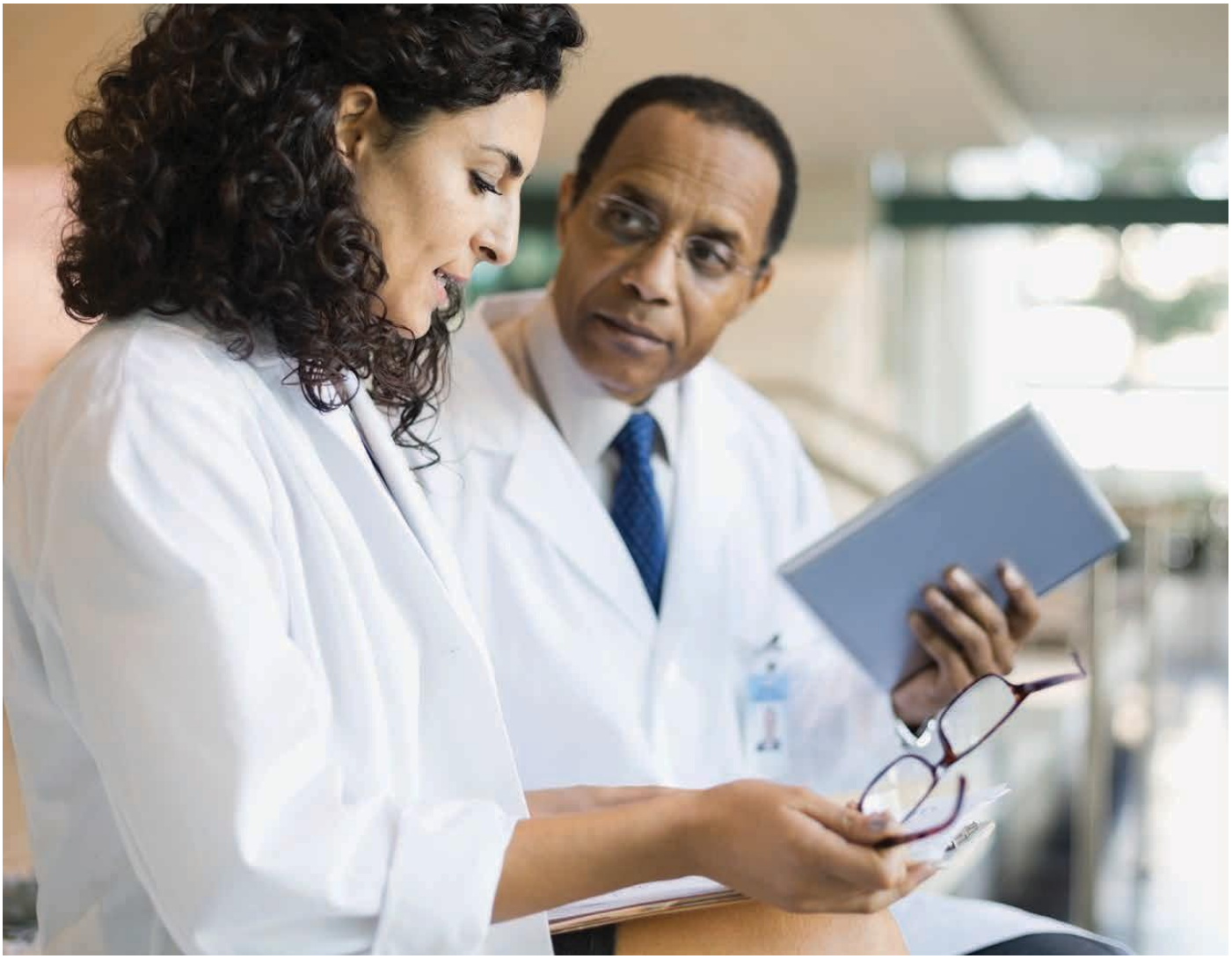
AETNA BETTER HEALTH® Premier Plan

Provider Handbook



www.aetnabetterhealth.com/illinois
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CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH OF ILLINOIS

Welcome

Welcome to the Aetna Better Health® of Illinois. Our ability to provide excellent service to our enrollees is dependent on the quality of our provider network. By joining our network, you are helping us serve those Illinoisans who need us the most.

About Aetna Better Health

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves more than 2 million people in 17 states. Aetna Medicaid and its affiliates currently own plans and administer Medicaid services in Arizona, Delaware, Florida, Illinois, Kentucky, Louisiana, Michigan, Maryland, Nebraska, New York, New Jersey, Ohio, Pennsylvania, Texas, Virginia and West Virginia.

Aetna Medicaid has more than 25 years' experience in managing the care of the most medically vulnerable, using innovative approaches to achieve both successful health care results and maximum cost outcomes. Aetna Medicaid has particular expertise in serving high-need Medicaid and LTC enrollees, including those who are dually eligible for Medicaid and Medicare also known as Premier Plan enrollees.

About the Premier Plan Program

The Illinois Department of Healthcare and Family Services (HFS), authorized by the Affordable Care Act, will enroll people who receive Medicare and full Medicaid benefits in managed fee-for-service or capitated managed care plans that seek to integrate benefits and align financial incentives between the two programs.

The Illinois Department of Healthcare and Family Services (HFS) have chosen the capitated managed care model offered by the Centers of Medicare and Medicaid Services (CMS). Through the Premier Plan Program managed by HFS, Illinois will develop a fully integrated care system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including Long Term Services and Supports (LTSS). HFS has chosen several Managed Care Organizations to implement Medicare-Medicaid benefit integration to selected counties across the state.

Aetna Better Health of Illinois was chosen by the Illinois Department of Healthcare and Family Services (HFS) to arrange for care and services by specialists, hospitals, and providers of LTSS and other non-Medicaid community based services and supports; allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services; cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals; and utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.

About this Provider Handbook
This Provider Handbook serves as a resource and outlines operations for Aetna Better Health's Premier Plan Program. Through the Provider Handbook, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. If you have a question, problem, or concern that the Provider Handbook does not fully address, please call our Provider Services Department at 1-866-600-2139 for Premier Plan concerns.

Aetna Better Health will update the Provider Handbook at least annually and will distribute bulletins as needed to incorporate any changes. Please check our website at https://www.aetnabetterhealth.com/illinois/providers/ for the most recent version of the Provider Handbook and/or updates. The Aetna Better Health Provider Handbook is available in hard copy form or on CD-ROM at no charge by contacting our Provider Services department at 1-866-600-2139.

About Medical Homes
A medical home, also referred to as a "health care home," is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The medical home features a personal care clinician who partners with each enrollee, their family and other caregivers to coordinate aspects of the enrollee's health care needs across care settings using evidence-based care strategies that are consistent with the enrollee's values and stage in life.

Service Area's
Aetna Better Health of Illinois' Premier Plan Program is offered in the following counties:

Premier Plan Program:

Premier Plan (Premier Plan) - Counties	
Cook	Kankakee
DuPage	Will
Kane	

Disclaimer
Providers are contractually obligated to adhere to and comply with all terms of the Premier Plan Program, and with your Aetna Better Health provider agreement, including all requirements described in this Handbook, in addition to all federal and state regulations governing a provider. While this Handbook contains basic information about Aetna Better Health, the Illinois Department of Healthcare and Family Services (HFS) and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply

HFS and CMS requirements when administering covered services. Please note: Providers who offer services to Premier Plan enrollees must comply with CMS requirements.

Please refer to **http://www2.illinois.gov/hfs/Pages/default.aspx** and **http://www.cms.hhs.gov/** for further information on the HFS and CMS, respectively.

Aetna Better Health Policies and Procedures

Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to assure all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed.

Model of Care

Our model of care offers an integrated care management approach, which offers enhanced assessment and management for enrolled enrollees. The processes, oversight committees, provider collaboration, care management and coordination efforts applied to address enrollee needs result in a comprehensive and integrated plan of care for the enrollee.

The integrated model of care addresses the needs of enrollees who are often frail, elderly, and coping with disabilities, compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues.

Our program's combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve seamless transitions of care across healthcare settings and providers.
- Promote appropriate utilization of services and cost-effective service delivery.

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:

- Review of network for adequacy and resolve unmet network needs.
- Clinical reviews and proactive discharge planning activities.
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.

Many components of our integrated care management program influence enrollee health. These include:

- Comprehensive enrollee assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status, and allow enrollees to reside in the least restrictive environment possible.
- Assessments and care plans that identify an enrollee's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Case Manager referrals and predictive modeling software that identify enrollees at increased risk for nursing home placement, functional decline, hospitalization, emergency department visits, and death. This information is used to intervene with the most vulnerable enrollees in a timely fashion.

CMS Website Links

Aetna Better Health administers our Premier Plan Program in accordance with the contractual obligations, requirements, and guidelines established by the Centers for Medicare & Medicaid Services (CMS). There are several manuals on the CMS website that may be referred to for additional information. Key CMS On-Line Manuals are listed below:

Medicare Managed Care Manual – http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

Medicare Prescription Drug Manual - http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp

CHAPTER 2: CONTACT INFORMATION

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

Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Aetna Better Health Premier Plan	1-866-600-2139 (follow the prompts in order to reach the appropriate departments)	Individual departments are listed below	8 a.m.-5 p.m. CT Monday-Friday
Aetna Better Health of Illinois Prior Authorization Department	See Program Numbers Above and Follow the Prompts	1-855-684-5259	8 am -5 pm CT - Monday -Friday
Aetna Better Health of Illinois Compliance Hotline (Reporting Fraud, Waste or Abuse)	1-855-478-1041	N/A	24 hours / 7 days per week through Voice Mail inbox
Aetna Better Health Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)	1-800-338-6361	N/A	24 hours / 7 days per week

Aetna Better Health of Illinois Department Fax Numbers	Fax Number
Member Services	1-855-802-4291
Provider Services	1-860-754-0435
Case Management/IP/OP Hospital Notification	1-855-687-6955
Medical Prior Authorization	1-855-802-4292
Pharmacy Prior Authorization	1-855-365-8109
Dental Prior Authorization	N/A (call 1-800-416-9185)
Behavioral Health, including Behavioral Health	1-866-600-2139
Crisis Line	

Community Resource	Contact Information
Illinois Tobacco "Quitline"	1-866-QUIT-YES (1-866-784-8937) Website: http://www.quityes.org/

Contractors	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
DentaQuest --- CVS CAREMARK Mail Order	1-800-416-9185 --- 1-800-552-8159	N/A	8 a.m.-6 p.m. CT.M-F ---
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired and CART reporting	Please contact Member Services at 1-866-600-2139 (for more information on how to schedule these services in advance of an appointment)	N/A	24 hours / 7 days per week
March Vision Care, Inc.	1-888-493-4070 1-877-627-2456 TTY	1-877-MARCH 88 (1-877-627-2488)	8 a.m.-5 p.m. CT Monday – Friday
Medical Transportation Management, Inc. (MTM/Ride Right)Please note that this number is for requesting non-emergency transportation only. Emergency transportation services are covered for emergencies only, and enrollees who experience a medical emergency should call	1-866-600-2139 1-888-513-1612 Ride Right/MTM	N/A	8am-6pm CT Monday-Saturday

911			

Agency Contacts & Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Illinois Department of Healthcare and Family Services (HFS)	Phone: 1-800-447-4278 Email: hfswebmaster@illinois.gov		
Division of Rehabilitation Services within (DHS-DRS)	1-877-761-9780 Voice 1-866-264-2149 TTY 1-866-588-0401 VP		
Illinois Department on Aging (DoA)	1-217-785-3356	217-785-4477	
The Department of Health, Office of Inspector General (OIG)	1-800-368-1463		
Emdeon Customer Service Email Support: hdsupport@webmd.com	1-800-845-6592	N/A	24 hours / 7 days per week
Illinois Client Enrollment Broker	1-877-912-8880 1-866-565-8576 (TTY) Spanish 1-877-912-8880 1-866-565-8576 (TTY)	N/A	8 a.m.-7 p.m. CT Monday-Friday
IL Relay	Dial 711	N/A	24 hours / 7 days per week
Reporting Suspected Abuse			
The Department of Health, Office of Inspector General (OIG) OIG Abuse	1-800-368-1463	N/A	24 hours / 7 days per week

Hotline			
24-Hour Elder Abuse Hotline	1-866-800-1409 1-888-206-1327 (TTY)	N/A	24 hours / 7 days per week
Department of Public Health Abuse Hotline (LTC & NFs)	1-800-252-4343	N/A	24 hours / 7 days per week
Department of Children and Family Services Child Abuse Hotline	1-800-25-ABUSE Or 1-800-252-2873 1-800-358-5117 (TTY)	N/A	24 hours / 7 days per week

Important Addresses	
Aetna (Provider Claim Disputes)	Aetna Better Health of Illinois Attention: Provider Disputes P.O. Box 66545 Phoenix, AZ 85082-6545
Aetna (Claims Submission & Resubmission)	Aetna Better Health PO Box 66545 Phoenix, AZ 85082
DentaQuest Claims Address www.dentaquestgov.com	12121 Corporate Parkway Mequon, WI 53092-9838
March Vision Claims Address www.marchvisioncare.com	March Vision Care Group 6701 Center Drive West, Suite 790 Los Angeles, CA 90045
Medical Transportation Management, Inc. (MTM/Ride Right) www.mtm-inc.net	16 Hawk Ridge Drive Lakes Saint Louis, MO 63367
CVS CAREMARK MAIL SERVICE ORDER FORM https://www.aetnabetterhealth.com/illinois/assets/pdf/members/MedicareMailOrderEng.pdf	CVS/caremark PO BOX 94467 PALATINE, IL 60094-4467

CHAPTER 3: PROVIDER SERVICES

Provider Services Overview

Our Provider Services Department serves as a liaison between the Health Plan and the provider community. Provider Liaisons conduct onsite provider training, problem identification and resolution, site visits, accessibility audits and develop provider communication materials, including the Provider Handbook. We support network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards.

Provider 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 of an address change
- View recent updates
- Locate Forms
- Review enrollee information
- Check enrollee 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 NPI change
- Obtain a secure web portal or enrollee care Login ID
- Review claims or remittance advice

Provider Orientation

Aetna Better Health provides initial orientation for newly contracted providers within one month after they join our network. In follow up to initial orientation, Aetna Better Health provides a variety of forums for ongoing provider training and education, such as routine site visits, group or individualized training sessions on select topics (i.e. claims coding, enrollee benefits, Aetna Better Health website navigation), distribution of periodic provider newsletters and bulletins containing updates and reminders, and online resources through our website at www.aetnabetterhealth.com/Illinois.

CHAPTER 4: PROVIDER RESPONSIBILITIES

Provider Responsibilities Overview

This section outlines general provider responsibilities; however, additional responsibilities are included throughout the Handbook. 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 Premier Plan Program, Provider Contract and requirements in this Handbook. Aetna Better Health may or may not specifically communicate such terms in forms other than the Provider Contract and this Handbook.

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 an enrollee, 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. Advice given to potential or enrolled enrollees should always be given in the best interest of the enrollee.

Providing Enrollee Care

Providers who provide services to Aetna Better Health enrollees must be enrolled as a Medicaid provider with the state of Illinois and credentialed by Aetna Better Health before they can provide health care to our enrollees. To access enrollment forms and other information about how to register with the state of Illinois, please refer to the Department's website at www.hfs.illinois.gov/enrollment.

Providers who provide services to Aetna Better Health enrollees must be enrolled as a Medicaid provider with the state of Illinois. The provider must be credentialed by Aetna Better Health before they can provide health care to our enrollees. To access enrollment forms and other information about how to register with the state of Illinois, please refer to the Department's website at www.hfs.illinois.gov/enrollment.

Providers that have been excluded from participation in any federally or state funded health care program are not eligible to become network providers.

Appointment Availability Standards

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek corrective action

plans, such as panel or referral restrictions, from providers that do not meet accessibility standards.

Provider Type	Urgent Care	Preventative & Routine Care	Post-hospitalization or Emergency Department Visit
PCP	Within 24 hours	5 weeks from the date of request for care Non-urgent complaints within 3 weeks	7 days from discharge

At a minimum, an enrollee will have access to a PCP within thirty (30) minutes of the enrollee's residence.

Behavioral Health. Enrollees shall be seen within the following timeframes:
Routine, within seven (7) Calendar days of request
Non-Life Threatening Emergency, within six (6) hours
Immediate treatment for potentially suicidal individual

Aetna Better Health's waiting time standards require that enrollees, on average, should not wait at a PCP's office for more than 30 minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating an enrollee with a difficult medical need, the waiting time may be expanded to one hour. The above access and appointment standards are provider contractual requirements. Aetna Better Health monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available or having on-call arrangements in place with other qualified participating Aetna Better Health Providers for the

purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care, and verifying enrollee enrollment with us.

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

All Providers must have a published after hours telephone number and maintain a system that will provide access to primary care 24-hours-a-day, 7-days-a-week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between enrollees, their PCPs, and practice staff. We will routinely measure the PCP's compliance with these standards as follows:

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

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, enrollees. This includes offering hours of operation that are no less than those for non-enrollees, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Services Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Covering Providers

Our Provider Services Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health. This notification must occur in advance of providing authorized services. Depending on the Program, reimbursement to a covering provider is based on the Premier Plan Program Fee Schedule. Failure to notify our Provider Services Department of covering provider affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying Enrollee Eligibility

All providers, regardless of contract status, must verify an enrollee's enrollment status prior to the delivery of non-emergent, covered services. An enrollee's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services

rendered to enrollees who lost eligibility or who were not assigned to the primary care provider's panel (unless, s/he is a physician covering for the provider).

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

- **Telephone Verification:** Call our Member Services Department to verify eligibility at 1-866-600-2139 for Premier Plan enrollee. To protect enrollee confidentiality, providers are asked for at least three pieces of identifying information such as the enrollees identification number, date of birth and address before any eligibility information can be released.
- **Monthly Roster:** Monthly rosters are found on the Secure Website Portal. Contact our Provider Services Department for additional information about securing a confidential password to access the site. Note, rosters are only updated once a month.

Additional enrollee eligibility requirements are noted in Chapter 7 of this Handbook.

Secure Web Portal

The Secure Web Portal is a web-based platform that allows us to communicate enrollee healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- Enrollee Eligibility Search – Verify current eligibility of one or more enrollees.
- Panel Roster – View the list of enrollees currently assigned to the provider as the PCP.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Search – Search for provider claims by enrollee, 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.
- Submit Claims Disputes- For faster processing, you may also submit your Dispute through our Secure Provider Web Portal. Instructions can be found on our website
- Authorization List – Search for provider authorizations by enrollee, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed.
- 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 enrollee's compliance with any of the HEDIS measures. A "Yes" means the enrollee has measures that they are not compliant with; a "No" means that the enrollee has met the requirements.

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

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health that allows providers access to our web-based application, CaseTrakker™ Dynamo system. This portal allows providers to view care management and relevant enrollee clinical data, and securely interact with Care Management staff.

Providers are able to do the following via the Member Care Web Portal:
For their Practice:

- Providers can view their own demographics, addresses, phone and fax numbers for accuracy.
- Provider can update their own fax number and email address.

For their Patients:

- View and print enrollee's care plan***** and provide feedback to Case Manager via secure messaging.
- View an enrollee's profile which contains:
  - Enrollee's contact information
  - Enrollee's demographic information
  - Enrollee's Clinical Summary
  - Enrollee's Gaps in Care (individual enrollee)
  - Enrollee's Care Plan
  - Enrollee's Service Plans
  - Enrollee's Assessments responses*****
  - Enrollee's Care Team: List of enrollee's Health Care Team and contact information (e.g., specialists, caregivers)*, including names/relationship
  - Detailed enrollee clinical profile: Detailed enrollee information(claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*****
  - High-risk indicator***** (based on existing information, past utilization, and enrollee rank)
  - Conditions and Medications reported through claims
  - Enrollee reported conditions and medications***** (including OTC, herbals, and supplements)
- View and provide updates and feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their enrollee panel*****
- Secure messaging between provider and Case Manager
- Provider can look up enrollees not on their panel (provider required to certify treatment purpose as justification for accessing records)

* Any enrollee can limit provider access to clinical data except for: Enrollees flagged for 42 CFR Part 2 (substance abuse) must sign a disclosure form and list specific providers who can access their clinical data.

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

Enrollee Temporary Move Out-of-Service Area
CMS defines a temporary move as an absence from the service area (where the enrollee is enrolled in the Premier Plan Program) of six months or less.

Enrollees are covered while temporarily out of the service area for emergent, urgent, post-stabilization, and out-of-area dialysis services. If an enrollee permanently moves out of our service area or is absent for more than six months, the enrollee will be disenrolled from the Premier Plan Program.

Coverage of Renal Dialysis – Out of Area
Aetna Better Health pays for renal dialysis services obtained by a Premier Plan Program enrollee from a contracted or non-contracted certified physician or health care professional while the enrollee is temporarily out of our service area (up to six months).

Preventive or Screening Services
Providers are responsible for providing appropriate preventive care to enrollees. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female enrollees may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral)
- Age and risk appropriate health screenings.

Behavioral Health Screening/Services
Providers are responsible for conducting a behavioral health screen to determine whether an enrollee needs behavioral health services. Providers must arrange for and/or coordinating the enrollee's care with Behavioral Health/Substance Abuse Services (i.e., Independent Behavioral Health/Substance Abuse providers and/or the Illinois DHS Division of Mental Health (DHS-DMH).

Provider must check with the enrollee's behavioral health provider before prescribing any medications if requested.

Educating Enrollees on their own Health Care

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

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

Emergency Services

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

Urgent Care Services

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

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

Primary Care Providers (PCPs)

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

- Providing primary and preventive care and acting as the enrollee's advocate;
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of enrollee care, and including, as appropriate, transitioning young adult enrollee s from pediatric to adult providers;
- Maintaining the enrollee's medical record.

PCPs are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our enrollees. These services will include, at a minimum, the

treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable.

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

- Referring enrollees to behavioral health providers, providers or hospitals within our network, as appropriate, and if necessary, referring enrollees to out-of-network specialty providers;
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for enrollees;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned enrollees by other providers, specialty providers and/or hospitals; and
- Coordinating the medical care for the programs the enrollee us assigned to, including at a minimum:
    - Oversight of drug regimens to prevent negative interactive effects
    - Follow-up for all emergency services
    - Coordination of inpatient care
    - Coordination of services provided on a referral basis, and
    - Assurance that care rendered by specialty providers is appropriate and consistent with each enrollee's health care needs.

PCPs are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of enrollees, or entering into formal arrangements for management of inpatient hospital admissions of enrollees. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists are required to coordinate with the PCP when enrollees need a referral to another specialist. The specialist is responsible for verifying enrollee eligibility as well as securing any needed prior authorizations prior to providing services.

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

Primary Care Providers (PCPs) should only refer enrollees to Aetna Better Health network specialists. If the enrollee requires specialized care from a provider outside of our network, a prior authorization is required.

Specialty Providers Acting as PCPs

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

- When the enrollee has a complex, chronic health condition that requires a specialist's care over a prolonged period of time.
- When an enrollee's health condition is life threatening or so degenerative and/or disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-enrollee relationship would leave the enrollee without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the enrollee vulnerable or at risk for not receiving proper care or services.

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

Self-Referrals/Direct Access

Enrollees may self-refer/directly access some services without an authorization from their PCP. These services include behavioral health care, vision care, dental care, family planning, and services provided by Women's Health Care Providers (WHCPs). The enrollee must obtain these self-referred services from an Aetna Better Health provider.

Family planning services do not require prior authorization. Enrollees may access family planning services from any qualified provider. Enrollees also have direct access to WHCP services. Enrollees have the right to select their own WHCP, including nurse midwives who participate in Aetna Better Health's network, and can obtain maternity and gynecological care without prior approval from a PCP.

Skilled Nursing Facility (SNF) Providers

Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to enrollees that need consistent care, but do not have the 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 enrollees.

SNFs are responsible for making sure that enrollees residing in their facility are seen by their PCP in accordance with the following intervals:

- For initial admissions to a nursing facility, enrollees must be seen by their PCP once every 30 days for the first 90 days and at least once every 60 days thereafter.
- Enrollees that become eligible while residing in a SNF must be seen by their PCP within the first 30 days of becoming eligible, and at least once every 60 days thereafter.

Home and Community Based Services (HCBS)
Home and Community Based Providers are obligated to work with Aetna Better Health Case Managers. Case Managers will complete face-to-face assessments with our enrollees, in their residence, every 90 days. Based on the assessment, Case Managers will then identify the appropriate services that meet the enrollees functional needs, including determining which network provider may be availability in order to provide services to the enrollee in a timely manner. Upon completion, the Case Managers will then create authorizations for the selected Provider and fax/ e-mail these authorizations accordingly. Case Managers will also follow up with the enrollee 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 enrollee. 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:
Enrollee is authorized to receive 40 hours of Personal Assistant per week over a 5-day period. The enrollee is receiving 8 hours of care a day.

The enrollee is admitted into the hospital on January 1, 2010 and is discharged from the hospital on January 3, 2010. There should be no billable hours for January 2, 2010, as no services were provided on that date since the enrollee was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the enrollee on the example above, since no services could be performed on January 2, 2010. 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 an enrollee has been hospitalized for the full 24 hours, the Personal Assistants and Agencies will be required to pay back any monies paid by Aetna Better Health. Aetna Better Health will conduct periodic audits to verify this is not occurring.

Second Opinions
An enrollee may request a second opinion from a provider within our network. Providers should refer the enrollee to another network provider within an applicable specialty for the second opinion.

Non-Compliant Enrollees
Providers are responsible for delivering appropriate services so that our enrollees understand their health care needs. Providers should strive to manage enrollees and ensure compliance with treatment plans and with scheduled appointments. If you need assistance helping noncompliant enrollees, please contact our Provider Services Department.

If you elect to remove the enrollee from your panel rather than continue to serve as the enrollee's medical home, you must provide the enrollee at least a thirty (30) days written notice prior to removal and ask the enrollee to contact Member Services to help them find a new provider. The enrollee will NOT be removed from a provider's panel unless the provider's efforts and those of our Health Plan do not result in the enrollee's compliance with medical instructions. If you need more information about this process, please contact our Provider Services Department.

Medical Records Review
Aetna Better Health's standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health provider network. Below is a list of Aetna Better Health medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health 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 enrollees immediately and completely available for review and copying by the Department and/or 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 enrollee'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:

- Enrollee identification information on each page of the medical record (i.e., name, Medicaid or Premier Plan Identification Number)
- Documentation of identifying demographics including the enrollee's name, address, telephone number, employer, Medicaid and or Premier Plan 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 enrollee medical records, including, but not limited to obtaining any required written enrollee consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the enrollee that includes family medical history, social history, operations, illnesses, accidents and preventive laboratory screenings (the initial history for enrollees under age 21 should also include prenatal care and birth history of the enrollee's mother while pregnant with the enrollee)
- Past medical history for all enrollees 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 enrollees if available)
- Dental history if available, and current dental needs and/or services
- Current problem list (The record shall contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)
- Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints.
    - Plan of treatment
    - Diagnostic tests
    - Therapies and other prescribed regimens
    - Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
    - Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof.
    - Other aspects of patient care, including ancillary services
- Fiscal records - Providers will retain fiscal records relating to services they have rendered to enrollees, regardless of whether the records have been produced manually or by computer.

- Recommendations for specialty care, as well as behavioral health, dental and/or vision care and results thereof
- Current medications (Therapies, medications and other prescribed regimens - Drugs prescribed as part of the treatment, including quantities and dosages, shall be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to the effect.)
- Documentation, initialed by the enrollee's PCP, to signify review of:
    - Diagnostic information including:
        - Laboratory tests and screenings;
        - Radiology reports;
        - Physical examination notes; and
        - Other pertinent data.
- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health and (2) prior admissions as necessary.)
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when an enrollee's health status changes or new medications are prescribed, and behavioral health history.
- Documentation as to whether or not an adult enrollee has completed advance directives and location of the document (Illinois advance directives include Living Will, Health Care Power Of Attorney, 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 enrollee was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the enrollee's health care.
- Entries - Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider shall 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 physician reviewer.

Medical Record Audits

Aetna Better Health or CMS 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 an enrollee or provider, administrative responsibilities or quality of care

issues. Providers must respond to these requests promptly. Medical records must be made available to the Illinois Department of Healthcare and Family Services (HFS) or CMS for quality review upon request and free of charge.

Access to Facilities and Records
Medicare laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to enrollees or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of 10 years from the end of the contract with Aetna Better Health;
- The date the HFS or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Documenting Enrollee Appointments
When scheduling an appointment with an enrollee over the telephone or in person (i.e. when an enrollee appears at your office without an appointment), providers must verify eligibility and document the enrollee's information in the enrollee's medical record. You may access our website to electronically verify enrollee eligibility or call the Member Services Department at 1-866-600-2139.

Missed or Cancelled Appointments
Providers must:

- Document in the enrollee's medical record, and follow-up on missed or canceled appointments.
- Conducting affirmative outreach to an enrollee who misses an appointment by performing the minimum reasonable efforts to contact the enrollee.
- Notify our Member Services Department when an enrollee continually misses appointments.

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

Confidentiality and Accuracy of Enrollee Records
Providers must safeguard/secure the privacy and confidentiality of and ensure the accuracy of any information that identifies an Aetna Better Health enrollee. 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 ensure timely access by enrollees 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 enrollee information.

Provider must follow both required and voluntary provision of medical records must be consistent with HIPAA privacy statute and regulations (http://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 has 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 **http://www.hhs.gov/ocr/hipaa/.** In accordance with HIPAA guidelines, providers may not interview enrollees 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 enrollee 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-in sheet;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred bins available.

The following enrollee information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- “Individually identifiable health information” is information, including demographic data, that relates to:
    - The individual’s past, present or future physical or mental health, or condition.
    - The provision of health care to the individual.

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

Additional privacy requirements are located throughout this Handbook. 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/pvcguide1.htm

Enrollee Privacy Rights

Aetna Better Health's privacy policy states that enrollees 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 enrollee privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

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

- Making information available to enrollees or their representatives about Aetna Better Health's practices regarding their PHI
- Maintaining a process for enrollees 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

Enrollee Privacy Requests

Enrollees 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 enrollee or enrollee's authorized representative. An enrollee's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the enrollee or the deceased enrollee's estate. Except for requests for a health plan Notice of Privacy Practices, requests from enrollees or an enrollee's representative must be submitted to Aetna Better Health in writing.

Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult enrollees. The advance directive must be prominently displayed in the adult enrollee's medical record. Requirements include:

- Providing written information to adult enrollees 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 enrollee's medical record whether or not the adult enrollee has been provided the information and whether an advance directive has been executed.
- Not discriminating against an enrollee 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.

Illinois advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.

Provider Marketing

Providers must adhere to all applicable Medicare laws, rules, and regulations relating to marketing guidelines. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting the Premier Plan Program, informing enrollees that they may enroll or remain enrolled in the Program, explaining the benefits of enrollment in the Program or rules that apply to enrollees, or explaining how services are covered under the Program.

Regulations prevent us from conducting sales activities in healthcare settings except in common areas. Aetna Better Health is prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive

health care services however, we are permitted to schedule appointments with patients residing in long-term care facilities, only if the patient requests it.

Providers may discuss, in response to an individual patient's inquiry, the various benefits of the Premier Plan Program. Providers are encouraged to display plan materials for all plans with which they participate. Providers can also refer their patients to 1-800-MEDICARE, HFS, or CMS' website at **www.medicare.gov** for additional information.

Providers cannot accept Premier Plan Program enrollment forms. Aetna Better Health follows federal anti-kickback statute and CMS marketing requirements associated with Premier Plan Program marketing activities that are conducted by providers. Payments that we make to providers for covered items and/or services will be fair market value, consistent with an arm's length transaction, for bona fide and necessary services, and otherwise will comply with relevant laws and requirements, including the federal anti-kickback statue.

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to the Premier Plan Program marketing activities conducted by providers, please refer to Chapter 3 of the Medicare Managed Care Manual, which can be found on CMS;s website at **http://www.cms.hhs.gov/manuals/downloads/mc86c03.pdf**.

Please note that providers may engage in discussions with potential enrollee should a potential enrollee seek advice. However, providers must remain neutral when assisting with enrollment decisions and may not:

- Offer scope of appointment forms.
- Accept Premier Plan enrollment applications.
- Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Aetna Better Health.
- Offer anything of value to induce plan enrollees to select them as their provider.
- Offer inducements to persuade potential enrollees to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for potential enrollee enrollment activities; and
- Distribute materials/applications within an exam room setting. (Following Section 1140 of the Social Security Act Under Section 1140 of the Social Security Act, 42 U.S.C. 1320b–10, it is forbidden for any person to use words or symbols, including "Medicare," "Centers for Medicare & Medicaid Services," "Department of Health and Human Services," or "Health & Human Services" in a manner that would convey the false impression that the business or product mentioned is approved, endorsed, or authorized by Medicare or any other government agency)

- Providers May:
    - Advise potential enrollees that they are contracted with Aetna Better Health.
    - Make available and/or distribute Aetna Better Health marketing materials (provider must include other Managed Care Organizations material when distributing Aetna Better Health materials).
    - Refer their patients to other sources of information, such as Aetna Better Health's Member Services Department, HFS, CMS' website, or to 1-800-MEDICARE.
    - Share information with potential enrollees from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov), or other documents that were written by or previously approved by CMS.
    - Providers may announce their affiliation with Aetna Better Health through general advertising, (e.g., radio, television, and websites). Providers may make the affiliation announcements within the first 30 days of the new contract agreement. Provider may announce to patients once, through direct mail, e-mail, or phone, a new affiliation, which names only one Managed Care Organization. The provider and or PCP must contact the Provider Services Department to review the guidelines surrounding this process. Requirements are outlined in Chapter 3, Section 70.12.1 of the Medicare Managed Care Manual.
    - Providers may distribute printed information provided by Aetna Better Health to potential enrollees comparing the benefits of all of the different plans with which they contract as long as it is completed by a third party. Materials may not "rank order" or highlight specific plans and should include only objective information. The provider and or the PCP must contact the Provider Services Department to review the guidelines surrounding the process.

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.

Enrollees 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 expects providers to treat all enrollees with dignity and respect as required by federal law. 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 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 enrollees' diverse backgrounds, including the various cultural, racial, and linguistic challenges that enrollees 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 enrollees from such backgrounds to seek needed treatment.
- The impact that an enrollee's religious and/or 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. On an annual basis, Providers are required to complete our online cultural competency course. 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:

http://www.aetnaeducation.com/ihtml/application/student/interface.NewAetna/index2.htm?page=calendar

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

For an Ask Me 3 poster to be displayed in your office, visit the following website: **http://www.npsf.org/askme3/pdfs/AskMe_poster_APost-E.pdf**.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills
In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health is

required to ensure that Limited English Proficient (LEP) enrollees 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.

Enrollees 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 enrollees with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all enrollees, 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 enrollees and to provide oral translation, oral interpretation, and sign language services to enrollees. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate enrollee interactions. These services are free to the enrollee 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 enrollees.

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

- If an enrollee requests interpretation services, Aetna Better Health Member Services Representatives will assist the enrollee via a three-way call to communicate in the enrollee's native language.
- For outgoing calls, Member Services Staff dial the language interpretation service and use an interactive voice response system to conference with an enrollee and the interpreter.
- For face-to-face meetings, Aetna Better Health staff (e.g., Case Managers) can conference in an interpreter to communicate with an enrollee 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 to link with an interpreter.

Aetna Better Health provides alternative methods of communication for enrollees who are visually impaired, including large print and/or 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 enrollee materials in other formats to meet specific enrollee needs. Providers must also deliver information in a manner that is understood by the enrollee.

Aetna Better Health offers sign language and over-the-phone interpreter services, as well as CART reporting, at no cost to the provider or enrollee. Please contact Aetna Better Health at 1-866-600-2139 for more information on how to schedule these services in advance of an appointment.

Individuals with Disabilities

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

Clinical Guidelines

Aetna Better Health has Clinical Guidelines and treatment protocols available to provider to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to enrollees 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 enrollee;
- 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

https://www.aetnabetterhealth.com/illinois/providers/resources/clinical-practice

Office Administration Changes and Training

Providers are responsible to notify Aetna Better Health of Illinois Provider Services Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Services Department to schedule staff training.

Additions or Provider Terminations

In order to meet contractual obligations and state and federal regulations, providers who are in good standing, are required to report any terminations or additions to their agreement at least ninety 90 days prior to the change in order for Aetna Better Health to comply with CMS requirements. Providers are required to continue providing services to enrollees throughout the termination period.

CMS requires that Aetna Better Health make a good faith effort to provide written notice of a termination of a network provider at least thirty (30) days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all enrollees who are patients of that PCP must be notified when a provider termination occurs.

Continuity of Care

Providers terminating their contracts without cause are required to provide a sixty (60) day notice before terminating with Aetna Better Health. Provider must also continue to treat our enrollees until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Enrollees 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 is not responsible for payment of services rendered to enrollees who are not eligible. You may also contact our Case Management Department for assistance.

Credentialing/Re-Credentialing

Aetna Better Health uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers and uses the CAQH Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through the Council for Affordable Quality Healthcare, or 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 practitioners 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 and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Providers update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide. All new providers, (with the exception of hospital based providers) including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee.

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Please note you may NOT treat enrollees until you are credentialed. Providers must also be board certified.

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

Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination
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); and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network providers must comply with all applicable Medicare laws, rules and regulations for the Premier Plan Program, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any enrollee on the basis of health status.

Financial Liability for Payment for Services
In no event should a provider bill an enrollee (or a person acting on behalf of an enrollee) for payment of fees that are the legal obligation of Aetna Better Health. However, a network provider may collect deductibles, coinsurance, or copayments from enrollees in accordance with the terms of the enrollee's Evidence of Coverage or their Enrollee Handbook. Providers must make certain that they are:

- Agreeing not to hold enrollees liable for payment of any fees that are the legal obligation of Aetna Better Health, and must indemnify the enrollee for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna to service such enrollees, as long as the enrollee follows Aetna's rules for accessing services described in the approved enrollee Evidence of Coverage (EOC) and or their Enrollee Handbook.
- Agreeing not to bill an enrollee for medically necessary services covered under the plan and to always notify enrollees prior to rendering services.

- Agreeing to clearly advise an enrollee, prior to furnishing a non-covered service, of the enrollee's responsibility to pay the full cost of the services.
- Agreeing that when referring an enrollee to another provider for a non-covered service must ensure that the enrollee is aware of his or her obligation to pay in full for such non-covered services.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

Under the Premier Plan Programs, Aetna Better Health is responsible for administering services to covered enrollees. Listed below is a summary of each service package including the services covered under the Premier Plan:

Non-Covered/EXCLUDED Services

The following services are not covered services:

- Services provided in a State-operated psychiatric hospital as a result of a forensic commitment
- Services provided through a Local Education Agency (LEA)

Limitations on Covered Services

The following services and benefits are limited:

- Termination of pregnancy – covered only as allowed by applicable State and federal law (42 CFR Section 441, Subpart E). Providers must complete HFS's form 2390 and file it in the enrollee's medical record.
- Sterilization services – covered only as allowed by State and federal law (42 CFR Section 441, Subpart F). Providers must complete HFS's form 2189 and file it in the enrollee's medical record.
- Hysterectomy - If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the enrollee's medical record.

Below is a list of services specific to the LTSS program:

Agency	Waiver Program	Services
Illinois Department on Aging (IDoA)	Elderly Waiver also known as the Aging Waiver Community Care Program	• Adult Day Service • Homemaker • Emergency Home Response
Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with Disabilities Waiver also known as the Disabilities Waiver	• Adult Day Service • Environmental Accessibility Adaptations • Home Delivered Meals • Home Health Aide • Homemaker • Nursing, Intermittent • Personal Care (Personal Assistant) • Personal Emergency Response System • Physical, Occupational, and Speech Therapy • Respite • Skilled Nursing • Specialized Medical Equipment and Supplies
Agency	Waiver Program	Services
The Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with Brain Injury Waiver also known as the Brain Injury Waiver or TBI Waiver	• Adult Day Service • Behavioral Services • Day Habilitation • Environmental Accessibility Adaptations • Home Delivered Meals • Home Health Aide • Homemaker • Nursing, Intermittent • Personal Care (Personal Assistant) • Personal Emergency Response System • Physical, Occupational, and Speech Therapy • Prevocational Services • Respite • Skilled Nursing

		• Specialized Medical Equipment and Supplies • Supported Employment
Division of Rehabilitation Services within DHS (DHS-DRS)	People with HIV or AIDS Waiver also known as the AIDS Waiver	• Adult Day Service • Environmental Accessibility Adaptations • Home Delivered Meals. • Home Health Aide • Homemaker • Nursing, Intermittent • Personal Care (Personal Assistant) • Personal Emergency Response System • Physical, Occupational, and Speech Therapy • Respite • Skilled Nursing • Specialized Medical Equipment and Supplies
Illinois Department of Healthcare and Family Services (HFS)	Supportive Living Facilities Waiver also known as the SIL Waiver	Also known as Assisted Living Service

Services must meet medical necessity criteria and some services require prior authorization. Medical necessity criteria are guidelines that provide a recommended guide to help practitioners make decisions about appropriate health care for specific clinical circumstances. Aetna Better Health uses only evidence-based clinical guidelines.

Covered services must be provided in accordance with your contract with Aetna Better Health. From time to time, a covered service may be changed. If you have any questions please visit our website at www.aetnabetterhealth.com/Illinois or contact our call our Provider Services Department at 1-866-600-2139. Aetna Better Health will give you at least 60 days advance notice of any changes, including new services, expanded services or eliminated services. You will be notified by one or more of the following methods: provider newsletter; e-mail, updates to the Aetna Better Health website; letter (U.S. Mail), telephone call; or office visit.

Aetna Better Health works with HFS and their vendors to coordinate services that are covered by entities other than Aetna Better Health. If you have an Aetna Better Health enrollee that needs one or more of these services and you are not sure how to reach an HFS vendor, please contact HFS at 1-800-447-4278 or our Member Services Department at 1-866-600-2139.

Value-Added Benefits

	Value-Added Service	Definition	How Enrollees Access this Service
Pharmacy	90-day supply of prescription drugs (up to 1 year of refills) mailed right to your home.	CVS Caremark Mail order services offers enrollees a safe, efficient way to receive maintenance medications through the mail.	Call CVS Caremark toll free at **1-800-552-8159** Monday to Friday between 8 a.m. and 8 p.m., Eastern time.
	Over-the-counter medications and formulary prescriptions for all enrollees	Full prescription drug and selected over-the-counter medications are covered.	Obtain a prescription from a doctor. Fill at a network pharmacy. To find a network pharmacy or find the List of Covered Medications, visit www.aetnabetterhealth.com/Illinois or call Member Services toll free at 1-866-600-2139.
	$10 monthly allowance for personal health and wellness products	Mailed directly to the member	To find the order form, visit www.aetnabetterhealth.com/Illinois or call Member Services toll free at 1-866-600-2139.
Co-pays	There are no co-pays for the standard Medicaid or Medicare services, medications, or additional services offered by Aetna Better	Aetna Better Health has no cost-sharing requirements.	Use their Aetna Better Health identification card at the point of service.

	Health.		
Dental Services	Dental cleaning two times a year.	All enrollees are eligible for this service.	Schedule an appointment with a network dentist. To find a network dentist, visit www.aetnabetterhealth.com/Illinois or call Member Services toll free at 1-866-600-2139.
	Practice visits if needed.	Aetna Better Health will include practice dental visits in its benefit package. These practice visits will include, but not be limited to when an enrollee comes into the dentist office for a "practice" or "dry run." No services are provided. The patient can view the equipment, sit in the chair, ask questions, and get themselves more comfortable about coming in for a real visit.	Schedule a practice appointment with a network dentist. To find a network dentist, visit www.aetnabetterhealth.com/Illinois or call Member Services toll free at 1-866-600-2139.
	Mobile dental services for Enrollees in intermediate care facilities and nursing homes.	Aetna Better Health dentists will provide services on-site at these facilities.	Facilities can call DentaQuest Member Services toll free at 1-800-416-9185 to get information about this program.
Non-Emergency/ Non-Ambulance Transportation	Rides to provider visits and to the pharmacy if the pharmacy visit	Enrollees can go right from their provider visits to the pharmacy to get their medications and then home.	Call the Aetna Better Health transportation broker, Medical Transportation Management (Ride Right/MTM); toll free at 1-888-513-1612 to schedule a ride.

	immediately follows a provider appointment.		
	Transportation also included for family support and personal assistant.	Family enrollees and personal attendants can ride with enrollees to medical visits at no additional charge.	
Member Services Hotline	Member Services hotline available 24 hours a day, 7 days a week (except state holidays).	Local call center staff manages the calls from 8:00 A.M. to 5:00 P.M. Monday through Friday. Specially trained enrollees of Aetna Better Health's corporate call center manage calls after business hours and on weekends and holidays.	Call Member Services toll free at 1-866-600-2139 for service.
Behavioral Health Crisis Line	The Behavioral Crisis hotline is available 24 hours a day, 7 days a week.	Aetna Better Health will provide telephonic behavioral health crisis intervention and referral 24 hours a day, 7 days a week. Local mental health centers will provide dispatch services to enrollees in crisis. Dispatch services can include going to the enrollee's home or meeting the enrollee at the hospital or	Call Member Services toll-free at 1-866-600-2139 and select the option for behavioral health crisis. This is one of the first options listed on the menu so that enrollees and caregivers do not have to listen too much of the message.

		provider's office. Referrals for appropriate follow-up care are coordinated and arranged according to the enrollee's resources and geographic location. The availability of a 24/7 crisis line has been known to reduce hospitalizations and save lives	
Care Coordinators	To help enrollees connect with health care providers and other services they may need.	High-risk enrollees will be assigned to care coordinators based on the results of their health risk questionnaire.	Call Member Services toll free at 1-866-600-2139 for service.
	A care plan is developed for each individual enrollee to help them reach your health care goals.	Enrollees in care management will have a care plan. This plan will be created by the enrollee and care coordinator in consultation with the primary care provider (PCP) and other care team participants.	
	Enrollee-centered care coordinators in the community.	Aetna Better Health care coordinators are located in each of the six counties of service.	
	Additional support for	Care coordinators can assist providers	Providers can call Member Services toll free at 1-866-600-2139 to work

	your doctor to help coordinate all your health care services.	with enrollee education, identifying medication compliance issues, and coordinating treatment from specialists and any other service providers.	with a care coordinator.
Health Education	Health education materials available in print and on CD.	Care coordinators have access to the Krames On-Demand medical library at www.krames.com. This on-line library has English and Spanish education materials on diseases and wellness written at the sixth grade reading level. Care coordinators can select articles that are individualized to an enrollee's needs. For enrollees who are unable to read, the materials will be recorded on audio-CD or can be read to them over the phone.	Call Member Services toll free at 1-866-600-2139 to obtain educational materials.
	Prevention and wellness reminder cards.	Enrollees will receive postcards to remind them to obtain preventive care such as flu shots and mammograms.	These will be mailed to the enrollee.

Telemonitoring	Eligible enrollees will get devices to help check on health problems at home when needed to manage health conditions.	Telehealth technology comprises remote monitoring of certain biological signals including blood pressure, pulse, blood oxygenation, weight, and blood glucose levels. Signals are transmitted to a monitoring facility where they are then reviewed against desired parameters established in conjunction with clinicians responsible for patient management. When readings are found to be out of desired parameters then appropriate interaction with patients and their clinicians is initiated to remediate the problem in a timely manner. Interactions can include telephonic contact and messaging to the patient through the monitoring device itself.	Medical management staff will determine eligibility for these services and then assist eligible enrollees with obtaining them. Call Member Services toll free at 1-866-600-2139 for more information.

Post-Stabilization Services

Aetna Better Health covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health authorized the services
- Such services were administered to maintain the enrollee has stabilized condition within one (1) hour after a request to Aetna Better Health for authorization of further post-stabilization services.
- When Aetna Better Health does not respond to a request to authorize further post-stabilization services within one (1) hour, could not be contacted, or cannot reach an agreement with the treating provider concerning the enrollee's care and a contracted provider is unavailable for a consultation. In this situation, the treating provider may continue the enrollee's care until a contracted provider either concurs with the treating provider's plan of care or assumes responsibility for the enrollee's care.

Pharmacy Services

You can find a more comprehensive description of covered services on our website at www.aetnabetterhealth.com/illinois. Please contact our Provider Services Department at 1-866-600-2139 with any questions.

Medical Necessity

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

You can view a current list of the services that require authorization on our website at https://www.aetnabetterhealth.com/illinois/providers/resources/priorauth.

If you are not already registered for the secure web portal, download an application from the Illinois 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 1-866-600-2139.

Emergency Services

Aetna Better Health covers emergency services without requiring prior authorization for enrollees, whether the emergency services are provided by a contracted or non-contracted provider. Aetna Better Health will cover emergency services provided outside of the contracting area except in the following circumstances:

- When services are for elective care.
- When care is required as a result of circumstances that could reasonably have been foreseen prior to the enrollees departure from the contracting area.
- When routine delivery, at term, if enrollee is outside the contracting area against medical advice, unless the enrollee is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalization due to complications of pregnancy are covered.

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

Transportation

Transportation services are covered through Medical Transportation Management, Inc. (Ride Right/MTM). This sub-contractor provides non-ambulance, non-emergent transportation services.

Ambulance services (including air ambulance) are covered by Aetna Better Health. Emergency transportation services are covered for emergencies only. Enrollees who experience a medical emergency should call 911.

Laboratory Services

Laboratory services will be provided.

Dental Services - DentaQuest

Dental services are provided through DentaQuest. DentaQuest is responsible for covering routine and specialty dental services, the administration of the dental network, and claim payment for dental services.

Vision Services - March Vision Care

Routine vision services are provided through March Vision Care Group, Inc. March Vision covers routine eye exams, prescription frames and lenses, administers the vision network and processes vision claim payment. Medical and surgical care of the eye (including any medical care provided by an optometrist) is covered directly by Aetna Better Health. Claims for routine vision care should be billed to March Vision Care. Claims for medical or surgical care of the eye should be billed to Aetna Better Health. Optometrists or ophthalmologists that plan to provide both routine care and medical care of the eye should be contracted both with March Vision and directly with Aetna Better Health.

Interpretation Services

Telephone interpretive services are provided at no cost to enrollees or providers. Personal interpreters can also be arranged in advance. Sign language and CART reporting services are also available. These services can be arranged in advance by calling Aetna Better Health

Member Services at 1-866-600-2139. Sign language and CART reporting services are available at no charge to enrollees and providers.

The Illinois Client Enrollment Broker

The Illinois Client Enrollment Broker (ICEB) is responsible for the enrollment of potential enrollees, including provision of health care plan choice education and enrollment by auto-assignment.

Premier Plan Services

All Medicare-covered services must be medically necessary, and except for emergency or urgently needed care, or otherwise authorized by Aetna Better Health, must be provided by a participating PCP or other qualified participating providers. Benefit limits apply.

Providers are required to administer covered services to enrollees in accordance with the terms of their contract and enrollee's Evidence of Coverage.

The full array of benefits and supportive services under the Premier Plan Program include, Medicare (including inpatient, outpatient, hospice, durable medical equipment, skilled nursing facilities, home health, and pharmacy) and Medicaid (including behavioral health, long-term institutional and community-based long-term supports and services).

The benefit information provided is a brief summary, not a complete description of the benefits. For more information contact our Provider Services Department at 1-866-600-2139.

Note: Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium, and/or co-payments/coinsurance may change on January 1 of each year.

Annual Notice of Change

Premier Plan benefits are subject to change annually. Enrollees are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period begins on October 15th each year for enrollees and ends on December 7th. Providers can access the Aetna Better Health website on or around October 15th for information on the individual plan and benefits that will be available for the following calendar year.

Medicare Coverage Overview

- **Part Hospital** Insurance; pays for inpatient care, skilled nursing facility care, hospice, and home health care.
- **Part B** – Medical Insurance; pays for doctor's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
- **Part C** – Medicare Advantage Plans (MA): combines Part A and B health benefits through managed care organizations; most plans include Part D (MAPD plans).

- **Part D** – Medicare Prescription Drug Plan: helps pay for prescription drugs, certain vaccines, and certain medical supplies (e.g. needles and syringes for insulin). Part D coverage is available as a standalone Prescription Drug Plan (PDP) or integrated with medical benefit coverage (MAPD).

CHAPTER 6: ENROLLEE RIGHTS AND RESPONSIBILITES

Aetna Better Health is committed to treating enrollees with respect and dignity at all times. Enrollee rights and responsibilities are shared with staff, providers, and enrollees each year.

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

It is Aetna Better Health's policy not to discriminate against enrollees based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of enrollee rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating enrollees with respect and dignity.

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

Enrollees have the following rights and responsibilities:

ENROLLEE RIGHTS

Aetna Better Health enrollees have the right to information related to their treatment or treatment options in a manner appropriate to the enrollee's condition and ability to understand. This includes, but is not limited to:

- Be treated with respect and with due consideration for the enrollee's dignity and privacy
- The freedom to exercise all enrollee rights without any adverse effect on the enrollee's treatment by Aetna Better Health or providers
- Names of primary health care and participating providers and, if appropriate, Case Managers
- Copies of medical records as allowed by law and the right to request that they be amended or corrected
- A description of the Aetna Better Health services or covered benefits
- A description of their rights and responsibilities as enrollees, including the right to refuse treatment
- How Aetna Better Health provides for after-hours and emergency health care services
- Information about how Aetna Better Health pays providers, controls costs and the use of services
- Summary results of enrollee surveys and grievances
- Information that an enrollee will not be balanced billed by a provider for any covered service
- Information about the cost to an enrollee if the enrollee chooses to pay for a service that is not covered
- Information about reasonable accommodation
- Procedures for obtaining services, including authorization requirements
- A description of how Aetna Better Health evaluates new technology for inclusion as a covered benefit
- What treatment choices or types of care are available to the enrollee, and the benefits or drawbacks of each choice
- Advance Directives - Aetna Better Health informs enrollees of the their right to formulate advance directives
- Health care benefit or network changes
- Receive information including all enrollment notices, informational materials, and instructional materials in a manner and format that be easily understood.

Enrollees have a right to respect, fairness, and dignity. This includes, but is not limited to:

- An ability to receive covered services without concern about payer source, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay or ability to speak English
- Quality medical services that support personal beliefs, medical condition and background
- Interpreter services for enrollees who do not speak English or who have impaired hearing or request written information in an alternative format
- The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience
- The right to reasonable accommodations when accessing care.

Enrollees have a right to participate in decision making about their health care, and/or have a representative facilitate care or treatment decisions when necessary. This includes, but is not limited to:

- Choosing a Primary Care Provider (PCP) to help with planning and coordinating care
- The right to see a women's health care provider without a referral
- Timely access to providers and care from a specialist when it is needed; timely access to prescriptions from a network pharmacy
- The right to know about all treatment options, no matter what they cost or whether they are covered
- The right to be told about any risks involved in care
- The right to be told in advance if a proposed care or treatment is part of a research experiment and the right to refuse experimental treatments
- The right to change PCP
- Requesting specific, condition-related information from a PCP
- Requesting information about procedures and who will perform them
- Deciding who should be in attendance at treatments and examinations
- Choosing to have a female in the room for breast and pelvic exams
- Refusing a treatment, including leaving the hospital even though a doctor advises against it, and requesting an explanation of consequences. Eligibility or medical care does not depend on an enrollee's agreement to follow a treatment plan.
- The right to stop taking medications
- Written notification when health care services are reduced, suspended, terminated, or denied. Notification is accompanied by instructions on how to file a grievance or request a Fair Hearing from HFS.
- The right to receive information concerning the structure and operations of the health plan

Enrollees have a right to seek emergency care and specialty services. These rights include:

- Obtaining emergency services without prior approval from the PCP or Aetna Better Health when they have an emergency
- Refusing care from a specialist the enrollee was referred to and requesting another referral
- Requesting a second opinion

Enrollees have a right to confidentiality and privacy. This includes, but is not limited to:

- Privacy and confidentiality of health care information. Information will be distributed only as allowed by law.
- The right to receive a copy of their medical records and to ask that additions or corrections be made to the records

- The right to ask how their health care information has been given out and used for non-routine purposes
- The right to talk to health care professionals and Case Managers privately

Enrollees have a right to report concerns to Aetna Better Health. This includes, but is not limited to:

- Filing a grievance or appeal against Aetna Better Health or its providers
- Requesting a fair hearing from HFS
- Recommendations for changes to policies and services
- The right to a detailed explanation if an enrollee believes that an Aetna Better Health provider has denied care the enrollee believes they are entitled to receive

Enrollee responsibilities

Aetna Better Health enrollees are responsible for:

- Knowing the name of the assigned PCP and/or Case Manager
- Familiarizing themselves about their coverage and the rules they must follow to get care
- Informing Aetna Better Health of any changes in eligibility, or any other information that may affect membership, health care needs or access to benefits
- Respecting the health care professionals providing service
- Sharing any concerns, questions or problems with Aetna Better Health
- Providing all necessary health related information needed by the professional staff providing care, and requesting more explanation if a treatment plan or health condition is not understood
- Following instructions and guidelines agreed upon with the health professionals giving care
- Protecting their enrollee identification card and providing it each time they receive services
- Disclosing other insurance they may have and/or applying for other benefits they may be eligible for
- Scheduling appointments during office hours, when possible
- Arriving for appointments on time
- Notifying the health care professionals if it is necessary to cancel an appointment
- Following instructions and guidelines given by those providing health care services

For questions or concerns, please contact our Provider Services Department for those enrollees enrolled in the Premier Plan at 1-866-600-2139.

<u>Enrollee Rights Under Rehabilitation Act of 1973</u>

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: 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.

CHAPTER 7: ELIGIBILITY AND ENROLLMENT

Aetna Better Health arranges medically necessary covered services for individuals who are enrolled in the Premier Plan Programs. This chapter describes eligibility categories, the role of the enrollment broker, enrollee marketing, and the enrollment and disenrollment processes.

Eligibility

Premier Plan Program Enrollees:

- Entitled to Medicare Part A and enrolled in Part B
- Currently enrolled in Medicaid medical assistance
- Have not been diagnosed with end-stage renal disease (ESRD) (exceptions may apply)
- Permanently reside in the service area
- Over the age of 21

The Illinois Department of Healthcare and Family Services (HFS) determines eligibility for Premier Plan Program. If an individual loses eligibility for the Premier Plan Program, Aetna Better Health is required to end their coverage under the Program.

Enrollment Broker
The Illinois Client Enrollment Broker (ICEB) is responsible for the enrollment of potential enrollees, including provision of health care plan choice education and enrollment by auto-assignment.

ICEB handles the enrollment process for the Integrated Care and Premier Plan Programs. ICEB mails eligible enrollees an enrollment packet, containing information about the programs, information about each available health plan, and instructions on completing the form, PCP choices, and the auto-assignment process. Eligible enrollees have 30 days to select a health plan by calling or completing the form on ICEB's website. ICEB will auto-assign eligible enrollees who do not make a selection to a health plan, using an algorithm that distributes enrollees equally between the health plans.

Aetna Better Health provides translated materials, interpretive services, and/or information available in alternative formats (i.e. Braille) as needed or requested by enrollees or potential enrollees.

Open Enrollment
Enrollees have the option to change health plans during the initial 90 days after the effective date of enrollment (the enrollee's anniversary date). Thereafter, enrollees can change health plans annually upon open enrollment, in which they will have a 60-day period to change health plans. The ICEB will send enrollees a notice of their option to change health plans and the associated deadline. Enrollment in a new health plan will be effective on the enrollee's anniversary date.

Re-Enrollment
Enrollees who lose their Medicaid eligibility and whose coverage is reinstated within the last two months will be re-enrolled with the health plan with which they were previously enrolled. Aetna Better Health will assign the enrollee to their previous PCP if the PCP is still accepting new patients.

PCP Changes
If an enrollee is dissatisfied with the auto-selection assignment, or wishes to change their PCP for any other reason, the enrollee may choose an alternative PCP at any time by calling the Member Services Department. Aetna Better Health will promptly grant the request and process the PCP change in a timely manner. Enrollees will receive a new ID card indicating the new PCP's name. Premier Plan enrollees cannot change PCPs more than once per month.

In cases where a PCP has been terminated for reasons other than cause, Aetna Better Health promptly informs enrollees assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where an enrollee fails to select a new PCP, the enrollee is reassigned to another compatible PCP prior to the PCP's termination date, informing the enrollee of the change in writing.

ID Card
Enrollees should present their Aetna Better Health ID card at the time of service. The effective date of eligibility will be on the ID card. This card also has information on where claims should be submitted.

Verifying Eligibility
The provider is responsible for verifying an enrollee's current enrollment status before providing care. Aetna Better Health will not reimburse for services provided to patients who are not enrolled with Aetna Better Health. Providers can verify enrollee eligibility by calling Aetna Better Health at 1-866-600-2139.

Tools to Identify and Track At-Risk Enrollees

Aetna Better Health uses data-driven tools to provide early detection of enrollees who are at risk of becoming high cost, who have actionable gaps or errors in care and/or who may benefit from case management. These tools have two main components. The first is our predictive modeling tool. The second, more comprehensive component is known as the CORE model, or Consolidated Outreach and Risk Evaluation. We supplement information from these tools with data collected from Health Risk Questionnaires (HRQs). We also track information in a customized care management tracking application.

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

Predictive Modeling

Aetna Better Health's predictive modeling software identifies and stratifies enrollees who are eligible for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each enrollee. The application funnels information from these various sources into an enrollee profile that allows our Case Managers to access a concise 12-month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks enrollees and prepares a monthly "target" report of the enrollees most likely to require care management services. In addition to the scoring methodology, predictive modeling also looks at certain "triggers" to alert Case Managers to potential risk factors, including:

- Enrollees with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e. home health or selected surgical procedures)
- Call tracking from Aetna Better Health's Member Services Department

CORE Model

The CORE (Consolidated Outreach and Risk Evaluation) accesses predictive modeling information and provides a more detailed analysis, including an enrollee's risk of using inpatient and/or emergency department services in the near future. By using the CORE, Aetna Better

Health can further drill down to identify specific health factors and at-risk enrollees who may benefit from intervention by our care management team.

Health Risk Questionnaires (HRQs)
Aetna Better Health also assesses enrollees through HRQs. Aetna Better Health staff enrollees go over the HRQ with the enrollee or caregiver during a telephone call made to each enrollee to welcome them to the health plan. The HRQ gathers:

- Enrollee contact information
- PCP or medical home information
- Enrollee's health history
- Frequency of ER use
- Medication usage

CM Business Application Systems
Our care management business application system stores and retrieves enrollee data, claims data, pharmacy data, and history of enrollee interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires; care plans and allows care management staff to set tasks and reminders to complete actions specific to each enrollee. It provides a forum for clear and concise documentation of communication with providers, enrollees, and caregivers. It retains history of events for use of the information in future cases. The system also provides a care consideration function, in which the Case Manager can view and respond to correspondence with the providers on recommended standards of practice and HEDIS interventions for certain conditions and medications. The system interfaces with our authorization business application system, predictive modeling software, the inpatient census tool and allows documents to be linked into 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 care 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 in accordance with Aetna Better Health's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the enrollee'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-Premier Plan approved, investigational, or cosmetic are specifically excluded from Medicaid 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 enrollee, the enrollee’s family/caregiver and the PCP, as well as any other providers, programs, agencies that have evaluated the enrollee. Medical necessity determinations must be made by qualified and trained health care providers.

CHAPTER 9: CONCURRENT REVIEW

Concurrent Review Overview

Aetna Better Health conducts concurrent utilization review on each enrollee 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 enrollee's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines® (MCG) for physical health or the Level of Care Utilization System (LOCUS) or the American Society of Addiction Medicine (ASAM) criteria for behavioral health. 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 nurses conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized enrollees.

Milliman Care Guidelines

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

Level of Care Utilization System (LOCUS)

The Level of Care Utilization System has three main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service arrays which vary according to the amount and scope of resources available at each “level” of care in each of four categories of service. The

third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.

American Society of Addiction Medicine (ASAM) Criteria
The American Society of Addiction Medicine criteria are used to provide outcome-oriented and results-based care in the treatment of addiction. The ASAM criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

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 enrollee and for involving the enrollee and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure 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 enrollees with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, 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 SNF must be coordinated with the enrollee's Case Manager. In accordance with Section 83 of Title 42 of the code of Federal Regulations, resident rights, any discharge or transfer of an enrollee 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 enrollee, his or her representative, and the enrollee's Case Manger must be involved in discharge planning.

CHAPTER 10: PRIOR AUTHORIZATION

Primary care providers (PCP) or treating practitioner/providers are responsible for initiating and coordinating an enrollees request for authorization. However, specialists and other practitioners/providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting practitioner or provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrollee of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the 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.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT),
  - International Classification of Diseases, 10th Edition (ICD-10),
  - Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the enrollee
- Primary care provider or treating practitioner
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

Timeliness of Decisions and Notifications to Practitioners, Providers, and/or Enrollees

Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable enrollees in a timely manner. Unless otherwise required by HFS or CMS, Aetna Better Health adheres to the following decision/notification time standards.

Decision/Notification Requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Seventy-two (72) hours from receipt of request	Practitioner/Provider Enrollee	Oral and Electronic/Written
Non-urgent pre-service approval	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider Enrollee	Electronic/Written
Urgent concurrent approval	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent concurrent denial	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider Enrollee	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least ten (10) Calendar Days before the date of the action.	Practitioner/Provider Enrollee	Electronic/Written

If Aetna Better Health approves a request for expedited determination, a notification will be sent to the enrollee and the physician involved, as appropriate, of its determination as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after receiving the request.

If Aetna Better Health denies a request for an expedited determination, the request will automatically be transferred to the standard time frame. Aetna Better Health will promptly provide the enrollee oral notice of the denial of an expedited review and of their rights. Aetna Better Health will subsequently deliver to the enrollee seventy-two (72) hours, a written letter of the enrollees' rights.

Out-of-Network Providers

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

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

Prior Authorizations List

Primary care providers (PCP) or treating practitioner/providers must request authorization for certain medically necessary services. Prior authorization is required for, but not limited to:

- Laboratory Services: Prior authorization is NOT required for approved in office routine lab procedures that are Clinical Laboratory Improvement Amendments (CLIA) certified. We are contracted with Quest to provide laboratory services. Quest is **preferred** but **not required**. Any laboratory can be used without prior authorization.
- Radiology Services: Prior authorization IS required for certain radiology services. The prior authorization summary on our website contains additional information on services that require prior authorization.
- Infusion or Enteral Therapy Services: Prior authorization is required for any medically necessary services rendered by an infusion or enteral provider.
- Durable Medical Equipment (DME): DME equipment and related services may require prior authorization.

For a completed and current list of services which require prior authorization can be found online at https://www.aetnabetterhealth.com/illinois/providers/resources/priorauth

Unauthorized services will not be reimbursed and authorization is not a guarantee of payment.

All out of network services must be authorized.

Prior Authorization and Coordination of Benefits
If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

How to request Prior Authorizations
A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health's website, or
- Fax the request form to 1-855-320-8445 (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing, or
- Call us directly at, or 1-866-600-2139

Pharmacy Prior Authorization
Aetna Better Health of Illinois will process coverage determinations and exception requests in accordance with Medicare Part D regulations and/or Medicaid regulations. Requests will be handled through the prior authorization review process. The prior authorization staff will adhere to approved criteria. Aetna Better Health of Illinois establishes clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit prior authorization requests by phone or fax. Providers will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

Coverage determination requests will be determined seventy-two (72) hours after receipt of complete information from the provider for Standard determinations. Expedited reviews will be determined within twenty-four (24) hours after receipt of complete information from the provider. Conditions meeting expedited review include an imminent or serious threat to the health of the Enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Determination notices will be faxed to the provider's office once the decision is made.

To submit a coverage determination or exception request, complete the Coverage Determination form and fax to 1-855-364-8109 or call or 1-866-600-2139 (Premier Plan)

Self-Referrals
Aetna Better Health does not require referrals from primary care providers (PCP), or treating practitioner/providers. Enrollees may self-refer access some services without an authorization from their PCP. These services include behavioral health care, vision care; Medicaid approved Alcohol and Drug Addiction facilities, dental care, family planning, and women's health care services. The enrollee must obtain these self-referred services from Aetna Better Health's provider network, except in the case of family planning.

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

CHAPTER 11: QUALITY MANAGEMENT

Overview
Our Quality Management (QM) Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. Aetna Better Health uses this approach to measure conformance with desired medical standards and develop activities designed to improve patient outcomes.

Aetna Better Health performs QM through a Quality Assessment and Performance Improvement (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of the QM Program is to improve the health status of enrollees or maintain current health status when the enrollee's condition is not amenable to improvement.

Aetna Better Health's QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. 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's quality improvement process.

Aetna Better Health's QM Program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization and committees from the Board of Directors to the Enrollee Advisory subcommittee. This structure allows enrollees and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. The Medical Director is supported in this effort by our QM Department and the Quality Management and Utilization Management (QM/UM) Committee.

Major functions of the QM/UM Committee include:

- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators and satisfaction surveys
- Recommend policies for development, review and approval

Additional committees such as Service Improvement (SIC), Credentialing, Appeals/Grievance, and Quality Management Oversight Committees (QMOC) further support our QM Program. Aetna Better Health encourages provider participation on key medical committees. Providers may contact the Medical Director or inform their Provider Services Representative if they wish to participate. You can reach Aetna Better Health by calling , or 1-866-600-2139 (Premier Plan).

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

Aetna Better Health's QM Department is an integral part of Medical Management and internal operations. 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 enrollees. Our QM and MM departments maintain ongoing coordination and collaboration regarding quality initiatives, case management, and disease management activities involving the care of our enrollees.

Aetna Better Health's QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, Aetna Better Health, in collaboration with providers, is able to monitor and reassess the quality of services provided to our enrollees. Providers are obligated to support and meet Aetna Better Health is QM/UM program standards.

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

Identifying Opportunities for Improvement

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

- Formal Feedback from External Stakeholder Groups: Aetna Better Health takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS), or focus groups with individuals, such as enrollees and families, providers, and state and community agencies.
- Findings from External Program Monitoring and Formal Reviews: Externally initiated review activities, such as an annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process assists Aetna Better Health in identifying specific program activities/processes needing improvement.
- Internal Review of Individual Enrollee or Provider Issues: In addition to receiving grievances and appeals from enrollees, providers, and other external sources, Aetna Better Health proactively identifies potential quality of service issues for review through daily operations (i.e. member services, prior authorization, and care management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services, and quality of care), Aetna Better Health is able to identify specific opportunities for improving care delivered to individual enrollees.
- Findings from Internal Program Assessments: Aetna Better Health 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: provider 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 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 is able to identify opportunities for improvement in clinical and operational functions. These measures include:
    - Adherence to nationally recognized best practice guidelines and protocols
    - Service 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 enrollees' care plans -Availability of 24/7 telephonic assistance to enrollees and caregivers receiving home care services

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

Potential Quality of Care (PQoC) Concerns

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

Performance Improvement Projects (PIPS)

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

- Target improvement in areas that will address a broad spectrum of key aspects of enrollees' 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 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, QM/UM Committee, and the Quality Management Oversight Committee (QMOC) prior to submission to the HFS for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health, as well as from network providers who are enrollees of our QM/UM 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 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. Providers who have been reviewed and disagree with the results are given an opportunity to appeal the committee's recommendation. Written appeals stating the reasons why the provider does not agree may be submitted. At any time, the provider may request all profiling data that was used during the provider's performance evaluation.

Performance Measures
Aetna Better Health collects and reports clinical and administrative performance measure data to HFS. The data enable Aetna Better Health and HFS to evaluate our adherence to practice guidelines, as applicable, and/or improvement in enrollee outcomes.

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

Enrollee Satisfaction Surveys
Consumer Assessment of Healthcare Providers and Systems (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Children) are subsets of HEDIS reporting. Aetna Better Health contracts with an NCQA-certified vendor to administer the survey according to HEDIS survey protocols. The survey is based on randomly selected enrollees and summarizes satisfaction with the health care experience.

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

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. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to enrollees. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.
Aetna Better Health cooperates fully with external clinical record reviews assessing our network's quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by the HFS. Aetna Better Health assists in the identification and collection of any data or records to be reviewed by the independent evaluation team enrollees. Aetna Better Health also provides complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Better Health'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.

Provider Profiles
In an effort to promote and ensure the provision of quality care, Aetna Better Health profiles providers who meet the minimum threshold of enrollees in their practices, as well as the minimum threshold of enrollees for specific profiling measures. Individual providers and practices are profiled for multiple measures and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

The Provider Profiling Program is designed to share standardized utilization data with physicians in an effort to improve clinical outcomes. Aetna Better Health's profiling program is intended to support clinical decision-making and patient engagement as physicians often have

little access to information about how they are managing their enrollees or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider- patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

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

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

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

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

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

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of enrollees, opportunities for improvement identified through our QM Program, and feedback from participating providers. Guidelines are updated as appropriate.

CHAPTER 12: PHARMACY MANAGEMENT

Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized prescriber, such as a PCP, specialist, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution

whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The formulary identifies all of the prescription and over the counter drugs covered by the Premier Plan Program. The formulary drug list has been approved by CMS and/or the state and reviewed by the Pharmacy and Therapeutics Committee (P&T Committee) to ensure that they are clinically appropriate to meet the therapeutic needs of our enrollees in a cost effective manner.

- All formulary utilization management restrictions are approved by CMS and the P&T Committee.

Updating the Formulary
Aetna Better Health's formulary is continuously reviewed by the P&T Committee and prescription drugs are added or removed based on objective, clinical, and scientific data and market changes. All updates to the formulary must be approved by CMS and/or the state and adhere to all mandated guidance on changes. Considerations include safety, efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change drugs listed in the formulary. Market share shifts, price increases, generic availability, and varied dosage regimens may affect the actual cost of therapy.
- The formulary must adhere to CMS and state requirements.
- Products are not added to the list if there are less expensive, similar products on the formulary unless provide superior outcomes or mandated by CMS or the state.
- When a drug is added to the formulary, other drugs in the same category may be removed.

Notification of Formulary Updates
Aetna Better Health must follow CMS and state policy regarding formulary changes. Aetna Better Health may add drugs to the formulary or delete utilization management requirements at any time during the year. After March 1st each year, Aetna Better Health may only make maintenance changes to the formulary, such as replacing a brand name drug with a new generic, or modifications to quantity limits based on new drug safety information. CMS limits non-maintenance formulary changes and must be approved by CMS.

If approved, enrollees currently taking the affected drugs are exempt from the change until the remainder of the calendar year. Aetna Better Health will provide notice to affected enrollees at least sixty (60) days prior to removing a covered drug from the formulary, or provide the enrollee with a 60-day supply of the drug. If the Federal Drug Administration (FDA) deems a drug unsafe or it is removed from the market by its manufacturer, Aetna Better Health will

provide a notice as soon as possible. A list of formulary changes is maintained on the Aetna Better Health website. Aetna Better Health may notify providers of changes to the formulary via direct letter or through our website.

Federal Part D regulations require Aetna Better Health to have a formulary that contains at least two Part D prescription drugs in each approved category, and all drugs in the six special classes listed below:

- Antidepressants
- Antipsychotic
- Anticonvulsants
- Antiretroviral
- Antineoplastic
- Immunosuppressant

Both generic and brand name drugs are covered, but some drugs are statutorily excluded from coverage or are excluded for certain indications. Excluded drugs include, but are not limited to:

- Drugs for anorexia, weight loss or weight gain
- Fertility drugs
- Erectile Dysfunction drugs
- Drugs for cosmetic purposes or hair growth
- Drugs for symptomatic relief of cough and cold (exceptions may apply)
- Prescription vitamins and mineral products (except pre-natal vitamins and fluoride preparations)
- Electrolytes/Replenishers
- Non-prescription drugs (exceptions may apply)
- Drugs covered under Medicare Part A or Part B (exceptions may apply)

Pharmacy Transition of Care Process

New Premier Plan enrollees (within their first 90 days) taking prescription drugs that are not on the formulary, or formulary drugs that are subject to certain restrictions, such as prior authorization or step therapy, will receive a temporary transitional fill of up to a 30-day supply of a non-formulary drug, or a formulary drug requiring prior authorization at a retail pharmacy. Enrollees and their prescribing physician will receive a letter instructing them to consult with their prescribing physician to decide if they should switch to an equivalent drug that is on the formulary or to request a formulary exception in order to get coverage for the drug.

Aetna Better Health will not pay for additional fills for the drug(s), unless the prescriber submits a request for a prior authorization or formulary exception and we approve. If the request is approved, the approval will be valid through the remainder of the calendar year or as specified on the approval letter.

LTC/ Nursing Facility
If a new enrollee is a resident of a long-term care facility, we will cover multiple fills of a temporary transitional fill of up to a 98-day supply within their first 90 days. We will also cover an additional 31-day emergency supply (unless the prescription is for fewer days) for an enrollee past the first 90 days while we process a requested coverage determination.

If the enrollee has unplanned level of care changes, (e.g., discharged from a hospital to a home, or ending a stay at a long term care facility and returning home), we will provide an emergency 31-day supply of a currently prescribed drug to transition the enrollee to their new level of care setting. The enrollee and the enrollee's physician will receive a letter notifying them that they will need to transition to a prescription drug on our formulary or request a coverage determination.

Please note that transition policy applies only to Part D drugs filled at a network pharmacy.

CHAPTER 13: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

Providers are required to comply with federal and state law regarding advance directives for adult enrollees. The advance directive must be prominently displayed in the adult enrollee's medical record. Requirements include:

- Providing written information to adult enrollees 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 enrollee's medical record whether or not the adult enrollee has been provided the information and whether an advance directive has been executed.
- Not discriminating against an enrollee 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 enrollee's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives (durable power of attorney and living wills).

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health as a grievance or complaint, or with the Illinois Department of Public Welfare at 1-800-252-8903.

CHAPTER 14: ENCOUNTERS, BILLING AND CLAIMS

Aetna Better Health processes claims for covered services provided to enrollees in accordance with applicable policies and procedures and in compliance with applicable state and federal

laws, rules and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in Integrated Care or Premier Plan Programs, or any program under federal law, or is not in good standing with the HFS.

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

Encounters

Billing Encounters and Claims Overview

Our Claims Inquiry Claims Research (CICR) Department is responsible for claims adjudication; resubmissions, claims inquiry/research, and provider encounter submissions to CMS for the Premier Plan Program.

Aetna Better Health is required to process claims in accordance with Medicare claim payment rules and regulations.

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of 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.
- Report all secondary diagnoses that impact clinical evaluation, management, and/or treatment.

- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

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

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

TAG Itemized Billing

Please note that although clean claims will pay within 30 days for 90% of all claims, some claims may be flagged for pre-payment review. In such cases, additional documentation such as medical records and/or itemized bills supporting billed charges will be requested. The request may come directly from Aetna Better Health or may come from our third party forensic review vendor, The Assist Group (TAG). Claims payment in these cases will be within 30 days of receipt of requested documentation.

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to ensure the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted. Premier Plan Programs like Aetna Better Health's, are annually selected for data validation audits by CMS.

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 enrollee'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 fairly and accurately adjust payments made to Aetna Better Health by CMS based on the health status and demographic characteristics of an enrollee. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category 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 enrollee. 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 and payments made by Aetna to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for an enrollee 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 enrollee 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. 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. 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 an Enrollee

All providers must adhere to federal financial protection laws and are prohibited from balance billing any enrollee beyond the enrollee's cost sharing, if applicable.

An enrollee may be billed **ONLY** when the enrollee knowingly agrees to receive non-covered services under Premier Plan Programs

- Provider MUST notify the enrollee in advance that the charges will not be covered under the program.
- Provider MUST have the enrollee sign a statement agreeing to pay for the services and place the document in the enrollee'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 an enrollee must be received in a timely manner. Our timely filing limitations are as follows:

- **New Claim Submissions** – Claims must be filed on a valid claim form within 120 days from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.
- **Claim Resubmission** – Claim resubmissions must be filed within 180 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

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

Non-network providers rendering prior authorized services follow the same timely filing guidelines as Original Medicare guidelines.

Injuries Due to an Accident

Under the Premier Plan Program, Medicare law only permits subrogation in cases where there is a reasonable expectation of third party payment. In cases where legally required insurance (i.e. auto-liability) is not actually in force, Aetna Better Health is required to assume responsibility for primary payment.

How to File a Claim

1) Select the appropriate claim form (refer to table below).

Service	Claim Form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**CMS UB04 Form (APL Services)**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**

Instructions on how to fill out the claim forms can be found on our website.

2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   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.

3) Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as enrollees' medical records, clearly label and send to Aetna Better Health at the correct address.
   a) Electronic Clearing House
      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.
      - Emdeon is the EDI vendor we use.
      - Contact your software vendor directly for further questions about your electronic billing.
      - Contact our Provider Services Department for more information about electronic billing.

      All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health policies and procedures.
   b) Through the Mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health P. O. Box 66545 Phoenix, AZ 85082	Electronic Clearinghouse Emdeon Payer ID 26337
Refunds	Aetna Better Health of IL Lockbox 842499 1950 N Stemmons Freeway Suite 5010 Dallas, TX 75207	Not Applicable

Correct Coding Initiative

Aetna Better Health 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 **http://www.cms.hhs.gov/NationalCorrectCodInitEd/.**

Aetna Better Health utilizes ClaimCheck as our comprehensive code auditing solution that will assist payors 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, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

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

Modifiers

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

- **Modifier 59 – Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

- **Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.

- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners indicate:

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

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

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.

Online Status through Aetna Better Health's Secure Website
Aetna Better Health encourages providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims.
https://www.aetnabetterhealth.com/illinois/providers/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:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
  - 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 NPI number with applicable suffix if appropriate.
    - Enrollee name and enrollee 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 (6) months 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 a 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.

Instruction for Specific Claims Types

Aetna Better Health General Claims Payment Information
Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

Skilled Nursing Facilities (SNF)
Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **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 Providers must bill according to CMS HHPPS requirement rules for Aetna. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: **http://www.cms.gov/HomeHealthPPS/**.

Durable Medical Equipment (DME) Rental Claims
Providers submitting claims for DME Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

There is a billing discrepancy rule difference between Days versus Units for DME rentals between Medicaid and the Premier Plan Program. Units billed for the FAD equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Same Day Readmission

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

There may be occasions where an enrollee may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with 24 hours.

Example: Discharge Date: 10/2/10 at 11:00 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

The only claims payable during a hospice election period by Aetna would be additional benefits covered under Aetna that would not normally be covered under the Premier Plan Program covered services. All other claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to hospice services or not.

HCPCS Codes

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

Remittance Advice

Provider Remittance Advice

Aetna Better Health generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure 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 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 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 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 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. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
    - Enrollee 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 claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Services Department for assistance with this process.

Claims Submission

Claims Filing Formats

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

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health encourages providers to electronically submit claims, through Emdeon.
- Please use Payer ID number 26337 for the Premier Plan Program when submitting claims to Aetna Better Health for both CMS 1500 and UB 04 forms. You can submit claims by visiting Emdeon at http://www.emdeon.com/. Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Emdeon.

Important Points to Re-enrollee

- Aetna Better Health does not accept direct EDI submissions from its providers.
- Aetna Better Health does not perform any 837 testing directly with its providers, but performs such testing with 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 via mail to the following address:

Aetna Better Health
P.O. Box 66545
Phoenix, AZ 85082

Health Plan	Medicare Services	Providers	Plan Rule	Recoupment of Paid Claims for COB	Recoupment of Paid Claims not COB	Resub Timeframes & Dispute Timeframe	COB Timeframes	New Day Claims
Illinois (IL Medicare)		All Providers		1 year from the Paid date	1 year from the DOS Exception: Refer to the Adjustments and Reversals procedure for providers that require a letter to be sent.	Par Providers: 180 days from the DOS Exception: If the claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Non Par Providers: 1 year from the DOS Note: The "Through" date is used to determine the DOS for inpatient claims; the "From" date is used to determine the DOS for outpatient UB/HCFA claims.	120 days from the date on the primary EOB	Par Providers: 120 days from DOS or discharge Non Par Providers: 1 year from the DOS. Note: The "Through" date is used to determine the DOS for inpatient claims; the "From" date is used to determine the DOS for outpatient UB/HCFA claims.

Health plan	Recoupment of Paid Claims for COB	Recoupment of Paid Claims not COB	Resubmission timeframes	COB timeframes	New Day Claims
Medicaid Illinois (IL)	1 year from the Paid date	1 year from the DOS Exception: Refer to the Adjustments and Reversals for IL procedure for providers that require a letter to be sent.	Par Providers: 180 days from the DOS. Exception: If a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Non Par Providers: 180 days from the DOS or discharge date. Note: The "Through" date is used to determine the date of service for inpatient claims; the "From" date is used to determine the DOS for outpatient UB/HCFA claims.	120 days from the date on the primary EOB	Par Providers: 120 days from DOS or discharge Non Par Providers (FHP): 180 days from the DOS or discharge date. Non Par Providers (ICP): 1 Year Note: The "Through" date is used to determine the date of service for inpatient claims; the "From" date is used to determine the DOS for outpatient UB/HCFA claims.

CHAPTER 15: GRIEVANCE SYSTEM

Enrollee Grievance System Overview

Aetna Better Health takes grievances and appeals very seriously. We want to know what is wrong so we can make our services better. Enrollees can file a complaint, grievance or appeal if they are not satisfied. A network provider, acting on behalf of an enrollee, and with the enrollee's written consent, may file a grievance, appeal, External Review, State Fair Hearing, Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review as applicable.

For Medicaid only covered items/services, an enrollee or their authorized representative may request an External Review or a State Fair Hearing through the HFS Bureau of Assistance Hearings upon completion of the appeal process.

For Medicare only covered items/services if Aetna Better Health upholds the coverage decision in whole or in part, it will automatically forward the case to the Independent Review Entity (IRE). If the IRE upholds the decision and the total of the item/services appealed meets the AIS established dollar amount the enrollee or their authorized representative may request an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review in successive order.

For items/services covered by Medicaid and Medicare upon completion of the appeal process, if Aetna Better Health upholds the coverage decision in whole or in part it will automatically forward the case to the Independent Review Entity (IRE) and the enrollee or their authorized representative may request an External Review or a State Fair Hearing through the HFS Bureau of Assistance Hearings. In instances where a case is reviewed both by the IRE an External Reviewer and or the State Fair Hearing officer the decision that is most favorable to the enrollee will be the one that counts. If both decisions are unfavorable to the enrollee and the total of the item/services appealed meets the AIS established dollar amount enrollees or their representative may request an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review in successive order.

Aetna Better Health informs enrollees and providers of the grievances, appeals, External Review, and State Fair Hearing procedures. This information is contained in the enrollee handbook and provider handbook and is available on the Aetna Better Health website. When requested, we give enrollees reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, provider interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Grievances
A grievance may be filed with Aetna Better Health orally or in writing by the enrollee or the enrollee's authorized representative, including providers. In most cases, a decision on the outcome of the grievance is reached within thirty (30) calendar days of the date the grievance was filed. If we are unable to resolve a grievance within thirty (30) calendar days, we may ask to extend the grievance decision date by fourteen (14) calendar days. In these cases, we will provide information describing the reason for the delay in writing to the enrollee and, upon request, to DHS.

Enrollees are advised in writing of the outcome of the investigation of the grievance within two (2) calendar days of its resolution. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the enrollee can speak with someone regarding the decision. The notice also tells an enrollee how to obtain information on filing an External Review or State Fair Hearing as applicable.

Expedited Grievance Resolution
Aetna Better Health resolves grievances effectively and efficiently as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where Aetna Better Health has:

- Taken an extension on prior authorization or appeal decision making timeframe; or
- Determined that an enrollee's request for expedited prior authorized or expedited appeal decision making does not meet criteria and has transferred the request to a standard request

Enrollees and their representative if designated are informed of their right to request an expedited grievance in the Enrollee Handbook and in the extension and denial of expedited processing prior authorization and appeal letters.

In most cases, a decision on the outcome of an expedited grievance is reached within twenty-four (24) hours of the date the grievance was filed. Enrollees are advised orally of the resolution within the twenty-four (24) hours followed by a written notification of resolution within two (2) calendar days of the oral notification. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the enrollee can speak with someone regarding the decision. The notice also tells an enrollee how to obtain information on filing an External Review or State Fair Hearing as applicable.

Quality Improvement Organization - Quality of Care Grievances
An enrollee may file a grievance regarding concerns of the quality of care received with Aetna Better Health. For items or services covered by Medicare an enrollee or their authorized representative may also file a quality of care concern with the CMS contracted Quality Improvement Organization (QIO). In Illinois, the QIO is Telligen, which is located at:

Telligen
711 Jorie Boulevard
Oak Brook, IL 60523
(800) 647-8089
www.telligenqio.org/illinois

Regulatory Complaints
For items/services covered by Medicaid, only an enrollee or their designated representative may submit complaints direct to the State, primarily through the Ombudsman's office at 1-800-252-8966 or 1-888-206-1327 (TTY).

For items/services covered by Medicare only an enrollee or their designated representative may submit complaints direct to CMS through 1-800- MEDICARE.

For items/services covered by both Medicaid and Medicare, an enrollee or their designated representative may submit complaints direct to the State, primarily through the Ombudsman's office at 1-800-252-8966 or to CMS through 1-800- MEDICARE.

Appeals
An enrollee may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health. Authorized enrollee representatives, including providers, may also file an appeal on the enrollee's behalf with the written consent of the enrollee. Appeals must be filed no later than sixty (60) calendar days from the postmark on the Aetna Better Health Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

The Notice of Action informs the enrollee of the following:

- Our decision and the reasons for our decision
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the enrollee can use to file an appeal by phone
- The procedures for exercising the rights to appeal and upon completion to request an External Review and a State Fair Hearing
- That the enrollee may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them
- The specific regulations that support, or the change in Federal or State law that requires the action
- The fact that, when requested by the enrollee benefits will continue if the enrollee files an appeal or a request for a State Fair Hearing within the timeframes specified for filing

Appeals may be filed either verbally by contacting the Member Services Department or by submitting a request in writing. Unless the enrollee is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written request.
Enrollees may appeal the decision and request a further review of Aetna Better Health's actions. Examples of appeals include:

- The denial or limited approval of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously approved service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to respond to an appeal in a timely manner
- The denial of an enrollee's request to obtain services outside of the contracting area when Aetna Better Health is the only health plan servicing a rural area.

Enrollees may file an appeal by:

- Calling Member Services
    - or 1-866-600-2139 TTY/TTD 1-877-734-7429 or the IL Relay 7-1-1
- Writing Aetna Better Health at:

Aetna Better Health
Appeals and Grievance Manager
333 West Wacker Dr.
Mail Stop F646
Chicago, IL 60606

If the enrollee requests services to continue while the appeal is reviewed, the appeal must be filed no later than ten (10) calendar days from the date of Aetna Better Health's Notice of Action letter, or the effective date of our proposed termination, suspension or reduction of previously authorized services. We will also provide enrollees with access to necessary medical records and information to file their appeals.

A brief overview of the appeals process follows:

- Verbal appeals must be put into writing and signed.
- Aetna Better Health notifies enrollees of receipt of the appeal within three (3) business days via an acknowledgment letter.
- Enrollees are advised of their or their authorized representative's rights to provide more information and document for their appeal either in person or in writing.
- Enrollees are advised of their or their authorized representative's right to view their appeal file.
- Enrollees or their authorized representative's may be present either onsite or via telephone when the Appeal Committee reviews their appeal.

- Appeals will be resolved within fifteen (15) business days (or fifteen (15) business days plus fourteen (14) calendar days if an extension is granted and we provide a reason for the extension, or the enrollee or their authorized representative requests the extension) after Aetna Better Health receives the appeal.
- Aetna Better Health makes reasonable effort to provide verbal notice and mails the decision letter, including an explanation for the decision, is within two (2) calendar days of the Appeal Committee's decision.
- If Aetna Better Health does not agree with the enrollee's appeal, the enrollee can ask for an External Review and or a State Fair Hearing and request to receive benefits while the hearing is pending. Enrollees can also request that the appeal be reviewed by DHS.
- If Aetna Better Health reverses our original decision and grants the appeal, services will begin immediately.

Expedited Appeal Resolution

Aetna Better Health resolves appeals effectively and efficiently as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where an enrollee's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the enrollee's condition cannot be adequately managed without urgent care or services. If the enrollee's ability to attain, maintain, or regain maximum function is not at risk the request to process the appeal in an expedited time frame may be denied and the appeal processed within the normal fifteen (15) business day time frame. An enrollee or their authorized representative, including providers, may request an expedited appeal either verbally or in writing within sixty (60) calendar days from the day of the decision or event in question. Written confirmation or the enrollee's written consent is not required to have the provider act on the enrollee's behalf.

Upon receipt of an expedited appeal, we begin the appeal process immediately. We attempt to acknowledge expedited appeals by telephone and in writing on the day the expedited request is received. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue is transferred to the standard appeal process. We make reasonable efforts to give the enrollee prompt verbal notice of the denial and follow up within two (2) calendar days with a written notice.

In cases where the health plan determines an enrollee's request meets expedited urgency or a provider supports the enrollee's request Aetna Better Health's medical director will render a decision as expeditiously as the enrollee's health requires, but no later than twenty-four (24) hours from the receipt of the additional information.

If enrollees wish for services to continue while their appeal is reviewed they must request the appeal within ten (10) calendar days from the date of the Notice of Action letter or the intended effective date of the action. If Aetna Better Health reverses our original decision and approves the appeal, services will begin immediately.

If Aetna Better Health is unable to resolve an expedited appeal within the specified timeframe, we may extend the period by up to fourteen (14) calendar days. In these cases, we will provide information describing the reason for the delay in writing to the enrollee and, upon request, to DHS.

Failure to Make a Timely Decision
Appeals must be resolved within stated timeframes and parties must be informed of Aetna Better Health's decision. If a determination is not made by the above timeframes, the enrollee's request will be deemed to have been approved as of the date upon which a final determination should have been made.

External Review
For items/services covered by Medicaid only or by both Medicaid and Medicare, an enrollee may file a request for External Review, a request to have to have an outside reviewer reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health. Authorized enrollee representatives, including providers, may also file a request for an external review. Requests for an external review must be made in writing within thirty (30) calendar days of the final adverse determination, the Appeal Decision Letter. The timeline of thirty (30) calendar days is stated in the Appeal Decision Letter. An enrollee or their authorized representative can only ask one time for an external review about a specific action.

An enrollee or their authorized representative can request an external review by completing the external review form or by sending in a letter. The letter the enrollee sends in **must be specific and address the request for an external review.** The form or the letter must be sent to:

Aetna Better Health
Attn: Grievance and Appeals Dept.
333 West Wacker Drive, Suite 2100, Mail Stop F646
Chicago, IL 60606

Aetna Better Health has five (5) business days to review the enrollee's request to see if it meets the qualifications for external review. Aetna Better Health will send the enrollee and their representative if designated a letter letting them know if their request meets these requirements. If the request meets the requirements, the letter will give the name of the external review organization.

The external reviewer has five (5) calendar days from when they receive all the information they need, to make a decision and send the enrollee and/or the enrollees representative and Aetna Better Health a letter with their decision. If the enrollee disagrees with the reviewer's decision, the enrollee can ask for a State Fair Hearing by HFS if they have not already done so. If an enrollee requests both an External review and a State Fair Hearing, the decision most favorable to the enrollee is the one that counts.

Expedited External Review

For items/services covered by Medicaid only or by both Medicaid and Medicare, an enrollee may file a request for an Expedited External Review, a request to have to have an outside reviewer reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health upon completion of the appeals process. Authorized enrollee representatives, including providers, may also file a request for an expedited external review.

External reviews are resolved effectively and efficiently, as the enrollee's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited external reviews, occur in situations where an enrollee's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the enrollee's condition cannot be adequately managed without urgent care or services. Enrollees can only ask one time for an expedited external review about a specific action. Requests for an expedited external review must be made in writing within thirty (30) calendar days of the final adverse determination (Appeal Decision Letter). The timeline of thirty (30) calendar days is stated in the Appeal Decision Letter. An enrollee or their authorized representative can only ask one time for an external review about a specific action.

The enrollee or their authorized representative can ask for an expedited external review by phone or in writing by completing the external review form and requesting that it be expedited or by sending in a letter**.** To ask for an expedited external review over the phone, call Member Services toll-free at 1-866-212-2851. The letter the enrollee sends in **must be specific and address the request for an expedited external review.** The form or the letter must be sent to:

Aetna Better Health
Attn: Grievance and Appeals Dept.
333 West Wacker Drive, Suite 2100, Mail Stop F646
Chicago, IL 60606

Aetna Better Health will immediately review the enrollee's request to see if it meets the qualifications for expedited external review. If it does, we will contact the enrollee and their representative if designated, to let the enrollee know that their request meets these requirements. If the enrollee request meets the requirements, the letter will give the enrollee name of the external review organization.

If Aetna Better Health determines that the enrollees request does not meet the requirements for an expedited external review, the enrollee can appeal that decision to the Director of the Department of Insurance (DOI). The enrollee can call the Department of Insurance to make this request.

As quickly as the enrollees health condition requires, but no more than two (2) business days after it receives all the information it needs, the external review organization will make a decision about the enrollee's request. They will let the enrollee and/or the enrollee's representative and Aetna Better Health know what their decision is verbally. They will also follow up with a letter to the enrollee and/or the enrollee's representative and Aetna Better Health with the decision within forty-eight (48) hours. If the enrollee disagrees with the reviewer's decision, the enrollee can ask for a State Fair Hearing by HFS if they have not already done so. If an enrollee requests both an External Review and a State Fair Hearing, the decision most favorable to the enrollee is the one that counts.

DHS State Fair Hearing

For items/services covered by Medicaid only or by both Medicaid and Medicare, the enrollee and/or the enrollee's representative acting on behalf of the enrollee may request a State Fair Hearing through the HFS Bureau of Assistance Hearings if it is within thirty (30) calendar days from Aetna Better Health's final adverse determination (Appeal Decision Letter).

If enrollees wish services to continue receiving services while their State Fair Hearing is reviewed, they must request a State Fair Hearing within ten (10) calendar days from the date of the appeal decision letter. At the State Fair Hearing, enrollees may represent themselves or be represented by a lawyer, their provider or other authorized representative, with the enrollee's written permission. To request a State Fair Hearing, enrollees must:

- Submit a request for a State Fair Hearing to the HFS Human Services Bureau of Assistance Hearing, or
- Call 1-800-435-0774 (Voice) or 1-877-734-7429 (TTY) toll free.

To submit a request in writing, enrollees should write to:

HFS Bureau of Assistance Hearings
401 S Clinton, 6th Floor
Chicago, IL 60607

HFS Bureau of Assistance Hearings renders the final decision about services. If the hearing decision favors the enrollee, then Aetna Better Health will commence the services immediately.

Independent Review Entity (IRE)

For items/services covered by Medicare only or by both Medicare and Medicaid, if decision is upheld at appeal in whole or in part Aetna Better Health will submit a case summary to the Independent Review Entity (IRE). Aetna Better Health will notify the enrollee that it has forwarded the case to the IRE for review in the Appeal Decision Letter. The notice will include contact information for the IRE and the enrollee's right to submit additional evidence that may be relevant to the case direct to the IRE.

The IRE will conduct the review as expeditiously as the enrollee's health condition requires and will notify all parties of the determination and will include the right to an ALJ hearing and the procedure to request one if the total dollar amount of the items/services being appeals meets or exceeds the established AIS threshold of $140.00.[1]

Administrative Law Judge (ALJ)
The enrollee or their authorized representative may file a request for an ALJ hearing in writing within sixty (60) calendar days of the IRE notice of determination to the entity specified in the IRE's reconsideration notice. If Aetna Better Health receives a written request for an ALJ hearing from the enrollee, it will forward the enrollee's request to the IRE. The IRE will compile the reconsideration file and forward it to the appropriate ALJ hearing office.

Medicare Appeals Council (MAC)
The enrollee or their authorized representative may request a Medicare Appeals Council (MAC) review in writing through a letter to the MAC within sixty (60) calendar days of the ALJ decision. The request should be submitted directly to the MAC at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

Judicial Review
Any party, the enrollee, their representative if designated or Aetna Better Health may request judicial review upon completion of the MAC review process when the total dollar amount of the items/services meets or exceeds the AIC threshold of $1,400.00[2].

The party may combine claims to meet the amount in controversy requirement. To meet the requirement:

- All claims must belong to the same enrollee;
- The MAC must have acted on all the claims;

[1] This amount is calculated annually and published in the Federal Register prior to the end of each calendar year.
[2] This amount is calculated annually and published in the Federal Register prior to the end of each calendar year.

- The enrollee must meet the 60-day filing time limit for all claims; and
- The request must identify all claims.

To request a Judicial Review any party, must file a civil action in a district court of the United States. The action should be initiated in the judicial district in which the enrollee lives or where the health plan has its principal place of business. If neither the organization nor the enrollee is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

Contracting Provider Disputes

Aetna Better Health and our contracted providers are responsible for timely resolution of any disputes between both parties. Disputes will be settled according to the terms of our contractual agreement and there will be no disruption or interference with the provision of services to enrollees as a result of disputes.

Aetna Better Health will inform providers through the Provider Handbook and other methods, including newsletters, training, provider orientation, the website and by the provider calling their Provider Services Representative about the provider dispute process. Aetna Better Health's Provider Services Representatives are available to discuss a provider's dissatisfaction with a decision based on this policy and contractual provisions, inclusive of claim disputes.

In the case of a claim dispute, the provider must complete and submit the Provider Dispute Form and any appropriate supporting documentation to Aetna Better Health's Claims Department via mail or submit through our Provider Web Portal. The Provider Dispute Form is accessible on Aetna Better Health's website, via fax or by mail.

In the event the provider remains dissatisfied with the dispute determination, the Provider is notified that a complaint may be initiated. Aetna Better Health's Complaint System policy, as well as the Aetna Better Health Provider Handbook, includes the process by which the provider can submit a complaint.

Providers have 180 days from the date of determination, unless otherwise indicated in your provider agreement, to submit a claims resubmission/reconsideration, corrected claim or dispute.

Non-Contracting Provider Claim Appeals
Upon denial of payment on a claim for an item/service that is covered by Medicare only or by both Medicare and Medicaid, non-contracted providers have the right to request a Non-Contracting Provider Claim Appeal.

Non-contracting provider claim appeals must be submitted in writing with a completed Waiver of Liability (WOL) form within sixty (60) calendar days of the remittance advice. If the provider remains in disagreement with the Non-Participating Provider Claim Appeal decision, the provider can submit a request in writing for IRE review within one-hundred-eighty (180) calendar days of the remittance advice. The IRE will process the request within sixty (60) calendar days of receipt and will notify all parties to the appeal of their decision. If the decision is, overturned Aetna Better Health will effectuate the decision within thirty (30) calendar days of receipt of IRE's notification of decision.

Provider Complaints
Both network and out-of-network providers may file a complaint verbally or in writing directly with Aetna Better Health in regard to our policies, procedures or any aspect of our administrative functions.

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

An acknowledgment letter will be sent within three (3) business days summarizing the complaint and will include instruction 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 Appeals and Grievance Manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures, collecting pertinent facts from all parties. The complaint with all research will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the complaint within forty-five (45) calendar days. The Appeals and Grievance Manager will send written notification within ten (10) calendar days of the resolution.

Management of the Process

The Quality Management (QM) Department has the overall responsibility for the management of the enrollee Grievance System process. This includes:

- Documenting individual grievances, appeals, External Reviews and State Fair Hearings
- Coordinating resolutions of grievances and appeals
- Tracking, trending and reporting data
- Identification of opportunities for improvement
- Maintaining the appeals and grievance database and records of the grievance and appeals

The Compliance Department has oversight responsibility of the enrollee grievance and appeals process. This includes:

- Review of individual grievances and appeals
- Monitoring for compliance with contractual obligations
- Monitoring for compliance with state and federal regulatory requirements

The Aetna Better Health Appeals and Grievance Manager will serve as the primary contact person for the grievance and appeals process with the Aetna Better Health QM Coordinator in the QM Department 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 enrollees and providers about an enrollee's right to file a grievance or appeal or request an External Review or DHS State Fair Hearing and for assisting enrollees throughout the grievance or appeal process.

Enrollees are advised of their grievance, appeal, External Review, DHS State Fair Hearing Independent Review Entity (IRE), Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review rights and processes as applicable at the time of enrollment and at least annually thereafter. Providers receive this information via the provider handbook, during provider orientation, within the provider contract and on Aetna Better Health's website.

CHAPTER 16: FRAUD, WASTE, AND ABUSE

Fraud and Abuse

Aetna Better Health has an aggressive, proactive Fraud, Waste, and Abuse Program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of 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 Illinois Administrative Code. During the investigation process, the confidentiality of the patient and or people referring the potential fraud and abuse case is maintained.

Aetna Better Health uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and Enrollees, 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 encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna'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 enrollee 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 all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the Premier Plan Programs.

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

- By phone to the confidential Aetna Better Health Compliance Hotline at 1-877-436-8154

- 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.

CMS requires us to have a compliance plan that guards against potential fraud, waste and abuse under 42 C.F.R. §422.503 (b) (4) (vi) and 42 C.F.R §423.504(b) (4) (vi).

CMS combats fraud by:

- Close coordination with contractors, provider, and law enforcement agencies.
- Developing Premier Plan Program compliance requirements that protect stakeholders.
- Early detection through medical review and data analysis.
- Effective education of providers, suppliers, and enrollees.

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

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

<u>Fraud, Waste and Abuse Defined</u>

- **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 include:

- Charging in excess for services or supplies.

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

Fraud, Waste and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions.
- Switching an enrollee'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 enrollees a cash payment as an inducement to enroll in a specific plan.
- Selecting or denying enrollees 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 an enrollee to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the enrollees 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 enrollees.
- Double billing such as billing both the enrollee, or billing Aetna Better Health and another enrollee.
- Misrepresenting the date services were rendered or the identity of the enrollee 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 enrollees as well:

- Unnecessary procedures may cause injury or death.

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

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

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit.
- Attempting to use an enrollee ID card to obtain prescriptions when the enrollee is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another enrollees ID).
- Forging and altering prescriptions.
- Doctor shopping (i.e., when an enrollee consults a number of doctors for the purpose of 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.

<u>Elements to a Compliance Plan</u>

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health'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 Premier Plan Program.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, and directors and enrollees 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.
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 that Apply to Fraud, Waste, and Abuse
Providers contracted with Aetna Better Health must agree to be bound by and comply with all applicable state and federal laws and regulations. There are several relevant laws that apply to Fraud, Waste, and Abuse:

The False Claims Act (FCA)

- The Federal False Claims Act was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

    - Knowingly presenting a false or fraudulent claim for payment or approval
    - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
    - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

  "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.

- 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 enrollees to an entity with which the provider or provider's immediate family enrollee 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

- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and or providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable).
- Suspension of provider payments.
- Being added to the OIG List of Excluded Individuals/Entities database.
- License suspension or revocation.

Potential Civil and Criminal Penalties

- False Claims Act – For each false claim, the penalty could range from $5,500.00 - $11,000.00. If the government proves it suffered a loss, the provider is liable for three times the loss.
- Anti-Kickback Statute – Up to five years in prison and fines of up to $25,000.00 for violations of the Anti-Kickback Statute. If an enrollee suffers bodily injury as a result of the scheme, the prison sentence may be 20+ years.

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 & Death Master Report

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 HFS may prescribe.

Aetna Better Health 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/or who have been terminated from the Medicaid or any programs by HFS for fraud, waste, or abuse. The provider must agree to assist Aetna Better Health as necessary in meeting our obligations under the contract with the HFS to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

CHAPTER 17: ENROLLEE ABUSE AND NEGLECT

Mandated Reporters

As mandated by Illinois General Assembly revised code § 2151.421, and Illinois Administrative Code, all providers who work or have any contact with an Aetna Better Health enrollee, are required to report any suspected incidences of physical abuse, neglect, mistreatment, and any other form of maltreatment.

Although anyone may make a report, mandated reporters are professionals who may work with children, elderly, or persons with disabilities. The following outlines the abuse, neglect, and exploitation reporting requirements for Illinois citizens.

Children (Under the Age of 18)

As mandated by the Abuse and Neglect Child Reporting Act, providers must report suspected or known child abuse, and or neglect to the Illinois Department of Child and Family Services (DCFS) or the law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, enrollees of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

If the child is in immediate danger, call 911. Providers may also contact the Illinois Department of Child and Family Services' (DCFS) 24 hour Child Abuse Hotline at 1-800-25-ABUSE. When you call, a trained Hotline social worker will listen to your report, ask questions, and determine whether to take a formal report. If a formal report is taken, you will be asked to send written confirmation. DCFS will provide a form to use and tell you where to send it.

A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink:
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1460&ChapAct=325%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=32&ChapterName=CHILDREN&ActName=Abused+and+Neglected+Child+Reporting+Act%2E

Vulnerable Adults (Between the Age of 18 and 59)
As mandated by Illinois Administrative Code, providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, death and or financial exploitation of a vulnerable adults within 24 hours of the initial discovery of the incident to one the following state agencies:

- The Department of Health Office of Inspector General (OIG) at 1-800-368-1463; or to
- The appropriate law enforcement.

A full version of Illinois' Administrative Code can be found within the following hyperlink:
http://www.ilga.gov/commission/jcar/admincode/059/059000500000200R.html

Elders (Ages 60 and Over)
As mandated by the Elder Abuse and Neglect Act, and the Adult Protective Services Act, providers, facilities and caretakers are obligated to report suspect or known physical abuse (domestic violence), neglect, maltreatment, and or financial exploitation of a vulnerable adults within 4 hours of the initial discovery of the incident to one the following state agencies:

- The Department of Aging (DoA) at 1-866-800-1409; or
- The Department of Health Office of Inspector General (OIG) at 1-368-1463; or
- The appropriate law enforcement.
- For Long Term Care Facilities, report to the Department of Public Health (DPH) Long Term Care/Nursing Home Hotline at 1-800-252-4343

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer, or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (four hours if Abuse or Neglect is suspected).
A full version of Illinois' Administrative Code and Illinois General Assembly can be found within the following hyperlink:

- http://www.ilga.gov/commission/jcar/admincode/059/059000500000200R.html
- http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1452&ChapAct=320%26nbsp%3BILCS%26nbsp%3B20%2F&ChapterID=31&ChapterName=AGING&ActName=Elder+Abuse+and+Neglect+Act%2E
- http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapAct=210%26nbsp%3BILCS%26nbsp%3B30%2F&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Abused+and+Neglected+Long+Term+Care+Facility+Residents+Reporting+Act%2E.

Information to Report
When reporting the incident, please be prepared to provide the following information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location.

- Information about family enrollees 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 enrollee says it happened, and any other pertinent information)

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Illinois's Compliance hotline at 1-877-436-8154.

Examinations to Determine Abuse or Neglect
When a State agency notifies us of a potential case of neglect and/or abuse of an enrollee, our Case Managers will work with the agency and the Primary Care Provider (PCP) to help the enrollee receive timely physical examinations for determination of abuse or neglect. In addition, we also notify the appropriate regulatory agency of the report.

Examples, Behaviors and Signs

Abuse
Examples of Abuse
- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints

Behaviors of Abusers (Caregiver and /or Family Enrollee)
- 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 an care because of lack of experience, information , or ability

Signs of Neglect
- Malnutrition or dehydration

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

Examples of Neglect

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

Financial Exploitation

Examples of Financial Exploitation

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