Competency Plan (CCP) to ensure that members receive care that is delivered in a culturally and linguistically sensitive manner. The CCP is comprehensive and incorporates all members, employees and Providers. The Health Plan recognizes that respecting the diversity of our members has a significant and positive effect on outcomes of care and have adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards, as developed by the Department of Health and Human Services, Office of Minority Health, as guidelines for providing culturally and linguistically competent services. These 15 standards are organized by themes:

- Principle Standard (Standard 1)
- Governance, Leadership, and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement and Accountability (Standards 9-15)

The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that may experience unequal access to health services.

Aetna Better Health of Florida 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

Our Provider Service Representatives will conduct initial cultural competency training during provider orientation meetings. The Quality Interactions® course series is designed to help you:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
• Work with your patients to help obtain better health outcomes

To access the online cultural competency course, please visit:
www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health of Florida supports the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between members and providers.

If you have any questions or would like to request a free copy of the Health Plan’s Cultural Competency Plan please contact a Member Service representative at 1-800-441-5501.

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 of Florida 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
• The homeless
• Individuals with physical and mental disabilities

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 of Florida makes its telephonic 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 of Florida Member Services Representatives will assist the member via a three-way call to communicate in the member’s native language.
• For outgoing calls, Member Services Staff dial the language interpretation service and use an Interactive voice response system to conference with a member and the interpreter.
• For face-to-face meetings, Aetna Better Health of Florida staff (e.g., case managers) can conference in an interpreter to communicate with a member in his or her home or another location.
• When Providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of Florida to link with an interpreter.
Aetna Better Health of Florida provides alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. 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 of Florida offers sign language and over-the-phone interpreter services at no cost to the Provider or member. Please contact Aetna Better Health of Florida at 1-844-645-7371 for more information on how to schedule these services in advance of an appointment.

**Interpretation services**

Telephone interpretive services are provided at no cost to 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 Aetna Better Health of Florida’s Member Services Department at 1-844-645-7371.

**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.

**Clinical guidelines**

Aetna Better Health of Florida has clinical guidelines and treatment protocols available to providers to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member;
- Constitute procedures for or the practice of medicine by the party distributing the guidelines; or,
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Guidelines are available on our website at [www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida).

**Staff/administration changes and training**

Providers are responsible to notify our Provider Services Department on any changes in professional staff at their locations (physicians/medical director, physician assistants, or clinician practitioners). Administrative
changes in office staff may result in the need for additional training. Contact our Provider Services Department to schedule staff training.

**Continuity of care**
Providers terminating their contracts without cause are required to provide a 60 day notice before terminating with Aetna Better Health of Florida. Provider 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 of Florida is not responsible for payment of services rendered to members who are not eligible. You may also contact our Case Management Department for assistance.

**Credentialing/Re-credentialing**
Aetna Better Health of Florida uses current NCQA standards and guidelines for the review, credentialing, and re-credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America’s leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers’ most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows Providers to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans designated by the Providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the Provider for the same standard information. Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. The CAQH gathers and stores detailed data from more than 600,000 providers nationwide. All new Providers, (with the exception of hospital based providers) joining Aetna Better Health of Florida, must complete the credentialing process and be approved by the Credentialing Committee.

Aetna Better Health of Florida is authorized to take whatever steps are necessary to ensure that the Provider is recognized by the Agency and its agent(s) as a participating provider of Aetna Better Health of Florida and that the provider’s submission of encounter data is accepted by the Agency;

A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating Providers not currently enrolled in Medicaid’s fee-for-service program, in accordance with the following:

- Aetna Better Health of Florida will verify Providers not currently enrolled in Medicaid’s fee-for-service program submit fingerprints electronically following the process described on the Agency’s Background Screening website. Aetna Better Health of Florida will verify Medicaid eligibility through the background screening system.
- Aetna Better Health of Florida will not contract with any Provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.
• Individuals already screened as Medicaid Providers or screened within the past 12 months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but will document the results of the previous screening

• Individuals listed in s. 409.907(8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency’s background screening website

http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/index.shtml

Aetna Better Health of Florida has established and verified additional Provider credentialing and re-credentialing criteria with respect to the applicable SMMC program as follows:

1. Aetna Better Health of Florida will verify the additional criteria specified in the LTC Exhibit.
2. Aetna Better Health of Florida will verify the additional criteria specified in the LTC Exhibit for LTC Providers.

Providers are re-credentialed every three (3) years and must complete the required reappointment application. Updates on malpractice coverage and state medical licenses are also required (where applicable). Please note you may NOT treat members until you are credentialed. Providers must also be board certified where applicable.

Aetna Better Health of Florida 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.

HCBS waiver members residing in assisted living facilities and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

• Private or semi-private rooms
• Roommate for semi-private rooms
• Locking door to living unit
• Access to telephone and unlimited length of use
• Eating schedule
• Activities schedule
• Participation in facility and community activities

Ability to have:

• Unrestricted visitation
• Snacks as desired

Ability to:

• Prepare snacks as desired
• Maintain personal sleeping schedule

Licensure and accreditation
Health delivery organizations such as skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually 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 on the basis of 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 of Florida. 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 of Florida, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health of Florida 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’s 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’s responsibility to pay the full cost of the services
- Agreeing that when referring a member to another Provider for a non-covered service must verify that the member is aware of his or her obligation to pay in full for such non-covered services.

**Monitoring gaps**
A gap in care is the difference between the number of hours scheduled in a member’s plan of care and the hours that are actually delivered to that member on any given day.

Aetna Better Health of Florida contractually requires that all Providers, both self-directed and agency Providers submit a non-provision of service log monthly, which identifies every time service is not provided as scheduled. This log may be submitted through our on-line portal system at any time, or may be faxed to the Long Term Care (LTC) Case Management department. Each Provider of essential HCBS is required to submit by the fifth business day of the current month a report identifying all occurrences of non-provision of service for the previous month. This includes any Provider working under a participant direction entity. Providers are educated on this process when they contract with the Plan, and re-education occurs as the need arises.
Any gap in care reported to the LTC Case Manager will be documented in the web-based case management application. A member may file a grievance for any gap in care. Upon learning of any reported gap in care, the LTC Case Manager immediately contacts the member, acknowledges the gap, works with the Provider, and provides detailed explanation to the member regarding the reason for the gap. Most importantly, the LTC Case Manager then works with the Provider or if necessary, another Provider to resolve the gap and allow the member’s immediate needs to be met to address the member’s safety.

All non-provision of service gap report documents are provided to the Director of LTC or their designee. These logs include the county code for the Provider, the service type, the member preference level at the time of the occurrence and the member preference level as determined by the last documented Case Manager event, the reason the gap occurred, and the resolution. The gap report identifies the original hours authorized, the hours provided to resolve the gap and the length of time before services were provided. The log also identifies if the member preference level was met and why and if the total authorized services were replaced and why. If unpaid caregivers are used to fill the gap, that information is collected as well. Upon receiving the non-provision of service log, the Director of LTC or their designee reviews the reports and identifies if the gaps are true gaps or if the non-provision was not a true gap due to the fact that:

- The member was not available to receive the service when the caregiver arrived at the member’s home at the scheduled time
- The member refused the caregiver when she/he arrived at the member’s home, unless the caregiver’s ability to accomplish the assigned duties was significantly impaired by the caregiver’s condition or state (for example drug and alcohol intoxication on the part of the caregiver)
- The member refused service
- The member and regular caregiver agreed in advance to reschedule all or part of a scheduled service.

All non-provision of service gaps and true gaps are reported to the LTC Case Manager so that they can be entered into the web-based case management application.

All non-provision of service logs are reviewed and split between non-provision of service and true gaps. They are tracked, aggregated, reviewed, analyzed, and trended quarterly for presentation to the Director of LTC or their designee, Quality Management Committee and the Compliance Department. The number and types of gaps, Providers, and Provider types are reviewed to identify any patterns of non-provision of services. Each month, the total number of number of service gap hours are calculated along with the total percentage of gaps hours per member per month and compared with the previous month.

Information is looked at in aggregate and by Provider agency. For example, if a particular agency is found to have re-occurring gaps, a recommendation would be made for the Provider Services Department to work with that agency to identify strategies to reduce the occurrence of gaps. Continued high numbers of gaps in service would require a corrective action plan to be put in place for that agency. Provider services will also intervene if a case manager has reported gaps in care that were not reported by the servicing Provider. This is a contract compliance issue and a corrective action plan will be required.

Network management may be involved if gaps in care are occurring in certain areas or for a certain service as it may mean that additional contracted providers are necessary to meet the needs of the member population. In this case, the Network Department would be requested to identify and contract with additional services providers to allow the members improved access to care that can meet their needs.
Should gaps in care result in a quality of care concern, the information will be reported to our Quality Management Department who will investigate the gap and determine if a corrective action plan is necessary or if there is additional action that must be taken. The Quality Management Department will be involved if it is identified that a particular gap resulted in a critical incident or if a particular worker or agency was frequently causing gaps. In these types of cases, the Quality Department may work with the service Provider agency to further investigate and take appropriate action. This action may include reporting the Provider to the state, implementing a corrective action plan, or recommending contract termination. The Credentialing Department reviews Provider history in the gap in care process as a part of the credentialing or re-credentialing process. All critical incidents are tracked and trended and are a part of the credentialing file. In addition, as part of the standard credentialing process, the Credentialing Department utilizes the Office of the Inspector General Sanction Practitioners list to identify any providers that have been sanctioned or barred from providing Medicare and Medicaid services.

Requirements regarding community outreach activities and marketing prohibitions
In accordance with the following regulatory requirements, Providers are not authorized to send referrals to Comprehensive Assessment and Review for Long Term Care Services (CARES) offices.

1. In accordance with 42 CFR 438.104(b)(1)(iv), the contractor and its subcontractors will not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
2. In accordance with 42 CFR 438.104 (b) (1) (v), the contractor and its subcontractors will not, directly or indirectly, engage in door-to-door, telephone, or other cold-calling marketing activities.
3. In accordance with 42 CFR 438.104 (b)(2)(i), the contractor and its subcontractors will not, directly make any assertion or statement (whether written or oral) that the beneficiary must enroll with the contractor in order to obtain (Medicaid State Plan benefits) or in order to not lose benefits (Medicaid State Plan benefits).
4. In accordance with s. 409.912(21) (B), F.S., and 42 CFR 438.104 (b) (2) (ii), the contractor and its subcontractors will not make any inaccurate false or misleading claims that the contractor is recommended or endorsed by any federal, state or county government, the Agency, CMS, department, or any other organization which has not certified its endorsement in writing to the contractor.

Community outreach and marketing
General provisions

A. Aetna Better Health of Florida’s Community Outreach Representative(s) may provide community outreach materials at health fairs/public events as noticed by Aetna Better Health of Florida to the Agency in accordance with sub-item 4, Community Outreach Notification Process, below. The main purpose of a health fair/public event will be to provide community outreach and will not be for Aetna Better Health of Florida marketing.

B. For each new contract period, Aetna Better Health of Florida will submit to the Agency for written approval all community outreach material no later than 60 calendar days before the start of the next contract period, and, for any changes in the community outreach material, no later than 30 calendar days before implementation. All materials developed will be governed by the requirements set forth in this section.

C. To announce participation at a specific event (health fair/public event), Aetna Better Health of Florida will submit a notice to the Agency in accordance with AHCA permitted Activities.
D. Aetna Better Health of Florida will be responsible for developing and implementing a written plan designed to control the actions of its community outreach representatives.

E. All community outreach policies set forth in the SMMC contract will apply to staff, subcontractors, Aetna Better Health of Florida volunteers, and all persons acting for, or on behalf of, Aetna Better Health of Florida.

F. Aetna Better Health of Florida is vicariously liable for any outreach and marketing violations of its employees, agents or subcontractors. In addition to any other sanctions available in Attachment II, Section 1XI, Sanctions and Exhibit B, Section XI, Sanction [of the SMMC contract], any violations of this section will subject Aetna Better Health of Florida to administrative action by the Agency as determined by the Agency. Aetna Better Health of Florida may dispute any such administrative action pursuant to Attachment II, Section XII, Terms and Conditions, Item I., Disputes and Exhibit B, Section XII, Terms and Conditions [of the SMMC contract].

G. Nothing in this section will preclude the Aetna Better Health of Florida from donating to or sponsoring an event with a community organization where time, money, or expertise is provided for the benefit of the community. If such events are not health fairs/public events, no community outreach materials or marketing materials will be distributed by Aetna Better Health of Florida, but Aetna Better Health of Florida may engage in brand-awareness activities, including the display of Aetna Better Health of Florida or product logos. Inquiries at such events from prospective members must be referred to Aetna Better Health of Florida’s member services section or the Agency’s enrollment broker.

Prohibited activities

Aetna Better Health of Florida is prohibited from engaging in the following non-exclusive list of activities:

A. Marketing for enrollment to any potential members or conducting any pre-enrollment activities not expressly allowed under the SMMC contract;

B. Any of the prohibited practices or activities listed in s. 409.912, F.S.;

C. Engaging in activities not expressly allowed under the SMMC contract for the purpose of recruitment or enrollment;

D. Practices that are discriminatory, including, but not limited to, attempts to discourage enrollment or re-enrollment on the basis of actual or perceived health status, in accordance with ss. 409.912 and 409.91211, F.S.;

E. Direct or indirect cold call marketing or other solicitation of Medicaid applicants and recipients, either by door-to-door, telephone or other means, in accordance with Section 4707 of the Balanced Budget Act of 1997 and s. 409.912, F.S.;

F. Activities that could mislead or confuse Medicaid recipients or misrepresent Aetna Better Health of Florida, its community outreach representatives or the Agency, in accordance with s. 409.912, F.S. No fraudulent, misleading, or misrepresentative information will be used in community outreach, including
information about other government programs. Statements that could mislead or confuse include, but are not limited to, any assertion, statement or claim (whether written or oral) that:

a. The Medicaid recipient must enroll in Aetna Better Health of Florida to obtain Medicaid or to avoid losing Medicaid benefits;
b. Aetna Better Health of Florida is endorsed by any federal, state or county government, the Agency, CMS or any other organization that has not certified its endorsement in writing to Aetna Better Health of Florida;
c. Community outreach representatives are employees or representatives of the federal, state:
d. The state or county recommends that a Medicaid recipient enroll with Aetna Better Health of Florida; and
e. A Medicaid recipient will lose benefits under the Medicaid program or any other health or welfare benefits to which the person is legally entitled if the recipient does not enroll with Aetna Better Health of Florida.

G. Granting or offering any monetary or other valuable consideration for enrollment;

H. Offering insurance, such as, but not limited to, accidental death, dismemberment, disability or life insurance;

I. Enlisting assistance of any employee, officer, elected official or agency of the state in recruitment of Medicaid recipients except as authorized in writing by the Agency;

J. Offering material or financial gain to any persons soliciting, referring, or otherwise facilitating Medicaid recipient enrollment. Aetna Better Health of Florida will verify that its staff do not market Aetna Better Health of Florida to Medicaid recipients at any location including state offices or DCF ACCESS center;

K. Giving away promotional items in excess of $5 retail value. Items to be given away will bear Aetna Better Health of Florida’s name and will be given away only at health fairs/public events. In addition, such promotional items must be offered to the general public and will not be limited to Medicaid recipients;

L. Providing any gift, commission or any form of compensation to the enrollment broker, including its full-time, part-time or temporary employees and subcontractors;

M. Discussing, explaining or speaking to a potential member about Aetna Better Health of Florida-specific information other than to refer all Aetna Better Health of Florida inquiries to the member services section of Aetna Better Health of Florida or the Agency’s enrollment broker;

N. Distributing any community outreach materials without prior written notice to the Agency except as otherwise allowed under Permitted Activities and Provider Compliance subsections of the SMMC contract;

O. Distributing any marketing materials not expressly allowed under the SMMC contract;

P. Subcontracting with any brokerage firm or independent agent as defined in Chapters 624-651, F.S., for purposes of marketing or community outreach;
Q. Paying commission compensation to community outreach representatives for new members. The payment of a bonus to a community outreach representative will not be considered a commission if such bonus is not related to enrollment or membership growth; and

R. All activities included in s. 641.3903, F.S.

**Permitted activities**

Aetna Better Health of Florida may engage in the following activities upon prior written notice to the Agency:

A. Aetna Better Health of Florida may attend health fairs/public events upon request by the sponsor and after written notification to the Agency as described in sub-item 4, Community Outreach Notification Process, below.

B. Aetna Better Health of Florida may leave community outreach materials at health fairs/public events at which Aetna Better Health of Florida participates.

C. Aetna Better Health of Florida may provide Agency-approved community outreach materials. Such materials may include Medicaid enrollment and eligibility information and information related to other health care projects and health, welfare and social services provided by the State of Florida or local communities. Aetna Better Health of Florida staff, including Community Outreach Representatives, will refer all Aetna Better Health of Florida inquiries to the member services section of Aetna Better Health of Florida or the Agency’s enrollment broker. Agency approval of the script used by Aetna Better Health of Florida’s member services section must be obtained before usage.

D. Aetna Better Health of Florida may distribute community outreach materials to community agencies.

**Provider compliance**

Aetna Better Health of Florida will verify, through Provider education and outreach, that its health care Providers are aware of and comply with the following requirements:

A. Health care Providers may display Aetna Better Health of Florida-specific materials in their own offices.

B. Health care Providers cannot orally or in writing compare benefits or Provider networks among Aetna Better Health of Florida, other than to confirm whether they participate in Aetna Better Health of Florida’s network.

C. Health care Providers may announce a new affiliation with Aetna Better Health of Florida and give their patients a list of managed care plans with which they contract.

D. Health care Providers may co-sponsor events, such as health fairs and advertise with Aetna Better Health of Florida in indirect ways; such as television, radio, posters, fliers, and print advertisement.

E. Health care Providers will not furnish lists of their Medicaid patients to Aetna Better Health of Florida, or any other entity, nor can Providers furnish other Managed Care Plans’ membership lists to Aetna Better Health of Florida, nor can Providers assist with Managed Care Plan enrollment.

F. For Aetna Better Health of Florida, health care Providers may distribute information about non-Managed Care Plan-specific health care services and the provision of health, welfare and social services
by the State of Florida or local communities, as long as any inquiries from prospective members are referred to the member services section of Aetna Better Health of Florida or the Agency’s enrollment broker.

Community outreach representatives
Aetna Better Health of Florida will register each Community Outreach Representative that represents the Aetna Better Health of Florida with the Agency as specified below.

A. Aetna Better Health of Florida will submit its registration file to the Agency in accordance with the MMA or LTC Report Guide (as applicable). The Agency-supplied template must be used as specified in Attachment II, Section XIV, Reporting Requirements, Exhibit B, Section XIV, Reporting Requirements and in the MMA or LTC Report Guide (as applicable).

B. Aetna Better Health of Florida will submit changes to the Community Outreach Representative’s initial registration to the Agency, using the same Agency-supplied template, immediately upon occurrence.

   a. While attending health fairs/public events, community outreach Aetna Better Health of Florida representatives will wear picture identification that shows they represent Aetna Better Health of Florida.

   b. If asked, the Community Outreach Representative will inform the Medicaid recipient that the representative is not a state employee and is not an enrollment specialist but is a representative of Aetna Better Health of Florida.

   c. Aetna Better Health of Florida will instruct and provide initial and periodic training to its Community Outreach Representative about the outreach and marketing provisions in the SMMC contract.

   d. Aetna Better Health of Florida will implement procedures for background and reference checks for use in hiring Community Outreach Representatives.

   e. Aetna Better Health of Florida will report to the Agency any Aetna Better Health of Florida staff or Community Outreach Representative who violates any requirements of the SMMC contract within 15 calendar days of knowledge of such violation.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

The Agency for Health Care Administration (AHCA) administers the benefits for recipients of the FL LTC program.

The tables on the next few pages show what services Aetna Better Health of Florida covers. All services must be medically necessary and the Provider may have to ask for a prior approval before some services can be provided.

 Covered Services

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<td>Adult Companion Care</td>
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<td>Adult Day Health Care</td>
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<td>Assistive Care Services</td>
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<td>Behavioral Management</td>
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<td>Caregiver Training</td>
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<td>Care Coordination / Case Management</td>
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<td>Home Accessibility Adaptation Services</td>
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<td>Home Delivered Meals</td>
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<td>Homemaker Services</td>
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<td>Hospice</td>
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<tr>
<td>Intermittent and Skilled Nursing</td>
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<td>Medical Equipment and Supplies</td>
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<td>Medication Administration</td>
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<tr>
<td>Medication Management</td>
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<tr>
<td>Nutritional Assessment / Risk Reduction Services</td>
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<td>Nursing Facility Services</td>
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<td>Personal Care</td>
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<td>Personal Emergency Response Systems (PERS)</td>
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<td>Respite Care</td>
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<td>Occupational Therapy</td>
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<td>Physical Therapy</td>
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<td>Respiratory Therapy</td>
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<td>Cellular Phone Services</td>
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<td>Dental Services</td>
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<td>Emergency Financial Assistance</td>
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<td>Hearing Evaluation</td>
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<tr>
<td>Over-the-Counter (OTC) Medication / Supplies</td>
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<tr>
<td>Support to Transition out of a nursing</td>
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<tr>
<td>Vision Services</td>
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<tr>
<td>Emergency Meal Supply</td>
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<td>Pill Organizer</td>
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Excluded services
If Aetna Better Health of Florida does not cover a service a member needs but Medicaid does, the member can get those services through other Medicaid programs. This includes the Fee-For-Service Medicaid system. The members’ Case Manager can help the member arrange these services based on the members’ need. If additional help is needed, you and the member can reach out to the local AHCA office or the Aging and Disability Resource Center. The members’ Case Manager will inform you and the member about possible costs the member may have to pay.

Non-covered services
Aetna Better Health of Florida does not cover certain services except for urgent care outside of the service area or for emergency care anywhere. In addition, Aetna Better Health of Florida does not cover:

- Acupuncture
- Health services not authorized by Aetna Better Health of Florida
- Chiropractic services, except for manual manipulation for subluxation of the spine when demonstrated by X-ray
- Christian Science practitioners’ services
- Cosmetic surgery: Services in connection with cosmetic surgery: cosmetic surgery (plastic and reconstructive), and any other service and supply to improve the covered persons appearance or perception, but it not expected to significantly restore normal bodily functions, including, not limited to, mammary reduction or augmentation, face lifts, cleft lip, cleft palate, varicose veins, correction of baldness; includes the diagnosis or treatment which arises as a complication of a non-covered cosmetic surgery
- Experimental and investigational procedures and items which are items and procedures determined by Medicaid not to be generally accepted by the medical community

Quality enhancement services
- In addition to the covered, excluded, and non-covered services specified above, Aetna Better Health of Florida will offer and coordinate access to quality enhancements (QEs). Aetna Better Health of Florida is not offering these services as expanded benefits. Aetna Better Health of Florida is required to offer QEs as follows: Aetna Better Health of Florida has written policies and procedures to implement QEs.
- Aetna Better Health of Florida will offer QEs in community settings accessible to members
- Aetna Better Health of Florida will actively collaborate with community agencies and organizations
- If Aetna Better Health of Florida involves the member in an existing community program for purposes of meeting the QE requirements, Aetna Better Health will verify documentation in the member’s medical/case record of referrals to the community program and follow up on the member’s receipt of services from the community program.

Aetna Better Health of Florida will offer quality enhancements (QE) to members as specified below:
- Safety concerns in the house and fall prevention
- End of life issues, including information on advanced directives; and
- Ensuring that Case Managers and Providers screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies
- If Aetna Better Health of Florida involves the member in an existing community program for purposes of meeting the QE requirements, Aetna Better Health will verify documentation in the member’s medical/case record and follow up on the member’s receipt of services from the community program.
Medical necessity
Services provided in accordance with 42 C.F.R. 438.210 (a)(4) and as defined in Section 59G-1.010(166), F.A.C., to include those medical or allied care, goods, or services furnished or ordered must:

a. Meet the following conditions:
   1. Be necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;
   2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs;
   3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
   4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
   5. Be furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or Provider;
   6. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type;
   7. “Medically Necessary” or “Medical Necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

b. The fact that Provider prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a Covered Service.

You can view a current list of the services that require authorization on our website at www.aetnabetterhealth.com/florida. If you are not already registered for the secure web portal, download an application from the Florida 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 Services Department at 1-844-645-7371.

Interpretation services
Telephone interpretive services are provided at no cost to 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 Aetna Better Health of Florida’s Member Services department at 1-844-645-7371.

Availability
Providers shall offer appointments and access to members within the following guidelines:
- Routine care: within 7 days
- Routine preventive care: within 30 days
- Symptomatic care/non-urgent acute complaint (e.g., sore throat): within 3 days
- Urgent complaint: Same day or within 24 hours

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES
Aetna Better Health of Florida is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, Providers, and members each year.

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 of Florida requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member’s rights and responsibilities is important because you can help members to better understand their role in and improve their adherence with treatment plans.

It is Aetna Better Health of Florida’s policy not to discriminate against members based on race, color, 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.

In the event that Aetna Better Health of Florida is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of Florida will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

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

Members have the following rights and responsibilities:

**Member Rights**

Aetna Better Health of Florida members, their families and guardians have the right to information related to their treatment or treatment options in a manner and language appropriate to the member’s condition and ability to understand. This includes, but is not limited to:

- the right to have their privacy protected
- the right to receive a prompt and reasonable response to questions and requests
- the right to know who is providing services to them
- the right to know the services that are available, including an interpreter if they don’t speak English
- the right to know the rules and regulations about their conduct
- the right to be given information about their health
- the right to get service from out-of-network providers for emergency services
- the right to be given information and counseling on the financial resources for their care
- the right to know if the provider or facility accepts the assignment rate
- the right to receive an estimate of charges for their care
- the right to receive a bill and to have the charges explained
- the right to be treated regardless of race, national origin, religion, handicap, or source of payment
- the right to be treated in an emergency
- the right to know if medical treatment is for purposes of experimental research and to give their consent or refusal to participate in such research
- the right to file a grievance if you think their rights have been violated
- the right to information about our doctors
- the right to be treated with respect and with due consideration for their dignity and privacy
• the right to receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand
• the right to participate in decisions regarding their health care, including the right to refuse treatment
• the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
• the right to request and receive a copy of their medical records and request that they be amended or corrected
• the right to be furnished health care services in accordance with federal and state regulations
• the freedom to exercise their rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat them
• the right to make a complaint about the health plan or the care it provides
• the right to file a grievance about any matter other than an adverse benefit determination
• the right to appeal a decision the health plan makes
• the right to make a recommendation regarding the health plan’s member rights and responsibilities

Member Responsibilities
Aetna Better Health of Florida members, their families, or guardians are responsible for:
• providing accurate and complete information about their health
• giving their case manager the information needed to assist them in getting the services they need
• helping their case manager develop a care plan that will best meet their needs
• reporting unexpected changes in their condition or needs for services
• reporting that they understand their care and what is expected of them
• contacting their case manager before they arrange for services from providers
• using LTC providers, such as home health agencies, homemaker services, assisted living facilities or skilled nursing facilities listed in the LTC Provider Directory
• presenting their Aetna Better Health ID card when seeking services from network providers
• following the treatment plan recommended
• keeping appointments
• following your provider’s instructions and advice
• making sure your health care bills are paid
• following health care facility rules and regulations
• letting us know if you decide to disenroll from the LTC program

For questions or concerns, please contact our Provider Services Department at 1-844-645-7371.

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 organizations that 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 opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, 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 one’s self, 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 with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, on the basis of 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: ELIGIBILITY AND ENROLLMENT

Eligibility
To become a member with Aetna Better Health of Florida, a member must first be eligible for the Florida Medicaid and LTC Programs. Benefits are predetermined by the State of Florida and not Aetna Better Health of Florida. The Agency for Health Care Administration (AHCA) must approve a member’s enrollment with Aetna Better Health of Florida. A member’s coverage with us starts on the first day of the month after the member receives approval from AHCA that their enrollment was accepted.

To be eligible for Florida Medicaid, a person must:

- Be a resident of Florida
- Be a U.S. Citizen
- Meet specific standards for financial income and resources

In addition, a person must qualify for the Florida LTC Program by meeting a nursing home level of care need as determined by CARES.

Our members
Our members may include the following groups:

- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI) — Aged, Blind and Disabled (ABD) and related groups
- Institutional Care
- Hospice
- Aged / Disabled Adult waiver
- Individuals who age out of Children’s Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:
  - Received care from Children’s Medical Services prior to turning 21
  - Age 21 and older
- Cognitively intact
- Medically complex
- Technologically dependent

- Assisted Living waiver
- Nursing Home Diversion waiver
- Channeling waiver
- Low Income Families and Children
- MEDS (SOBRA) for children born after 9/30/1980 (age 18 – 20)
- MEDS AD (SOBRA) for aged and disabled
- Protected Medicaid (aged and disabled)
- Full Benefit Dual Eligibles (Medicare and Medicaid)
- Individuals enrolled in the Frail / Elderly Program component of United Healthcare HMO
- Medicaid Pending for Long-term case Managed Care HCBS waiver services

Open Enrollment
Members have the option to change health plans during the initial 90 days after the effective date of enrollment (the member’s anniversary date). Thereafter, members can change Health Plans annually during open enrollment, in which they will have a 60-day period to change Health Plans. The Agency will send members a notice of their option to change Health Plans and the associated deadline. Enrollment in a new Health Plan will be effective on the member’s anniversary date.

Disenrollment
Member may dis-enroll from Aetna Better Health of Florida at any time during the first 120 days of enrollment. After the first one hundred and twenty (120) days, the member is “locked in” as a Aetna Better Health of Florida member unless there is good cause to dis-enroll. AHCA will decide if the member has good cause.

ID Card
Members should present their Aetna Better Health of Florida ID card at the time of service. Please note that some members may still carry a Medicaid card for those services not covered under Aetna Better Health of Florida. In addition, some members may have Medicare coverage and will receive a separate Medicare ID card from the Centers of Medicare and Medicaid (CMS). This is often referred to as a red, white, and blue card. If the member has Original Medicare, they will use the Aetna Better Health of Florida ID card instead in order to receive services. They will NOT use their Medicare card.

The member ID card contains the following information:
- Member Name
- Member ID Number
- Date of Birth of Member
- Member’s Gender
- Effective Date of Eligibility
- Claims address
- Emergency Contact Information for Member
- Health Plan Name - Aetna Better Health of Florida
- Aetna Better Health of Florida Logo
- Aetna Better Health of Florida’s Website
- Carrier Group Number

Sample ID Card
Front:
Verifying eligibility
Presentation of an Aetna Better Health of Florida ID card is not a guarantee of eligibility. The Provider is responsible for verifying a member’s current enrollment status before providing care. Aetna Better Health of Florida will not reimburse for services provided to patients who are not enrolled with Aetna Better Health of Florida. Providers can verify member eligibility by calling the Member Services department at 1-844-645-7371, or online through the Secure Web Portal at www.aetnabetterhealth.com/florida.

CHAPTER 9: MEMBERS WITH SPECIAL NEEDS

Members with Special Needs
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, and developmental disabilities. Members may be identified as having special needs because they are homeless.

Aetna Better Health of Florida developed methods for:
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
Diagnostic and intervention strategies to address the specific special needs of these members

- Coordination and approval of home therapies and home care services when indicated
- Case management for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so that long-term complications may be treated as necessary
- Case management systems to verify that children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers for diagnosis and treatment of rare disorders

The Comprehensive Assessment and Review for Long –Term Care Service (CARES) for new members will assist us in identifying those with special needs. We will also review hospital and pharmacy utilization data. Additionally, we rely on you, our network providers, to identify members who are at risk of or have special needs. Once identified, we will follow up with a Comprehensive Needs Assessment for each of these members.

Aetna Better Health of Florida has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Aetna Better Health of Florida will develop care plans that address the member’s service requirements with respect to specialist any and all care or services they may need. Our case 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.

Aetna Better Health of Florida works to provide immediate transition planning for a new member with complex and chronic conditions or any special needs. The planning will be completed within a time frame appropriate to the member’s condition, but in no case later than 10 business days from the effective date of enrollment when indicated on the Plan Selection form or within 30 days after special conditions are identified by a provider. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan to maintain continual care during the transfer to the Plan
- Coordination and follow-through to approve and provide any necessary DME if it was ordered prior to the member’s enrollment with us and it was not received by the date of enrollment with us

Outreach and enrollment staff is 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 who prefer not to or are unable to communicate in English, and use the FL Relay system and American Sign Language interpreters, if necessary.

Aetna Better Health of Florida will arrange for the provision of dental services to members. At a minimum, dental services coverage will provide:

- Consultations and assistance to the member’s caregivers
- Adequate time for members with developmental disabilities, knowing that initial and follow-up comprehensive dental visits may require up to 60 minutes on average. Our standards allow for up to two visits annually without prior authorization
- Home visits when medically necessary and where available
- Adequate support staff to meet the needs of the members

After-hours protocol for members with special needs is addressed during initial provider trainings and, in our Provider Manual. Providers must be aware that a 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 of Florida clinician Line is available 24 hours a day 7 days a week for members with an urgent or crisis situation. For urgent or crises for dental services, the member must contact their dentist right away. If the dentist’s office is closed, the member should leave a message and wait for a call back. If the dentist is not able to see the member, the member should call MCNA at 1-800-494-6262 for help in scheduling an appointment or finding another dentist; if the member is out of town and in need of emergency dental care, he/she can go to any dentist for care or call MCNA for help to find a dentist.

Aetna Better Health of Florida requires our contracted Providers to use of the most current diagnosis and treatment protocols and standards established by the Agency for Health Care Administration (AHCA) and medical community. During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

CHAPTER 10: MEDICAL MANAGEMENT

Comprehensive Assessment and Review for Long Term Care Service (CARES)
Aetna Better Health of Florida also assesses members through the Comprehensive Assessment and Review for Long Term Care Service (CARES). Aetna Better Health of Florida staff members go over the CARES assessment with the member or caregiver during a telephone call made to each member to welcome them to the Health Plan. The CARES assessment gathers:

- Member contact information
- Medical home information
- Member’s health history and self-rated assessment of health
- Medication usage

CM business application systems
Our case management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires and care plans and allows case 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 in future cases. The system interfaces with our predictive modeling software, the inpatient census tool and allows documents to be linked to the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in case management.

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 and in accordance with Aetna Better Health of Florida’s guidelines. Furthermore, this definition includes 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.
Any such services must be clinically appropriate, individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-demonstration approved, investigational, or cosmetic are specifically excluded from Medicaid/LTC coverage and will be deemed “not medically necessary”.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member’s family/caregiver and the PCP, as well as any other Providers, programs, agencies that have evaluated the member. Qualified and trained health care Providers must make medical necessity determinations.

CHAPTER 11: CONCURRENT REVIEW

Concurrent Review Overview
Aetna Better Health of Florida conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the MCG® (Milliman Care Guidelines)(MCG)® Admission certification is conducted within one business day 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 clinicians conduct these reviews. The clinicians work with the Medical Directors in reviewing medical record documentation for hospitalized members. Our medical directors make rounds on site as necessary.

Clinical Care Guidelines
Aetna Better Health of Florida uses the MCG®(Milliman Care Guidelines) to verify consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. The MCGs 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.

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 are responsible for developing a discharge plan for the member and for involving the member and family in implementing 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 early discharge planning
- Facilitating or attending discharge planning meetings for members with complex and multiple discharge 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

Discharge from a Skilled Nursing Facility
All discharges from a Skilled Nursing Facility (SNF) must be coordinated with the member’s Case Manager. In accordance with Section 83 of Title 42 of the code of Federal Regulations, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of reason, the member, his or her representative, and the member’s Case Manager must be involved in discharge planning.

CHAPTER 12: PRIOR AUTHORIZATION AND REFERRAL PROCESS

Service planning must involve the member and member representative working cooperatively with the member's Case Manager. Service authorizations must reflect services specified in the plan of care. When service needs are identified, the member must be given information about available Providers, so that an informed choice of Providers can be made. All services for the Long Term Care program require a review and approval by the Case Manager. The Plan will verify that, applicable criteria is utilized when making authorization decisions. These authorized decisions will be made with consideration given to characteristics of the local delivery systems available for specific members as well as member specific factors, such as; member’s age, co-morbidities, complications, progress in treatment, psychosocial situation, home environment, and to promote the concept of appropriate care for the appropriate condition in the most cost-effective setting. Prior authorization review determinations will be based solely on the information obtained at the time of the review. If needed a Medical Director will review service requests for medically necessity before a denial of service authorization occurs. The Case Managers will send you the Authorization Forms if applicable.

The requesting Provider is responsible for complying with Aetna Better Health of Florida’s prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of Florida 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 of Florida. This includes matters about the patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of 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.

Medical Necessity Criteria
To support prior authorization decisions, Aetna Better Health of Florida 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 of Florida policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Florida uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Florida’s 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. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Applicable clinical guidelines (MCG) as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health of Florida Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Florida Policy Council Review

If the MCGs state “current role remains uncertain” for the requested service, the next criteria in the hierarchy, Aetna Better Health of Florida CPBs, should be consulted and utilized.

Medical, dental, and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Prior Authorization and Coordination of Benefits
If other insurance is the primary payer before Aetna Better Health of Florida, 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 of Florida does not require referrals from treating providers. Member may self-refer access to some services without an authorization from their treating provider. These services include vision care and dental care services. The member must obtain these self-referred services from Aetna Better Health of Florida’s Provider network.

CHAPTER 13: QUALITY IMPROVEMENT

QI Program
In accordance with 42 CFR 438.204, 438.240 and accreditation standards, the Plan has a QI Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. The Quality Management department monitors, evaluates and improves the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys and related activities. Providers are expected to participate in the Plan’s QI activities. To the extent required by applicable laws, regulations and the accreditation standards, the Quality Management department monitors and analyzes:

- Continuity and coordination of care to facilitate continuous and appropriate care for member and strengthen continuity and coordination of care among LTC Providers
- Monitor the coordination and continuity of care across health care network settings and transitions in those settings. E.g.:
Medical/case record reviews:
- Against documentation and record-keeping standards, including but not limited to the presence of medical and/or behavioral health consultant reports, home health continuing care plans and discharge summaries post hospitalization (for medical or behavioral diagnosis)
- For state-defined performance measures data collection

- Assess member satisfaction and monitor member complaints
- Notification and movement of members from a terminated provider
- Utilization of services provided by LTC service Providers.

- Performance indicators such as state-defined (contractual) performance measures
- Facility audits and case record reviews to monitor services provided by LTC Providers
- Results of annual provider and member satisfaction surveys
- Complaints and grievances
- Provider compliance with practice guidelines
- Findings and retrospective reviews of complaints regarding quality of care

The Plan reports on these monitoring activities through its QI committee structure, such as the Quality Management Oversight Committee, Peer Review Committee and Credentialing Committee.

Measuring Quality Performance

These activities continuously and proactively 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 the interventions as necessary

The use of data in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of Aetna Better Health of Florida’s quality improvement process.

Aetna Better Health of Florida’s QM department is an integral part of the health plan. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards, and recommend and 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, case management, and disease management activities involving the care of our members.

Aetna Better Health of Florida’s QM activities that assess Provider performance 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 of Florida, in collaboration with providers, is able to monitor and reassess the quality of services provided to our members. Providers are obligated to support and meet Aetna Better Health of Florida’s QI and Medical Management Programs.

Providers must also participate in the CMS and AHCA quality improvement initiatives. Any information provided must be reliable and complete.
Identifying opportunities for improvement
Aetna Better Health of Florida 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 of Florida monitors to identify opportunities for quality improvements include:

- **Formal Feedback from External Stakeholder Groups**: Aetna Better Health of Florida 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), 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 of Florida in identifying specific program activities/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 of Florida proactively identifies potential quality of service issues for review through daily operations (i.e. member services, prior authorization, and case management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our case management processes, access to Provider care and covered services, and quality of care), Aetna Better Health of Florida is able to identify specific opportunities for improving care delivered to individual members.

- **Findings from Internal Program Assessments**: Aetna Better Health of Florida conducts a number of 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/re-credentialing 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 of Florida 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 of Florida is able to 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 of Florida 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 of Florida uses a myriad of monitoring processes to confirm effective delivery of services to all of our members, such as Provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health of Florida 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 the adequacy 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 of Florida has a process for identifying Potential Quality of Care (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 of Florida 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 of Florida 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.

Critical incident reporting
Provider agrees to implement a systematic process for incident reporting. HCBS providers will notify Aetna Better Health of Florida within 24 hours of an occurrence of an incident that may jeopardize the health, safety, and welfare of a member or impair continued service delivery. Licensed facilities must provide notification within 15 days in accordance with Florida Law 400.147, 429.23, Chapter 39 and Chapter 415, F.S. Reportable conditions include but are not limited to:

- Closure of provider services or facilities due to license violations
- Provider financial concerns/difficulties
- Loss or destruction of member records
- Compromise of data integrity
- Fire or natural disasters
- Critical issues or adverse incidents that affect the health, safety, and welfare of members

In the member’s record, the Provider will contain a brief summary of the problem(s) and proposed corrective action plans and timeframes for implementation within a reasonable time after the incident is reported. Provider will inform Aetna Better Health of Florida within 30 days of the occurrence date with process and password protection for HIPAA related information.

LTC Providers will also report member Adverse Events to the Case Manager and assist Case Manager with review. Such adverse events would include the following:

- Adverse Events required by rule or law to be reported to regulatory authorities such as neglect, abuse, exploitation, and fraud.
- Adverse Events related to the following:
  - Decline in management of medications
  - Significant worsening of ADLs
  - Significant change in toileting ability
  - Falls or Accidents (with or without injury)
Disaster that leaves Provider facility diminished

All Adverse Event reporting and reviews are part of the quality initiatives for both Aetna Better Health of Florida and the Provider. This quality initiative and risk management process anticipates the information will not be included in the discoverable elements of the member file.

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 of Florida 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 and services over time
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Better Health of Florida enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM department prepares PIP proposals that are reviewed and approved by our Medical Director, Quality Management Oversight Committee prior to submission to AHCA 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 of Florida, as well as from network providers who are members of our 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 improvement or even a decline in performance, Aetna Better Health of Florida immediately conduct additional analyses 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 and/or the Practitioner Appeals Committee. This committee may take action 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.

Although peer review activities are coordinated by the Quality Management department, they may require the participation of Utilization and Case Management, Provider Services, or other departments. Aetna Better Health of Florida may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plans peer review process adheres to Aetna Better Health of Florida 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 of Florida network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension, or termination of a contract under specific circumstances.

**Performance measures**
Aetna Better Health of Florida collects and reports clinical and administrative performance measure data to AHCA. The data enables Aetna Better Health of Florida and AHCA to evaluate our adherence to practice guidelines, as applicable, and improvement in member outcomes.

**Satisfaction survey**
Aetna Better Health of Florida 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 of Florida uses member and Provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

**Member satisfaction surveys**
Aetna Better Health of Florida is committed to a better health care system. We continue to solicit feedback from consumers, physicians, hospitals, employers, LTC service Providers and government and regulatory organizations to provide information in a way that is clear, useful and relevant.

Aetna Better Health of Florida conducts a LTC member satisfaction survey annually to assess the quality of its LTC member experience. They survey is conducted by a qualified, Agency-approved, NCQA-certified survey vendor is required under the LTC contract. The Agency specifies the survey requirements including survey specifications, survey questions and any applicable supplemental items.

Aetna Better Health’s survey tool, sampling methodology, administration protocol, analysis plan and reporting description along with evidence of NCQA certification of the survey vendor are approved by AHCA annually. The results of the LTC member satisfaction survey are submitted to AHCA by July 1 each year and reviewed through the Aetna Better Health’s Quality Improvement Oversight Committee.

For additional information on our LTC member satisfaction survey, please contact Customer Service at 1-844-645-7371.

**Provider satisfaction surveys**
Aetna Better Health of Florida works hard to support providers and members to create a culture of better health: connected, simpler, intuitive, convenient, affordable and powerful.

Providers influence consumer satisfaction and Aetna Better Health of Florida empowers them with better tools, information and payment models. Surveys are important tools for us to measure and assess how we impact our network Providers. We use the survey results to make administrative and operational changes at the health plan, in areas that may require improvement.

Aetna Better Health of Florida conducts an annual Provider survey to assess satisfaction with our operational processes. Topics include claims processing, Provider training and education, and Aetna Better Health of
Florida’s response to inquiries. In addition to the annual survey, Aetna Better Health of Florida encourages Provider feedback and suggestions through the Provider Service department at 1-844-645-7371.

External Quality Review (EQR)
External Quality Review (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 of services furnished under State contracts with Managed Care Organizations, 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 of Florida cooperates fully with external clinical record reviews assessing our network’s quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by AHCA. Aetna Better Health of Florida assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. Aetna Better Health of Florida also provides complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Better Health of Florida’s contracted Providers are required to provide any records that the EQRO may need for its review.

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.

CHAPTER 14: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

Providers are required to comply with the Patient Self-Determination Act (PSDA), and the Florida Health Care Advance Directive State Statute (FLSA 765), including all other State and federal laws regarding advance directives for adult members.

Advance Directives
Aetna Better Health of Florida advance directives as a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

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

- Providing written information to adult members regarding each individual’s rights under State law to make decisions regarding medical care and any Provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member’s medical/case record whether or not the adult member has been provided the information 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 patients on Advance Directives (durable power of attorney and living wills).

For advance directive forms and frequently asked questions, please visit: www.fhca.org/consumers/health_care_advanced_directives.

**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) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health of Florida requires network Providers to comply with this act.

For additional information about the PSDA, please visit www.gapna.org/patient-self-determination-act-psda.

**Concerns**

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health of Florida as a grievance or complaint or with the Agency for Health Care Administration at 1-888-419-3456.

**CHAPTER 15: ENCOUNTERS, BILLING AND CLAIMS**

Aetna Better Health of Florida 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 of Florida will not pay claims submitted by a Provider who is excluded from participation in the Florida Medicaid or the LTC program or any program under federal law, or is not in good standing with the Agency for Health Care Administration (AHCA). Aetna Better Health of Florida will notify providers and take necessary steps to ensure that the provider’s claims/encounters are recognized by the Agency for Health Care Administration (AHCA).

Aetna Better Health of Florida uses an internal business application 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 of Florida encourages Providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health of Florida has developed a business relationship with Emdeon. Aetna Better Health of Florida 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 business application each business day. Within 24 hours of file receipt, Aetna Better Health of Florida provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

**Encounters**
Billing Encounters and Claims Overview
Our Claims Inquiry Claims Research (CICR) department is responsible for claims adjudication; resubmissions, and claims inquiry/research.

Aetna Better Health of Florida 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-10CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services’ (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 the Risk Adjustment Processing System. Important notes: The ICD-10 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 for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Provider must also follow the service and product standards specified in the Agency’s Medicaid Services Coverage & Limitations Handbooks available on the AHCA web site.
- 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/case record provides adequate documentation for assignment of a more specific code.
- Aetna Better Health of Florida is authorized to take whatever steps are necessary to ensure that the Provider is recognized by the Agency and its agent(s) as a participating Provider of Aetna Better Health of Florida and that the Provider’s submission of encounter data is accepted by the Agency;

Review of the medical/case 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/case records to support randomly selected claims to verify the accuracy of diagnosis codes submitted.

It is important for Providers and their office staff to be aware of risk adjustment data validation activities because we may 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 later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to adjust payments fairly and accurately made to Aetna Better Health of Florida 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.

The 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 based on 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 of Florida and payments made by Aetna Better Health of Florida 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 are as 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 by Aetna Better Health of Florida. 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 the diagnoses 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. The Centers for Medicare and Medicaid Services (CMS) may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at http://csscoperations.com/.

**Billing and claims**

**When to bill a member**

All Providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member’s cost sharing, if applicable. Aetna Better Health of Florida requires that non-participating Providers coordinate with the health plan in respect to payment and Aetna Better Health of Florida will verify that the cost to the member, if any, is no greater than it would be if the covered services were furnished within the network.

A member may be billed **ONLY** when the member knowingly agrees to receive non-covered services under the FL LTC Program.
• Provider MUST notify the member in advance that the charges will not be covered under the program.
• Provider MUST have the member sign a statement agreeing to pay for the services 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 timely manner. Our timely filing limitations are as follows:

• Claims must be submitted within 180 calendar days from the date of service. The claim will be denied if not received within the required timeframes.
• Corrected claims must be submitted within 180 days from the date of service.
• Coordination of Benefits (COB) claims must be submitted within 90 days from the date of primary insurer’s Explanation of Benefits (EOB), unless the claim is a Medicare cross over claim, these must be submitted within 36 months of the original submission to Medicare.

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

Non-network providers rendering prior authorized services are to submit claims within 365 days from the date of service.

Aetna Better Health of Florida will comply with the following standards regarding timely claims processing:

A. Aetna Better Health of Florida will pay 50% of all clean claims submitted within 7 days.

B. Aetna Better Health of Florida will pay 70% of all clean claims submitted within 10 days.

C. Aetna Better Health of Florida will pay 90% of all clean claims submitted within 20 days.

How to file a claim
Select the appropriate claim form (refer to table below).

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and professional services</td>
<td>CMS 1500 Form</td>
</tr>
<tr>
<td>Hospital inpatient, outpatient, skilled nursing and emergency room services</td>
<td>CMS UB-04 Form</td>
</tr>
<tr>
<td>Dental services that are considered medical services (oral surgery, anesthesiology)</td>
<td>CMS 1500 Form</td>
</tr>
</tbody>
</table>

Instructions on how to fill out the claim forms can be found on our website at www.aetnabetterhealth.com/florida.

1) Complete the claim form.
   a) Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

2) Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members’ medical records, clearly label and send to Aetna Better Health of Florida at the correct address.
   a) Electronic Clearing House
      i) Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
         (1) Emdeon is the EDI vendor we use
         (2) Contact your software vendor directly for further questions about your electronic billing.
         (3) Contact our Provider Services department for more information about electronic billing.
      ii) All electronic submission will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Florida policies and procedures.
   b) Through the Mail

<table>
<thead>
<tr>
<th>Claims</th>
<th>Mail To</th>
<th>Electronic Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Aetna Better Health of Florida</td>
<td>Through Electronic Clearinghouse</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 63578</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85082-1925</td>
<td></td>
</tr>
</tbody>
</table>

**Correct coding initiative**

Aetna Better Health of Florida follows the same standards as Medicare’s Correct Coding Initiative (CCI) policy and performs CCI 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: [www.cms.hhs.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd](http://www.cms.hhs.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd)

Aetna Better Health of Florida utilizes ClaimCheck 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 ClaimCheck. It enables us to share with our Providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

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 code when those services:
  • Represent the standard of care for the overall procedure
  • Are necessary to accomplish the comprehensive procedure
  • 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 of Florida can request copies of operative reports or office notes to verify services provided. Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Checking status of claims
Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) department. To check the status of a disputed, resubmitted, and reconsidered claim, please contact the CICR department.

Online status through Aetna Better Health of Florida’s secure portal
Aetna Better Health of Florida encourages Providers to take advantage of using our online Provider Secure Web Portal at aetnabetterhealth-florida.aetna.com 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 website. Providers must register to use our portal. Please see Chapter 4 for additional details surrounding the Provider Secure Web Portal.

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
  • Correct errors in claims processing:
    o Excludes corrections to prior authorization numbers (providers must call the Prior Authorization department directly).
    o Excludes rebilling a claim (the entire claim must be resubmitted with corrections).
Please be prepared to give the service representative the following information:

- Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
- Member name and member identification number
- Date of service
- Claim number from the remittance advice on which you have received payment or denial of the claim.

**Claim resubmission**

Providers have 180 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not 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
- Clearly label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address

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

**Please note:** Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR department during regular office hours to speak with a representative about their claim dispute. 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. 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: [www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida).

**Claim reconsideration**

Providers have 180 days from the date of remittance to resubmit a claim or the original payment will be considered full and final for the related claims. Providers must include the nature of the request, member’s name, date of birth, member identification number, service/admission date, location of treatment, service or procedure, documentation supporting request, copy of claim, and a copy of remittance advice on which the claim was denied or incorrectly paid.

**Medicare and other primary payer sources**

Eligible members can access services that are covered by Medicare through fee-for-service Medicare or a Medicare Advantage product. In the LTC program, Aetna Better Health of Florida is the payer of last resort for
Medicaid-covered services. As applicable, Providers must bill third party insurance before submitting a claim to Aetna Better Health of Florida. We will pay the difference between the primary insurance payment and the state allowable amount. If the payment from the primary payer is greater than or equal to the amount allowable under the terms of the Provider Agreement with Aetna Better Health of Florida, we have no further obligation. Providers cannot balance bill members.

Aetna Better Health of Florida does not require any co-payment or cost sharing by members except the patient responsibility amount for nursing facilities or assisted living services or any co-payments established under state law for beneficiaries of the State’s Medicaid Program. Typically, Aetna Better Health of Florida is financially responsible for Medicare co-insurance and deductibles for covered services. Aetna Better Health of Florida would then reimburse Providers for Medicare deductibles and co-insurance according to Medicaid Guidelines or the rates negotiated by Aetna Better Health of Florida with the Provider.

Aetna Better Health of Florida is responsible for collecting patient responsibility as determined by DCF and we have policies and procedures to ensure that, where applicable, members are assessed for and pay their patient responsibility. Some members have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility. Aetna Better Health of Florida may transfer the responsibility for collecting its members’ patient responsibility to residential Providers and compensate these Providers net of the patient responsibility amount. If Aetna Better Health of Florida transfers collection of patient responsibility to the Provider, the Provider contract will specify complete details of both parties’ obligations in the collection of patient responsibility. Aetna Better Health of Florida will either collect patient responsibility from all of its residential Providers or transfer collection to all of its residential Providers. Aetna Better Health of Florida has a system in place to track the receipt of patient responsibility at the member level irrespective of which entity collects the patient responsibility. This data will be available upon request by the Agency. Aetna Better Health of Florida or its Providers shall not assess late fees for the collection of patient responsibility from members. Aetna Better Health of Florida will submit a Patient Responsibility Report annually, Reporting Requirements, and the Managed Care Plan Report Guide. If a member’s patient responsibility exceeds the reported Medicaid Home and Community Based service expenditure, the Agency will employ the reconciliation process to determine if a payment adjustment is required.

If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to Aetna Better Health of Florida for a coverage determination. It is the Provider’s responsibility to obtain the primary insurance carrier’s explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to Aetna Better Health of Florida. The primary carrier’s EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier’s EOB or the remittance advice. This information is essential in order for Aetna Better Health of Florida to coordinate benefits. If a service is non-covered or benefits have been exhausted from the primary carrier, the Provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for members where third party insurance is indicated will be denied in most cases. Providers have a maximum of 180 days from the date of the EOB for Coordination of Benefits, unless the claim is a Medicare cross over claim, these must be submitted within 36 months of the original submission to Medicare.

Instruction for specific claims types

Aetna Better Health of Florida 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 of Florida, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: [www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp](http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp)

**Home Health Claims**
Providers submitting claims for Home Health should use CMS 1500 Form.

Providers must bill in accordance with contract. Non-participating health care Providers must bill according to CMS requirements and the specific Home Health Prospective Payment System (HHPPS) rules for Aetna Better Health. For additional information regarding CMS HHPPS, please refer to the following CMS website address: [www.cms.gov/HomeHealthPPS/](http://www.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 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 later that same day. We define same day readmission as a readmission within 24 hours.

*Example:* Discharge Date: 10/2/10 at 1100 a.m.
Readmission Date: 10/3/10 at 9:00 a.m.

Since the readmission was within 24 hours, this would be considered a same day readmission per above definition.

**Hospice claims**
Aetna Better Health of Florida will comply with the following requirements:

1. For Medicaid-only members residing in a nursing facility and receiving hospice services, Aetna Better Health of Florida will pay the hospice Provider the per diem rate set by the Agency for hospice services.
2. For dually eligible members residing in a nursing facility and receiving hospice services, the hospice Provider will bill Medicare for the per diem rate for hospice services.

**HCPCS Codes**

There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicaid 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.

**Remittance advice**

**Provider remittance advice**

Aetna Better Health of Florida 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. Call our Provider Services department if you are interested in receiving electronic remittance advices.

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 for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Florida 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 early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the Provider has returned to Aetna Better Health of Florida due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- 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 of Florida 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 are 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
- 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 as grievance rights information.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claims 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. Please contact our Provider Services department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare, and one check from Medicaid.

Claims submission

Claims filing formats
Providers can elect to file claims with Aetna Better Health of Florida 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.

Electronic claims submission
- In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health of Florida encourages Providers to electronically submit claims, through Emdeon.
- Please use the Payer ID number 128FL when submitting claims to Aetna Better Health of Florida for both CMS 1500 and UB 04 forms. You can submit claims by visiting Emdeon at www.emdeon.com/. Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Emdeon.

Important points to remember
- Aetna Better Health of Florida does not accept direct EDI submissions from its Providers.
- Aetna Better Health of Florida does not perform any 837 testing directly with its Providers, but performs such testing with Emdeon.
- For electronic resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

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

Aetna Better Health of Florida  
P.O. Box 63578  
Phoenix, AZ. 85082-1925

Risk pool criteria
If the claims paid exceed the revenues funded to the account, the Providers will fund part or the entire shortfall. If the funding exceeds paid claims, part or all of the excess is distributed to the participating Providers.

Encounter Data Management (EDM) System
Aetna Better Health of Florida uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to AHCA requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to AHCA. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness and we then submit encounter data to AHCA. Our EDM System processes CMS1500, UB04 (or UB92), Dental, vision 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.

The EDM System has top-of-the-line functionality to accurately, and consistently track encounters throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to 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 EDM System for processing, including data from our QNXT ™ claims adjudication system as well as data from third-party vendors under contract to process various claims, such as dental, vision, transportation and pharmacy. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, 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 EDM System. Our Encounter Management Unit validates the receipt of all claims data into EDM System using a transfer validation report. The Encounter Management Unit researches, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Encounter staging area
One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and
third party vendors (e.g., Pharmacy Benefit Management, dental or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and is populated with appropriate values.

Our Encounter Management Unit directs, monitors, tracks, and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

**Encounter Data Management (EDM) System scrub edits**

This EDM System feature allows the Encounter Management Unit to apply AHCA edit profiles to identify records that may be unacceptable to the AHCA. Our Encounter Management Unit is able to customize our EDM System edits to match the edit standards and other requirements of the AHCA. This means that we can align our encounter edit configuration with the AHCA’s configuration to improve encounter acceptance rates.

**Encounter tracking reports**

Encounter Tracking Reports are another unique feature of our EDM System. Reports are custom tailored for each plan.

Our Encounter Management Unit uses a series of customized management reports to monitor, identify, track, and resolve problems in the EDM System or issues with an encounter file. Using these reports our Encounter Management Unit is able to identify the status of each encounter in the EDM 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 EDM System, 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 EDM System. 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 encounter errors 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 EDM for resubmission to the Agency in accordance with the encounter correction protocol, which is tailored to the Agency’s requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement and corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the Agency’s acceptance process we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EDM System scrub and edit described above. In this way, we will expand our EDM System scrub 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 AHCA. 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 AHCA. The team includes a Technical Supervisor 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 report upon receipt of response files from the Agency, and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. This data facilitates the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

CHAPTER 16: PROVIDER COMPLAINT AND MEMBER GRIEVANCE SYSTEM

Provider complaint system
The Provider complaint system allows providers to dispute any aspect of Aetna Better Health of Florida’s policies, procedures, administrative functions, including proposed actions, claims, billing disputes and prior authorizations.

Aetna Better Health of Florida will inform Providers through this 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 complaint system processes.

Dedicated provider relations staff are available to answer questions, assist in filing a provider complaint and review/resolve any issues that the providers may have. Requests and inquiries are responded within 72 hours or 3 business days by sending an acknowledgment letter. A provider may also contact the Provider Relations team, via the following email: FLMedicaidProviderRelations@aetna.com or by calling 1-800-441-5501.

Both network and out-of-network providers may file a dispute verbally or in writing direct to Aetna Better Health of Florida to resolve any dispute. Providers can file a verbal dispute with Aetna Better Health of Florida by calling Provider Services department at 1-844-645-7371. To file a dispute in writing, Providers should write to:

Aetna Better Health of Florida
LTC- Provider Services
1340 Concord Terrace
Sunrise, FL 33323

The Provider may also be asked to complete and submit the Dispute Form with any appropriate supporting documentation. The Dispute Form is accessible on Aetna Better Health of Florida’s website, via fax or by mail.

If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department. For all disputes, Aetna Better Health of Florida will notify the Provider of the dispute resolution by phone, email, and fax or in writing. A provider may also contact the Provider Relations team, via the following email: FLMedicaidProviderRelations@Aetna.com.
Dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. Requests and inquiries are responded to within 72 hours or 3 business days.
**Provider Complaints (non-claims related)**
Both network and out-of-network Providers may file a formal complaint verbally or in writing directly with Aetna Better Health of Florida in regard to our staff behavior, vendor behavior, policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a dispute that is not requesting review of an action. Provider complaints are an expression of dissatisfaction not related to an action. Provider complaints must be filed within 45 calendar days from when the Provider became aware of the issue for issues not related to claims or within 45 calendar days from the dispute resolution. All provider complaints concerning claims issues are processed and resolved in accordance with s. 641.3155, F.S. and s. 408.7057, F.S. To file a provider complaint, call 1-844-645-7371 or write to:

Aetna Better Health of Florida Medicaid Provider Relations
1340 Concord Terrace
Sunrise, FL 33323

The Provider Relations department assumes primary responsibility for coordinating and managing Provider complaints, and for disseminating information to the Provider about the status of the complaint.

An acknowledgement letter will be sent within three (3) business days summarizing the complaint, including the expected date of resolution and instructions on how to:
- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time until Grievance Committee review

If the complaint requires research or input by another department, the Provider Relations department will coordinate with the Appeals and Grievances department. The Appeal and Grievance department will forward the information to the appropriate department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Florida’s written policies and procedures, collecting pertinent facts from all parties. Aetna Better Health of Florida will provide a status update on the complaint every 15 calendar days will resolve all Provider complaints within 90 calendar days of receipt of the complaint and will notify the provider of the resolution within 3 business days of the decision.

**Provider Complaints (Claims related)**
Both network and out-of-network Providers may file a formal complaint verbally or in writing directly with Aetna Better Health of Florida in regards to a claims or billing dispute that is not requesting review of an action. Provider complaints must be filed within 45 calendar days from when the provider became aware of the issue for issues not related to claims or within 45 calendar days from the dispute resolution. All provider complaints concerning claims issues are processed and resolved in accordance with s. 641.3155, F.S. and s. 408.7057, F.S. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their claim within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Aetna Better Health of Florida, or similar receipt from other commercial delivery services. All disputes concerning claims payment issues must be filed in writing. To file a provider complaint, call 1-844-645-7371 or write to:

Aetna Better Health of Florida Provider Relations Department
The Provider Relations department assumes primary responsibility for coordinating and managing Provider complaints, and for disseminating information to the Provider about the status of the complaint.

An acknowledgement letter will be sent within three (3) business days summarizing the complaint, including the expected date of resolution and instructions on how to:

- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time until Appeal Committee review

If the complaint requires research or input by another department, the Provider Relations department will coordinate with the Appeals and Grievances department. The Appeal and Grievance department will forward the information to the appropriate department and coordinate with the appropriate department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Florida’s written policies and procedures, collecting pertinent facts from all parties.

Aetna Better Health of Florida will provide a status update to providers periodically and will resolve all Provider appeals within 90 calendar days of receipt of the claims related complaint and will notify the Provider of the resolution within three (3) business days of the decision.

**Oversight of the provider complaint system processes**

The Appeals and Grievances department has the responsibility for oversight of the Provider complaint system processes. The Appeal and Grievance Manager has overall responsibility for management of the Provider complaint System processes and reports to the Director of Operations. This includes:

- Documenting individual complaints in the G&A database
- Coordinating resolutions
- Maintaining the appeal and grievance database
- Tracking and reviewing complaint and appeal data for trends in quality of care or other service related issues
- Reporting all data to the Provider Advisory Committee (PAC) and Quality Management Oversight Committee (QMOC)

Aetna Better Health of Florida's Provider complaint system processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility of the grievance system processes includes:

Review of individual complaints

- Aggregation and analysis of complaint and appeal trend data
- Use of the data for quality improvement activities including collaboration with credentialing and re-credentialing processes as required
- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

The Aetna Better Health of Florida Appeal and Grievance Manager will serve as the primary contact person for the complaint system processes with the Aetna Better Health of Florida Appeal and Grievance Coordinator serving 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 complaint, grievance, appeal, or State Fair Hearing and for assisting members in filing a complaint, grievance, or appeal throughout the Member Grievance System and the Provider Complaint System.

Providers receive this information via the Provider Manual during Provider orientations, within the Provider Agreement and on Aetna Better Health of Florida’s website.

**Member Appeal and Grievance System Overview**

**Important Information about Member Appeal Rights**

A plan appeal is a formal request from an enrollee to seek a review of an action taken by the Managed Care Plan. An action is any denial, limitation, reduction, suspension or termination of a service, denial of payment, or failure to act in a timely manner.

A plan appeal must be filed within thirty (60) days of receiving the notice of adverse benefits determination. If the plan appeal is filed orally (except for an expedited appeal), it must be followed up with a written notice within ten (10) calendar days of calling in the plan appeal.

A Medicaid member may file a plan appeal, or a Provider acting on the Medicaid member’s behalf with written authorization, may file a plan appeal.

The address and telephone number to contact the Grievance and Appeals department is:

Aetna Better Health of Florida
Grievances and Appeals
1340 Concord Terrace
Sunrise, FL 33323
Telephone: 1-844-645-7371
Fax: 1-860-607-7894

You can contact the Member Service department to file a plan appeal and request the form by calling (844-645-7371) Monday through Friday 8:00 a.m. – 7:00 p.m. Eastern Time. The Plan and/or the Provider must give the Medicaid member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The appeals and grievance coordinator will send an acknowledgement letter within three (3) business days of the receipt of the Medicaid grievance or within five (5) days of getting a plan appeal. The plan appeal will be reviewed as expeditiously as the Medicaid member’s health requires, or in a reasonable amount of time, not to exceed thirty (30) days.

An “expedited appeal” can be requested if the provider or member feels that waiting 30 days for a decision could put the member’s life, health or ability to attain, maintain, or regain maximum function in danger. This can be done by phone or in writing, but you need to make sure to ask for the plan appeal to be expedited. We may not agree that the plan appeal needs to be expedited, but we will let you know of our decision. If we do not expedite the plan appeal, it will be processed under normal time frames. If we do expedite the plan appeal, we will advise of the decision within seventy two (72) hours after receiving the expedited plan appeal request.
For decisions that involve a plan appeal of a denial that is based on medical necessity, a Medicaid grievance regarding the denial of an expedited resolution of a plan appeal, or a grievance/appeal that involves clinical issues, the decision maker will be someone other than the person involved in making the initial determination, and who has the clinical expertise in the Medicaid member’s condition or disease.

The Medicaid Member or their representative will have an opportunity to review the case file, including medical records and any other documents and records.

**How to Ask for a Fair Hearing**

A member must go through the plan appeal process before asking for a Fair Hearing. A fair hearing can be requested by phone or in writing. A Provider may request a hearing on behalf of a member, but the member must give written approval to the provider to request a hearing on their behalf. A Fair Hearing can be requested any time up to 120 days after getting our decision on the member’s plan appeal. A Fair Hearing can be requested by calling or writing to:

Agency for Health Care Administration  
Medicaid Hearing Unit  
P.O Box 60127  
Ft. Myers, FL 33906  
(877) 254-1055 (toll-free)  
239-338-2642 (fax)  
MedicaidHearingUnit@ahca.myflorida.com

**How to Ask for Services to Continue:**

If a member was receiving a service that was reduced, suspended or terminated, they have the right to keep getting those services until a final decision is made in a plan appeal or Fair Hearing. The member MUST file the plan appeal or request for Fair Hearing within the following time frames:

*For a plan appeal:*

File the plan appeal with Aetna Better Health of Florida no later than ten (10) days from the date the Notice of Adverse benefits determination letter was mailed OR no later than 10 days after the first day our action will take place, whichever is later. The plan appeal can be requested by phone, but must be followed up with a request in writing. The member MUST tell us they want their services continued.

*For a Fair Hearing:*

The member must file the request with the Medicaid Hearing Unit no later than ten (10) days after the Notice of Plan Appeal Resolution letter was mailed or before the first day the action will take place, whichever is later.

If services are continued and our decision is upheld in a plan appeal or Fair Hearing, we may ask that the member pay for the cost of the services. We will not take away the member’s Medicaid benefits. We cannot ask the member’s family or legal representative to pay for the services.

Aetna Better Health is required to continue the Medicaid member’s benefits while a Medicaid fair hearing is pending if: (a) The Medicaid fair hearing is filed timely, meaning on or before the latter of the following:

(i) within ten (10) days of the date on the Notice of Plan Appeal Resolution;

(ii) the intended effective date of Aetna Better Health’s proposed action;

(b) The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
(c) The services were ordered by an authorized Provider;
(d) The authorization period has not expired; and
(e) The Medicaid member requests an extension of benefits.

Right to Request a Review from the Subscriber Assistance Program
If a member does not like our plan appeal decision, they have one year after receiving the final decision letter to request a review by the Subscriber Assistance Program (SAP). The Plan’s appeal process must be finished first. If the member, or provider on behalf of a member with written permission, asks for a Fair Hearing, they cannot have a SAP review. To ask for a SAP review, the member should call 1-888-419-3456 (toll free) or 1-850-412-4502 or send the request to:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, FL 32308
(850) 412-4502
(888) 419-3456 (toll-free)

CHAPTER 17: FRAUD, WASTE, AND ABUSE

Fraud, Waste, and Abuse
Aetna Better Health of Florida has an aggressive, proactive fraud, waste, and abuse program that comply 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 the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or waste to appropriate State and federal agencies as mandated by Florida 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 of Florida uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as Providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of Provider service 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 in responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full-time, a 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 report potential fraud, waste, or abuse. The number is 1-800-338-6361. The hotline has proven to be an effective tool, and Aetna Better Health of Florida encourages providers and contractors to use it.

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To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna Better Health’s 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 significantly from 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 of Florida all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

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

- By phone to the confidential Aetna Better Health of Florida Compliance Hotline at **1-844-645-7371**
- 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.

You can also report provider fraud to the Florida Attorney General’s Office, at **1-888-9FRAUD (1-866-966-7226)** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477)**.

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 you submitted 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 includes beneficiary 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 supplies
- 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 of Florida 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 login information
- 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 supplied 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 20 nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health of Florida and the member, or billing Aetna Better Health of Florida 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-covered service 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 narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Elements of a Compliance Plan
An effective Compliance Plan includes seven (7) core elements:
1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of Florida’s commitment 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 or actual non-compliance, will maintaining confidentiality.
   b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of Florida.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry

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:
   o Knowingly presenting a false or fraudulent claim for payment or approval
   o Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
   o 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 of Florida must agree to be bound by and comply with all applicable 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 Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

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

- **Red Flag Rule (Identity Theft Protection)**
  - Requires “creditors” to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

- **Health Insurance Portability and Accountability Act (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 the government makes a payment. The amount of the false claims 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 of Florida services through FL LTC.**

- **Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of Florida 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 of Florida services through the Florida LTC program.**

- **The Florida False Claims Act (FFCA) s. 68.081 F.S. authorizes civil actions by individuals and the state against persons who file false claims for payment or approval by a state agency. Under the FFCA any person who knowingly presents or causes to be presented a false or fraudulent claim or payment or approval; knowingly
makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent
claim; conspires to commit a violation of act; has possession, custody, or control of property or money used
or to be used by the state and knowingly delivers or causes to be delivered less than all of the money or
property is knowingly makes, uses or causes to be made or used a false record or statement material to an
obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and
improperly avoids or decreases an obligation to pay or transmit money or property to the state is liable to
the state for a civil penalty not less than $5,500 and not more than $100,000 and for the treble the amount
of damages the state sustains because of the act of that person.

- Under the Florida Anti-Tampering Act s. 501.001 F.S., refers to any drug which means any agent or product
recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United
States, or official National Formulary, or nay supplement thereof; any agent or product intended for use in
the diagnosis, cure, mitigation, treatment, therapy, or prevention of disease. It also refers to any device
which means any apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or
related article, including any component, part, or accessory, which is:
  - To affect the structure or any function of the body of humans
  - In addition, which does not achieve any of its principal intended purposes through chemical action within or
on the body of humans and is not dependent upon being metabolized for the achievement of any of its
principal intended purposes.

- Whoever, with reckless disregard for the risk that another person will be placed in danger of death or bodily
injury, tampers with, or conspires or attempts to tamper with, any consumer product or the labeling of, or
container for, any such product is guilty of a felony of the first degree, punishable as provided in s. 775.082
or s. 775.083. or whoever, with intent to cause serious injury to the business of any person, tampers with
any consumer product or renders materially false or misleading the labeling of, or container for, a consumer
product is guilty of a felony of the second degree, punishable as provided in s. 775.082 or s. 775.083. or
whoever knowingly communicates false information that a consumer product has been tampered with, if
such tampering, had it occurred, would create a risk of death or bodily injury to another person, is guilty of a
felony of the second degree, punishable as provided in s. 775.082 or s. 775.083. or “Communicates false
information” means to communicate information that is false, and that the communicator knows is false,
under circumstances in which the information may reasonably be expected to be believed. Alternatively,
whoever knowingly threatens, under circumstances in which the threat may reasonably be expected to be
believed, that he or she will commit or cause to be committed an act which would violate paragraph (a) is
guilty of a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083.

- Under the Medicaid Provider Fraud Act s. 409.920 F.S., refers to any particular item, device, medical supply,
or service claimed to have been provided to a recipient and listed in an itemized claim or payment; or in the
case of a claim based on costs, any entry in the cost report, books of amount, or other documents
supporting such claim

A person may not:
  - Knowingly make, cause to be made, or aid and abet in the making of any false statement or false
representation of a material fact, by commission or omission, in any claim submitted to the
agency or its fiscal agent or a managed care plan for payment.
  - Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services
that are not authorized to be reimbursed by the Medicaid program.
o Knowingly charge, solicit, accept, or receive anything of value from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.

o Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider.

o Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

o Knowingly submit false or misleading information or statements to the Medicaid program for being accepted as a Medicaid Provider.

o Knowingly use or endeavor to use a Medicaid Provider’s identification number or a Medicaid recipient’s identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

- 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 (LEIE) database
- License suspension or revocation

**Remediation**

Remediation may include any or all of the following:

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

**Exclusion lists & reports**

We are required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any other such databases as the Agency for Health Care Administration (AHCA) may prescribe.
Aetna Better Health of Florida does not participate with or enter into any Provider agreement with any individual or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded Providers and who have been terminated from the Medicaid or any programs by AHCA for fraud, waste, or abuse. The Provider must agree to assist Aetna Better Health of Florida as necessary in meeting our obligations under the contract with the AHCA to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional resources

- http://ahca.myflorida.com/
- http://laws.flrules.org/
- http://www.leg.state.fl.us/Welcome/index.cfm?CFID=3497165&CFTOKEN=24cbe8d8e31ef5bc-A27CF37E-C61F-5A4F-E89523F2CB74D9BC
- http://www.flsenate.gov/
- http://oig.hhs.gov/hotline.html

Details may be included in the State’s Medicaid Provider General Handbook. For Florida see Chapter 5, Medicaid Fraud, and Abuse. http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf


The Florida Bureau of Medicaid Program Integrity audits and investigates Providers suspected of overbilling or defrauding Florida’s Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

To report suspected fraud and abuse in Florida Medicaid:

- Call the Consumer Complaint Hotline toll-free at 1-888-419-3456
- Complete a Medicaid Fraud and Abuse Complaint Form, which is available online at https://apps.aha.myflorida.com/InspectorGeneral/fraud_complaintform.aspx
- Reportar Fraude llamando al 1-866-966-7226

CHAPTER 18: MEMBER ABUSE AND NEGLECT

Mandated reporters

As mandated by Florida Administrative Code and Florida Statues (F.L.F. A.C. 65C-29.002 ), all Providers who work or have any contact with any Aetna Better Health of Florida members, are required as “mandated reporters” to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency. A full version of the Florida Administrative Code (FAC) can be found on the State of Florida Administrative Code & Administrative Register website at https://www.flrules.org/

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 National Domestic Violence Hotline at **1-800-799-SAFE (7233)**
- The State of Florida Department of Elder Affairs at **1-800-963-5337** or **1-800-962-2873 (1-800-96-ABUSE)** [http://elderaffairs.state.fl.us/index.php](http://elderaffairs.state.fl.us/index.php)

For members age 60 or older living in a long-term care community, Providers may report any suspected or known physical abuse verbally or in writing to the following:

- Toll-free at **1-888-831-0404** or in writing via fax at **1-850-414-2337**

**Reporting identifying information**

Any Provider who suspects that a member may be in need of protective services should contact the appropriate State agencies within 24 hours 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).

Abuse can be reported by calling the Florida Abuse Hotline, which is a statewide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873). Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the member’s case file, that is designated as confidential. Such file will be made available to the Agency upon request.

After reporting the incident, concern, issue, or complaint to the appropriate agency, the Provider office must notify Aetna Better Health of Florida's Compliance Hotline at **1-844-645-7371**. Aetna Better Health of Florida may be required to verify that all direct care Providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation. It is your responsibility as the Provider to verify that abuse, neglect and exploitation training occurs and to maintain necessary documentation of this training for the employees that have contact with Aetna Better Health of Florida members. You may be requested to make such documentation available. You may use the “Adult Abuse, Neglect and Exploitation Guide for Professionals” as a training tool. It is available at:

[www.dcf.state.fl.us/programs/aps/docs/GuideforProfessionals.pdf](http://www.dcf.state.fl.us/programs/aps/docs/GuideforProfessionals.pdf)

In the event you feel an member will be seen by a direct care staff without such training, please bring that to the attention of the Case Manager prior to accepting their authorization for your services. For further information or assistance in filing a report, you may contact the Department of Elder Affairs State Elder Abuse Prevention Coordinator at **(850) 414-2000**.

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 and Privacy Act (20 U.S.C. § 1232g).

**Examinations to determine abuse or neglect**
When a State agency notifies Aetna Better Health of Florida of a potential case of neglect and abuse of a member, our Case Managers will work with the agency and the member’s Primary Care Practitioner (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health of Florida also notifies the appropriate regulatory agency of the report.

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

Examples, behaviors, and signs of member abuse, neglect and/or exploitation

**Abuse**
Potential Symptoms/Signs 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

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

Additional resources