



AETNA BETTER HEALTH® OF PENNSYLVANIA

HealthChoices Provider Manual

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Chapter 1: Introduction

WELCOME

Welcome to Aetna Better Health. We're one of the managed care organizations serving the state of Pennsylvania for the HealthChoices managed care program and Healthy PA. The Commonwealth of Pennsylvania Department of Human Services (Department) offers this program to Medical Assistance (MA) members

Our ability to serve our members well depends on the quality of our provider network. As part of our network, you can provide the people in the Commonwealth of Pennsylvania quality health care and access to Medically Necessary services. We're grateful for your participation and hope this manual will serve as a helpful resource to you and your office staff.

Use this manual as an extension of your participating provider agreement, a communication tool and reference guide for you and your office staff. While the provider manual contains basic information about the Commonwealth of Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS), make sure you fully understand and apply PA DHS and CMS requirements when administering covered services. Refer to www.dhs.state.pa.us and www.cms.hhs.gov. You can find the Commonwealth of Pennsylvania Medical Assistance Program at www.dhs.state.pa.us.

ABOUT AETNA BETTER HEALTH

Aetna Better Health is a wholly owned subsidiary of Aetna Health Holdings, LLC, which is a wholly owned subsidiary of Aetna Inc. We combine the financial and administrative strength of Aetna with the depth of Medicaid experience and expertise of our Aetna Medicaid Business Unit. Aetna has more than 150 years of experience in meeting members' health care needs. Aetna Better Health, together with our parent and affiliates, has more than 20 years of experience in serving Medical Assistance (Medicaid) members throughout the United States.

Visit www.aetnabetterhealth.com/pennsylvania for more information about us.

ABOUT THE HEALTHCHOICES PROGRAM

The HealthChoices Program is one of Pennsylvania's managed care programs for Medical Assistance (MA) members.

Through Physical Health Managed Care Organizations, MA members get quality medical care and timely access to all appropriate physical health services. This is true whether the services are delivered in an inpatient or outpatient basis. The Department of Human Services's Office of Medical Assistance Programs oversees the Physical Health component of the HealthChoices Program. This manual outlines the operations for the Physical Health component of the HealthChoices Program.

This manual pertains to the participation in the HealthChoices Physical Health Program across the state of Pennsylvania, including the New East, New West, South East, South West, and Lehigh-Capital zones.

- To improve access to health care services for Medical Assistance members

- To improve the quality of health care available to Medical Assistance members
- To stabilize Pennsylvania's Medical Assistance spending

AETNA BETTER HEALTH SUBCONTRACTORS

Dental Services Subcontractor – DentaQuest

Our subcontractor, DentaQuest, will provide dental services under the HealthChoices contact. See DentaQuest’s contact information below. Dental services are only available to Aetna Better Health Medical Assistance members.

Mailing Address:	12121 Corporate Parkway Mequon, WI 53092-9838
Member Services	1-888-307-6548
Provider Services	1-800-341-8478
TTY:	1-800-466-7566
Website:	www.dentaquestgov.com

Vision Services Subcontractor – Superior Vision Inc.

Our subcontractor, Superior Vision, will provide vision services under the HealthChoices and Healthy PA contracts. See Block Vision’s contact information below.

Mailing & Claims Address:	939 Elkridge Landing Rd Suite 200 Linthicum, Maryland 21090
Member Services	1-800-879-6901
Provider Services:	1-866-819-4298
Website:	www.blockvision.com

Language Line Services (Interpretation Services)

Language Line Services will provide language services under the HealthChoices contract. Language Line provides telephonic interpretive services in more than 175 languages. Personal interpreters can also be arranged in advance. All interpreter services are provided free of charge for HealthChoices members and providers. Call Aetna Better Health

Member Services at **1-866-638-1232** for Language Line services.

Pharmacy Services – CVS Caremark

For questions about pharmacy, call Aetna Better Health Member Services at **1-866-638-1232**.

Chapter 2: Contact Information

KEY CONTACT INFORMATION

Aetna Better Health Contact Information

Contact one of the Aetna Better Health departments below to assist your patients.

Aetna Better Health Administrative Office

Aetna Better Health
2000 Market Street, Suite 850
Philadelphia, PA 19103

1-866-638-1232 (HealthChoices)

www.aetnabetterhealth.com/pennsylvania

Aetna Better Health Department	Contact	Hours of Operation (ET)	Days of Operation (excluding State holidays)
Member Services/Eligibility Verification	1-866-638-1232 (HealthChoices)	24 hours a day	7 days a week
Prior Authorization	P: 1-866-638-1232 (HealthChoices) F: 1-877 363-8120	24 hours a day	7 days a week
Provider Relations	1-866-638-1232 (HealthChoices)	8 a.m. to 5 p.m.	Mon - Fri

If your inquiry is related to Complaints & Grievances, call the Aetna Better Health Complaints and Grievances Department at **1-866-638-1232**.

To submit paper claims, use the following address:

Aetna Better Health Claims Submissions

Aetna Better Health
P.O. Box 62198
Phoenix, AZ 85082-2198

AETNA BETTER HEALTH Secure Web portal

Our secure web portal fosters open communication and provides information in a multitude of ways. The secure web portal supports the following functions:

- Prior authorization submission and status inquiry
- Claim status inquiry
- Eligibility status inquiry
- Provider Directory search
- Member and provider education and outreach materials

For more information, call your Provider Relations representative at **1-866-638-1232**.

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

Contact Information/Help for MA Providers

Name	Phone Number	Hours of Operation
Department of Human Services	DHS Helpline: 1-800-692-7462	Monday – Friday (time?)
Department of Human Services	DHS Child Line: 800-932-0313 TDD: 866-872-1677	24 Hours/Day, 7 Days/Week
Behavioral Health	1-800-433-4459	Monday - Friday, 7:45 a.m.-3:45 p.m.
Department of Human Services OMAP-HealthChoices Program Complaint, Grievance, and Fair Hearings	1-800-798-2339	Monday – Friday 8:30 a.m.-4:30 p.m.
Eligibility Verification System (EVS)	1-800-766-5EVS (5387)	24 Hours/Day, 7 Days/Week
MA Provider Compliance Hotline (Formerly Fraud and Abuse Hotline)	1-866-379-8477	Monday – Friday 9 a.m.-3:30 p.m.
Provider Inquiry Hotline	1-800-537-8862 Prompt 4	Monday - Friday, 8 a.m. - 4:30 p.m.
Medical Assistance Provider Enrollment Applications Applications In-Process (Inpatient and Outpatient Providers)	1-800-537-8862 Prompt 1	Monday-Friday, 8:30 a.m.-12 noon and 1 p.m. – 3:30 p.m.

Name	Phone Number	Hours of Operation
Medical Assistance Provider Enrollment Changes	1-800-537-8862 Prompt 1	Monday - Friday, 8 a.m. - 4:30 p.m.
Outpatient Providers Practitioner Unit	1-800-537-8862 Prompt 1	Monday - Friday, 8 a.m. - 4:30 p.m.
Pharmacy Hotline	1-800-558-4477 Prompt 1	Monday – Friday 8 a.m. - 4:30 p.m.

MENTAL HEALTH, DRUG & ALCOHOL SERVICES

Aetna Better Health Medical Assistance members receive mental health, drug, and alcohol services through Behavioral Health (BH) Managed Care Organizations (MCO) in each county. Refer to the list below to contact the office in the member’s county.

County	BH MCO/Phone Number
Adams	Community Care Behavioral Health 1-866-738-9849
Berks	Community Care Behavioral Health 1-866-292-7886
Bucks	Magellan Behavioral Health 1-877-769-9784
Chester	Community Care Behavioral Health 1-866-622-4228
Cumberland, Dauphin, Lancaster, Lebanon & Perry	Community Behavioral Healthcare Network of PA 1-888-722-8646
Delaware	Magellan Behavioral Health 1-888-207-2911
Franklin	Community Behavioral Healthcare Network of PA 1-866-773-7917
Fulton	Community Behavioral Healthcare Network of PA 1-866-773-7917
Huntingdon	Community Care Behavioral Health 1-866-738-9849

County	BH MCO/Phone Number
Lehigh	Magellan Behavioral Health 1-866-238-2311
Montgomery	Magellan Behavioral Health 1-877-769-9782
Northampton	Magellan Behavioral Health 1-866-238-2312
Philadelphia	Community Care Behavioral Health 1-888-545-2600
York	Community Care Behavioral Health 1-866-542-0299

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

Below is a list of MATP contacts by county. You can refer members needing assistance with transportation to these local county offices. Members can use these numbers to obtain information on how to enroll in the MATP program.

County	Local Telephone Number	Toll Free Number
Adams	717-337-1345	800-830-6473
Berks	610-921-2361	800-383-2278
Bucks	215-794-5554	888-795-0740
Chester	610-594-6930	877-873-8415
Cumberland	717-240-6340	800-315-2546
Dauphin	717-232-7009	800-309-8905
Delaware	610-490-3960	866-450-3766
Franklin	717-264-5225	1-800-548-5600
Fulton	717-485-0931	1-888-329-2376
Huntingdon	814-641-6408	1-800-817-3383
Lancaster	717-291-1243	800-892-1122
Lebanon	717-273-9328	Same as Local
Lehigh	610-253-8333	888-253-8333
Montgomery	215-542-7433	215-542-7433
Northampton	610-253-8333	888-253-8333
Perry	717-567-2490	877-800-7433
Philadelphia	267-515-6400	877-835-7412
York	717-845-7553	800-632-9063

Chapter 3: General Information

PROVIDER RESPONSIBILITIES

Overview

All providers who provide services to HealthChoices members must enroll in the Commonwealth's Medical Assistance (MA) Program and possess an active PROMISE™ provider ID. Provider responsibilities include, but are not limited to, the responsibilities outlined in the provider contract and within this provider manual.

Adherence to the Provider Agreement

Providers are contractually obligated to adhere to and comply with all terms of the Provider Agreement, including all requirements in this manual. We may or may not specifically communicate such terms in forms other than the Provider Agreement and this manual. Contracted network providers must also comply with all federal and state requirements governing Aetna Better Health and provider.

Documentation

Providers must document and maintain in the member's medical record all office visits, referrals, contacts, patient education, Advance Directives, family planning counseling, and follow up with members, including referrals for behavioral health and dental services member.

Where applicable and required by regulatory agencies, providers must make all medical records available. Notations regarding follow-up of canceled and missed appointments should also be evident. Records must be signed, dated and legible.

We'll conduct routine audits of medical records to ensure that documentation meets standard requirements.

PRIMARY CARE PRACTITIONER (PCP) RESPONSIBILITIES

A Primary Care Practitioner (PCP) is a specific physician, physician group or a Certified Registered Nurse Practitioner (CRNP) operating under the scope of his/her licensure. A PCP is responsible for:

1. Maintaining continuity of care on behalf of the MA member
2. Locating, coordinating, and monitoring other medical care and rehabilitative services
3. Supervising, prescribing and providing primary care services

We assist members in establishing a source of primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. Every HealthChoices member chooses or is assigned to a Primary Care Practitioner (PCP). We work with PCPs to ensure members receive timely, Medically Necessary and appropriate services.

The PCP is the member's initial and most important point of contact regarding health care needs. The PCP is primarily responsible for:

- Providing primary and preventive care
- Acting as the member's advocate by providing, recommending and arranging for care
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications
- Maintaining continuity of each member's health care, including as appropriate, transitioning young adult

- members from pediatric to adult providers beginning no later than the member's 18th birthday
- Making referrals for specialty care and other Medically Necessary services both in and out of-plan
- Maintaining a current medical record for the member, including documentation of all services provided to the member by the PCP as well as any specialty or referral services
- Arranging for Medically Necessary Behavioral Health Services for members by appropriate referrals to a HealthChoices Behavioral Health – Managed Care Organization (BH-MCO) in accordance with the specifications of the Provider Agreement (see Chapter 2 for a list of BH-MCOs and Substance Abuse offices by county) . Mental health and substance abuse services are not covered by Aetna Better Health except ambulance and emergency room services. All outpatient pharmacy services, except those otherwise assigned, are the payment responsibility of the Member's PH-MCO. The only exception is that the ***BH-MCO is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service Providers.***
- Using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those with Limited English Proficient (LEP) when needed by the member. Services are free of charge to the member. This directive was established in the July 2010 State HealthChoices Agreement.

Preventive Services

The PCP is responsible for providing appropriate preventive care for eligible members. These preventive services include, but are not limited to:

- Age-appropriate immunizations
- Disease risk assessment
- Age-appropriate physical examinations
- Well child visit
- Adult well visits
- EPSDT visits

You can find preventive health information on our website at www.aetnabetterhealth.com/pennsylvania.

Members who are women may:

- Go to any Aetna Better Health contracted obstetrician/gynecologist (OB/GYN) for all women's care services. Neither a referral nor prior authorization is required.
- Receive family planning services from an in or out-of-network provider without a referral or prior authorization

MEMBER ASSIGNMENT TO A PRACTICE

Upon enrollment, members choose a PCP for themselves and any other eligible family members. We'll automatically assign a contracted PCP for any member who does not select a PCP within 14 business days of enrollment. If the member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, he or she can choose an alternative PCP at any time by calling Member Services at **1-866-638-1232 (HealthChoices)**. We'll grant the request and process the PCP change in a timely manner.

We manage each PCP's panel to automatically stop accepting new members after the limit of 1,000 members has been reached. Upon contracting with Aetna Better Health, PCPs may not close their panels. If the PCP/PCP site employs Certified Registered Nurse Practitioners/Physician Assistants, then the provider/provider site will be

permitted to add an additional 1,000 members to the panel.

SPECIALTY CARE AND STANDING REFERRALS

The primary care practitioner (PCP) is responsible for initiating, coordinating, and documenting referrals to specialists within Aetna Better Health, the BH-MCO and dentists. Members may request a second opinion from providers within the contracted network. If there is not a second provider with the same specialty in the network, members can request a second opinion from a provider out of network at no charge to the member.

Specialists must coordinate with the PCP when members need a referral to another provider. Upon request, you must share records with the appropriate providers and forward at no cost to the plan member or other providers. Specialists are responsible for obtaining referrals from referral physicians and bringing referred members into compliance with medical treatment plans.

Members with a disease or condition that is life threatening, degenerative, or disabling may request a medical evaluation. If evaluation standards are met, members will receive:

- A standing referral to a specialist for treatment of their disease or condition. If a member needs on-going care from a specialist, we'll authorize, if Medically Necessary, a standing referral to the specialist with clinical expertise in treating the member's disease or condition. In these cases, we may limit the number of visits or the period during which such visits are authorized. We may also require the specialist to provide the PCP with regular updates on the specialty care provided, as well as all necessary medical information.

OR

- A specialist may be designated to provide and coordinate both primary and specialty care for the member. The specialist, in treating the member's disease or condition, will then serve as the member's PCP and be responsible for coordinating care and making referrals to other specialists as needed.

Refer to Chapter 9-Medical Management for more information.

Specialists as PCPs

A member may qualify to select a specialist to act as PCP if she/he has a disease or condition that is life threatening, degenerative or disabling. Providers credentialed as specialists and approved to act as PCPs must meet all standards for credentialed PCPs and specialists. The specialist as a PCP must agree to provide or arrange for all primary care and routine preventive care consistent with our preventive care guidelines. They must also provide the specialty medical services consistent with the member's "special need" in accordance with our standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist acting as a PCP also must have admitting privileges at a hospital in our network.

PCPs are responsible for initiating and coordinating member referrals for Medically Necessary services beyond the scope of their contract of practice. In addition, PCPs and specialists must monitor the progress of the referred members' care and specialists must see that members are returned to the PCP's care as soon as medically appropriate.

BEHAVIORAL HEALTH REFERRALS

Behavioral Health Referral

We provide a full range of covered physical health services for HealthChoices members who have behavioral health needs and/or are admitted to non-hospital residential detoxification, rehabilitation, and halfway house facilities for drug/alcohol dependence/addiction.

Services currently covered under the above-mentioned facilities' per diem payment *are not* provided by us nor are we responsible for providing Behavioral Health Services. Behavioral Health is managed through the BH-MCOs serving the HealthChoices program.

Members should be referred to the BH-MCO for the following benefits/service:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital
- Inpatient drug and alcohol detoxification
- Psychiatric partial hospitalization services
- Inpatient drug and alcohol rehabilitation
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction
- Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq.
- Psychiatric outpatient clinic services, licensed psychologist and psychiatrist services
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 21 with psychiatric, substance abuse or mental retardation disorders
- Residential treatment services for individuals under the age of 21 whether treatment is provided in facilities that are Joint Commission for the Accreditation for Healthcare
- Organizations [JCAHO] accredited and/or without JCAHO accreditation
- Outpatient drug and alcohol services, including Methadone Maintenance Clinic
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider
- Laboratory studies ordered by behavioral health physicians and clozapine support services
- Crisis intervention with in-home capability
- Family-based mental health services for individuals under the age of 21
- Targeted mental health care management (intensive care management and resource coordination)

In addition to the in-plan mental health, drug and alcohol and behavioral services that are covered, supplemental mental health and drug and alcohol services may be made available pursuant to coordination agreements between the BH-MCO and the county mental health, mental retardation, and drug and alcohol authorities. These supplemental benefits covered by the BH-MCO may include:

- Partial hospitalization for drug and alcohol dependence/addiction
- Psychiatric Rehabilitation: Site Based, Clubhouse or Mobile
- Targeted drug and alcohol care management and Intensive Outpatient Services
- Supported living services
- Assistance in obtaining and retaining housing, employment, and income support services to meet basic needs
- Continuous community based treatment teams
- Adult residential treatment (including long term structured residences and residential treatment facilities for adults)

- Consumer operated/directed self-help programs; e.g., drop-in centers, 12-step programs, double trouble groups
- Drug and alcohol prevention/intervention services, including student assistance programs
- Support groups for individuals under the age of 21
- Social rehabilitation and companion programs
- Drug and alcohol transitional housing
- Drug and alcohol drop-in centers

CHIP Behavioral health

Some members diagnosed with severe mental health disorders or conditions (e.g., schizophrenia, autism) that significantly affect a child's behavioral health may be eligible for a broader range of services. They may also have different benefit limitations. Call Member Services at **1-866-638-1232** if you have questions about your patients' eligibility for certain mental health services or benefit limits. CHIP covers inpatient detoxification, non-hospital residential treatment, and outpatient treatment relating to drug and alcohol abuse for your child.

- Except in the case of an emergency, behavioral health services must be provided by participating providers and facilities unless the use of a non-participating provider or facility is preauthorized
- A referral from a PCP is not required to see a participating provider. A member (14 years of age or older) or a parent or guardian may self-refer.

If your patient needs self-referral assistance, needs help finding a participating provider in their area, has difficulty getting an appointment scheduled with a participating provider or has questions about behavioral health benefits, call Aetna Better Health Kids Member Services at **1-800-822-2447**. This number is also on your patient's Aetna Better Health Kids ID card.

SELF-REFERRALS/DIRECT ACCESS

There are some services that patients can access without a referral from the PCP:

- Vision
- Dental care
- Obstetrical and Gynecological (OB/GYN) services
- Chiropractic services in accordance with the process set forth in Medical Assistance Bulletin 15-07-01.
<http://services.dhs.state.pa.us/olddhs/bulletinsearch.aspx?BulletinId=4092>
- Physical therapy services in accordance with the amended Physical Therapy Act (63 P.S. 1301 et seq.).

To self-refer, the member must get the self-referred services from an Aetna Better Health network provider. Family planning services do not require prior authorization or referral. Members may access family planning services from any qualified provider.

Family planning services include, but are not limited to:

- Health education
- Counseling necessary to make an informed choice about contraceptive methods
- Pregnancy testing and breast and cervical cancer screening services

- Contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies and condoms (male and female)
- Norplant, injectables, intrauterine devices and other family planning procedures
- Diagnostic screens, biopsies, cauterizations, cultures and assessments

Members have direct access to OB/GYN services. They also have the right to select their own OB/GYN provider; this includes nurse midwives in our network. Members can get maternity and gynecological care without prior approval from a PCP. This includes:

- Selecting a provider to give an annual well-woman gynecological visit
- Primary and preventive gynecology care
- PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care
- Perinatal and postpartum maternity care

In situations where a new (and pregnant) member already receives care from an out-of-network OB-GYN specialist at the time of enrollment, the member can continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.

APPOINTMENT STANDARDS AND FOLLOW-UP

We work with providers to outreach members concerning appointments for Medically Necessary care, preventive care and scheduled screenings and examinations. Contracted Aetna Better Health providers are responsible to adhere to the appointment availability standards. Providers must monitor the adequacy of their appointment processes and reduce unnecessary emergency room visits.

Condition	Members(s)	Provider Types	Standards
Emergency	All	PCPS	Members must be seen immediately, or referred to an emergency facility
		Specialist	Appointments immediately upon referral
Urgent	All	PCPS	Appointments must be scheduled within 24 hours
		Specialist	Appointments within 24 hours of referral
Routine	All	PCPS	Appointments must be scheduled within 10 business days
		Specialist:	Appointments must be made within 15 business days
		Otolaryngology	
		Dermatology	
		Pediatric endocrinology	
		Pediatric general surgery	
		Pediatric infectious disease	

Condition	Members(s)	Provider Types	Standards
		Pediatric neurology	
		Pediatric pulmonology	
		Pediatric rheumatology	
		Dentist	
		Orthopedic surgery	
		Pediatric allergy & immunology	
		Pediatric gastroenterology	
		Pediatric hematology	
		Pediatric oncology	
		Pediatric rehab medicine	
		Pediatric urology	
		All other specialty	Appointments must be scheduled within 10 business days
Health assessment	All	PCP	Appointments must be scheduled within 3 Weeks of Enrollment
General physical examination	All	PCP	Appointments must be scheduled within 3 Weeks of Enrollment
First physical examination	All	PCP	Appointments must be scheduled within 3 Weeks of Enrollment
Initial appointment	HIV/AIDs members	PCP or Specialist	Must be scheduled within 7 days of enrollment unless the member is already in active care with a PCP or specialist
	SSI members	PCP or Specialist	Must be scheduled within 45 days of enrollment unless the member is already in active care with a PCP or specialist
Initial prenatal care appointment	Pregnant members	OB/GYN or Certified Nurse Midwife	
	First trimester		Must be scheduled within 10 business days of the member being identified as pregnant
	Second trimester		Within 5 business days of member being identified
	Third trimester		Within 4 business days of being identified
	High risk pregnancy		Within 24 hours of identification or immediately if an emergency exists
EPSDT screens	All under the age of 21	PCP	Appointments must be scheduled within 45 days of enrollment unless the child is already under the care of a PCP and current with screens

Our appointment availability standards reflect minimum requirements. We routinely monitor providers for compliance with these standards. Noncompliance may result in the initiation of a corrective action plan or further

corrective actions.

Hours of Operation/Appointment Availability

Aetna Better Health requires that the hours of operation that provider's offer to Medicaid members be no less than those offered to commercial members. Appointment availability standards are located above.

PCP Waiting Times

Waiting time standards for PCPs require that members, on average, should not wait in a PCP office for more than 30 minutes for a routine care appointment. Under certain emergent circumstances, for example if a physician encounters an unanticipated urgent visit or treats a member with a difficult medical need, the waiting time may be extended to one hour. These access and appointment standards are physician contractual requirements. We monitor compliance with appointment and waiting time standards. We'll work with providers to ensure that they meet these standards.

Appointment Notification and Follow-up

The PCP, dentist, or specialist must conduct affirmative outreach to a member when a member misses an appointment. You must make three outreach attempts. You must also record the date and type of outreach attempt in the member's medical record. Communication with the member may include, but is not limited to:

- Written attempts
- Telephone calls
- Home visits

At least one attempt must be a follow-up telephone call. Finally, you should take the member's language and literacy capabilities into consideration when making the outreach attempt.

EXAMINATIONS TO DETERMINE ABUSE OR NEGLECT

When the County Children and Youth Agency system notifies us of a potential care of child neglect and/or abuse of a HealthChoices member, we work with the Agency and the PCP to ensure that the member receives timely physical examinations for the abuse or neglect in accordance with the Child Protective Services Law, 23 Pa. C.S. 6301 et seq. and Department regulations. If a PCP determines that a member needs a mental health assessment, the PCP must inform the member or the County Children Youth Agency representative of how to access mental health services. They must also coordinate access to these services, when necessary.

In addition to conducting physical examinations, providers must proactively report suspected abuse and/or neglect of HealthChoices members. Providers can report abuse to the DHS's Child Line at 800-932-0313 TDD: 866-872-1677. Child Line accepts calls from the public and professional sources 24 hours-a-day, 7 days- a-week. The Child Line provides information, counseling and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

Professionals who have reasonable cause to suspect that a child has been abused are required to file a report. The individual may remain anonymous. Each call to Child Line is answered by a trained intake specialist who will interview the caller to determine the most appropriate course of action. Actions include:

- Forwarding a report to a county agency for investigation as child abuse or general protective services
- Forwarding a report directly to law enforcement officials
- Referring the caller to local social services (such as counseling, financial aid and legal services)

For more information on how to help children and families, visit the Child Welfare Services section of the DHS's website <http://www.dhs.state.pa.us>.

AMERICANS WITH DISABILITIES ACT (ADA)

Title III of the ADA mandates that public accommodations, such as a physician's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity
- Denial of the benefits of services, programs or activities of a public entity
- Discrimination by any such entity

Physicians should ensure that their offices are as accessible as possible to persons with disabilities. They should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. We offer sign language and over-the-phone interpreter services at no cost to the provider or member.

Call your Provider Relations Representative at **1-866-638-1232** for more information.

MEMBER EDUCATION

Providers are responsible for educating members about:

- Their unique health care needs
- Physical examinations
- Potential treatment options, side effects, management of symptoms, disease prevention and the importance of regular health maintenance
- The member's right to choose the final course of action among clinically acceptable options
- How to access emergency and urgent care providers

EMERGENCY/URGENT CARE

Members can go to the nearest emergency department without prior authorization.

You can refer patients to an urgent care facility in our network if you cannot see the patient immediately. Visit our website for a complete list of centers at www.aetnabetterhealth.com/pennsylvania.

In addition to our own network of urgent care centers, we have written policies and procedures requiring PCPs to offer after hour care or on call arrangements with qualified providers on a 24 hours a day, 7 days a week basis. This helps ensure that members with emergency or urgent care needs can receive timely treatment. Our policies and procedures also detail how providers and members make contact to receive instructions for treatment.

Providers offering after hours care are not permitted to sign off to the emergency room or to use an answering machine in lieu of a live response.

Post-stabilization Services

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

- The post-stabilization services were approved by Aetna Better Health.
- The practitioner/provider requested prior approval for the post-stabilization services, but Aetna Better Health did not respond within one (1) hour of the request.
- The practitioner/provider could not reach Aetna Better Health to request prior approval for the services;
- The Aetna Better Health representative and the treating practitioner could not reach an agreement concerning the member's care, and a Aetna Better Health medical director was not available for consultation.

Note: In such cases, the treating practitioner must be allowed an opportunity to consult with an Aetna Better Health medical director; therefore, the treating practitioner may continue with the member's care until a medical director is reached or any of the following criteria are met;

- An Aetna Better Health physician with privileges at the treating hospital assumes responsibility for the member's care;
 - An Aetna Better Health physician assumes responsibility for the member's care through transfer;
 - Aetna Better Health and the treating physician reach an agreement concerning the member's care; or
 - The member is discharged.
- The practitioner/provider is required to notify Aetna Better Health of the admission to an observation or inpatient status in accordance with plan requirements.

NON-ADHERENT MEMBERS

It's important to manage your patient's care in a way that motivates the member to comply with treatment plans and attend scheduled appointments. Make every effort to do this rather than transferring non-compliant patients to another provider. If you have non-compliant patients who aren't responding to reasonable efforts, you can refer them to the care management team. Just call us at **1-866-638-1232**.

PROVIDER ADMINISTRATIVE RESPONSIBILITIES

Providers are responsible for adhering to all administrative procedures.

Enrollment with the Commonwealth of Pennsylvania DHS

In order to participate with Aetna Better Health, providers must first enroll with the Department of Human Services. To be eligible:

- Practitioners in Pennsylvania must be licensed and currently registered by the appropriate State agency
- Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state

and they must provide documentation that they participate in that state's Medicaid program

- All other providers must be approved, licensed, issued a permit or certified by the appropriate state agency, and if applicable certified under Medicare.

To enroll, providers must complete a base provider enrollment form and any applicable addenda documents dependent on the provider type. To access enrollment forms and other information about how to register with the Commonwealth, visit http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/S_001994

Member Eligibility Verification

The provider is responsible for:

- Verifying a member's current enrollment status and whether they have been assigned to your practice before providing care
- Understanding that Aetna Better Health will not reimburse for services provided to patients who are not enrolled with Aetna Better Health
- Using members' MA identification ACCESS cards to obtain online eligibility information from the Eligibility Verification System (EVS)
- Verifying members' eligibility by calling Member Services at **1-866-638-1232** or by visiting the site at www.aetnabetterhealth.com/pennsylvania. See Chapter 6 for further details regarding eligibility verification.

Prior Authorization for Services and Referrals

A PCP or contracted specialist must request authorization for certain Medically Necessary services. Unauthorized services will not be reimbursed. Please note that authorization is not a guarantee of payment. Call your Provider Relations representative for further information. All out of network services must be authorized.

You can find a current list of services, which require prior authorization at www.aetnabetterhealth.com/pennsylvania

Encounters and Claims

An encounter is any covered health care service provided to a member, regardless of whether it has an associated claim. Generally, encounters include claims records of Medically Necessary services rendered by a provider registered with the Commonwealth of Pennsylvania, Department of Human Services (Department) to a member enrolled in Aetna Better Health on the date of service.

Encounter data is a record of any covered health care service provided to a member. It includes encounters reimbursed through capitation, Fee-for-Service or other methods of compensation, regardless of whether payment is due or made. We use encounter data to evaluate whether providers meet care requirements and establish rate adjustments.

Providers must report all claims and encounters to us by following certain procedures explained in Chapter 12-Billing Procedures. We then report these encounters to the Department of Human Services. We review members' medical records and compare utilization with encounter data submissions. If you don't submit encounters, we may require you to implement a corrective action plan. Periodically, the Department of Human Services will also review encounter data.

Electronic Billing

We strongly encourage the electronic filing of claims. Electronic billing:

- Eliminates the cost of sending paper claims
- Allows you to track each claim sent

- Minimizes clerical data entry errors
- Ensures faster processing and payment of claim

To file your claims electronically, use our EDI payer number 23228.

We have agreements with EDI claim clearinghouses. They have software that sends pre-edited CMS 1500 02/12 and UB 04 claims to our Claim Department for review.

If you file your claims electronically, please be aware that the claim receipt acknowledgment file that we return to the clearinghouse is the only accepted proof of timely filing. If you have questions about this, contact your vendor directly.

Electronic Funds Transfer (EFT)

You can direct funds to a designated bank account. To enroll in EFT, submit an Electronic Funds Transfer Authorization Form found online at www.aetnabetterhealth.com/pennsylvania in the forms section under “For providers”. You can also find the form on our secure web portal.

Submit this form with voided check to begin processing the request. It takes about 30 days for EFT implementation.

Billing of Members

You cannot balance bill patients for covered services. You only bill patients for:

- Non-covered services
- Services that have not been authorized
- Services that are out of network

You can only bill patients for those services if you told the patient before rendering the service that it’s not covered and they agree in writing to pay the cost. You can bill members for their applicable Medical Assistance copayments. However, cannot bill members for Medicare deductibles or coinsurance.

REIMBURSEMENT

We reimburse providers according our fee schedule or other contracted rates. Your contract tells you the type of reimbursement you receive and the services you can provide. Call your Provider Relations representative with questions.

COORDINATION OF BENEFITS

We’re the “payer of last resort” when the member has other health insurance like Medicare, a Medicare HMO, commercial carrier or other third party resources. In these cases, we’ll coordinate payment of benefits and pay all clean claims for prenatal or preventive pediatric care (including EPSDT services to children). We’ll also pay clean claims for services to children having medical coverage under a Title IV-D child support order. This is true as long as we’re notified by the Department of Human Services of such support orders or we become aware of such orders. We’ll then seek reimbursement from liable third parties. We will not cost avoids the aforementioned claims with the exception of hospital delivery claims. Your contract with us contains guidelines for these situations.

MEMBER COMPLAINTS, GRIEVANCES, AND DHS FAIR HEARINGS

We can request medical records from the provider when researching complaints, grievances, and requests for a DHS Fair Hearing, or quality of care issues. It's important that you respond to these requests promptly. You can act on behalf of a member with written consent. See Chapter 13 for more information about member complaints, grievances, and requests for a DHS Fair Hearing.

COMPLIANCE FEDERAL REGULATION

You must comply with regulatory requirements under Title 55, Chapter 1101 of the Pennsylvania Public Welfare Code. To access the most current regulatory requirements, review the Medical Assistance Manual, Chapter 1101 (General Provisions) online at: <http://www.pacode.com/secure/data/055/055toc.html>

If you want a hard copy, call your Provider Relations representative or Member Services at **1-866-638-1232**. To ensure that you have the most updated version of these regulations, visit the DHS's website below.

All providers contracting with Aetna Better Health must adhere to all federal and state rules and regulations. To access more information about the Commonwealth's regulations, guides and handbooks, visit the Provider Information section of the DHS's website at <http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/index.htm>.

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. Culture competency is also the ability to translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members should receive covered services regardless of race, ethnicity, national origin, religion, gender, age, gender identification, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

We expect contracted providers to treat all members 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.

Cultural Competency Training

We've developed effective provider education programs that:

- Encourage respect for diversity
- Foster skills that facilitate communication within different cultural groups
- Explain the relationship between cultural competency and health outcomes

These programs provide information related to our members' diverse backgrounds. They also address the cultural, racial and linguistic challenges members face in navigating the various components of our healthcare system. ,

We also developed and implemented methods and techniques that are useful for both the member and provider in responding to these challenges. Through our Special Needs Unit (SNU), you can request and access educational materials and training on such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and/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.)
- Historical experience with American medicine and a reluctance to access services (e.g., the Tuskegee experiments, current racial disparities in health services)

You can directly contact the Special Needs Unit to discuss their diversity practices. We'll help you respond to the diverse needs of our members by providing training and information through a variety of channels, including, but not limited to:

- **Care Management Activities.** Our Care Management staff assesses and stratifies members based on their individual health care needs. Through this process, we identify members who have racial, cultural, linguistic, and other special needs. We then collaboratively develop an individual care plan and work closely with members and their providers to facilitate the coordination and delivery of care.
- **Training Forums.** We use professional trainers to educate our provider network on topics of cultural competency. We also offer online cultural competency training through our website.
- **Provider Meetings.** Provider Relation staff schedules regular visits to in-network providers' offices to discuss various topics, including cultural competency and the specific needs of our members.

In addition, we promote and encourage regularly scheduled and ad hoc interaction between medical management and our network providers. These interactions present a valuable opportunity to discuss and resolve specific cultural, racial, or linguistic challenges that may arise.

Most importantly, to the extent possible, we strive to meet member needs by developing and maintaining a provider network that mirrors the racial, ethnic, and linguistic composition of our members.

Note: Provider education on cultural competence is required.

LIMITED ENGLISH PROFICIENCY AND ALTERNATE METHODS OF COMMUNICATION

Our policies conform to federal government limited English proficiency (LEP) guidelines. These guidelines state that programs and activities normally provided in English must be accessible to LEP persons. Services must be provided in a culturally effective manner to all members, including those:

- With limited English proficiency (LEP) or reading skills
- With diverse cultural and ethnic backgrounds
- Who are deaf or hard of hearing
- Who are homeless
- With physical and mental disabilities

To ensure members' privacy, you must not interview members about medical or financial issues within hearing range of other patients.

In compliance with federal and state requirements:

We make certain that LEP members and member those who are deaf or hard of hearing have access to health care and benefits by providing a range of language assistance services at no cost to the member or the provider. We offer translation and interpreter services to providers and members free of charge. These services include American Sign Language. We strongly encourage using professional interpreters, rather than family or friends, as the member may wish to keep their state of health and treatment plan private. In addition, using a family member or friend doesn't ensure an accurate translation and could lead to multiple office visits. We offer interpretation services to HealthChoices members and providers through the Language Line. Language Line employs trained and qualified professionals who are well versed in medical terminology. They provide telephonic interpretation in over 175 languages. You can make arrangements in advance for personal interpreters. Call your Provider Relations representative or our Member Services department at **1-866-638-1232** to learn more about these services. In addition, we have bilingual staff to assist LEP members. Member materials, Member such as the member handbook, are available in English and Spanish. Members can also request to receive materials in another language or format.

You can use Language Line® services in the following scenarios:

- If a member requests interpretation services, Member Services representatives will assist the member via a three-way call to Language Line® to communicate in the member's native language.
- For outgoing calls, Member Services staff dial Language Line® and use an interactive voice response system to conference with a member and the interpreter
- For face-to-face meetings, our staff (e.g., care managers) can conference in a Language Line® interpreter to communicate with a member in his or her home or another location
- When you need interpreter services and cannot access them from your office, call us to connect with a Language Line® interpreter

Upon member request, we'll make all written materials accessible to visually or hearing impaired members, including:

- Braille
- Audio tapes
- Large print
- Computer diskette (CD) or DVD
- Sign language interpreters

TTY services or Pennsylvania Telecommunication Relay Service at 7-1-1MemberWe must include appropriate instructions on all materials about how to access or receive assistance with accessing desired materials in an alternate format.

HIPAA AND CONFIDENTIALITY

HIPAA Notice of Privacy Practices

We maintain strict privacy and confidentiality standards for all medical records and member health care information, according to federal and state standards. You can access up-to-date Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices on our website at www.aetnabetterhealth.com/pennsylvania. This includes explanations of members' rights to access, amend and request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of protected health information (PHI).

Confidentiality Requirements

You must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

You're also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and member information, whether oral or written in any form or medium. The following information is considered confidential:

- All "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). "Individually identifiable health 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
 - 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)

The Privacy Rule 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.

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 of Welfare, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Member Privacy Rights

Our privacy policy assures that all members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists our personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request including:

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

Member Privacy Requests

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

- Make a privacy complaint
- Receive a copy of all or part of their 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

The member or member’s authorized representative must submit a privacy request. A member’s representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member’s estate. Except for requests for a health plan Notice of Privacy Practices, members or a member’s representative must submit requests to us in writing.

Privacy Process Requirements

Our processes for responding to member privacy requests include components for the following:

Verification

If the requester is the member, we’ll verify the member’s identity. Verification examples include asking for:

- The last four digits of member’s Social Security Number
- Member’s address
- Member’s date of birth.

If the requester is not the member, we’ll require the member to complete an Authorization for Use or Disclosure to verify the requester’s authority to obtain the member’s information. If the requester identifies him/herself as a member’s authorized representative, we’ll require a healthcare Power of Attorney (POA) or comparable document for a representative to act on behalf of the member.

Review, Disposition, and Response

Aetna Better Health personnel review and disposition of privacy requests comply with applicable federal, state, and local laws and regulations, and applicable contractual requirements, including those that govern use and disclosure of PHI. Responses to privacy requests conform to guidelines prescribed by HIPAA, including response time standards. They’ll also include a notice of administrative charges, if any, for granting the request.

Use and Disclosure Guidelines

We're required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law.

We may deny a privacy request under any of the following conditions:

- We don't maintain the records containing the PHI
- The requester is not the member and we're unable to verify his/her identity or authority to act as the member's authorized representative
- The documents requested are not part of the designated record set (e.g., credentialing information)
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the member or another person
- We're not required by law to honor the particular request (e.g., accounting for certain disclosures)
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA.

PROVIDER RELATIONS AND SUPPORT

Provider Relations Representatives

Provider Relations representatives serve as liaisons between providers and Aetna Better Health. They work to ensure open and ongoing communications. They also conduct initial orientation and ongoing training sessions for your and your office staff.

You can call **1-866-638-1232** to connect with Provider Relations representatives. They'll answer questions and assist you in meeting requirements and obtaining necessary information. You can also find your provider relations contact information on our website at www.aetnabetterhealth.com/pennsylvania.

Claims Inquiry & Claims Research Team (CICR)

The CICR team can assist you with claim related questions and concerns. They enhanced their broad service model to include calls related to claims status, as well as billing or contractual related inquiries. The CICR staff is available to assist from 8:00 a.m. to 5:00 p.m. Monday through Friday. Just call **1-866-638-1232**.

Provider Training and Education

We provide a variety of training opportunities for network providers, including, but not limited to:

- Orientation sessions
- Distribution of written materials through mailings and on our Web site
- Ongoing site visits
- Regularly scheduled provider training forums and meetings
- In-person training sessions at provider offices
- WebEx training sessions for providers
- Annual updates of the provider manual

Provider Orientation

We provide initial orientation for newly contracted providers within one month after joining our network. We conduct the orientation either through group sessions or during visits to individual provider offices, clinics, or group practice locations. Sessions cover such topics as:

- Covered benefits and member and provider responsibilities
- Cultural competency
- Provider tools, such as the provider manual, website, newsletters
- Process for checking eligibility
- The role of the PCP and appropriate use of the emergency department
- Provider responsibilities for compliance with the Americans with Disabilities Act and how to access health plan interpretation and sign language services
- Methods used to update providers on program and health plan changes
- The role of care managers and related activities
- Reporting requirements, including encounter data submission requirements
- Medical records documentation requirements
- The provider complaint, grievance and appeals process
- Medical management processes, including:
 - Referrals to specialists and out-of-network providers
 - Prior authorization
 - Care and disease management
 - Pharmacy drug list
 - Evidence-based clinical guidelines
- Appointment availability standards, including wait times and after hours availability
- Pay-for-performance opportunities and supporting tools, such as provider profiles
- Members' rights and responsibilities, including the right to file a grievance, complaint or request a DHS Fair Hearing and how a provider can assist members in this process
- Member resources (e.g., Language Line[®], community resources)
- Claims payment, including the availability of electronic funds transfer (EFT)
- Coordination of Benefits
- Provider responsibility for compliance with Commonwealth and federal laws
- Contact information for provider relations and other departments

Site Visits

We conduct ongoing site visits for PCPs every three months and at least annually for all other providers and practitioners. We'll schedule more meetings with providers who are not meeting their contractual requirements/obligations. We also hold formal Joint Operating Committee meetings with hospitals on a mutually agreed upon basis. During these sessions, our Provider Relations staff communicates upcoming plan initiatives, new regulatory requirements, or new policies that may affect providers.

Provider Forums

We conduct provider forums for continued education, including:

- Individualized provider training on select topics (e.g., website navigation)
- Group training sessions on select topics (e.g., claims coding, member benefits health forum)
- Provider newsletters and bulletins containing updates and reminders
- Frequently updated online web materials and training

On-going Education and Communications

We annually update this provider manual, which serves as a primary resource for educating new and existing network providers regarding our policies and procedures. We also notify providers of important revisions through newsletters, provider bulletins, fax blasts, regularly scheduled and ad hoc communications with our staff and on our website.

Chapter 4: Credentialing Overview

PROVIDER CREDENTIALING OVERVIEW

We use the HealthChoices Agreement and current National Committee for Quality Assurance (NCQA) standards for the review, credentialing and re-credentialing of providers. We also use the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks; the credentialing application process.

The Universal Credentialing DataSource program allows 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. Practitioners update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. The Council for Affordable Quality Healthcare (CAQH) gathers and stores detailed data from more than 600,000 practitioners nationwide.

Practitioners may not treat members until they become credentialed.

Initial Credentialing Individual Practitioners

Initial Credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, (with the exception of hospital based providers) including practitioners joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee.

Recredentialing Individual Practitioners

We re-credential practitioners on a regular basis (every 36 months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA & URAC) requirements (as applicable to the health plan). Termination of the provider contract can occur if a provider misses the 36-month timeframe for recredentialing.

Facilities (Re) Credentialing

As a pre-requisite for participation or continued participation in our network, all applicants must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation in the network, and every three years thereafter, Aetna Better Health Credentialing will confirm that each Organizational Provider meets assessment requirements.

Ongoing monitoring

Ongoing Monitoring consists of monitoring practitioner and or provider sanctions, or loss of license to help manage potential risk of sub-standard care to our members.

PROVIDER CREDENTIALING PROCESS

1. As a participant with the Council for Affordable Quality Healthcare (CAQH®), we utilize the web-based CAQH uniform provider application. If the provider doesn't have a complete CAQH application, registration is required via online at cagh.updadminhelp@acsgs.com or telephonically at 1-888-600-9802.
2. Once the registration is complete, create a personal ID and password to ensure the privacy and accuracy of your confidential information.
3. Utilize your ID and password to access the secured website to complete the online application. You can request a paper copy of the application by calling CAQH.
4. When you identify your provider type and state(s) of practice, the system automatically leads you through the application. Some fields may be pre-populated from information provided by health care organizations and/or hospitals with which you are affiliated.
5. The system allows you to complete the application over time.
6. Once the application is complete, a system audit is conducted to identify errors and/or omissions.
7. Once the corrections are made, you'll review and attest to the accuracy of the information.
8. Fax the requested supporting documents to the designated secure site.
9. **The application is complete ONLY when ALL supporting documents are received AND you have attested to the accuracy of information.**
10. You'll receive e-mail or fax notification when your application is complete.
11. **The credentialing process will begin once the application is complete.**
12. You're notified via e-mail or fax every 3 months to re-attest to the accuracy of your information and to fax updated supporting documents, if applicable.
13. **Failure to re-attest or provide update documents timely may negatively impact your 3-year recredentialing cycle. This may result in termination from the Aetna Better Health network.**

Please fax all completed documents to Aetna Better Health at **1-860-754-5435**. Or mail to:

Aetna Better Health
2000 Market Street, Suite 850
Philadelphia, PA 19103

CREDENTIALING DECISION NOTIFICATION

Once all information and supporting documents have been verified, the credentialing files are presented for committee decision. We notify all applicants of initial credentialing decisions and recredentialing denials only. We don't notify providers of recredentialing approvals.

Between Credentialing Cycles

If participation requirements, such as unrestricted DEA or state mandated CDS certification, are not met, we'll notify you in writing, via certified mail, that we're terminating your participation with Aetna Better Health in accordance with the specific terms identified from the Agreement.

If you respond within 30 calendar days of the date of the notice correcting any factual discrepancies or correctable deficiencies, the chief medical officer or designee has the discretion to overturn the determination.

If your license isn't current or has been encumbered (e.g., license status of probation, suspension, or revocation), you'll be terminated and notified by certified mail of the termination. The notice will inform you to contact the chief medical officer or designee noted in the letter within five calendar days if the information is erroneous.

Call your Provider Relations representative with questions about our provider credentialing application or participation process at **1-866-638-1232**.

Chapter 5: Benefits and Cost Sharing

COVERED BENEFITS & SHARED COSTS/HEALTHYCHOICES for HealthChoices members

HealthChoices is the name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to members within identified multi-county areas (zones). Medical Assistance (MA) covers eligible MA members for the following Medically Necessary services as outlined in the chart below.

Copayments

Copayments do not apply to the following members:

- Pregnant (including post-partum care)
- Under 18 years old
- 18 – 20 years old and qualify for Medical Assistance under Title IV-B Foster Care or Title IV-E Foster Care and Adoption Assistance
- In a long term care facility or other medical institution

Copayments do not apply to services provided in an emergency situation or items costing less than \$2.

Maximums

Copays	Medical Assistance	General Assistance
There is a six-month limit (between January and June and between July and December) on the amount a single member can pay in copayments. The limit is \$90 for Medical Assistance members and \$180 for General Assistance members. Aetna Better Health reconciles member copayments made between January and June and between July and December each year to determine if any members paid more than the maximum. Aetna Better Health will refund members for any overpayments.		
Ambulance		
Per Trip	\$0	\$0
Dental Care	\$0	\$0
Inpatient Hospital		
Per Day	\$3	\$6
Maximum with limits	\$21	\$42
Medical Centers		
Ambulatory Surgical Center	\$3	\$6
FQHCs/RHCs	\$0	\$0
Independent medical/surgical center	\$3	\$6
Short Procedure Unit	\$3	\$6
Medical Equipment		
Purchase	\$0	\$0
Rental	\$0	\$0
Medical Visits		

Copays	Medical Assistance	General Assistance
There is a six-month limit (between January and June and between July and December) on the amount a single member can pay in copayments. The limit is \$90 for Medical Assistance members and \$180 for General Assistance members. Aetna Better Health reconciles member copayments made between January and June and between July and December each year to determine if any members paid more than the maximum. Aetna Better Health will refund members for any overpayments.		
Certified Nurse Practitioner	\$0	\$0
Chiropractor	\$0	\$0
Doctor	\$0	\$0
Optometrist	\$0	\$0
Podiatrist	\$0	\$0
Outpatient Hospital		
Per visit- outpatient surgical except maternity	\$3	\$6
Per visit- non-surgical or diagnostic	\$0	\$0
Prescriptions		
Generic	\$1	\$1
Brand name	\$3	\$3
X-rays		
Per visit	\$0	\$0

Benefit Limit Exception Process

A member or member's provider can request a benefit exception asking us to approve services above our benefit limits. **This is called a benefit limit exception.**

An exception to the limit can be granted if:

- The member has a serious chronic illness or other serious health condition and without the additional service his/her life would be in danger
- The member has a serious chronic illness or other serious health condition and without the additional service his/her health will get much worse
- The member would need more costly services if the exception is not granted
- Granting the exception is necessary in order to comply with Federal law

We'll let you know whether or not the exception is granted within the time frame given below:

- If the member or member's provider requests an exception before the member receives the service, you'll get a response within 21 days of the date we get the request
- If the member or member's provider requests an exception before the member receives the service, and the member's provider tells us the member has an urgent need for a quick response, you'll get a response within 48 hours of the date and time we get the request
- If the member or member's provider requests an exception after the member received the service, you'll

get a response within 30 days of the date that we get the request

If the member isn't happy with our decision, he or she can file a complaint and/or a grievance or request a DHS fair hearing about our decision.

The member's doctor or dentist must submit the benefit limit exception request with the following information:

- Member's name, address and member ID number
- The service requested
- The exception rationale
- The provider's or dentist's name and phone number

The request must include documentation from the patient's primary care or specialty care physician supporting the need for the exception, e.g., medical/dental history, chart documentation, diagnostic study results, radiographs (if applicable), etc.

For a medical benefit limit exception mail to:

Aetna Better Health
2000 Market Street, Suite 850
Philadelphia, PA 19103

For a dental benefit limit exception mail to:

DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092

Behavioral Health Services

For Medical Assistance members, the Department of Human Services covers behavioral health services under a separate contract. Physical Health Services are covered under the Aetna Better Health contract for HealthChoices members.

Aetna Better Health and its providers are required to coordinate and refer identified members to behavioral health services for assessment. Through our care management programs, we can assist in coordination activities and referrals to community resources. Contact Aetna Better Health Care Management at **1-866-638-1232** for help. For more information about our Care Management program, read Chapter 9: Medical Management.

For Aetna Better Health PCO members, please see chapter 18 of this manual.

Dental

Dental cleaning, dental trauma, dental x-rays and anesthesia for general dental procedures are covered services. Oral surgery is also a covered service, but prior authorization is required. Members can find an Aetna Better Health dentist in their area by logging onto www.aetnabetterhealth.com/pennsylvania or by calling Member Services at **1-866-638-1232**. Members don't need a referral to see the dentist. Dentists provide regular check-ups and take care of regular dental care. Our subcontractor, DentaQuest will provide all dental services for covered benefits.

Members 21 years of age and older, will be eligible for the following:

- One partial upper denture or one full upper denture and one partial lower denture or one full lower denture per lifetime. Additional dentures will require a benefit limit exception (BLE).
- One oral evaluation and prophylaxis per 180 days, per adult member. Additional oral evaluations and prophylaxis will require a BLE.

- Root Canals, crowns and adjunctive services, periodontal and endodontic services are covered if the member does not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), and receives a BLE. DentaQuest will grant benefit limit exceptions to the dental benefits when one of the BLE criteria described above is met.

Durable Medical Equipment (DME)

DME is covered for most members, but prior authorization may be required. Refer to the prior authorization grid at www.aetnabetterhealth.com/pennsylvania.

Covered DME items include, but are not limited to, the following:

- Bathroom and safety equipment
- Beds and accessories
- Electric nerve stimulators
- Lymphedema pump and supplies
- Medically Necessary DME and supplies
- Monitoring equipment
- Respiratory equipment and supplies
- Seating equipment (lift chair, wheelchair, commode)
- Wheelchairs

Emergency Services

Covered emergency services include:

- Emergency ambulance transportation
- Emergency room (ER)
- ER physician consultation (non-ER specialty)
- ER physician services (radiology, anesthesiology, ER and pathology)

Family Planning

Members can choose any provider for family planning services. Covered family planning services include, but are not limited to:

- Medically Necessary abortions only as allowed in MA Bulletin 99-06-15
- Contraceptive implants/injections
- Education/counseling
- In-office visit with Primary Care Provider or Primary Care Obstetrician
- Tubal ligation/Hysterectomies/other sterilizations for both male and female are covered for all members over the age of 20. The appropriate consent form must be received at least 30 days prior to – but not more than 180 days before – the procedure.

Health Education

Some health educational services may require prior authorization to ensure appropriate utilization. Refer to the Prior Authorization grid at www.aetnabetterhealth.com/pennsylvania.

Hearing

EPSDT/well-child hearing screening is covered for members under age 21. Hearing aids are covered, but require prior authorization for members under age 21.

Home Health Care

Home health care is a covered benefit, but requires prior authorization. General Assistance MA members are limited to 30 days per fiscal year.

Hospice Care

We contract with providers certified according to 42 CFR 418.1 to offer hospice care to our members. Inpatient and outpatient hospice care are covered for those under age 21 and adults who are not on General Assistance, but care does require prior authorization.

Hospital Care

The following are covered benefits for hospital care:

- Inpatient hospital stays (acute/rehabilitation)
- Outpatient maternity services and medical observation
 - Outpatient surgery and maternity surgery
 - Outpatient diagnostic/therapeutic services are covered for all members
- Inpatient maternity stays are covered, but require notification to us by the next business day. All rooms are semi-private unless deemed Medically Necessary.

Laboratory Services

Laboratory services provided at the PCP's office and HIV/AIDS testing are covered. Genetic and other lab services are also covered, but require a PCP referral.

Maternity Services

Maternity Care and Obstetrics (OB) services are covered. Prenatal and postpartum visits are included.

Newborn Care

Included in EPSDT services. Refer to Chapter 7: Early Periodic Screening and Diagnostic Testing for more information.

Obstetrical/Gynecological (OB/GYN) Care

Obstetrical and gynecological services do not require a referral, but they must be performed by a participating provider. In situations where a new and pregnant member is already receiving care from a non-participating OB-GYN specialist at the time of enrollment in Aetna Better Health, she may continue to receive services from that specialist throughout the pregnancy as well as postpartum care related to the delivery.

Orthotics/Prosthetics

These are limited to children under 21 and E-02 (Categorically Needy 21 and over under MA) members.

Diabetic and non-diabetic orthopedic shoes is a covered benefit for those under age 21 with prior authorization. There is a limit of 4 pairs per year. Orthotic supplies, prosthetics, and artificial limbs are covered; however they do require prior authorization.

PCP Office Visits

Regular and routine office visits and procedures are covered.

Prenatal Care

Maternity Care/Obstetrics is covered. We reimburse Maternity Care/Obstetrics on a fee-for service basis. Nurse midwife (OB) care is covered, including prenatal and postpartum visits. One postpartum visit is included in the delivery fee and is not considered in the 12-visit limit. Refer to page 86 of this manual for additional care management information.

Preventive Services

Cervical screening, immunizations, mammograms and prostate/colorectal screenings are covered. Health and wellness services including smoking cessation classes and nutritional counseling are covered, but require prior authorization.

Procedures

In-office procedures (treatment and diagnostics) for PCP and specialists are covered. The following procedures are also covered:

- Allergy testing
- Cardiac catheterization
- Angioplasty
- Stents
- Chemo/radiation therapy
- Circumcision
- EMG/NCVs
- Nerve blocks/epidurals
- Sleep studies

Radiology (X-ray) Services

Angiograms, angioplasty, embolization, bone densitometry, CT scans, discogram, /myelogram, electromyography, other diagnostic radiology procedures and routine x-rays are covered. MRI/MRA and PET scans are also covered, but require prior authorization. Portable x-rays are covered, but a maximum \$2 co-payment applies and PCP referrals are required.

Skilled Nursing Facility (SNF) Care

Covered for members for 30 consecutive days with prior authorization based on Medical Necessity.

Skilled Home Nursing Services

Covered for all members with prior authorization based on Medical Necessity. General Assistance members have a limit of 30 days per fiscal year.

Specialist Office Visits

In office visits to a specialist are covered, but a PCP referral is required. Please refer to page 14 of this manual for information about how to arrange a specialist as a PCP and/or for a standing referral to a specialist.

Supplies

Diabetic testing supplies, asthma medical supplies, urinary catheter supplies and other medical supplies are covered for

members under 21, E-02 (Categorically Needy 21 and over under MA) and E-03 (Categorically Needy 21 and over under GA) members.

Therapy (Occupational, Physical and Speech)

These services are covered, but they do require prior authorization. For specific prior authorization information refer to the prior authorization grid at www.aetnabetterhealth.com/pennsylvania.

Transplant (Organ)

Organ donor costs, organ evaluation, transplant, and transplant facility are covered, but require prior authorization.

Transportation

We cover emergency, emergency air, facility-to-facility transportation and non-emergent ambulance transportation.

Non-emergent, non-ambulatory transportation is covered by the Medical Assistance Transportation Program (MATP).

MATP is responsible for:

- Non-emergency transportation to a medical service that is covered by the MA Program. This includes transportation for urgent care appointments
- Transportation to another county to get medical care as well as advice on locating a train, the bus and route information
- Reimbursement for mileage, parking and tolls with valid receipts if the consumer used their own car or someone else's to get to the medical care provider

For additional information visit <http://matp.pa.gov>.

Vision Care

Our subcontractor, Block Vision, will provide covered vision benefit services to HealthChoices members. Members can contact Block Vision member services at 1-800-879-6901.

Members are eligible for two eye examinations every calendar year. Members don't need a referral to access their vision benefits, but they must use providers who are part of our vision network.

Members age 21 and over are also covered for one pair of standard eyeglass lenses or contact lenses per calendar year. In addition, members age 21 and over are covered for one pair of eyeglass frames up to \$30 each calendar year.

Members under the age of 21 are eligible for two basic pairs of eyeglasses (frames and lenses) from a network vision provider each calendar year and replacement pairs, if Medically Necessary. Members under the age of 21 may choose to receive one pair of contact lenses in lieu of one pair of eyeglasses.

Members age 21 and over with a diagnosis of aphakia can get two pairs of standard eyeglass lenses and two frames up to \$30 each or two pairs of contact lenses per calendar year. If a member has a medical condition such as cataracts, the member will also be covered for glasses or contacts to treat the condition.

The above limitations do not apply to members under age 21, if Medically Necessary.

PHARMACY

Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. You should write prescriptions to allow generic substitution whenever possible. Also, your signature should be legible in order for the pharmacy to dispense the prescription. For the most current and up-to-date version of the formulary or preferred drug list (PDL), visit our website at www.aetnabetterhealth.com/pennsylvania.

Pharmacy Drug List (PDL)

Visit www.aetnabetterhealth.com/pennsylvania for the most updated PDL. Click on "For providers" and then "pharmacy". The Pharmacy Drug List gives you information about the drugs we cover. The first column of the chart lists the covered drug. Brand name drugs are capitalized (e.g., DRUG). Generic drugs are listed in lower case italics (e.g., drug). The second column serves as a reference for providing the brand name of the drug when a generic is covered by the plan. The third column lists any requirements for the drug such as prior authorization (PA); quantity limits (QLL) or step therapy (ST).

Development

The agents included in the PDL represent those medications that, in the opinion of the DHS and our Pharmacy and Therapeutics (P&T) Committee, are of established value, present a broad choice of options to treat common clinical problems and avoid duplication of therapeutic effect in a cost effective manner. We add drugs to the PDL based on objective, clinical and scientific data. Considerations include:

- Effectiveness
- Side-effect profile
- Cost/ benefit analysis
- Comparison to alternative agents, if available.

Therapeutic superiority outweighs cost considerations in all decisions.

Pharmacy Drug List Process

We continuously review the PDL. The P&T Committee can add or remove drugs from the PDL with approval from the Department of Human Services. You can make requests for additions or deletions for the P&T Committee to consider.

Your requests should include basic product information, indications for use, therapeutic advantage over drugs already listed on the PDL and any supporting literature from medical journals. You may be invited to attend the P&T Committee meeting to support the PDL addition request and answer questions. The P & T Committee meets quarterly.

Send your request to:

Aetna Better Health
Pharmacy Department
2000 Market Street, Suite 850
Philadelphia, PA 19103

Quantity Limits

We limit prescriptions to a 34-day supply or 100 units, whichever is greater or according to the quantity limits specified on the PDL.

Generics

Generic bioequivalent medications represent a considerable cost savings to health care. Those products available generically will be covered with the generic equivalent only, unless the brand has been specifically authorized or as otherwise noted.

Generic forms of medications will be substituted as they become available unless otherwise designated. We may grant an exception to the generic substitution.

You must write in your own handwriting on the valid prescription that the “Brand Name is Medically Necessary.” You must also submit a FDA MedWatch Form indicating that the member had an adverse reaction to the generic drug or had, in the prescriber’s medical opinion, better results when taking the brand name drug. You can find the FDA MedWatch Form at <https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm>.

Brand Medications

Brand medications listed on the PDL are designated in all CAPS and are covered by the plan. The PDL may cover the brand and the generic of certain medications (i.e., Depakote ER), where both the brand and generic forms of the medication are available.

Pharmacy Prior Authorization (PA)

We require pharmacy prior authorization if:

- The charge for any single prescription exceeds \$9,999.
- The prescription requires compounding
- Injectables are prescribed (those to be dispensed by a pharmacy), with the exception of heparin and insulin
- Prescriptions exceed recommended doses
- Drugs which require certain established clinical guidelines be met before consideration for prior approval

- Non-formulary drugs

You can find a complete list of all prior authorization guidelines at www.aetnabetterhealth.com/pennsylvania/PennPrescriptionDrugInfo.aspx?menu=3

Procedure for Obtaining Pharmacy Prior Authorization

Fax your pharmacy prior authorization requests to 1-877-309-8077. Use the authorization form designed specifically for pharmacy requests available, which you can find on our website at www.aetnabetterhealth.com/pennsylvania. Incomplete forms will delay processing of your request. Also, remember to include any supporting medical records that will assist with the review of the prior authorization request. Allow 24 hours to complete a request.

We’ll make available those drugs not on the PDL, when requested and approved, if the drugs on the PDL have been used in a step therapy sequence or when you provide other documentation.

For medications that require prior authorization, we’ll allow a 72-hour supply if there is an immediate need for the

medication or a 15-day supply if the prescription qualifies as an ongoing medication at the time the member presents at the pharmacy.

Medicaid Home and Community Based Waiver Programs

Outlined below is a list of the current waiver programs available within the Pennsylvania Medicaid Program. Aetna Better Health and its providers are responsible for providing members with medical services that are not covered under the waiver program covered benefits.

- **OBRA Waiver:** Provides service to persons with severe developmental physical disabilities, such as cerebral palsy, epilepsy or similar conditions.
- **Independence Waiver:** Provides support and services to persons with physical disabilities to help them to live in the community and remain as independent as possible.
- **Attendant Care Waiver:** Helps individuals with physical disabilities perform activities of daily living.
- **Consolidated Waiver for Individuals with Mental Retardation:** Provides service to eligible persons with mental retardation so that they can remain in the community.
- **COMM CARE Waiver:** For individuals who have a diagnosed traumatic brain injury. This is a type of head injury that can happen in a bad car accident, or from a bad fall.
- **Adult Autism Waiver:** Designed for adults 21 years and older who have been diagnosed with Autism Spectrum Disorder. This waiver applies to all eligible members living in the state of Pennsylvania.
- **HIV Waiver:** Provides services to eligible persons age 21 or older who have symptomatic HIV Disease or AIDS
- **Infant, Toddlers, and Families Waiver:** Provides services to children from birth to age three who are in need of Early Intervention services and would otherwise require the level of care provided in an Intermediate Care Facility for Persons with Mental Retardation or Other Related Conditions (ICF/MR-ORC)

SERVICES REQUIRING REFERRAL AND PRIOR AUTHORIZATION

The following list represents the majority of services requiring authorization. However, please refer to the **code specific** and current listing at www.aetnabetterhealth.com/pennsylvania for the most current list. Please note that this listing is subject to change.

All Inpatient services

- Surgical and non- surgical
- Skilled nursing
- Rehabilitation
- Hospice

Outpatient Services

Outpatient services vary based upon the code and are not location specific. Please check the code specific listings for details. Listed below are selected services requiring prior authorization:

- Surgical services - refer to code specific listing as requirements may vary
- Home based services including hospice and skilled nursing
- Therapy - All therapy services require authorization with the exception of therapy diagnostic analysis and therapy evaluations
- Imaging
- MRI

- MRA
- Angiography
- PET scans
- DME - refer to code specific listing as requirements may vary. In general the following require authorization:
 - Hospital beds
 - Wheelchairs
 - Oxygen
 - CPAP
- Injectables
- Therapy management services provided by a pharmacist - refer to code specific listing as requirements may vary
- Orthotics / Prosthetics
- Implantable devices
- Electronic devices
- Implantable breast prosthetics
- Injectable bulking agents
- Other
 - Sleep studies
 - Osteopathic manipulation and chiropractic services
 - Hearing and vision services vary; refer to specific code
 - Specialized multidisciplinary services
 - Enteral feeding supply and formulas, additives all pumps
 - Supply based services vary please refer to specific code
 - All unlisted codes require authorization

Emergency Services

No authorization is required for emergency services.

Referral Process

If a PCP determines the need for medical services or treatment that will occur outside the office, the PCP must approve and/or arrange referrals to a participating specialist, hospital or other outpatient facility. For information on the referral process, call Provider Relations at **1-866-638-1232**.

Chapter 6: Member Rights and Responsibilities

We treat our members with respect and dignity. We don't discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation or any other basis prohibited by law. Members have responsibilities too. Together, we can advise members of their rights and responsibilities. Review the member rights and responsibilities below.

MEMBER RIGHTS

Aetna Better Health members have the right to information related to their treatment or treatment options in a language they can understand. This includes, but is not limited to:

- The freedom to exercise all member rights without any adverse effect on the member's treatment by Aetna Better Health or our participating providers
- Names of primary healthcare and participating providers and, if appropriate, care managers
- Copies of medical records as allowed by law
- A description of the Aetna Better Health services or covered benefits
- A description of their rights and responsibilities as members, 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 member surveys and grievances
- Information about the cost to a member if the member chooses to pay for a service that is not covered
- 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 member, and the benefits or drawbacks of each choice
- Advance Directives - Aetna Better Health informs members of the member's right to formulate advance directives
- Health-care benefit or network changes

Members 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 cultural background
- Interpreter services for members who are Limited English Proficient (LEP), have impaired hearing, or have requested written information in an alternative format such as Braille.
- The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience.
- Receiving information from their provider about appropriate or medically necessary treatment options and alternatives for your condition(s) regardless of cost or benefit coverage in a manner appropriate to your ability to understand.

Members 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 participating primary care physician (PCP) to help with planning and coordinating care
- The right to see a women's health specialist 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 their PCP
- Request specific, condition-related information from a PCP
- Request information about medical 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
- Participate in health care decisions including refusing a treatment, including leaving the hospital even though a doctor advises against it, and requesting an explanation of consequences. Eligibility for medical care does not depend on a member'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 complaint or grievance or request a DHS Fair Hearing.

Members 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
- Obtaining services from a specialist with a referral from the PCP
- Refusing care from a specialist the member was referred to and requesting another referral
- Requesting a second opinion

Members 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 their 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 care managers privately

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

- Filing a complaint or grievance against Aetna Better Health or its providers
- Requesting a fair hearing from the Department of Human Services (DHS)
- Providing recommendations for changes to policies and services
- The right to a detailed explanation of a denial of care if a member believes that an Aetna Better Health provider has denied care the member believes they are entitled to receive

MEMBER RESPONSIBILITIES

Aetna Better Health members are responsible for:

- Knowing the name of their assigned PCP and/or care manager
- Familiarizing themselves with their coverage and the rules they must follow to receive care
- Informing Aetna Better Health of any changes in eligibility, or any other information that may affect membership, healthcare needs or access to benefits
- Respecting the healthcare 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 member 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 healthcare professionals if it is necessary to cancel an appointment
- Bringing immunization records to all appointments for children under eighteen (18) years of age

COMMUNICATION WITH MEMBERS AND PARTICIPATING PROVIDERS

Aetna Better Health members' rights and responsibilities can be found in the Member Handbook and in this Provider Manual. You can access the most current Member Handbook and Provider Manual on our website at www.aetnabetterhealth.com/pennsylvania. Members can request the Member Handbook in print or in another language or format. We notify them by mail when we update the handbook.

We also send written notification if we reduce, suspend, deny or terminate a covered service. Included with this notification is a description of the member's right to appeal such actions, the timeframe for filing such an appeal and the process for submitting the appeal.

Chapter 7: Eligibility and Enrollment for HealthChoices

OVERVIEW

We provide quality medical and dental services to enrolled Medical Assistance (MA) members. The County Assistance Office determines whether or not an applicant is eligible for MA services. We make payments to providers and vendors for covered services, medications and medical supplies for enrolled MA members.

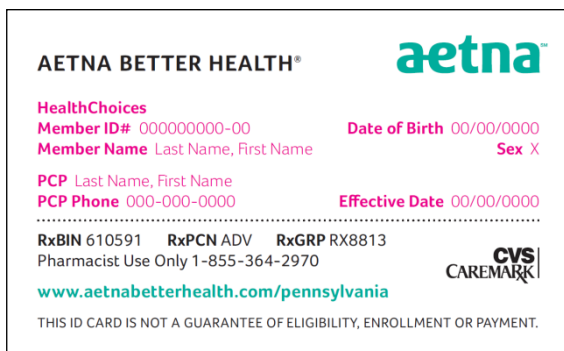
ACCESS Card

The Department of Human Services issues an ACCESS card to each MA Member. MA-enrolled Health Care Providers must use this card to access the Department's Eligibility Verification System (EVS) and verify the Member's MA eligibility and specific covered benefits. Below is an image of a sample ACCESS card.



Aetna Better Health ID Card

HealthChoices members will also receive an Aetna Better Health Identification Card. Member should present both their Aetna Better Health ID and their ACCESS ID at the time of service. This card has information on where you should submit claims. A sample Aetna Better Health ID card is shown below.



Role of EAP and Enrolment Specialists

The Enrollment Assistance Program (EAP) is responsible for enrollment activities. They employ trained, professional staff called Enrollment Specialists. The specialists assist eligible Medical Assistance (MA) members in selecting a Physical Health Managed Care Organization (PH-MCO) and Primary Care Practitioner (PCP) to manage their care. They also provide information regarding HealthChoices Behavioral Health Services.

Verifying Eligibility

You can use the ACCESS card to obtain online eligibility information from the Eligibility Verification System (EVS). The EVS is an automated system available to MA Providers and other specified organizations for automated verification of MA members' current and past (up to three hundred sixty-five [365] days):

- MA eligibility
- PH-MCO Enrollment
- PCP assignment
- Third Party Resources
- Scope of Benefits

For more information regarding the EVS and ways to access eligibility data, visit

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/softwareandservicevendors/eligibilityverificationinformation/index.htm>

Enrollment Procedures

We'll enroll any eligible HealthChoices member who selects or is assigned to Aetna Better Health, in accordance with rules, regulations and guidelines provided by the Department of Human Services. All members who are determined eligible and select us as their managed care health plan will be enrolled on the date determined by the Department of Human Services. Newborns are considered enrolled as of their birth date, with services being covered immediately.

CHANGING PCPS

If a member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, the member can choose an alternative PCP at any time by calling Member Services at **1-866-638-1232**. We'll grant the request and process the PCP change in a timely manner. Members will receive a new ID card indicating the new PCP's name.

We maintain policies and procedures allowing members to select or be assigned to a new PCP when:

- Requested by the member
- A PCP is terminated from the network
- A PCP change is required as part of the resolution to a grievance or complaint proceeding

In cases where a PCP has been terminated for reasons other than cause, we'll immediately inform members assigned to that PCP so that they can select another PCP before their current PCP's effective termination date. In cases where a member fails to select a new PCP, we'll reassign the member to another compatible PCP before the PCP's termination date and notify the member of the change in writing.

ENROLLMENT OF NEWBORNS

We have policies and procedures in place to enroll and provide all Medically Necessary services to members' newborn infants. Newborns are immediately enrolled in the program and can receive all Medically Necessary services.

We make every effort to identify what PCP/pediatrician the mother chooses to use for the newborn prior to the birth, so that the provider chosen by the parent can be assigned to the newborn on the date of birth.

Hospitals need to notify the member's CAO as soon as the member gives birth to ensure that the newborn will be accurately enrolled in MA and in Aetna Better Health. Payment for deliveries will be delayed to the extent that this accurate enrollment process is delayed.

ENROLLMENT OF MEMBERS WITH SPECIAL NEEDS

Members with Special Needs can request a specialist as a PCP or a standing referral to a specialist. The HealthChoices program defines "Special Needs" as follows: "The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by DHS." Refer to page 14 for information on how to arrange a specialist as a PCP and for a standing referral to a specialist.

RETRO-ENROLLMENT

At times, a member's enrollment date is adjusted so that it precedes the original enrollment date received from the Department of Human Services or the enrollment date is prior to the current date. These requests are evaluated by our Member Services Manager and/or designee for referral to DHS.

MEMBER RIGHTS UNDER REHABILITATION ACT OF 1973

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

Section 504 prohibits organizations from excluding or denying individuals with disabilities and 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, which 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.

Providers treating members in the HealthChoices program may not, on the basis of disability:

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

We work with you to assure that qualified individuals with disabilities have access to all Medically Necessary benefits and services.

Chapter 8: Early Periodic Screening, Diagnosis and Treatment

EPSDT OVERVIEW

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are federally mandated services intended to provide preventive health care to children and young adults (under the age of 21 years) at periodic intervals. These intervals are based on the recommendations of the American Academy of Pediatrics (AAP), American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). All PCPs who provide services to members under age 21 are required to provide comprehensive health care, screening and preventive services. We require our network PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules. You can find the most recent periodicity guidelines on the Pennsylvania DHS Web site for the HealthChoices program at http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_201845.pdf.

2014 Recommended Childhood and Adolescent Immunization Schedules can be viewed at this link: <http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-combined-schedule-bw.pdf> as well as in *Chapter 16: Immunization Schedules*.

IDENTIFYING BARRIERS TO CARE

Understanding barriers to access is essential to ensuring that members receive appropriate care including regular preventive services. We find that although most parents understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. To address this, we train our Member Services and Care Management staff to identify potential obstacles to care during member communications opportunities. We also train our staff to work with family members/caregivers, PCPs and other relevant entities to ensure access to services.

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

- Cultural or linguistic issues
- Lack of perceived need if children are not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues.

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

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

Call your Provider Services Representative at **1-866-638-1232** for help arranging any of these services.

DIAGNOSIS AND TREATMENT

You're required to make the following recommended and covered services available to EPSDT-eligible members at the ages recommended on the periodicity schedule.

Screening services, provided at recommended ages in the child's development, including all of the following:

- Comprehensive health and developmental history, including nutritional and developmental assessments (WIC evaluations and child abuse assessments are also included when necessary)
- Inpatient physician visits and routine inpatient and outpatient screenings for newborns
- Comprehensive unclothed physical exam
- Appropriate immunizations (in accordance with the Advisory Committee on Immunization Practices (ACIP) schedule)TB testing:
- Laboratory tests, including urinalysis, hemoglobin/hematocrit count and lead toxicity screening
- Health education including anticipatory guidance, child development, healthy lifestyles, accident and disease prevention
- Vision services, including periodic screening and treatment for defects in vision, including eyeglasses
- Dental services, including oral screening, periodic direct referrals for dental examinations, relief of pain and infections, restoration of teeth, and maintenance of dental health (oral exam by PCP should begin at age one with a referral to a dentist beginning at age three)
- Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Other necessary health care to correct or ameliorate physical and mental illnesses and conditions discovered by the screening process
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services
- Developmental delay and Autism Spectrum screening
- Lead poisoning prevention

Practitioners are expected to do the following in providing EPSDT services:

- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization or screening during a sibling's visit)
- Give immunizations to members in accordance with federal and Commonwealth of Pennsylvania standards
- Comply with our Minimum Medical Record Standards (contained in the provider agreement) for Quality Management, EPSDT Guidelines, and other requirements under the law
- Cooperate with our periodic reviews of EPSDT services, which may include chart reviews to assess compliance with standards
- Report members' EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form

If you detect a suspected problem during a screening examination, you must evaluate the child as necessary for further diagnosis. This diagnosis is used to determine treatment needs. If you suspect developmental delay following an EPSDT screening, and the child is not receiving services at the time of the screening, you must refer the child (not over five years

of age) through CONNECT at 1-800-692-7288 for the appropriate referral to local Early Intervention Program services.

We track treatment needs as we identify them. We also assure that appropriate follow-up is pursued and reflected in the medical record.

OBRA '89 entitles individuals under the age of 21 to receive all Medically Necessary health care services contained in Section 1905(a) of the Social Security Act and required to treat a condition diagnosed during any encounter with a health care provider practicing within the scope of state law. Any Medically Necessary health care procedure or service that is eligible under the federal Medicaid program and required to treat conditions detected during a visit are covered except for Behavioral Health Services, which will be covered through the Behavioral Health Program. Providers are responsible for identifying members in need of behavioral health treatment services, notifying Aetna Better Health and assisting members by referring them to appropriate behavioral health providers under the State's Behavioral Health Program.

We work collaboratively with PCPs to provide SSI and SSI-related members under age 21 a comprehensive assessment of their anticipated primary and specialty health needs over a 12-month period. This assessment determines if the member would benefit from care management intervention. If the PCP recommends care management and the member's family/caregiver consents, we'll enroll the member in our care management program. Our care managers discuss the results of the child/adolescent's assessment with the family/caregiver (or custodial agency) and develop an appropriate plan of care. We'll inform the family/caregiver in writing about the plan and explain the process for submitting a complaint if they disagree with the member's proposed care plan.

TRACKING

We track compliance with EPSDT guidelines in the following areas:

- Initial visit for newborns. The initial EPSDT screen is the newborn physical exam in the hospital.
- EPSDT screen and reporting of all screening results
- Diagnosis and/or treatment, or other referrals for children

We also track and report to the Department of Human Services on a variety of EPSDT screenings and treatments including:

- Number of comprehensive screens (reported by age)
- Hearing and vision examinations
- Dental screens
- Age appropriate screens
- Complete age appropriate immunizations
- Blood lead screens
- Prenatal care for teen mothers
- Provision of eyeglasses to those in need of them
- Dental sealants
- Newborn home visits
- Referral of very low birth weight babies to early intervention
- Referral of members under the age of 21 with elevated blood lead levels to early intervention
- Routine evaluation for iron deficiencies
- Timely identification and treatment of asthma

FOLLOW-UP AND OUTREACH

We'll work with you to assure that members with EPSDT needs are identified and treated in a timely and appropriate manner. We submit reports to the Department of Human Services identifying provider performance in the four required services:

- Screening
- Diagnosis and treatment
- Tracking
- Follow-up and Outreach

Arranging for medically necessary follow-up care for health care services is also an integral part of each provider's continuing care responsibility after a screen or any other health care contact. In cases involving a member under the age of 21 with complex medical needs or serious or multiple disabilities or illnesses, our case management services must be offered. You can reach our Case Management staff at **1-866-638-1232** to arrange these services.

We closely monitor EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. We also identify any children who have not yet received a well care visit in the last 12 months as a priority for follow up. We continuously update our "interventions database" that includes children with missing services and contact information for the member and the provider. Also, each month we calculate provider level HEDIS rates at the group level for the previous 12- month period. Then we identify which members have gaps in care.

Our reminders, follow-up and outreach to members include:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of members
- Telephone calls to remind members of upcoming visits and follow-up on missed appointments within a set time period
- Help with transportation when requested so members can get necessary EPSDT screening services. Assistance is offered prior to each due date of a child's periodic examination
- Outreach to non-compliant members, including home visits, as appropriate

We mail monthly age-appropriate reminders to all households with children under the age of 21, with frequent reminders for every age group from 2 to 18 years. The mailings remind parents/guardians to make sure their child receives:

- An unclothed physical exam
- A physical, mental and social health history
- Hearing, dental and vision screenings
- Nutrition and health education
- Lab screenings and testing as needed
- Required immunizations.

In addition, tips are provided for parents on the age-appropriate topics to discuss with their providers.

To assist in provider monitoring for follow-up in the four required services (Screening, Diagnosis and Treatment,

Tracking and Follow-up and Outreach) for children in substitute care, we maintain master lists of all enrolled children coded as such on the monthly membership files. Specific staff is assigned to monitor the services provided to these children and to ensure that they receive comprehensive EPSDT screens and follow-up services. Our staff contacts the relevant agencies with custody of these members or with jurisdiction over them (e.g., County Children and Youth Agency, Juvenile Probation Office) when a particular child has yet to receive an EPSDT screen or is not current with their EPSDT screen and/or immunizations. We also ensure that an appointment for such service is scheduled.

We also submit reports to the Department of Human Services providing all data regarding children in substitute care (e.g., the number of children enrolled in substitute care who have received comprehensive EPSDT screenings, the number who have received blood level assessments, etc.).

Our care managers are responsible for coordinating and tracking EPSDT services, including services for children and adolescents with developmental disabilities, behavioral health needs and complex health problems who are enrolled in the care management program. All assessments evaluate members under the age of 21 to identify needed EPSDT visits and incorporate these services into the care plan. Care managers use a variety of care management tools (e.g., CORE, Aetna Better Health's proprietary predictive modeling application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls. They enter information gathered from these activities into Dynamo™, our customized care management tracking application. This enables care managers to review a member's encounter history, schedule needed appointments and plan follow-up activities.

In addition to outreach to members participating in our care management program, we generate reports to identify members who are due or past due for EPSDT screenings and services. We perform targeted outreach through reminder mailings, phone calls and mailing a monthly flyer to parents/guardians of children under the age of 20 who are due for an EPSDT visit. For members under the age of six, an EPSDT coordinator will call after these mailings to remind members about the importance of well-child visits.

PCPs are required to contact new members identified in the quarterly encounter lists who haven't:

- Had an encounter during the first six months of enrollment
- Complied with scheduling requirements for screenings, testing and treatment

PCPs must also contact members identified as not complying with the EPSDT periodicity and immunization schedules for children to set up appointments. If members don't comply within one month of being contacted by the PCP, the PCP must notify us. The PCP must document the reasons for noncompliance, where possible, and document efforts to bring the member's care into compliance with EPSDT standards.

PCPs must also contact all members who have not had an encounter during the previous 12 months or within the appointment standards timeframes established in the Provider Agreement.

On a quarterly basis, we prompt an automated call to members who haven't received EPSDT services within the recommended timeframes. If necessary, care managers will make up to three additional efforts to contact parents and guardians by telephone. If those attempts are unsuccessful, we'll send another letter and initiate any extra follow-up needed in order to reach the member,, including researching returned mail and contacting the member's PCP's office for assistance (for members who are enrolled in care management).

If needed, a care manager will contact a member's PCP every six months to inquire whether an EPSDT visit occurred. If an EPSDT visit didn't occur, we'll ask the PCP reach out to the parent/guardian to schedule an appointment.

EDUCATING MEMBERS AND PROVIDERS ABOUT EPSDT SERVICES

We developed a comprehensive strategy for educating members and providers about the importance of preventive health screenings and immunizations.

These strategies include, but are not limited to:

- Member educational materials
- Provider educational materials
- Integration of information into care management programs (i.e., care coordination, care management and disease management).

Members

We developed an effective process to inform members about the availability and importance of EPSDT services, including:

- New Member Welcome Packet
- Member Handbook
- Member newsletters and bulletins
- Aetna Better Health's website;
- Educational flyers
- Reminder postcards
- Reminder calls
- Care plan interventions for high-risk members enrolled in care management or disease management.

Providers

We've implemented provider educational and outreach activities designed to emphasize the importance of EPSDT screenings and services and help you more readily identify patients overdue for services. These activities will also help you document preventive services and identify and resolve other issues that impede provider participation, including reimbursement. We'll work with you to increase compliance with EPSDT screening and treatment standards through the following strategies:

- Providing online training modules and access to educational Web sites
- Increasing reimbursement for preventive care services
- Linking pay for performance criteria to preventive service delivery rates
- Implementing initiatives to increase well-child and dental visits
- Developing clinical practice guidelines specific for EPSDT
- Developing member profiling and provider report cards that target EPSDT services
- Conducting on-site visits with providers to identify barriers to care
- Conducting an annual audit using HEDIS® criteria and American Academy of Pediatrics screening standards to improve compliance with EPSDT benchmark
- Establishing a Special Needs EPSDT Workgroup comprised of PCPs who serve children and youth with

developmental disabilities where “best practices” and strategies for improving EPSDT screening rates can be shared

- Implementing Performance Improvement Plans that include EPSDT, if needed.

We work collaboratively with providers to stress the importance of EPSDT screenings and services. We also closely monitor compliance with established benchmarks and produce periodic reports for PCPs showing which members need EPSDT services.

Please note that failure to submit a claim for complete EPSDT screenings and services may result in denial of payment.

INTERAGENCY TEAMS

For the ongoing coordination of EPSDT services for members under the age of 21 identified with Special Needs, our staff will ensure coordination with community-based organizations, schools and other appropriate entities. Our staff works collaboratively with these organizations, the member (if appropriate), the member’s family/caregiver and other stakeholders to develop a comprehensive plan of care for the delivery of all Medically Necessary and appropriate services. This includes pediatric care and other specialized services, whether covered or uncovered and whether in- or out-of-network. As needed, we also initiate care management interventions for members under the age of 21 with complex and/or co-morbid conditions.

SUBSTITUTE CARE OR RESIDENTIAL FACILITY PLACEMENT

We work with you to meet the following requirements for children and adolescent members who have been placed in substitute care or in a residential facility.

Children and adolescent members placed in foster care:

- Ensure that the child/adolescent receives a health screening within 60 days of his or her admission to foster family care, unless he or she has had a screening within the previous 90 days and the results of the evaluation are available. The screening must include:
 - Review of the child’s health history
 - Physical examination
 - Appropriate laboratory or diagnostic tests, including those required to detect communicable disease
- Ensure the child/adolescent receives immediate attention when a medical problem is recognized at the time of referral
- Ensure that the child/adolescent receives age appropriate well-child visits and screenings on an ongoing basis according to the following schedule:
 - Birth through six months: once every six weeks
 - Seven months through 23 months: once every three months
 - 23 months and older: once a year

Children and adolescent members placed in residential and day treatment facilities:

- Ensure that the child/adolescent receives a written health and safety assessment within 24 hours of admission. This assessment includes:

- A comprehensive medical exam and history, including physical, dental, behavioral and emotional health, as well as the identification of ongoing medical care needs
- Documentation of known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide
- Documentation of known incidents of aggressive or violent behavior
- Substance abuse history
- Documentation of sexual history or behavior patterns that may place the child/adolescent or other children at a health or safety risk

We keep a copy of the assessment in the member's record in accordance with all federal and Commonwealth regulations, including HIPAA. We assign specific staff to monitor services provided to members in substitute care or residential facilities. This helps ensure that the member receives all recommended EPSDT screenings and follow-up services. We also submit comprehensive performance reports to the Department of Human Services.

Chapter 9: Services Covered by Other Entities

OTHER COVERED SERVICES

We work with the Department of Human Services (DHS) and their vendors to coordinate services that are covered by entities other than us. These services include behavioral health services such as mental health and drug and alcohol services, as well as transportation services.

MENTAL HEALTH, DRUG & ALCOHOL SERVICES

Medicaid

Through Behavioral Health Managed Care Organizations (BH-MCOs), MA members receive quality medical care and timely access to appropriate mental health and/or drug and alcohol services. This component is overseen by the DHS's Office of Mental Health and Substance Abuse Services. Refer to Chapter 2 for contact information for these organizations.

Aetna Better Health and its providers are required to coordinate and refer identified members to behavioral health services and for assessment. Through our care management programs, we can assist in coordination activities and referrals to community resources. Contact Aetna Better Health Care Management at **1-866-638-1232** for help. For more information about our Care Management program, refer to Chapter 9: Medical Management for more information.

CHIP

CHIP covers inpatient detoxification, non-hospital residential treatment, and outpatient treatment relating to drug and alcohol abuse for children. If you have a patient with a drug or alcohol problem, don't delay getting them the help they need. The sooner a child begins treatment with a professional provider, the more likely he or she is to have a successful recovery.

Substance abuse services must be provided by participating providers and facilities unless the use of a non-participating provider or facility is preauthorized.

Some members diagnosed with severe mental health disorders or conditions that significantly impact a child's behavioral health (i.e. schizophrenia, autism, etc.) may be eligible for a broader range of services or different benefit limitations. Contact Aetna Better Health Kids Member Services at **1-866-638-1232** if you have questions about your patient's eligibility for certain mental health or substance abuse services or benefit limits.

Private Coverage Option

Our Private Coverage option covers inpatient and outpatient behavioral health services, including inpatient and outpatient drug and alcohol abuse services. Members can receive counseling, information on managing their medications, and psychological, laboratory, and diagnostic testing related to determining treatment.

Behavioral Health services are available to members at participating providers and facilities from qualified professionals. Aetna Better Health does not cover services administered at a state hospital.

Chapter 10: Medical Management

OVERVIEW

Our Medical Management Program encompasses activities directed toward prospective, retrospective and concurrent utilization review. It also covers integrated care management and disease management services.

Prospective review (prior authorization) determines the medical necessity and appropriateness of the service before it's provided. Concurrent review determines the appropriateness of the level of care and length of stay throughout a member's inpatient stay. Retrospective review involves assessment of the appropriateness of medical services after the services have been provided.

Care management services assist physicians with members who have special needs, complex health problems and/or high-risk pregnancy. Our disease management programs assist members to manage their chronic illnesses.

Our Integrated Care Management (ICM) Program uses a bio-psycho-social model (BPS) to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time.

We use evidence-based practices to identify members at high risk of not doing well over the next 12 months. We offer them intensive care management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary provider. This relationship continues throughout the care management engagement. We also offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support.

To support our care and disease management activities, we use our proprietary health risk assessment, questionnaires and predictive modeling software. A customized care management application enables our care management team to work closely with members, their families and providers to help improve clinical outcomes and enhance the quality of life for members. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from care management, and then stratify them into intensive and supportive levels of service.

We use three tools to identify complex, high-risk members. We then assign them to one of these levels of care management services. The tools we use to identify the right members for ICM include:

- Predictive modeling using our CORE analysis
- Self-report – HRQs and/or their state-mandated alternatives
- Surveillance – Daily census, readmissions and other “traditional” case finding methods

The functionality of the care management software includes:

- Case finding tools
- Outreach questionnaire
- Integrated clinical assessments
- Integrated care plan
- Correspondence
- Condition-specific assessments

- Member satisfaction survey
- Audit tools
- Reporting (e.g., tracking of member outcomes)

Our utilization management and quality management staff work with providers, monitoring the care provided to members and performing the following functions:

- Coordination of member services, including:
 - Detecting inappropriate patterns of care (e.g. over- or under-utilization of services, including pharmacy)
 - Identifying diagnoses or multiple co-morbidities that place members at risk for serious consequences
- Monitoring compliance with treatment protocols, including:
 - Untreated co-morbid conditions
 - Gaps in care, such as a failure to fill prescribed medications or get a flu shot based on evidence-based guidelines
 - Use of medications that are less than optimal for chronic conditions (e.g., rescue medication for asthma when controller medications would be more optimal)
- Assessing provider performance, including:
 - Adherence to evidence-based clinical guidelines, including prescribing patterns
 - The delivery of care or services which, if improved, could enhance member safety and health outcomes
 - The provision of preventive screenings and treatments
- Tracking and trending quality measures, including:
 - Verification that emergency and inpatient hospital services are appropriately used
 - Post hospital discharge services are adequate, including medication regiment
 - Inpatient readmissions are reduced
 - Inappropriate use of the emergency room

MEDICAL NECESSITY

All services provided to members must be “Medically Necessary” and delivered at the appropriate level of care.

A service or benefit is “Medically Necessary” if it’s compensable under the Medical Assistance Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member’s family/caretaker and the

PCP, as well as any other providers, programs, and/or agencies that have evaluated the member.

All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

Please note: Services previously determined to be medically necessary, authorized, and scheduled shall not be denied or cancelled based upon eligibility and benefits.

PRIOR AUTHORIZATION, CONCURRENT REVIEW AND RETROSPECTIVE REVIEW CRITERIA

We use the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient 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. You can request a copy of the medical necessity criteria by sending a written request via fax to 877-363-8120 or by mail to:

Aetna Better Health
Attn: Medical Management Department
2000 Market Street Suite 850
Philadelphia, PA 19103

To support prior authorization, concurrent review and retrospective review decisions, we use nationally recognized evidence-based criteria with input from health care providers in active clinical practice. We apply these criteria on the basis of medical necessity and appropriateness of the requested service, the individual member's circumstances and applicable contract language concerning the benefits and exclusions. The criteria will not be the sole basis for the decision.

For inpatient medical care reviews and for elective inpatient and outpatient medical services, we use the following medical review criteria. These are to be consulted in the order listed if the specific request is not addressed by that set of criteria:

- Criteria required by the DHS and the HealthChoices contract
- Milliman Care Guidelines
- Aetna Better Health Clinical Policy Bulletins (CPBs)

For prior authorization of elective inpatient and outpatient behavioral health services, Aetna Better Health Kids (CHIP) uses the following clinical review criteria. These are to be consulted in the order listed:

- Criteria required by applicable state regulatory agency or client contract
- American Society Addiction Medicine (ASAM) for substance abuse services, or
- Child and Adolescent Level of Care Utilization System (CALOCUS) for mental health services
- Aetna Clinical Policy Bulletins (CPBs)

We review criteria sets annually for appropriateness to our needs and change as applicable in order to reflect current medical standards. The annual review process involves appropriate practitioners in developing, adopting or reviewing criteria. You can get a copy of the utilization criteria upon request.

Prior Authorization, concurrent review, and retrospective review requests are presented to the designated medical director for review when the request does not clearly meet criteria applied as defined above. Before making a determination of medical necessity, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area.

The prescribing or treating practitioner may request a peer review to discuss a medical necessity denial with a medical director reviewer.

Information Required for Prior Authorization, Concurrent Review and Retrospective Review

Health care services and items must be medically necessary and provided in an appropriate, effective, timely and cost efficient manner. Generally, a member's PCP is responsible for initiating and coordinating a request for prior authorization. The admitting or treating practitioner or provider is responsible for making the necessary information available for concurrent review. However, specialists and other participating providers may need to contact the prior authorization or concurrent review department directly to obtain or confirm an authorization.

Providers are responsible for complying with our prior authorization policies and procedures and for getting an authorization number to ensure reimbursement of claims. Information in the prior authorization request or made available for concurrent review must validate the medical necessity for covered care and services, procedures and level of care and medical or therapeutic items. A request for authorization must also include the following information:

- Current, applicable codes (e.g., Current Procedural Terminology)
- Name, date of birth, sex and identification number of the member
- Primary care or treating provider
- Name, address, phone and fax number and signature, if applicable of the referring provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-9 code
- Reason for the referral
- Clinical information such as progress notes, consultation reports, a letter of medical necessity, reports of laboratory and imaging studies, and treatment dates, as applicable for the request.

Inpatient admission notifications received from the facilities administrative offices, including Admissions, Business or Finance, satisfies the requirement to notify Aetna Better Health of an admission. These notifications will be processed as an authorization once the required information to validate medical necessity outlined in this section is provided.

DECISION AND NOTIFICATION STANDARDS

We adhere to the following timeframes when notifying PCPs, prescribing clinicians and members of prior authorization, concurrent review and retrospective review decisions:

Type of Decisions	Decision	Initial Notification	Written Confirmation
Urgent Precertification	24 hours from receipt of request*	24 hours from receipt of request	24 hours from initial notification
Non-Urgent Precertification	2 business days from receipt of the request	2 business days from receipt of the request	2 business days from initial notification
Urgent Concurrent Review	24 hours (1 calendar day) from receipt of the request*	24 hours (1 calendar day) from receipt of the request	24 hours (1 calendar day) of the initial notification*
Retrospective Review	30 calendar days from receipt of the request	30 calendar days from receipt of the request	30 calendar days from receipt of the request

*The timeframes for decisions and notification may be extended if additional information is needed to process the request.

If we need more facts, documents or information to make a decision, we'll request it from the appropriate practitioner within 48 hours of receiving the request. The practitioner has 14 days to submit the additional information. We also notify members of requests for more information on the date we request it from the practitioner.

If the practitioner provides the additional information within 14 days, we make a decision to approve or deny the service and notify the member, member's PCP and prescribing practitioner according to the time frames in the table above.

If we don't receive the requested information within 14 days, we make a decision to approve or deny the service based upon the available information and notify the member, member's PCP and prescribing practitioner according to the time frames above.

You can request a copy of the medical necessity criteria by sending a written request via fax to 877-363-8120 or by mail to:

Aetna Better Health
Attn: Medical Management Department
2000 Market Street, Suite 850
Philadelphia, PA 19103

DENIAL, REDUCTION, SUSPENSION OR TERMINATION OF SERVICES

We notify the prescribing practitioner, member's PCP and member in writing of any decision to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.

Our medical directors conduct medical review for each case identified as a potential denial of authorization. The

requesting physician may be asked to submit more information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

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

For inpatient denials, the attending physician and hospital staff are verbally notified when we stop payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone (Peer to Peer) or formally in writing. If the finding of the medical director is disputed, a grievance or a request for a DHS fair hearing may be filed according to the established grievance and fair hearing process.

PEER-TO-PEER CONSULTATION

Our medical directors participate in the utilization review process and conduct clinical review. They're available to discuss review determinations with attending physicians or other ordering providers. We'll notify practitioners/providers verbally, at the time of notification of the denial, that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer. We provide, within one business day of a request by the attending physician or ordering practitioner, the opportunity to discuss the denial decision:

- With the medical director making the initial determination; or
- With a different medical director if the original medical director cannot be available within one business day; and
- If a peer-to-peer conversation or review of additional information does not result in a certification, the denial letter informs the practitioner/provider and member of the right to initiate an appeal and the procedure to do so.

DISCHARGE PLANNING COORDINATION

Our concurrent review nurses assist hospital staff in coordinating appropriate individualized discharge plans for members' post-hospital care. The concurrent review nurses assist with, but don't duplicate discharge services that Medicare, Medicaid, and the Joint Commission on Accreditation of Healthcare Organization (JCAHO) require hospitals to provide.

Our post-hospital planning function is carried out under the direction of the chief medical officer by concurrent review nurses who are responsible for:

- Coordinating members' post-hospital discharge planning with facility personnel
- Documenting a member's hospital discharge plans upon the initial review and ongoing as needs are identified
- Documenting a member's discharge date and status within 24 hours of knowledge of the discharge

Designated case management staff members are responsible for:

- Calling the member within three business days of the member's discharge date if required*
- Determining whether the member obtained appropriate supplies and scheduled appointments*
- Determining whether a case and/or disease management case needs to be opened to further assist the member with their health care needs

*If we cannot reach the member after at least three calls, we send the member a letter on day 5 and close the case.

MEDICAL CLAIMS REVIEW

We identify certain claims to determine whether services were delivered as prescribed and consistent with our payment policies and procedures. In these instances, our medical claims reviewers determine whether the documentation provided supports the billing, whether billed charges are necessary and reasonable, and identify non-covered supplies and services as well as inappropriate and undocumented charges. The medical claims reviewers report any cases of potential fraud or abuse to our Compliance Department for review.

CASE MANAGEMENT

Our Chief Medical Officer (CMO) is responsible for directing and our care management program with the assistance of the Director of Medical Management and the Manager of Care Management. This includes ensuring the incorporation of clinical practice guidelines into the care management practice and program. Case managers [RNs and other independently licensed physical and behavioral health professionals] and other care management staff perform the day-to-day care management functions. These employees are trained on the special healthcare needs of the member population, care management approaches and motivational interviewing to improve member engagement.

Our Integrated Care Management (ICM) Program uses a bio-psycho-social model (BPS) to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at high risk of not doing well over the next 12 months. We then offer them intensive care management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary care provider. This relationship continues throughout the care management engagement. We also offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support.

ICM considers all the member's needs as they relate to their current and future health. We achieve this by evidence-based member identification and stratification. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from care management, and then stratify them into intensive and supportive levels of service.

This is followed by assessment, case formulation and case planning. Highly skilled case managers interview members entering intensive care management to identify the root causes driving poor health and the critical barriers to improvement. These might be related to their physical health or behavioral health conditions directly, to psychosocial issues that impact the member's ability to participate effectively in their own care, or to barriers created by the health care system itself. The member and case manager then collaborate to identify the highest priority issues, goals important to the member, and activities to reach those goals. Engaging and motivating members to make critical changes in persistent patterns of behavior and to assume greater responsibility for their health as care management progresses are essential skills for the case managers.

Members entering supportive care management have fewer complex presenting issues that typically respond well to straightforward problem solving. These are more likely to be condition-specific or are related to the need for coordination of different elements of the member's treatment and support services. Supportive case managers and care management associates help members resolve these issues effectively, safely and quickly.

The final element of ICM is accountability for outcomes. We strive to measure the member's ability to achieve and sustain better health by becoming a more engaged and activated participant in their own healthcare and making better use of more appropriate healthcare resources.

Integrated Care Management (ICM) Guiding Principles:

- **Moving from disease focus to member focus:** Evaluating every member for physical, behavioral and social risks to their current and future health
- **Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services.** Facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- **Behavioral engagement for change:** Using a single point of contact to engage each member in a plan that addresses his or her critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management
- **Teaming with the member and care providers to enhance care outcomes:** Work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psycho-social complexity and challenging relationships with members and their families
- **Collaboration with Plan sponsors to influence benefit design:** Focus on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community

Key components

Aetna Better Health Kids ICM Program has eight key components:

1. Focusing on the Right Members
2. Right People, Right Skills
3. Individualized, Relationship-Based Care
4. Bio-Psycho-Social Care Planning
5. Electronic Tools
6. Interdisciplinary Case Rounds
7. Progression of Care
8. Outcomes Accountability

We offer case management services to help you serve members who have special needs and/or complex health problems. Case management services assist members in gaining access to necessary medical, behavioral, social, educational and other services. Our case managers are available to you to coordinate case management services for your Aetna Better Health patients.

Case management services may be offered to members who are at high risk for:

- Complications during their pregnancy

- Developing a chronic debilitating disease
- Drug dependency
- Non-compliance with medication or treatment plan
- Multiple medical or social needs
- Requiring frequent contact and follow up
- Long-term home care IV or enteral therapy
- Special needs programs

When a member enrolls in the Aetna Better Health Case Management Program, we'll assign the member to a case manager or care coordinator. The case manager or coordinator will work with the member's primary care physician/specialist, community case managers or other program case managers to develop a care plan. The care plan uses a goal-oriented process that moves the member toward optimal health and wellness and encourages the member to take an active role towards self-care. The goal is to improve the member's health outcomes and the member or caregiver's ability to self-manage the condition.

If you have a member that you believe would benefit from our Case Management Program because of a special health care needs, serious, chronic, disability or complex medical condition, complete the Case Management Referral form (Appendix E) and fax to 1-877 683-7354. If you have questions concerning the Case Management Program, call **1-866-638-1232**.

DISEASE MANAGEMENT

Our Disease Management (DM) program provides an integrated treatment approach that includes the collaboration and coordination of patient care delivery systems. It focuses on measurably improving clinical outcomes for a particular medical condition. This is accomplished through the use of appropriate clinical resources such as:

- Preventive care
- Treatment guidelines
- Patient counseling
- Education
- Outpatient care

It includes evaluation of the appropriateness of the scope, setting, and level of care in relation to clinical outcomes and cost of a particular condition.

Our DM program assists you in managing members diagnosed with targeted chronic illnesses. The illnesses targeted are those that have been shown to respond to coordinated management strategies. They've also shown to frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources and that incur high costs. Our Disease Management Program has six components:

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models that include physician and support-service providers
- Patient self-management education

- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback loop (including communication with members, physicians, ancillary providers and provider profiling)

We identify members as candidates for the Disease Management Programs through a stratification process using claims data and ICD-9 codes through our predictive modeling program. If a member is stratified and placed in the high-risk category, a representative from our program will contact the member and complete an assessment to determine enrollment in the disease management program.

Disease Management Oversight

Our chief medical officer is responsible for:

- Overseeing the DM programs in collaboration with the senior medical director of clinical operations
- Participating on the Disease Management (DM) Steering Committee (along with the Aetna Better Health disease management manager)
- Reviewing disease management reports monthly and making recommendations to our QM/UM committees, the Quality Management Oversight Committee (QMOC) and the DM program as applicable

Our DM Department is responsible for helping to coordinate members' care within the DM program in the following ways:

- Managing internal functions and processes that are integrated with the DM program to promote the smooth coordination of members' care and services (e.g., prior authorization, case management, member services)
- Coordinating functions or activities that need to be handled locally (e.g., prior authorization, referrals to local resources, communications with members' primary care practitioners)
- Receiving referrals for any members identified by their primary care practitioners, family members, themselves, an Aetna Better Health department, or through the predictive modeling/stratification database
- Coordinating communications between providers and the DM Department as necessary
- Receiving case management referrals and referring members back upon completion of DM goals, if applicable
- Generating weekly or monthly member-specific reports from the DM database for review with the chief medical officer, presentation to Aetna Better Health's internal medical committees, and submission to applicable entities if required by contract

The DM Department also carries out day-to-day disease management operations, including:

- Identifying potential DM members using the predictive modeling/stratification database
- Conducting initial questionnaires of potential DM members and enrolling them in the program, if applicable
- Educating members about their disease process and effective self-management strategies
- Developing a goal-oriented plan of care for each member
- Evaluating at least monthly members' progress toward goals and the effectiveness of the program, with more frequent evaluations if the case indicates
- Communicating members' progress updates to their primary care practitioners
- Identifying members who meet criteria for referral to case management or behavioral health care management

- Assessing each case after six months for completion of goals and, if applicable, rest ratification to low risk
- Providing monthly reports of aggregate DM program outcome measures for each plan with an Aetna Medicaid Business Unit DM program
- Annually surveying member and provider satisfaction with the program

Plan-specific DM programs are structured to include nationally recognized, evidence-based guidelines, risk group interventions, risk scores, assessment of outcomes data, and report formats.

We also utilize a National Committee for Quality Assurance (NCQA) Certified Disease Management Programs to assist members in reducing the frequency and severity of exacerbations of a chronic illness. We do this by improving the members' health status and helping them to appropriately self-manage their disease. We developed our programs using nationally recognized evidence-based guidelines. We distribute all DM guidelines to all contracted providers.

DM Programs available to members include:

- Asthma (children and adults)
- Diabetes
- Congestive Heart Failure (CHF)/Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)

For our pediatric Medicaid members, we developed disease management programs for children with asthma and diabetes. Also, all of our DM programs address co-occurring, physical concerns like obesity and hypertension and behavioral health conditions like depression and anxiety. We collaborate with the BH-MCOs to assure that HealthChoices members with chronic and/or complex physical health conditions also receive needed treatment for behavioral health conditions. This collaboration helps to assure that members with primary behavioral health diagnoses (e.g., serious emotional disturbance) receive needed physical health services.

If you have a member who has one of the above listed chronic conditions, i.e. Asthma, Diabetes, CHF or COPD, you or your staff can make a referral to our Disease Management Program at any time. To make a referral, call **1-866-638-1232** and ask for disease management.

We provide Clinical Practice Guidelines for Asthma, Chronic Heart Failure and Diabetes. You can get a copy of the guidelines through our web portal at www.aetnabetterhealth.com/Pennsylvania.

MEMBERS IDENTIFIED WITH SPECIAL NEEDS

We manage the care of members with special health care needs through our Case Management Unit. The Case Management Unit operates under the direction of our chief medical officer and special needs coordinator. The unit's primary responsibility is to work aggressively to identify and assess special needs members prior to the onset of an adverse event. To this end, the Special Needs Unit:

- Interfaces directly with the Department's Special Needs Unit
- Provides care coordination/case management
- Works as an advocate for special needs members throughout Aetna Better Health
- Collaborates with others involved in each member's care (e.g., BH-MCOs, OCYF, community agencies, schools, etc.)

Our Special Needs Unit staff has direct access to the plan medical director, a behavioral health coordinator and case managers with specialized expertise in the diverse and complex needs of members with chronic and/or complex health conditions.

To refer a patient to our Special Needs Unit, call **1-855-346-9828** or fax a referral form (Appendix E).

Linking Special Needs Members with Practitioners

All members require a source of primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective. Typically, a primary care physician (PCP) provides this type of care. However, special needs members may need a specialist to act as a PCP if the member has a disease or condition that is life threatening, degenerative or disabling. For example, a pediatric pulmonologist may be the preferred PCP for a child with cystic fibrosis. Physicians in a specialized HIV/AIDS clinic may be the best source of primary care for our members with that diagnosis. Our Special Needs Unit will facilitate these PCP relationships, as appropriate.

Many special needs members may not require a specialist to manage their care, but need PCPs who are knowledgeable about their condition(s). Our members always have the option to select or to change their PCP. See Page 14 for additional information.

Coordination of Care

We tailor our case management care coordination model for special needs members in several ways, including:

- Carefully managing staff caseloads to reflect the complexity of special needs members
- Ensuring that special needs coordinators have the appropriate expertise to manage the care of their assigned members (e.g., behavioral health, out-of-home placement, home based services, skilled nursing)
- Providing care coordination planning that is member-centric, holistic, integrated, collaborative and culturally competent

For each of our special needs members, the care planning process integrates the full range of services required by that member, regardless if they're covered under HealthChoices, Medicaid fee-for-service, a Medicaid waiver or not covered under Medicaid at all, including state funded services and community resources. Whatever the circumstance, our staff will develop care plans in collaboration with the relevant stakeholders in a member's care (e.g., BH-MCOs, Area Agencies on Aging, Medicare, Early Intervention programs, Home and Community-based Waiver Case Managers, Schools, Subsidized adoption agencies, Juvenile Justice, ICF MRs, Residential Treatment Facilities, Extended Acute Psychiatric Facilities, Adolescent and Adult Substance Abuse Treatment programs, Family Members and other Caregivers).

HEALTHY BEGINNING PLUS PROGRAM AND PERINATAL CASE MANAGEMENT

The Department's Healthy Beginnings Plus Program (HBP) covers pregnant women and children up to the age of one if the mother is eligible for MA benefits at the time of the child's birth and the child continues to live with the mother. Prenatal care for women and infants must meet or exceed HBP standards outlined in the Department's MA Bulletins. Services include comprehensive prenatal and postpartum care.

Our perinatal through postpartum care management supports and fulfills the goals of the Healthy Beginnings Plus

Program. The following services are available to enrolled and eligible pregnant members.

Covered perinatal care management range from pre-conception counseling through postpartum care address both clinical and social needs. They're also provided in a manner that accommodates members' cultural needs (e.g., for language translation). The services may include:

- Perinatal case management for high risk members
- Outreach contacts, such as telephone reminders of appointments, referrals, and follow-up calls
- Maternity care services from a qualified health care professional or specialist (a participating obstetrician, a primary care practitioner experienced in maternity care, a certified nurse midwife, or perinatologist)
- Health risk questionnaires to identify high-risk populations and appropriate interventions
- Education, available through mailings or group classes
- Social support services to address individual risks, such as smoking cessation classes, alcohol and/or substance abuse treatment, services to address spousal or partner abuse and emotional or mental health concerns
- Family planning services whenever appropriate
- Referrals to community resources, such as the Women, Infants, and Children (WIC) Program, birthing or nutrition resources, behavioral health or other resources to assist the member with other needs, such as housing and transportation, if applicable.
- Coordination with programs in the community that support the members' needs (e.g., high schools for teen mothers, hospital- or church-sponsored programs)

All HBP providers must follow DHS billing guidelines for correct reimbursement. The correct HCPCS codes are T1001, H0004, and S9174.

Perinatal Program Components

Identification of Pregnant Members

The identification of pregnant members can be through:

- An external source
- The results of a health-risk questionnaire from the state regulator
- The member or a provider
- An internal process or referral, such as review of pharmacy reports, laboratory reports, emergency department logs or concurrent review.

Any internal department that receives information identifying a pregnant member directs the information to the Case Management Department through the call tracking system or by forwarding the applicable referral or records to the department.

Health-Risk Questionnaire

A perinatal case manager conducts outreach to each identified pregnant member to administer a health-risk questionnaire, which becomes the foundation of the member's pregnancy record. The questionnaire includes:

- Demographic information (including the member's educational and family status)
- General history of the member's health
- Nutritional status
- Psychosocial issues (such as domestic or sexual abuse, alcohol and/or substance use/abuse)

- History of the member's previous and current pregnancies.

The case manager documents the member's responses in the perinatal case management database and evaluates indicators of medical or social risk to determine the need for intervention. Medical or social risks could include:

- Late initiation of prenatal care
- Maternity alcohol and/or substance abuse
- Pre-term labor
- History of postpartum depression

Maternity Care Practitioner

We encourage pregnant members to promptly select a maternity care practitioner. This may be one of the following practitioners, subject to our policies and procedures:

- A participating obstetrician, a certified nurse midwife, or certified nurse practitioner, who handles only the member's maternity care while the member's primary care practitioner retains responsibility for the member's general health care
- The member's primary care practitioner, if he or she is experienced in caring for pregnancies

The member may choose a maternity care practitioner referred by her primary care practitioner or to a network practitioner of her own choosing. In situations where a new (and pregnant) member is already receiving care from an out-of-network OB-GYN specialist at the time of enrollment, the member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery. If the practitioner is not contracted with us, a case manager and/or Member Services representative will coordinate the authorization necessary for the practitioner to continue the member's care until postpartum care is completed.

Our network includes perinatologists to provide care and monitoring for members with high-risk conditions. A member's maternity care practitioner may refer her to a perinatologist for consultation and evaluation at any point during pregnancy.

Certified Nurse Midwives

Our members may select a certified nurse midwife working under the direct supervision of a participating obstetrician. Such a coverage arrangement must be approved by our chief medical officer.

Any midwife providing services to Aetna Better Health's members must:

- By contract, provide only services within the scope of his/her specialty
- Be credentialed by Aetna Better Health
- Meet state licensing and certification requirements
- Have clinical privileges at a participating licensed clinical facility with established maternity care services (e.g., hospital, freestanding maternity center)

Perinatal Case Management Services

Perinatal case management services educate pregnant members to use the maternity care services available. They also assist those with complex clinical or social issues to obtain the support services they need. Case managers assist members in developing a plan of care to meet their individualized needs. An individual's risk factors determine the

interventions we use to overcome barriers to care and promote a healthy pregnancy that will result in healthy outcomes for the newborn and mother. Case managers provide an important link between members, their providers and community resources or agencies, such as health departments. As an advocate for the member, the case manager is able to coordinate care and services to focus on the specific individual member's needs.

Pregnant Member Education

Education of pregnant members includes the following information, presented by the case manager, the members' practitioners, through group classes or in mailed materials:

- Education in healthy practices is integrated into the care of all expectant members, including:
 - Education about and support for breastfeeding
 - Special education for complex cases (e.g., diabetes)
 - Importance of folic acid to a healthy pregnancy
 - Referral to the Women, Infants, and Children (WIC) Program for supplemental nutrition
- Pregnancy
 - Prenatal
 - Fetal development
 - Labor and delivery
- Postpartum
 - Postpartum self-care
 - Postpartum depression
 - Family planning
- Infant care
- Availability of enhanced services such as referrals for social service or health education and referrals for:
 - Special supplemental nutrition program (WIC)
 - Dental care
 - Child health services (for other children)
 - Family planning
- Availability of testing for HIV/AIDS and other sexually transmitted diseases
- Availability of counseling if HI V/AIDS test results are positive
- Prenatal/childbirth classes

OVERSIGHT OF PERINATAL CASE MANAGEMENT

Perinatal operations are carried out under the direction of our chief medical officer (CMO) and/or designee. The CMO is responsible for overseeing the core operations and activities and monitoring productivity. Case Management Perinatal staff member coordinates the outreach, questionnaire and intervention processes. Staff members include licensed nurses and social workers experienced in maternity care and social issues.

Our perinatal case management responsibilities include:

- Maintaining adequate staff with appropriate experience in perinatal care services, including:
 - Medical directors specializing in maternity care (either Aetna Better Health staff, corporate medical directors, or contracted practitioners)
 - Maternal Health/EPSTDT Coordinator (CMO): a licensed physician, registered nurse, or physician's assistant, or who has an MA degree in health services, public health, or health care administration experienced in obstetrics and managed care

- Perinatal case managers (licensed nurses and social workers experienced in maternity care)
- Care coordinators
- Outreach staff
- Support staff
- Maintaining a network of providers qualified to deliver services during the pregnancy and postpartum, including:
 - Participating obstetricians
 - Primary care practitioners qualified to provide obstetrical care (including physician assistants and nurse practitioners)
 - Perinatologists
 - Neonatologists
 - Certified nurse midwives
- Providing members with educational materials and information to enhance the educational materials provided by the member's maternity care practitioner
- Educating providers about our Case Management Program and how to refer members to it

Perinatal Case Management is responsible for the following:

- Conducting risk questionnaires to identify members in the high-risk category
- Assisting members in selecting a provider qualified in maternity care, if necessary
- Encouraging members to keep perinatal appointments
- Assisting members in developing a plan of care to meet their individualized needs and determining and carrying out interventions indicated by the member's risk level
- Making follow-up contacts as applicable to remind and educate members
- Documenting and tracking information about members' pregnancies, interventions, referrals, and outcomes

Practitioners' Responsibilities

Our website site includes information about the perinatal case management program, how providers can refer members to the program and the maternity care standards. Visit www.aetnabetterhealth.com/pennsylvania. The information is found under "Health & Wellness".

Practitioners who provide maternity care are responsible for:

- Completing the Obstetrical Needs Assessment Form (ONAF) and submitting to Aetna Better Health. This form should be completed electronically through our secure portal and submitted to the plan. The website to request access to the electronic ONAF is:
- <http://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/dynamo-provider-portal-user-guide-PA.pdf>
- Educating the member through discussion and materials about the physical changes to be expected during pregnancy, the process of labor and delivery, breastfeeding and other infant care information, as well as the importance of complying with the care plan, nutritional recommendations, and maintaining healthy behaviors
- Complying with the standards of care recommended by the American College of Obstetrics and Gynecology (ACOG), including use of a comprehensive medical risk assessment tool and ongoing monitoring
- Coordinating the member's maternity care needs throughout the pregnancy and providing postpartum

- care between 21 and 56 days of delivery
- Referring members as necessary for medical specialty services, such as perinatology, or to Aetna Better Health's Case Management Department for coordination of other services
- Complying with our time standards for first-time appointments and ACOG-recommended standards for return appointments (see the tables below)
- Assessing for possible depression and making appropriate referrals

First Prenatal Appointment Time Standards

Pregnancy Status	First Appointment Time
First trimester	within ten (10) business days of identification
Second trimester	within five (5) business days of identification
Third trimester	within four (4) business days of identification
High-risk condition	within twenty-four (24) hours of identification
Emergency condition	immediately upon identification

Prenatal Return Visit Time Standards*

Pregnancy Status	Return Visit Frequency
Through 28 weeks	every 4 weeks
Between 29 and 36 weeks	every 2 weeks
After week 36	once a week
High-risk condition	according to the member's need

*Recommended by the American College of Obstetrics and Gynecology (ACOG) for women with uncomplicated pregnancies

EMERGENCY SERVICES

The Department of Human Services defines an emergency medical condition as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

An emergency service is defined as covered inpatient and outpatient services that:

- Are furnished by a provider that is qualified to furnish such service under Title XIX of the Social Security Act and b) are needed to evaluate or stabilize an emergency medical condition.

We'll work with you to assure that members needing emergency services receive medically necessary treatment at

appropriate levels in a timely manner.

Monitoring ED Utilization

We closely monitor trends in Emergency Department (ED) utilization and implement appropriate interventions to address identified issues. PCPs are not contractually allowed to “sign out” to the ED or leave outgoing messages on their phone lines or with their answering services instructing Aetna Better Health members to go the emergency room for after-hours care.

We employ a variety of strategies to monitor and address emergency department utilization, including:

- Reviewing claims and other relevant data to monitor utilization patterns
- Educating providers and members about the appropriate use of the emergency department
- Making referrals to case management for evaluating a member’s access to care
- Ensuring behavioral health crisis intervention services are provided in the most appropriate setting (in collaboration with the BH-MCOs)
- Monitoring and profiling the accessibility of PCPs whose members have a high ED utilization trend

Our case management staff generates and reviews the following reports:

- High utilizing members (i.e., top 100 members with the highest utilization)
- ED visits by member and by primary care provider (PCP)
- ED visits by referring PCP groups
- ED visits by diagnosis, including those with primary mental health and substance abuse diagnoses as well as co-occurring disorders

Our care management staff uses these reports to track and trend information and identify potential over-utilization patterns, including:

- Identifying providers who may be driving inappropriate use of emergency department services (e.g., signing out with a message to their patients to go to the emergency department with any after-hours problems or those who lack urgent, same day appointment availability)
- Identifying members who are frequent utilizers of emergency department services for non-emergent conditions and situations and informing PCPs about their patients’ utilization of the ED (e.g., otitis media)
- Identifying hospitals who have high utilization or regular follow-up arranged through the ED

If needed, we can develop and implement corrective action plans, including one-on-one visits with providers and members.

We’ll work collaboratively with providers to address issues that may affect ED utilization, such as prescribing patterns (e.g., asthma controller and rescue medications). Our medical management staff may also conduct educational sessions for either an individual or larger group of providers who we have identified as contributing to excessive ED utilization. Also, we may require a provider to attend a special training session and/or to develop a corrective action plan.

MEMBER RESTRICTION PROGRAM

The Department's Bureau of Program Integrity manages a centralized Member Restriction Program for all managed care and Fee-For-Service delivery systems. We maintain a Member Restriction Program that interfaces with the centralized program and cooperates with the Department in all procedures. The program identifies, restricts and monitors members who have been determined to be abusing and/or misusing MA services or who may be defrauding the HealthChoices program. With the approval of the Department, members may be restricted to receiving services from a single, designated provider for a period of five years.

Our Prior Authorization Department monitors and evaluates the utilization of members who are referred to the Member Restriction Program. You'll receive notification of members who are restricted.

Restrictions are enforced through the claims payment system. We may not pay for a service rendered by any provider other than the one to whom the member is restricted. The exception to this is if you provide services in response to an emergency or if you completed and submitted a Medical Assistance Member Referral Form (MA 45) with the claim. The MA 45 must be obtained from the practitioner to whom the member is restricted. If a member is restricted to a provider with your provider type, the EVS will notify you if the member is locked into you or another provider. The EVS will also indicate all type(s) or provider(s) to which the member is restricted. Valid emergency services are excluded from the lock-in process.

We obtain approval from the Department prior to implementing a restriction, including approval of written policies and procedures and correspondence to restricted members.

We will:

- Refer to the Department's Bureau of Program Integrity (BPI) those members identified as over utilizing or mutualizing medical services
- Evaluate the degree of abuse including review of pharmacy and medical claims history, diagnoses and other documentation, as applicable
- Propose whether the member should be restricted to obtaining services from a single, designated provider for a period of five years
- Forward case information and supporting documentation to BPI for review to determine appropriateness of restriction and to approve the action
- Upon BPI approval, send notification via certified mail to Member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated provider(s) and option to change Provider, with a copy to BPI
- Send notification of member's restriction to the designated provider(s) and the County Assistance Office
- Enforce the restrictions through appropriate notifications and edits in the claims payment system
- Prepare and present case at a DHS Fair Hearing to support restriction action
- Monitor subsequent utilization to ensure compliance
- Change the selected provider per the member's or provider's request within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet provider change process
- Continue a member restriction from the previous delivery system as a member enrolls in the Managed Care Organization, with written notification to BPI
- Review the member's services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, member, provider(s) and County Assistance Office
- Perform necessary administrative activities to maintain accurate records
- Educate members and providers to the restriction program, including explanations in handbooks

and printed materials.

Member Right to Appeal

Members have the right to appeal a restriction by requesting a DHS Fair Hearing. Members cannot file a Complaint or Grievance with us regarding the restriction action. A request for a DHS Fair Hearing must be in writing, signed by the member and sent to:

Department of Human Services
Office of Medical Assistance Programs of Bureau of Program Integrity
Division of Program and Provider Compliance: Member Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17 105-2675
Phone number: 717-772-4627

Chapter 11: Quality Management

OVERVIEW

Quality management (QM) is an ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care and service. This methodology is used by professional health personnel that review the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Our Quality Assurance and Performance Improvement (QAPI) 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/QI 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 encounter data, ad-hoc internal reports, HEDIS, EQR and CAHPS in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Our Health's QAPI Program uses an integrated and collaborative approach, involving our entire senior management team, all functional areas within the health plan and all committees from the Board of Directors to the Health Education and Member Advisory subcommittee. Our chief medical officer (CMO) oversees the QAPI program. The CMO is supported in this effort by our QM Department and the Quality Management and Utilization Management (QM/UM), Service Improvement (SIC), Credentialing, Appeals/Grievance and Delegation Subcommittee and Quality Management Oversight (QMOC) Committees.

Our QM staff, under the direction of the CMO, develops and implements an annual work plan, which specifies projected quality management activities. Based on the work plan, we conduct an annual QAPI Program Evaluation. We encourage you to participate in medical committees and quality projects. If you wish to participate, call your Provider Relations representative.

Our Quality Management Department is an integral part of both Medical Management and internal operations. Through our team of quality management professionals, our focus is to review and trend services and procedures for compliance with nationally recognized standards, and to recommend and promote improvements in the delivery of care and service to our members. Our QM, UM and Special Needs Unit (SNU) maintain ongoing coordination and collaboration regarding quality initiatives, care management and disease management activities involving the care of special needs populations.

Our quality management includes, but is not limited to, medical record reviews, site reviews, peer reviews and provider profiling. Utilizing these tools, we, in collaboration with all participating health providers, are able to monitor and reassess the quality of care and services provided to our members.

Our highly effective Utilization Management (UM) program manages monitors, evaluates and improves the care and services provided to our members. Our UM program is designed to:

- Educate members and providers about the appropriate utilization of care/service delivery systems
- Assess member and provider satisfaction with the processes
- Identify opportunities to optimize members' health outcomes
- Manage health care costs

Our UM program is integrated with our quality management program, both of which are dedicated to ensuring high quality, cost-effective, outcomes-oriented health care for our members.

IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT

We effectively identify and evaluate opportunities for quality improvement. We determine the best intervention strategies through the systematic collection, analysis and review of a broad range of external and internal data sources. We identify opportunities for improvement by monitoring the following types of data:

- **Formal Feedback from External Stakeholder Groups-** We take 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 members and families, providers, state and community agencies.
- **Findings from External Program Monitoring and Formal Reviews-** As a result of externally-initiated review activities such as an annual external quality program assessment or issues identified through a state's ongoing contract monitoring oversight process, we're made aware of specific program activities/processes needing improvement.
- **Internal Review of Individual Member or Provider Issues-** In addition to receiving complaints and grievances and appeals from members, providers and other external sources, we proactively identify potential quality of care issues for review through daily operations (e.g., member services, prior authorization, and care management). Through established formalized review processes (e.g., grievances, appeals and quality of care), we're able to identify specific opportunities for improving care delivered to individual members.
- **Findings from Internal Program Assessments-** We conduct a number of formal assessments/reviews of program operations and subcontractors that are used to identify opportunities for improvement. This includes but is not limited to: ambulatory medical record reviews of contracted providers, credentialing/recredentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment and assessment of provider accessibility and availability.
- **Clinical and Non-Clinical Performance Measure Results-** We use an array of clinical and non-clinical performance standards (e.g., HEDIS[®], call center response times, claim payment lag times) to monitor and evaluate member outcomes. Through frequent monitoring and trending of our performance measure results, we are able to identify opportunities for improvement in clinical and operational functions.
- **Data Trending and Pattern Analysis-** With our innovative information management systems and data mining tools, we make extensive use of data trending and pattern analysis for the identification of opportunities for improvement.

PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

Performance improvement projects (PIPs), a key component of our QAPI program, are designed to achieve and sustain a

demonstrable improvement in the quality or appropriateness of services over time. All our PIPs follow CMS protocols.

We participate in state-mandated PIPs and select PIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of member care and services over time
- Address clinical or non-clinical topics (e.g., care of acute conditions)
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect our plan 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 CMO, the QM/UM Committee and the QMOC prior to submission to the Department for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health, as well as from network providers who are members of our 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, we 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.

CREDENTIALING

All contracted health professionals are required to be credentialed by Aetna Better Health with the exception of hospital-based providers. Before rendering services, you must be credentialed with us. In addition, all providers must be enrolled with the Department of Human Services in the Medical Assistance Program.

New providers will receive a credentialing application as part of their initial contract packet. Physicians and certain other health professionals are responsible for the completion of our credentialing application, and for providing all supplemental documentation required. All new providers, including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process. They must also be approved by our Credentials Committee and governing body as the final phase of their contract. Physicians and certain other health professionals need to have a site visit completed by our Provider Relations Department before we can complete the credentialing process.

Established providers will be re-credentialed at least every three years. If any documents (i.e., license, insurance, DEA, etc.) expire before the recredentialing period, you must forward the updated documents to our Credentialing department.

The Aetna Credentialing and Performance Committee is responsible for the review of the professional credentials and profile data of potential participating health professionals, facilities and certain allied health professionals. For contracted providers, profile data is reviewed along with credentials.

PHYSICIAN PROFILES

We profile all providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for each profiling measure. We profile all providers and all practices for multiple measures

compared with their own colleagues in their specialty. Also, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

We designed the Provider Profiling Program to share standardized utilization data with physicians in an effort to improve the utilization and health outcomes of members. Physicians often have little access to information about how they're managing their members or about how practice patterns compare to those of their peers. The overall goal is to reduce variation in care delivery and improve efficacy of care.

The indicators that we measure in the provider profile 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 (e.g., appropriate asthma management linked with correct use of inhaled steroids)
- Use of medications
- ER utilization and inpatient service utilization

Semi-annually, we distribute profile reports to each practice and provider so they can evaluate:

- Potential gaps in care and opportunities for improvement
- Information relating to specific cares
- A snapshot of their overall practice

Our CMO and medical directors regularly visit individual network providers to interpret profile results, review quality data and discuss any new medical guidelines.

PEER REVIEW

The Credentialing and Performance Committee evaluates Peer Review activities. You can appeal the Committee's recommendation if you get a review and disagree with the results. All you have to do is submit written appeals stating the reasons you disagree with the results.

We encourage physician participation on key QM/UM committees. You can contact the Chief Medical Officer or inform their Provider Relations Representative if you wish to participate.

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

AMBULATORY MEDICAL RECORDS REVIEW

Our standards for medical records exceed the medical record keeping requirements referenced in 55 Pa. Code Section 1101.51 (d)(e) of the MA Manual and medical record keeping standards adopted by DOH. We adopted standards from

the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our Provider Network. Below is a list of our criteria for documentation of care medical record review. Our quality management initiatives require consistent organization and documentation in patient medical records to assure continuity and effective, quality patient care.

Medical records may be on paper or electronic. Records must be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Records will be readily available for review and copying by State and Federal officials or their authorized agent at the provider's place of business, or upon written request and shall be forwarded without charge to the Department of Human Services. If you are subject to an annual audit, you must submit your cost reports within 90 days following the close of their fiscal years. If the Department of Human Services terminates its written agreement with a provider, the records relating to services up to the effective date of the termination remain subject to the requirements stated in this section.

Records, including both medical and fiscal types that fully disclose the nature of services rendered to members and that meet the criteria established in 55 Pa. Code Section 1101.51 (d)(e), will be retained for at least four (4) years, unless otherwise specified in the provider regulations. The standards for records are as follows:

- 1) **Medical records standards** – Records must reflect all aspects of patient care, including ancillary services. We have set the following standards for medical records:
 - a. Patient identification information - Each page or electronic file in the record contains the patient's name or patient ID number.
 - b. Personal/biographical data - Personal/biographical data includes: age, sex, address, employer, home and work telephone numbers, and marital status.
 - c. Entries - All entries will be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record will be signed and dated.
 - d. Provider identification - All entries are identified as to author.
 - e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.
 - f. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies-NKA) is noted in an easily recognizable location.
 - g. Past medical history - (for patients seen 3 or more times) Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
 - h. Immunizations- For pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date.
 - i. Diagnostic tests and results. Documentation of Medical Necessity of rendered, ordered and prescribed services.
 - j. 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.
 - k. Treatment plan, progress and changes in treatment plan
 - l. Identification of current problems – 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.
 - m. Smoking/ETOH/substance abuse - Notation concerning cigarettes and alcohol use and substance abuse is present (for patients 12 years and over and seen three or more times). Abbreviations and symbols may be appropriate.

- n. Consultations, referral and specialist reports - Notes from consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record and follow-up plans.
 - o. Emergency care
 - p. Hospitalizations
 - q. Reports of operative procedures and excised tissues
 - r. Hospital discharge summaries/disposition of the care - Discharge summaries are included as part of the medical record for (1) all hospital admissions, which occur while the patient is enrolled in Aetna Better Health and (2) prior admissions as necessary.
 - s. Referrals and results thereof
 - t. All other aspects of patient care
 - u. Advance directives - For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
 - v. Fiscal records- Providers will retain fiscal records relating to services they have rendered to members regardless of whether the records have been produced manually or by computer. This may include, but not limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are not MA members, either the originals or copies of Departmental invoices and records of payments made by other third party payers.
 - w. Additional record keeping requirements for providers in a shared health facility-Practitioners and purveyors in a shared health facility shall meet the requirements set forth in 55 Pa. Code Section 1101.51(d) (e).
- 2) Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum;
- a. History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints.
 - b. Plan of treatment
 - c. Diagnostic tests
 - d. Therapies and other prescribed regimens; and
 - e. 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 PRN. Unresolved problems from previous visits are addressed in subsequent visits.
 - f. Referrals and results thereof; and
 - g. All other aspects of patient care, including ancillary services.

The purpose of the review is to verify that medical records of contracted family practice, internal medicine, general practice, obstetric and pediatric physicians comply with established DHS, NCQA, and Aetna Better Health medical record keeping standards. Also, OB/GYN specialists must comply with ACOG standards. We review records for completeness of documentation, coordination of care and evidence of appropriate health maintenance screenings.

Penalties for Non-Compliance

The Department of Human Services may terminate its written agreement with a provider for noncompliance with the record keeping requirements of 55 Pa. Code Section 1101.5 1(d) (e) or for noncompliance with other record keeping requirements imposed by applicable Federal and State statutes and regulations.

HEDIS REQUIREMENTS®

The Department of Human Services requires that we produce Healthcare Effectiveness Data and Information Set (HEDIS) rates for all Medicaid reporting measures, with the exception of behavioral health measures. HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) designed to reliably compare health plan performance.

HEDIS performance measures are divided into eight domains of care:

- Effectiveness of care
- Access/availability of care
- Satisfaction with the experience of care (Adult and Child CAHPS)
- Health plan stability
- Use of services
- Informed health care choices
- Cost of care
- Health plan descriptive information

We work with providers to assure that all DHS requirements concerning HEDIS performance measures are met on an ongoing basis, including:

- Produce rates for all Medicaid reporting measures, with the exclusion of behavioral health measures
- Follow NCQA specifications as outlined in the HEDIS Technical Specifications, clearly identifying the numerator and denominator for each measure.
- All HEDIS results are validated by an NCQA-licensed vendor

We assist with the HEDIS validation process by the Department's NCQA-licensed contractor and submit validated HEDIS results annually to the Department of Human Services. We then incorporate HEDIS results into the annual overall Quality Improvement Plan.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS

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 Child) are subsets of HEDIS reporting required by the Department of Human Services. We contract with an NCQA-certified vendor to administer the survey according to HEDIS survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience.

In addition to the Adult survey, HEDIS incorporates a CAHPS survey of parental experiences with their children's care. The separate survey is necessary because children's health care frequently requires different provider networks and addresses different consumer concerns (e.g. child growth and development). We contract with a certified vendor to complete both Adult and Child CAHPS surveys and submit member level data files to the NCQA for calculation of HEDIS CAHPS survey results.

EXTERNAL QUALITY REVIEW (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c). The requirement mandates states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations. The annual review includes 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 members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

We cooperate fully with external clinical record reviews assessing our network's quality of care, access to care and timeliness of care, as well as any other studies determined necessary by the Department of Human Services. We assist in the identification and collection of any data or clinical records to be reviewed by the independent evaluation team members. We also provide complete medical records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO.

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

Chapter 12: Advance Directives (The Patient Self-Determination Act)

OVERVIEW

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members written information about the members' right to have an Advance Directive. An Advance Directive is a legal document through which a member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Members can use Advance Directives when the member is unable to make or communicate decisions about his or her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes the member to be unable to actively make a decision about his or her medical care.

In Pennsylvania, there are two types of advance directives:

- Living will or health care instructions
- Appointment of a Health Care Power of Attorney

PROVIDER RESPONSIBILITY

Providers must comply with federal and state laws regarding advance directives (also known as health care power of attorney and living wills). Providers must also comply with contractual requirements for adult members. Also, we require that providers obtain and maintain advance directive information in the member's medical record.

Requirements for providers include:

- Maintaining written policies that address a member's right to make decisions about their medical care, including the right to refuse care
- Providing members with written information about advance directives
- Documenting the member's advance directives or lack of one in his or her medical record
- Communicating the member's wishes to attending staff in hospitals or other facilities
- Not discriminating against a member or making treatment conditional on the basis of his or her decision to have or not have an advance directive
- Providing staff education on issues related to advance directives

Members can file complaints or grievances concerning noncompliance with advance directive requirements with Aetna Better Health or with the Pennsylvania Department of Human Services.

We provide information about Advance Directives to members in the Member Handbook, including the member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney and general instructions.

For more information or complaints regarding noncompliance with advance directive requirements, contact:

Pennsylvania Office of Attorney General
Strawberry Square, 16th Floor
Harrisburg, PA 17120 Phone: 717-787-3391

Chapter 13: Billing Procedures

BILLING INSTRUCTIONS

PROMISe ID Number Required

All providers who provide services to HealthChoices members must be enrolled in the Commonwealth's Medical Assistance (MA) program and possess an active PROMISe™ Provider ID in order to bill for services. For information on how to enroll in PROMISe™ and enrollment forms, please visit the DHS's website at:

<http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/index.htm>.

Member Eligibility Verification

An MA Identification Card, titled Pennsylvania ACCESS card, is an identification card issued by the Department of Human Services to each MA member. The card must be used by MA-enrolled providers to access the Department's EVS and verify the member's MA eligibility and specific covered benefits. Prior to rendering or billing for services, verify each member's eligibility for benefits through the online eligibility information from the Eligibility Verification System (EVS). The EVS offers Medicaid providers the information to make an informed decision prior to rendering a service or item. For more information regarding the EVS and ways to access eligibility data, visit the following:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/softwareandservicevendors/eligibilityverificationinformation/index.htm>

Payment for Medically Necessary Services

In accordance with Pennsylvania Code 55, Chapter 1101, the Department of Human Services will only pay for Medically Necessary services for covered benefits. A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program AND if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker and the primary care practitioner, as well as any other providers, programs or agencies that have evaluated the member. All Medical Necessity determinations must be made by qualified and trained health care providers. A healthcare provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this agreement.

PROVIDER BILLING

We use the Trizetto QNXT® system to process and adjudicate claims. We accept both electronic and manual claims submissions. However, we encourage providers to submit claims electronically. This helps us process and pay claims efficiently, accurately and timely. To facilitate electronic claims submissions, we developed business relationships with major clearinghouses, including NDC, WebMD/Envoy, SPSI and Gateway. We receive EDI claims directly from these clearinghouses, process them through pre-import edits to ensure the validity of the data, HIPAA compliance and member enrollment and then upload them into QNXT® each business day. Within 24 hours of file receipt, we provide production reports and control totals to all trading partners to validate successful transactions and identify errors for correction and resubmission.

You can submit paper claims to our designated post office box. Paper claims are scanned into our system each business day.

Co-payments

Certain services require a member co-payment. You should collect this amount from the member and deduct it from the amount billed to us.

You must submit all claims whether or not the member made full payment. You shouldn't deny services to a member even if the member hasn't made full payment of their cost-sharing amounts. It's important to document on the claim submitted the amount that the member paid or the amount you billed to the member.

Coordination of Benefits/Third Party

We are the primary payer on the following services:

- Preventive care
- OB/GYN
- Prenatal or preventive pediatric care (including EPSDT services to children), and services to children having medical coverage under a Title IV-D child support order

For HealthChoices, we're the payer of last resort on all other services. You must bill third party insurance before submitting a claim to us. We'll pay the difference between the primary insurance payment and the Aetna Better Health allowable amount. You cannot balance bill members.

If the primary insurance carrier denies the claim as a non-covered service, you can submit the claim with the denial to us for a coverage determination under the member's program.

It's your responsibility to get the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to HealthChoices. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential in order for us to coordinate benefits.

If a service is non-covered or benefits have been exhausted from the primary carrier, you must get an updated letter every January and July to submit with each claim. In most cases, we'll deny claims submitted without the EOB for members where third party insurance is indicated.

In the event a claim we play a claim and later discover the member has other insurance, we'll recover the payment made to the provider.

If you need help with the billing of third party payers, call Provider Relations at **1-866-638-1232**.

To prevent denials for coding mismatches, claims submitted to the primary carrier on a form that differs from our requirements should be clearly marked with COB Form Type Conversion.

Timely Claim Submission Requirements

We require providers to submit claims within 180 days from the date of service. Aetna Better Health must receive claims resubmission no later than 365 days from the date of the Provider Remittance Advice or Explanation of Benefits if the initial submission was within the 180 day time period whether or not the claim was denied on the first submission.

We require clean claim submissions for processing. A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the provider of service or from a third party.

CLAIMS PAYMENT TIME FRAMES

In compliance with federal regulations applicable to Medicaid managed care plans, we process clean claims in the following time frames:

- 90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt
- 100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt
- 100.0% of all Claims must be adjudicated within ninety (90) days of receipt

These time frames apply to the HealthChoices program. The majority of claims are processed by us within 10 days of receipt. Claims that are not paid within 45 days are paid with interest at the rate of 10% per annum.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your submitted claims must be in compliance with HIPAA regulations regarding NPI numbers and the new claim forms. Claims for the HealthChoices program must also contain the provider PROMISe identification number. We'll return any claims that are not in compliance.

Compliance

The new CMS-1500 (08-05) form contains fields for the NPI numbers:

- Field 17 requires the NPI of the referring physician, if appropriate
- Field 24J is available for the NPI number of the provider rendering service(s)
- Field 32 requires the NPI of the facility location if other than office
- Field 33 should be completed with the billing provider's NPI number
- The new UB-04 form requires the NPI number of the billing provider in field 56
- The NPIs of the attending physician and the operating physician should be located in fields 76 and 77 respectively

EDI Claims

Your electronic billing vendor should have provided you with the newest version of the software to comply with the NPI requirements. If EDI claims are rejected, check with your vendor first. If you experience any issues with EDI claims,

contact our Provider Relations Department at **1-866-638-1232**.

ACCEPTABLE CLAIMS FORMS

We require all providers to use one of the following forms when submitting claims:

- A CMS 1500 02/12 (formerly CMS 1500 08/05) billing form is used to submit claims for all professional services including ancillary services and professional services billed by a hospital
- Hospital inpatient and outpatient services, dialysis services, nursing home room and board, and inpatient hospice services must be billed on the UB 04 billing form
- We will not process claims received on any other type of claim form

Completing a CMS 1500 02/12 (Formerly CMS 1500 05/08)

The CMS 1500 02/12 (formerly CMS 1500 05/08) billing form is used to submit claims for all professional services. When submitting a CMS 1500 form, certain fields are required.

CMS 1500 Documentation

Before submitting a claim, you should ensure that you include all required attachments. All claims that involve other insurance or Medicare must be accompanied by an Explanation of Benefits (EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.

Completing the UB 04

The UB 04 form is used when billing for facilities services including hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice service.

UB 04 Documentation

Inpatient, ER and Outpatient Hospital claims above a certain threshold require additional documentation, which may include the medical record and an itemized bill.

Refer to your contract for documentation requirements and/or to the provider specific billing sections of this manual.

REMITTANCE ADVICE

For each claim that we pay or deny, you'll receive a remittance advice (remit). We provide a separate remit for each benefit plan (line of business) in which you participate. If we deny a claim, you'll receive a remittance advice that summarizes:

- Payment activity for the provider (the provider's account balance, claims processed, co-payments/coinsurance/deductibles applied, interest payments or penalties, discounts, the amount recouped if the beginning balance was negative and the net paid amount)
- The check number
- Denial reasons for claims or line items denied
- Claims inquiry contact information
- Claims resubmission and reconsideration steps and details of resubmissions
- Appeals process

To access a copy of the Remittance Advice including a description of information provided on the remit, log on to the secure web portal on our website.

CLAIMS RESUBMISSION

You can resubmit:

1. Corrected claims
2. Previously submitted claims to which additional information has been attached.

When submitting a *corrected* claim, indicate on the claim whether it is a *corrected* claim or a *resubmitted* claim with appropriate supporting documentation.

- Submit a corrected claim or a request for reprocessing a claim within the contracted timely filing guidelines. Submit corrected or resubmitted claims that don't require supporting documentation. through the our Electronic Data Interface (EDI) vendors
- Submit corrected or resubmitted claims that require supporting documentation on paper to our processing center

TECHNICAL ASSISTANCE

For technical assistance related to claims submissions, call Provider Relations at **1-866-638-1232**.

PROGRAM EXCEPTION PROCESS

You can request coverage for items or services that are included under the member's benefit package, but are not currently listed on the MA Program Fee Schedule. You can also request an exception for services or items that exceed limits on the fee schedule if the limits are not statute or regulation based. You should request these exceptions in advance of providing services. In order to request program exceptions, follow our prior authorization process.

OMAP HOTLINES

We cooperate with the functions of OMAP's Hotlines, which are intended to address clinically related systems issues encountered by members and their advocates or providers. The OMAP Hotline facilitates resolution according to our policies. To contact the HealthChoices OMAP Hotline, call 1-800-426-2090, Monday through Friday, 9:00 a.m. – 5:00 p.m.

CLAIMS INQUIRIES

You can call the claims inquiry line from 8:00 a.m. to 5:00 p.m. EST each business day by calling **1-866-638-1232**. An automated telephone system allows you to speak directly with a representative or leave a detailed message regarding your inquiry. Our claims administration department employs full-time claims inquiry and research representatives to respond to your questions, status inquiries and claims payment disputes. You can also check on a

claims status by logging on to the secure web portal on our website.

Our claims staff accepts telephonic and written inquiries from providers concerning claims issues. Please ensure that the following information is included with the inquiry:

- Member's identification number
- Date of service
- Procedure code
- Provider's name
- Provider's NPI
- Provider's PROMISe Medicaid ID
- Claim number (if known)

Written inquiries should be directed to the claims staff at:

Aetna Better Health
PO Box 62198
Phoenix, AZ 85082-2198

PROVIDER DISPUTE AND APPEALS RESOLUTION

We offer providers:

- An informal disputes process for expressing dissatisfaction with an Aetna Better Health decision that directly impacts the provider
- A formal appeals process to request reversal of a denial by Aetna Better Health with regard to:
 - Provider credentialing
 - Network provider claims, including payment denial for services already rendered by the provider to a member
 - Provider agreement termination by Aetna Better Health

We encourage you to resolve your post-service claims denial using the informal dispute processes prior to utilizing the formal provider appeal process. The Provider Relations Manager and representatives will work with you to resolve disputes and provide education on how to access and utilize the Aetna Better Health informal dispute and formal appeal process.

Informal Provider Dispute:

A dispute is a verbal or written expression of dissatisfaction concerning a decision that directly impacts the provider. Disputes are typically administrative and do not include decisions concerning medical necessity decisions. There are multiple avenues to resolve claims and other provider disputes. You can:

- Access our secure web portal
- Contact your assigned Provider Relations Representative
- Call the toll-free Claims Inquiry and Claims Research Unit at **1-866-638-1232**

The formal provider appeal process should only be used after other attempts to resolve the matter have failed through the informal dispute process.

You can contact the Provider Relations Department at **1-866-638-1232** and/or contact your assigned Provider Relations representative. To submit information regarding your concern or dispute, send all documents to the following address:

Aetna Better Health
Attention: Provider Relations
2000 Market Street, Suite 850
Philadelphia, PA 19103

Formal Provider Appeal Process

You can request a reversal of an action related to:

- Provider credentialing
- Network provider claims, including payment denial for services already rendered by the provider to a member
- Provider agreement termination by Aetna Better Health

Pre-service requests resulting in a prior authorization denial, reductions or terminations must follow the member complaint and grievance process. You must submit provider appeals within 60 days from the date of notification of claim denial unless otherwise specified within the provider contract. For questions concerning the provider appeal process, contact the Provider Appeal Department at **1-866-638-1232**.

To submit a provider appeal in writing, send to the address below:

Aetna Better Health
Attention: Provider Appeals
2000 Market Street, Suite 850
Philadelphia, PA 19103

For a Provider Appeal to be accepted, you must:

- Submit the appeal in writing to Aetna Better Health to the address specified in the provider manual or website
- State the factual basis for the relief requested
 - Include all supporting documentation with the appeal submission, such as: Remittance Advice(s) Medical Records Claims

Failure to specifically state the factual basis of the appeal and/or failure to submit support documentation may result in denial of the provider appeal.

We'll acknowledge a provider appeal within five (5) business days after receipt. If you don't receive an acknowledgement letter within five (5) business days, contact the Provider Appeals department. Once received, appeal will be reviewed, and a decision will be rendered within 60 days after receipt. We may request an extension of up to 30 days, if necessary.

Also, we have a Provider Appeals Committee to review and decide provider appeals. The decision of the Provider

Appeals Committee is final. We send decision notification letters to the requesting provider within five (5) business days of the committee decision. We will not take any punitive action against a provider for using the provider appeal process.

Chapter 14: Member Complaints, Grievances and DHS Fair Hearings

OVERVIEW

The Complaints and Grievances Department has the overall responsibility for the management of the member complaint and grievance process for HealthChoices. This includes:

- Documenting individual complaints and grievances
- Coordinating resolutions
- Maintaining logs and records of the complaints and grievances
- Tracking, trending and reporting data

Our Complaint, Grievance and Fair Hearing coordinator (the Coordinator) will serve as the primary contact person for the complaint and grievance process.

The Complaints and Grievances Department in collaboration with the Member Services and Provider Relations Departments, is responsible for:

- Informing and educating members and providers about a member's right to file a complaint or grievance or request a DHS Fair Hearing
- Assisting members in filing a complaint or grievance or in requesting a DHS Fair Hearing

We tell members about their complaint, grievance and DHS Fair Hearing rights and the complaint, grievance and DHS Fair Hearing process at the time of enrollment and at least annually thereafter. We provide this information to members via the member handbook, member newsletters and our website. The information includes, but is not limited to:

- The method for filing a complaint, grievance or for requesting a DHS Fair Hearing including procedural steps and timeframes for filing each level of a complaint or grievance or for requesting a DHS Fair Hearing
- Notification of member's rights related to complaints, grievances and DHS Fair Hearing, including the right to voice complaints or grievances about Aetna Better Health or care provided
- The availability of assistance from Aetna Better Health with filing a complaint, grievance or requesting a DHS Fair Hearing along with Aetna Better Health toll-free number and address for filing complaints, grievances or requesting a DHS Fair Hearing
- Upon request, reasonable assistance with the complaint, grievance and DHS Fair Hearing process is provided to members. This includes but is not limited to providing oral interpreter services and toll free numbers with TTY/TDD and sign language interpreter capability. Aetna Better Health staff members are trained to respond to members with disabilities with patience, understanding and respect.

The Department of Human Services defines "complaint" and "grievance" as two separate and distinct types of issues. Members and their representatives (including providers) may file a complaint or grievance if they are not able to resolve issues through informal channels with Aetna Better Health or the DHS. Members and their representatives may request a DHS Fair Hearing.

The Department of Human Services defines "Complaint" as a dispute or objection regarding a participating health care provider or the coverage, operations, or management policies of Aetna Better Health, which has not been resolved by Aetna Better Health and has been filed with Aetna Better Health or with the Department of Health or the Pennsylvania

Insurance Department of the Commonwealth. This definition does not include grievances.

Please note that this process only applies to HealthChoices Medical Assistance members.

COMPLAINTS

Complaints include, but are not limited to:

- A denial because the requested service/item is not a covered benefit
- Failure of Aetna Better Health to meet the required timeframes for providing a service/item
- Failure of Aetna Better Health to decide a complaint or grievance within specified timeframes
- Denial of payment by Aetna Better Health after a service has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- Denial of payment by Aetna Better Health after a service has been delivered because the service/item provided is not a covered service/item for the member

GRIEVANCES

A “grievance” is a request to have Aetna Better Health or a utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. Members or their representatives (including providers) may file a grievance. A grievance may be filed regarding Aetna Better Health’s decision to:

- Deny, in whole or in part, payment for a service/item
- Deny or issue a limited authorization of a requested service/item, including the type or level of service/item
- Reduce, suspend or terminate a previously authorized service/item
- Deny the requested service/item, but approve an alternative service/item

This definition does not include complaints.

DHS FAIR HEARING

A DHS Fair Hearing is a hearing conducted by the Department of Human Services Bureau of Hearings and Appeals or its subcontractor. Members or their representatives (including providers) may request a DHS Fair Hearing within 30 days from the mail date on the initial written notice of decision and within 30 days from the mail date on the written notice of Aetna Better Health’s first or second level complaint or grievance notice of decision. Members do not have to exhaust the complaint or grievance process prior to filing a request for a DHS Fair Hearing.

Our Complaint and Grievance Department provides members with help as necessary. This includes interpreter and translation services in filing complaints, grievances and requests for DHS Fair Hearings. The Complaint and Grievance Department can be reached at:

Aetna Better Health
Complaints & Grievances Dept.

Aetna Better Health Provider Manual
Original 4/1/10 Revision 09/25/15
www.aetnabetterhealth.com/pennsylvania
Provider Relations: 1-866-638-1232

REGISTERING A COMPLAINT OR GRIEVANCE OR REQUESTING A DHS FAIR HEARING

We'll accept complaints and grievances telephonically via a toll-free telephone number, in writing or by facsimile. If the member has a sensory impairment, we'll assign a representative to help that member throughout the grievance system process. We'll accept complaints and grievances through a TTY/TDD line, Braille, tape, CD and other commonly accepted alternative forms of communication. If a member needs a sign language interpreter, we'll provide one at no cost to the member. Also, we'll train our staff to be aware of speech limitations of some members with disabilities and treat these members with patience, understanding and respect.

If we receive a complaint or grievance, the Member Service Representative (MSR) will commit it to writing and send to the member for a signature. We'll proceed with the complaint and grievance process and denote in the file that signature is needed by the end of the process. The MSR will document the call into the QNXT™ Call Tracking System and place into the Complaint and Grievance queue. The Complaint and Grievance Coordinator (Coordinator) monitors the queue throughout the day in order to obtain the information.

If we receive a complaint or grievance in writing (surface mail, facsimile, Braille), we'll forward it to the Coordinator.

A provider may file an appeal for the client; however, the provider must get the member's written consent. A member who consents to the filing of a grievance by a health care provider may not file a separate grievance. The member retains the right to rescind consent throughout the grievance.

A provider may not require a member to sign a document authorizing the provider to file a grievance as a condition of treatment.

The consent form must maintain the following elements:

- The member's name, address, date of birth, and identification number
- If the member is a minor or is legally incompetent, the name address and relationship to the member of the person who signed the consent
- The name address and Aetna Better Health provider identification number who is providing consent
- The name and address of Aetna Better Health
- An explanation of the specific service/item for which coverage was provided or denied to the member to which the consent will apply
- The following statement – "The member or the members representative may not submit a grievance concerning the services/items listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or the member's representative has the right to rescind consent at any time during the grievance process."
- The following statement – "The consent of the member or the member's representative shall be automatically rescinded if the provider fails to file a grievance or fails to continue to prosecute the grievance through the second level grievance process"
- The following statement – "The member of the member's representative, if the members is a minor or legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The member or the member's representative understands the information in the members consent form."

- The dated signature of the member, or the member’s representative, and the dated signature of a witness

The Coordinator will assign the appropriate category (complaint or grievance or DHS fair hearing request), level (first, second, expedited or external) and ensure the required timeframe.

Filing Complaints – Time frames

First Level

45 days from the date of the incident complained of or the date the member receives written notice of the decision.

Second Level

45 days from the date the member receives written notice of our first level complaint decision.

Expedited Review

At any point prior to the second level complaint decision.

External Review of Second Level Complaint

15 days from the date the member receives the written notice of our second level complaint decision.

Filing Grievances – Time frames

First Level

45 days from the date the member receives the written notice to file a grievance.

Second Level

45 days from the date the member receives the first level grievance decision.

Expedited Review

At any point prior to the second level grievance decision.

External Review of Second Level Grievance

15 days from the date the member receives the second level grievance decision.

PROCESS AFTER RECEIPT OF COMPLAINT OR GRIEVANCE

Once the coordinator verifies, acknowledges and documents the complaint or grievance in the complaint and grievance database, the Coordinator will start the research process. We’ll issue an acknowledgement letter within five business days of receiving the complaint or grievance.

Once the Coordinator verifies the timeframes, the Coordinator will send the required acknowledgement letter (using the DHS approved templates) to the member and document the complaint or grievance into the complaint and grievance database.

We categorize the complaint or grievance as one of the following:

- **Service Issues (non-clinical).** Includes those such as accessibility or communication, and involve no clinical concerns, (e.g., changing PCP, assisting a member with scheduling an appointment).
- **Clinical/Quality Issues (clinical).** Involve circumstances related to medical care or treatment (e.g. medical care did not meet member's expectations).

We may use sub-categories to help with a more detailed identification of recurring issues and corresponding improvement opportunities.

Depending on the nature of the complaint or grievance, the coordinator will forward the complaint or grievance to the Aetna Better Health department with the appropriate expertise. For example, all clinical/quality issues and expedited review issues are immediately forwarded to the Quality Management Department for investigation and resolution. Services issues such as those related to changing the member's primary care provider or providing assistance with scheduling an appointment are forwarded to the Member Services Department for resolution.

If you believe that the usual timeframes for deciding a member's complaint or grievance will endanger their health, call us at **1-866-638-1232** and request an expedited review of the complaint or grievance. This request must be accompanied by a Provider Certification letter stating that the usual timeframe for deciding the complaint or grievance will endanger the member's health. Fax the letter to the attention of the Complaints and Grievance Department at 1-866-275-1266. We'll make a reasonable effort to obtain the certification from the provider.

If we're unable to obtain a Provider Certification from the provider within 48 hours of a request for an expedited complaint or grievance, we'll decide the complaint or grievance within the standard timeframes (see section 17.7).

Complaint and Grievance Reviews

Aetna Better Health complaints and grievances will be reviewed by the following committees:

Complaints – First Level

- **Non-clinical** – 1 or more employees of Aetna Better Health who were not involved in any previous level review or decision making of the issue that is the subject of the complaint
- **Clinical** – One or more employees of Aetna Better Health who were not involved in any previous level review or decision making of the issue that is the subject of the complaint, and a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. The licensed physician must decide the complaint

Complaints – Second Level

Review team – Three or more individuals who were not involved in any previous level of review or decision-making on the matter under review. One-third of this committee will not be an employee of Aetna Better Health or a related subsidiary or affiliate. All members of the committee have voting rights for this review

Expedited Complaints

Review team - Three or more individuals who were not involved in any previous level of review or decision-making on the matter under review. One-third of this committee will not be an employee of Aetna Better Health or a related subsidiary or affiliate. All members of the committee have voting rights for this review

Grievance – First Level

Review team - will include one or more employees of Aetna Better Health who was not involved in any previous level of review or decision making on the subject of the grievance and a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. The licensed physician must decide the grievance.

Grievance – Second Level

Review team will include three or more individuals who were not involved in any previous level of review or decision making to deny coverage or payment for the service/item. One third of the committee will not be an employee of Aetna Better Health or its subsidiary. The committee will include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review.

All members will have voting rights for this review.

Expedited Grievance

Review team- Three or more individuals who were not involved in any previous level of review or decision-making on the matter under review. One-third of this committee will not be an employee of Aetna Better Health or a related subsidiary or affiliate. All members of the committee have voting rights for this review

Member Notice

Members will receive a notice at least seven days prior to first level review committee meetings and 15 days prior to second level committee meetings. They will also have the opportunity to attend the meeting in person, via videoconferencing or telephonically.

We'll send all materials to the member prior to the meeting in regular or alternative formats.

All committee meetings for all levels of complaints and grievances will be transcribed verbatim and a summary prepared and maintained as part of the grievance record.

RESOLUTION TIMEFRAMES

Aetna Better Health resolves each complaint or grievance as expeditiously as the member's health requires, but no later than the timeframe identified by the Department of Human Services:

Complaints Decision Timeframe

First level complaint – 30 days from receipt of the complaint, which may be extended 14 days at the request of the member.

Second Level complaint – 45 days from Aetna Better Health receipt of the member's second level complaint.

Expedited Review – within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter for an expedited complaint

External Review – information sent to the Pennsylvania Department of Health or the Pennsylvania Insurance Department within 30 days from the request.

Grievances Decision Time frame

First Level grievance – 30 days from receipt of the grievance, which may be extended 14 days at the request of the member.

Second Level grievance – 45 days from receipt of the member’s second level grievance.

Expedited Review – within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member’s request for an expedited review, whichever is shorter for the expedited review.

External Review – We’ll notify the Department of Health of the request for the external grievance within five business days. Within 15 days, we’ll forward the written information regarding the denial to the assigned CRE.

We’ll send all decisions to the member or member’s authorized representative, the service provider and the prescribing provider if applicable via a written notice within five days of the review committee’s decision.

MEMBERS CONTINUING TO RECEIVE DENIED SERVICES/ITEMS

If a member files a complaint or grievance at any level stated above or to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, the member can continue receiving the disputed service/item at the previously authorized level pending resolution of the complaint or grievance, if the complaint or grievance is hand delivered or post-marked within 10 days from the mail date on the written notice of a complaint or grievance decision until the final decision is reached.

Our complaint and grievance process is linked to Aetna Better Health’s Quality Assurance Program and Utilization Management Program for resolving members’ formal complaints and grievances. This system includes:

- Procedures for registering and responding to complaints and grievances in the timeframe determined by the Department of Human Services
- Documentation of the substance of the complaint or grievance, and actions taken
- Procedures to ensure a resolution of the complaint or grievance
- Aggregation and analysis of complaint and grievance data and use of the data for quality improvement. We maintain a log, which is made available to the Department of Human Services upon request. It includes a short dated summary of the problem, the response and the resolution.

DHS FAIR HEARING

The member has the right to request a DHS fair hearing within 30 days from the mail date on the written decision of any level complaint or grievance.

DHS Fair Hearing Process

Members don’t have to exhaust the complaint or grievance process prior to filing a request for a DHS Fair Hearing.

The member or the member’s representative may request a DHS Fair Hearing within 30 days from the mail date on the initial written notice of a decision and within 30 days from the mail date on the written notice of Aetna Better Health’s first or second level complaint or grievance notice of decision.

The request for a DHS Fair Hearing must include a copy of the written notice of decision that is the subject of the request and be submitted to the DHS Complaint, Grievance and Fair Hearings Department.

Fair hearing requests for a fair hearing should include the following information:

- Member name
- Member social security number and date of birth
- Telephone number where the member can be reached during the day
- If the member wants to have the fair hearing in person or by telephone
- Any letter(s) the member may have received about the issue

Members and their representatives may attend and participate in the fair hearing in person or on the phone. Members will receive a letter from the Department of Human Services's Bureau of Hearings and Appeals advising of where the hearing will be held and the date and time for the hearing at least 10 days before the hearing.

Members must request a fair hearing in writing by sending a letter to:

Department of Human Services
Office of Medical Assistance Programs
HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17 105-2675

Fair hearing decisions after a first level complaint or grievance decision will be made no more than 60 days after the DHS receives a fair hearing request. If members request a fair hearing and did not file a first level complaint or grievance, or if they request a fair hearing after a second level complaint or grievance decision, the fair hearing will be decided within 90 days of the DHS receiving the request.

Chapter 15: Fraud and Abuse

DETECTING FRAUD AND ABUSE

The vast majority of Medical Assistance (MA) providers and members provide and receive care within the boundaries of applicable regulations. Unfortunately, a small number of Medical Assistance members and providers may engage in practices that are fraudulent or abuse the Medical Assistance program. The DHS is committed to eliminating all forms of fraud and abuse within the Medical Assistance program.

We employ a variety of methods to detect potential fraud and abuse, including monitoring claim edits, prior authorization, utilization and concurrent review, quality management audits and provider profiling. We have also developed algorithms to detect potential claims upcoding, with follow-up procedures for chart audits as appropriate. Also, our business software applications use historical claims information to detect and correct questionable billing practices. Claims that reach an adjudicated status of “pay” will receive a control edit, which includes, but is not limited to:

- Verification of member eligibility
- Verification of covered services
- Determining whether services are within the scope of a provider’s specialty
- Valid prior authorization
- Submission of required documentation
- Excessive or unusual services based on the member’s age or gender
- Duplication of services
- Invalid procedure codes
- Duplicate claims

Federal False Claims Act (FCA)

We support efforts to detect, prevent and report fraud and abuse within the Medicaid system. These efforts are consistent with our mission to provide care to our members while exercising sound fiscal responsibility. Management of limited resources is a key part of this responsibility. Examples of actions that we’ll report to the State’s investigative agencies include:

- Consistently demonstrating a pattern of submitting falsified encounters or service reports
- Consistently demonstrating a pattern of overstated reports or up-coded levels of service
- Altering, falsifying or destroying clinical record documentation
- Making false statements relating to credentials
- Misrepresenting medical information to justify enrollee referrals
- Failing to render medically necessary covered services that providers are obligated to provide according to their contract
- Charging enrollees for covered services

INVESTIGATING FRAUD AND ABUSE

If we receive reports of potential fraud and abuse, our staff will document the information, issue a tracking number and

report it to the Department of Human Services and other appropriate investigative and law enforcement agencies whether or not they are resolved internally.

Aetna's Special Investigations Unit (SIU) is responsible for the health care fraud and abuse program. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators, field fraud (claims) analysts, a full-time, dedicated information technology organization and supporting management and administrative staff.

To achieve its program integrity objectives, SIU has developed state-of-the-art systems capability to monitor our huge volume of claims data across all health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment or patient demographic profiles differ significantly from those of their peers. If it identifies a care of suspected fraud, SIU's Information Technology and investigative professionals collaborate closely with external investigators to conduct in-depth analyses of care-related data.

REPORTING FRAUD AND ABUSE

Special Investigative Unit (SIU)

Aetna's SIU has a national toll-free fraud hotline: 1-800-338-6361 for members and providers who may have questions, seek information or want to report potential fraud-related problems. The SIU staffs the hotline 24/7/365 and callers can remain anonymous. The hotline has proven to be an effective service. We encourage HealthChoices members, providers and contractors to use it.

Pennsylvania MA Provider Self Audit Protocol

Network providers may voluntarily disclose overpayments or improper payments of MA funds through the Department's Provider Self Audit Protocol. The protocol is available on the Department of Human Services's website at <http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/index.htm> by clicking on the Fraud and Abuse link.

Aetna's Compliance Hotline

We have a toll-free Compliance (Fraud and Abuse) Hotline: 1-800-333-0119 for members and providers who may have questions, seek information or want to report potential fraud-related problems. Voicemail box for Medicare Advantage (MA Provider Compliance hotline) at 1-866-379-8477)

DHS Provider Compliance Hotline

Providers and members can also report suspected fraud and abuse directly to the DHS Provider Compliance Hotline by calling 1-866-DHS-TIPS (1-866-379-8477). Providers can also make a report by going online to <http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/index.htm> clicking on the Fraud and Abuse link and filling out the MA Provider Compliance Hotline Response Form or send communications via U.S. Mail to:

Bureau of Program Integrity
MA Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17 105-2675

Reported problems will be referred to the Office of Medical Assistance Program's Bureau of Program Integrity for investigation, analysis and determination of the appropriate course of action.

Aetna Better Health and the DHS maintain strict confidentiality concerning the providers and members who report suspected fraud and abuse.

FRAUD AND ABUSE EXAMPLES

Examples of health care provider fraud and abuse are:

- Billing or charging members for services that we cover (other than co-pays)
- Offering members gifts or money to receive treatment or services
- Offering members free services, equipment or supplies in exchange for use of a member's Aetna Better Health member ID number
- Providing members with treatment or services that they do not need
- Physical, mental or sexual abuse by medical staff

Examples of member fraud and abuse are:

- Members selling or lending their identification cards to other people
- Members living outside the state of Pennsylvania
- Members abusing their benefits by seeking drugs or services that are not Medically Necessary

PROVIDER TERMINATION

Termination Procedures

We follow termination procedures as set forth in the provider agreement. We receive notice from DHS if a participating provider is suspended or terminated from participation in the Medicaid or Medicare Programs. Upon notification, we must immediately act to terminate the provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

Termination without Cause

Provider agreements may be terminated by either Party with at least ninety (90) days prior written notice to the other Party. In addition to the foregoing, Physician may terminate this Agreement in accordance with the provisions of Section 5.1 of the provider agreement.

Termination for Breach of Contract

The Provider agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to the Provider Agreement Section 6.3 will be ineffective for the period reasonably necessary to cure such sixty (60) day period.

Chapter 16: Helpful Links to Forms and Schedules

FORMS

We produce a number of forms for providers to expedite and standardize administrative functions. Provider orientation includes a review of these forms. If you have any questions or would like help completing forms, contact your Provider Relations representative at **1-866-638-1232**.

For sample forms visit <http://www.aetnabetterhealth.com/pennsylvania/providers/forms>.

LINKS

Care Management Referral Form:

<http://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/provider-forms/SpecialNeedsCaseMgmtReferralForm-PA.pdf>

ePocrates (Registration required):

<https://online.epocrates.com/rxmain.jsp>

To view the Fee Schedule visit:

<http://services.dhs.state.pa.us/olddhs/OutpatientFeeSchedule.aspx>

Pharmacy Formulary:

<http://www.aetnabetterhealth.com/pennsylvania/assets/pdf/pharmacy/pharmacy-info/formulary-guide-pa.pdf>

Prior Authorization Form:

<http://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/provider-forms/PriorAuthForm-PA.pdf>

Provider Appeals:

<http://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/provider-forms/ProviderAppealFormABH-PA.pdf>**Immunization Schedules:**

<http://www.cdc.gov/vaccines/schedules/>

<http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-combined-schedule-bw.pdf>

Chapter 17: Provider Incentive Programs

PAY-FOR-PERFORMANCE PROGRAM (P4P)

We fully recognize the value of structuring financial incentives to promote improvements in the delivery of effective health care services. We also know that there is a proven track record of successfully implementing pay for performance (P4P) programs that reward improvements in both processes and outcomes. P4P initiatives include those with financial rewards, as well as those that develop partnerships with physician groups with the sole objective of improving health care outcomes. We'll participate in the HealthChoices P4P as funded and allowed by contract.

MONITORING PROVIDER PERFORMANCE

We closely monitor clinical, quality and utilization factors to determine which providers are demonstrating best practices. Our experience has taught us that there are always providers whose practice profiles statistically reflect a level of service utilization above the norm. In the case of physicians who care for members with complex medical and/or behavioral health needs, these patterns may be completely expected and justified. The factors that we measure in developing provider profiles include, but are not limited to, the following:

- Frequency of individual patient visits
- Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) measures
- HEDIS measures
- Prescribing patterns
- Emergency department and inpatient service utilization
- Adherence to evidence-based practice guidelines

We distribute provider profile results to individual providers and practitioners to enable them to evaluate their performance against their peers and identify potential gaps in care and opportunities for improvement. Also, if our medical management staff identifies a provider whose performance deviates significantly from the norm for his or her specialty, we'll perform outreach and, if needed, require the implementation of a corrective action plan.

Chapter 19: Glossary of Key Terms

ABUSE

Any practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs to the MA Program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations for health care in a managed care setting.

ACCESS CARD

An identification card issued by the Department of Human Services to each MA Member. This card must be used by MA-enrolled Health Care Providers to access the Department's EVS and verify HealthChoices members' MA eligibility and specific covered benefits.

BEHAVIORAL HEALTH MANAGED CARE ORGANIZATION (BH-MCO)

An entity operated by county government or licensed by the Commonwealth as a risk-bearing Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which manages the purchase and provision of Behavioral Health Services under an agreement with the Department of Human Services.

BUSINESS DAYS

A business day includes Monday through Friday except for those days recognized as federal holidays and/or Pennsylvania State holidays.

CARE MANAGEMENT

Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.¹

¹Adapted from: R. Mechanic. Will Care Management Improve the Value of U.S. Health Care? Background Paper for the 11th

Annual Princeton Conference. Available at:

<http://sihp.brandeis.edu/council/pubs/Princeton%20XI/Rob%20Mechanic%20paper.pdf>.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.

CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP)

A registered nurse licensed in the Commonwealth of Pennsylvania who is certified by the boards in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.

CHILDREN IN SUBSTITUTE CARE

Children who have been adjudicated dependent or delinquent and who are in the legal custody of a public agency

and/or under the jurisdiction of the juvenile court and are living outside their homes, in any of the following settings: shelter homes, foster homes, group homes, supervised independent living and Residential Treatment Facilities (RTFs) for Children.

CLIENT INFORMATION SYSTEM (CIS)

The Department of Human Services's database of members, this database contains demographic and eligibility information for all members.

CLINICAL SENTINEL HOTLINE

Resource operated by OMAP. Staff is available to assist MA members with obtaining timely responses to requests for Medically Necessary care and services. Staff does not approve or deny services. However, they assist MA members who call the hotline in problem solving.

COMMUNITY PROVIDER

Private and public service organizations that are not part of Aetna Better Health's provider network, with which Aetna Better Health coordinates Out-of-Plan services for members.

COMPLAINT

A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management policies of Aetna Better Health, which has not been resolved by Aetna Better Health and has been filed with Aetna Better Health or with the Department of Health or the Pennsylvania Insurance Department of the Commonwealth, including but not limited to:

- A denial because the requested service/item is not a covered benefit
- A failure to meet the required time frames for providing a service/item
- A failure of Aetna Better Health to decide a complaint or grievance within the specified time frames
- A denial of payment by Aetna Better Health after a service has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- A denial of payment by Aetna Better Health after a service has been delivered because the service/item provided is not a covered service/item for the member

The term "complaint" does not include a grievance.

COMPLETE MEDICAL HISTORY

A chronological medical record that includes, but is not limited to, major medical complaints, present medical history, past medical history, family history and social history.

CONCURRENT REVIEW

A review conducted by Aetna Better Health during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether a different service or lesser level of service is Medically Necessary.

CORE

CORE stands for Consolidated Outreach and Risk Evaluation, and is Aetna Medicaid's proprietary methodology for identifying high risk members for outreach and evaluation. Core is based on three risk metrics:

- Predictive Pathways Risk Score – ranking by score the highest to lowest “high risk” members.
- Emergency Department Risk Score – risk of an emergency department visit in the next 12 months.
- Inpatient Admission Risk Score – risk of an inpatient department admit in the next 12 months.

COUNTY ASSISTANCE OFFICE (CAO)

The county offices of the Department that administer all benefit programs, including MA, on the local level. Department staff in these offices performs necessary functions such as determining and maintaining MA member eligibility.

COVERED SERVICE

A benefit to which a MA member is entitled under the MA Program of the Commonwealth of Pennsylvania.

CULTURAL COMPETENCY

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

DENIAL OF SERVICES

Any determination made by Aetna Better Health in response to a request for approval which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service.

DEPARTMENT

The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.

DEVELOPMENTAL DISABILITY

A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments.
- Manifested before the individual attains age twenty-two (22).
- Likely to continue indefinitely.
- Manifested in substantial functional limitations in three or more of the following areas of life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency.
- Reflective of the individual’s need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

DISEASE MANAGEMENT

An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

DHS FAIR HEARING

A hearing conducted by the Department of Human Services, Bureau of Hearings and Appeals.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) Items and services that must be made available to persons under the age of 21 upon a determination of Medical Necessity and required by federal law.

ELIGIBILITY VERIFICATION SYSTEM (EVS)

An automated system available to MA providers and other specified organizations for automated verification of MA members' current and past (up to 365 days) MA eligibility, Aetna Better Health enrollment, PCP assignment, Third Party resources and scope of benefits.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES

Covered inpatient and outpatient services that a) are furnished by a provider that is qualified to furnish such service under Title XIX of the Social Security Act and b) are needed to evaluate or stabilize an emergency medical condition.

ENROLLMENT ASSISTANCE PROGRAM (EAP)

The program that provides enrollment specialists to assist MA members in selecting a PH-MCO and Primary Care Practitioner (PCP) and in obtaining information regarding HealthChoices Physical and Behavioral Health Services and service providers.

ENROLLMENT SPECIALIST (ES)

The individual responsible to assist MA members with selecting a PH-MCO and PCP as well as providing information regarding Physical and Behavioral Health Services and service providers under the HealthChoices program.

EXPANDED SERVICES

Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to members.

EXPERIMENTAL TREATMENT

A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.

EXTERNAL QUALITY REVIEW (EQR)

A requirement under Section 1902(a)(30)(C) of Title XIX of the Social Security Act, 42 U.S.C. 1396(a)(30)(C) for states to obtain 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.

FQHC

Federally Qualified Health Center. An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d (l) or is receiving funding from such a grant under a contract with the member of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.

FEE-FOR-SERVICE (FFS)

Payment by the Department of Human Services to providers on a per-service basis for health care services provided to MA members.

FRAUD

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting.

GRIEVANCE

A request to have Aetna Better Health or a utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A grievance may be filed regarding an Aetna Better Health decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. The term does not include a complaint.

HEALTH CARE PROVIDER

A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

HEALTHCHOICES PROGRAM

The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to members.

HOME AND COMMUNITY BASED WAIVER PROGRAM

Necessary and cost-effective services, not otherwise furnished under the State's Medicaid Plan, or services already furnished under the State's Medicaid Plan but in expanded amount, duration, or scope which are furnished to an individual in his/her home or community in order to prevent institutionalization. Such services must be authorized under the provisions of 42 U.S.C. 1396n.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

HIPAA means the Administrative Simplification, Privacy and Security provisions of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). Administrative Simplification is found in Parts 160 and 164 of 45 C.F.R, the HIPAA Privacy Rule (Privacy Rule) is in 45 C.F.R. Parts 160 and 164, as amended, and the HIPAA Security Rule (Security Rule) is in 45 C.F.R. Parts 160, 162 and 164,, as amended.

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

A non-emergency medical transportation service provided to eligible persons who need to make trips to/from a MA

reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

MEDICALLY NECESSARY

A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker and the primary care practitioner, as well as any other providers, programs, agencies that have evaluated the member. All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under the terms of the HealthChoices Program Agreement.

MEMBER

An MA member who is enrolled with Aetna Better Health under the HealthChoices Program and for whom Aetna Better Health has agreed to arrange the provision of Physical Health Services under the provisions of the HealthChoices program.

NETWORK PROVIDER

A health care provider who has a written provider Agreement with and is credentialed by Aetna Better Health and who participates in Aetna Better Health's provider network to serve HealthChoices members.

NON-PARTICIPATING PROVIDER

A provider, whether a person, firm, corporation or other entity, either not enrolled in the Pennsylvania MA Program or not participating in Aetna Better Health's Network, which provides medical services or supplies to Aetna Better Health's members.

OTHER RESOURCES

With regard to TPL, "Other Resources" include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance.

OUT-OF-AREA COVERED SERVICES

Medical services provided to MA members under one or more of the following circumstances:

- An emergency medical condition that occurs while outside this HealthChoices Zone
- The health of the member would be endangered if the member returned to this HealthChoices Zone for needed services

- The provider is located outside the HealthChoices Zone, but nonetheless regularly provides medical services to members at the request of the Aetna Better Health
- The needed medical services are not available in the HealthChoices Zone

OUT-OF-NETWORK PROVIDER

A health care provider who has not been credentialed by and does not have a signed Provider Agreement with Aetna Better Health.

OUT-OF-PLAN SERVICES

Services which are non-plan, non-capitated and are not the responsibility of Aetna Better Health under the HealthChoices Program comprehensive benefit package.

PRIVATE COVERAGE ORGANIZATION (PCO)

PHYSICAL HEALTH MANAGED CARE ORGANIZATION (PH-MCO)

Aetna Better Health is a PH-MCO, which is a risk bearing entity that has an agreement with the Department of Human Services to manage the purchase and provision of Physical Health Services under the HealthChoices Program.

PRESCRIPTION FOR PENNSYLVANIA (RX FOR PA)

Rx for PA is a set of integrated strategies for improving health care and containing costs for all Pennsylvanians. Rx for PA's core components are affordability, accessibility and quality.

PRIMARY CARE PRACTITIONER (PCP)

A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of the MA member.

PRIOR AUTHORIZATION

A determination made by Aetna Better Health to approve or deny payment for a provider's request to provide a service or course of treatment of a specific duration and scope to a member prior to the provider's initiation or continuation of the requested service.

PROMISE™ PROVIDER ID

A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

PROVIDER

A person, firm or corporation, enrolled in the Pennsylvania MA Program, which provides services or supplies to members.

PROVIDER APPEAL

A request from a Provider for reversal of a denial by Aetna Better Health, with regard to the three (3) major types of issues that are to be addressed in a Provider Appeal system as outlined in the HealthChoices Agreement. The three (3) types of Provider Appeals issues are:

- Provider credentialing denial by Aetna Better Health

- Claims denied by Aetna Better Health for Providers participating in the Provider Network: This includes payment denied for services already rendered by the provider to the member; Provider Agreement termination by Aetna Better Health.
- Provider agreement termination by Aetna Better Health

PROVIDER DISPUTE

A written communication to Aetna Better Health, made by a Provider, expressing dissatisfaction with an Aetna Better Health decision that directly impacts the Provider. This does not include decisions concerning medical necessity.

QUALITY MANAGEMENT (QM)

An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care. This methodology is used by professional health personnel that review the degree to which services provided and results achieved conform to desired medical practices and standards. Activities are then designed to improve and maintain quality service and care. This is performed through a formal program with involvement of multiple organizational components and committees.

MEMBER

A person eligible to receive Physical and/or Behavioral Health Services under the MA Program of the Commonwealth of Pennsylvania.

RETROSPECTIVE REVIEW

A review conducted by Aetna Better Health to determine whether services were delivered as prescribed and consistent with our payment policies and procedures.

SCHOOL-BASED HEALTH SERVICES

An array of Medically Necessary health services performed by licensed professionals that may include, but are not limited to, immunization, well child care and screening examinations in a school-based setting.

SPECIAL NEEDS

The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by DHS.

SPECIAL NEEDS UNIT

A special dedicated unit within Aetna Better Health's and the Employee Assistance Program contractor's organizational structure established to deal with issues related to members with Special Needs.

TARGETED CARE MANAGEMENT (TCM) PROGRAM

A care management program for members who are diagnosed with AIDS or symptomatic HIV.

THIRD PARTY LIABILITY (TPL)

The financial responsibility for all or part of a member's health care expenses of an individual entity or program (e.g., Medicare) other than Aetna Better Health.

THIRD PARTY RESOURCE (TPR)

Any individual, entity, or program that is liable to pay all or part of the medical cost of injury, disease or disability of a member. Examples of Third Party Resources include: government insurance programs such as Medicare or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); private health insurance companies, or carriers; liability or casualty insurance; and court-ordered medical support.

URGENT MEDICAL CONDITION

Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and if left untreated, could rapidly become a crisis or emergency medical condition. The term also includes situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

UTILIZATION MANAGEMENT (UM)

An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

UTILIZATION REVIEW CRITERIA

Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of Medical Necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.