WELCOME TO THE

Aetna Better Health Premier Plan MMP

MI LTSS and Waiver Provider Overview

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Aetna Better Health Premier Plan MMP Overview for Waiver Providers

Agenda

- Comparing Models
- Member Enrollment & Eligibility
- Provider Roles & Responsibilities
- Claims, Billing & Authorizations
- Secure Provider Portal
- Provider Resources

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Comparing LTSS Models

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Comparing LTSS Models—What's the Difference?

	Home- and Community-Based Care	Facility-Based Care
What LTSS services can be provided?	Medical and personal services to help with daily living tasks	Medical and personal services to help with daily living tasks
Where does the patient live?	In their own home, or with a family member	In a facility designed to provide LTSS to patients who live there
Where are the services provided?	By caregivers who visit the home, or by going out to visit providers in the community	Many services are provided by onsite caregivers who work at the facility
Who are the paid or reimbursable caregivers?	Family members can sometimes be certified as live-in or visiting caregivers, depending on the state's requirements. Other care can be provided by medical providers in the community	Caregivers are the professional medical staff who work at or visit the facility

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Medicare and Medicaid Alignment

- Integrated plan for people who are eligible for Medicare and full Medicaid medical benefits (known as full benefit duals)
- Aetna Better Health Premier Plan MMP can provide both Medicare and Medicaid benefits to enrollees
- Care coordination without the barriers that exists between the two programs in order to improve the quality of care for our members
- Aetna Better Health of Michigan providers must enroll in CHAMPS as atypical providers to receive payment for Medicaid claims. **michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers**

Enrollment options for individuals who qualify for ABH of Michigan

- Select and enroll with the MCO of their choice
- If selection is not made by the individual, they will be passively enrolled and assigned to an MCO

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Medicare Medicaid Plan (MMP)

As an Integrated Care Management model, Aetna Better Health of Michigan Premier Plan is designed to address enrollees'

- Physical Health
- Behavioral Health
- Long-term Care
- Social Supports

Eligibility

Enrollment Qualifications & Service Area

Aetna Better Health Premier Plan Provides benefits to people 21 and over who qualify for both Medicare and Medicaid under the Michigan Department of Health and Human Services (MDHHS) MI Health Link Program

Service Area Counties Include:

Service Area	Counties
Region 4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren
Region 7	Wayne
Region 9	Macomb

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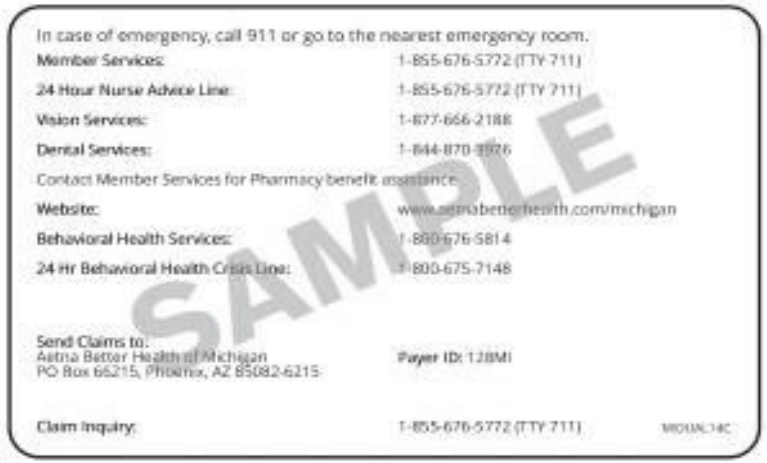
ID Cards & Enrollment

Verifying Member Eligibility:

You can verify member eligibility, PCP assignment, and benefits by:

- Using the State CHAMPS system: **michigan.gov/medicaidproviders**
- Using the Availity Provider Portal: **availity.com**

- Members have only one ID card for Medicare and Medicaid.
- You will only submit claims directly to Aetna Better Health.
- Do not submit claims directly to Medicare or Medicaid.



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Covered Benefits

Basic Aetna Better Health of Michigan

- 24/7 nurse line
- Behavioral health services
- Doctor services
- Eyecare services
- Hearing services
- Home health care
- Hospital services
- Lab tests and x-rays
- Medical supplies
- Prescriptions
- Therapy
- Dental Services
- Transportation to medically necessary appointments

Aetna Better Health of Michigan

Value Added Benefits

- $105 OTC pharmacy benefit
  - Per quarter, per member, no rollover
  - Some restrictions on use
- Dental: Preventive, 2 visits per year
- Expanded Podiatry (3 visits per year)
- Vision Services (1-2 visits per year, depending on age)
- Health Education and Nutrition
- Smoking cessation

Copays

- No copays for any benefits, including pharmacy

Transition of Care

Transition of care coverage allows the member to continue to receive services for specified medical and/or behavioral health conditions for a defined period of time with designated health care professionals.

- 90 days TOC begins for first time members that enroll in a Medicare-Medicaid plan
- 90 days TOC for members that change to Aetna Better Health of Ohio from a different Medicare-Medicaid plan.

Primary Care Physician (PCP)

- All members are required to have a PCP
- PCPs may participate only with the Aetna Better Health of Ohio.
- Find a Provider tool on Aetna Better Health of Ohio website
- PCP changes are effective immediately
- Members will need to call into Member Services and request a new ID card anytime a PCP change is made

Provider Roles & Responsibilities

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Provider Roles & Responsibilities

- Aetna Better Health Premier Plan participating providers are contractually obligated to comply with all guidelines and laws outlined in their Michigan MMP Contract and their Provider manual.
- The quality of our network and the ability to provide excellent service is dependent on having accurate provider data. Please update us if you have any change of address, telephone number, or other demographic information as soon as possible.

Provider Appointment & Access Standards

Provider Appointment Standards

Aetna Better Health of Ohio monitors provider compliance to the Ohio Integrated Care Program appointment availability standards

- Routine, preventive care available within 28 days for most providers from request
- Urgent care appointments, not deemed an emergency medical condition, triaged, and if deemed necessary, provided within 24 hours
- Appointment not deemed serious (non-urgent complaints) within 28 days
- Post-hospitalization or emergency department visits within 7 days of discharge

Provider Access Standards

- Aetna Better Health of Ohio members require access to their medical home/PCP, including after hours and on weekends (“live person” and no answering machines). Provider voicemail messages should direct members to the emergency room in cases of emergency
- Aetna Better Health of Ohio will monitor the availability of 24/7 access and the processes that support after hours availability and response
- Providers are encouraged to use alternative options for communication, such as scheduling appointments via the web, communicating via secure email and expanded office hours or open access scheduling
- This membership necessitates that providers make their practices accessible to accommodate the full range of disabilities that may exist with the population

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Provider Type	Emergency Appointment	Urgent Appointment	Routine Appointment	Wait Time in the Office
Primary Care	Immediate	Within 24 Hours	Within 28 Days	No more than 45 minutes, except when the provider is unavailable due to an emergency
Specialist	Immediate	Within 24 Hours Of Referral	Within 28 Days	No more than 45 minutes, except when the provider is unavailable due to an emergency
OB/GYN	Immediate	Within 24 Hours	1st Trimester: Within 3 Weeks 2nd Trimester: Within 7 Calendar Days 3rd Trimester: Within 3 Calendar Days High Risk: Within 3 Calendar Days Routine Care: Within 3 Weeks Postpartum: Within 6weeks	No more than 45 minutes, except when the provider is unavailable due to an emergency
Behavioral Health	Immediate	Within 24 Hours	Within 10 Days	No more than 45 minutes, except when the provider is unavailable due to an emergency

In addition to the standards above, Behavioral Health providers are contractually required to offer:

- Follow-up Behavioral Health Medical Management within 3 months of the first appointment
- Follow-up Behavioral Health Therapy within 10 business days of the first appointment
- Next Follow-up Behavioral Health Therapy within 30 business days of the first appointment

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Pharmacy

- CVS Caremark is the Pharmacy Benefit Manager (PBM)
- Formulary/Preferred Drug List
  - Indications for Medicare drugs
- For more information on pharmacy benefits and materials see the provider prescription drug page at:
- Additional information is available on the Aetna Better Health of Michigan website under:

Aetna Better Health of Michigan

- Vision: VSP
  - Coverage for routine eye exams, prescription frames and lenses
  - Contact VSP directly at **800-877-7195**
  - 8:00am – 5:00pm CST, Monday – Friday
  - Website: https://www.vsp.com/eye-doctor
- Transportation: MTM
  - 30 round trips or 60 one-way trips
  - Three days advance notice required for non-emergent transportation – including non-emergent ambulance transportation
  - MTM can be reached at **888-889-0094**
  - Trips are scheduled through Aetna customer service at **1-855-676-5772**
- Interpreter Services: Language Line can be used by calling Aetna provider services at **1-855-676-5772**

Provider Training Requirements

The State of Michigan requires the following courses to be completed every year.

- Person-Centered Planning
- Introduction to MI Health Link
- Care Coordination
- Critical Incidents
- Cultural Competency
- Disability Awareness
- Self-Determination
- Behavioral Health Consent

You may register and take them here:
Michigan HealthLink required annual training

Aetna Better Health Premier Plan training and information can be found **on our website**.

- Fraud Waste and Abuse
- Provider Newsletter

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Claims, Billing & Authorizations

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Understanding Authorizations

- Waiver services are only paid if there is a current authorization in place in the name of the rendering provider. Any prior AAA Authorizations are not valid.

- A Care Manager will reach out to you directly to provider authorization for a member needing personal care services. Authorizations for personal care services generally last for 6 months.

- We will send a fax out to providers in the area to bid on chore services. Responses are required within 3 business days. If your bid is approved, an authorization for chore services will be issued. These authorizations generally last for 12 months.

- Should a member require additional services, and an authorization is nearing its end date, please reach out to the assigned care manager for additional authorization. Please note that authorization dates can not overlap.
- Please ensure provider is registered with the State CHAMPS system
www.michigan.gov/medicaidproviders

If you have general questions or are unable to reach a care manager directly, you may contact the Michigan Care Management inbox at **midualltssfaxregion7-9@aetna.com**
or by fax at **1-866-586-6075**

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Claim Submission

Electronic Claims Submissions:

Change Health (Emdeon) is the EDI vendor we use

Payer ID: 128MI

Aetna Better Health of Michigan

P.O. Box 982963

EL Paso, TX 79998-2963

- **Paper Claims Submissions**: Send the appropriate claim forms to the address above, following timely filing and billing guidelines found in the Provider Manual.

- **Check Claim Status:** You can contact Claims Inquiry/Claims Research Phone: **1-866-316-3784** or you may use the **Availity Provider Portal.**

You find the CMS 1500 form on the provider website or here.

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Tips for Submitting Claims

- Bill only for the procedure codes and diagnosis codes that are included on your authorization. Do not submit an invoice, but please save them in case of a future audit.
- Include your authorization number in Box 23
- Places of service that are acceptable are 11 (office), 12 (home) or 99 (other)
- It is highly recommended that you obtain an NPI number (National Provider ID number) to ensure seamless billing and faster claims processing and payment. You can sign up for an NPI number **here**. For detailed information about NPI numbers you can learn more **here**.
- An NPI number will make electronic claims easier to submit and speed up payment
- Please note, that MMP members do not have a copayment and can not be balance billed. Should you have any questions about claims payment, you can reach out to Provider Services for assistance and clarification **1-855-676-5772**.

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Timely Filing

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

- New claim submissions – Claims must be filed on a valid claim form within 120 days from the date services were performed, unless there is a contractual exception.

- Claim Resubmission – Claim resubmissions must be filed within 120 days from the date of service. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may support a different outcome or decision.

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Connect Center: A Free Online Claims Clearinghouse.

Aetna Better Health encourages providers to electronically submit claims. Please use the following Payor ID number when submitting claims electronically to the health plan

- **Payor ID #128MI**

- **WebConnect** is our free provider claims submission portal via Emdeon Office. Emdeon Office is a contracted vendor used by Aetna Better Health of Michigan and Aetna Better Health Premier Plan for electronic claim submission, processing and support. To read the Webconnect manual click **here** (PDF).

- Change Healthcare has produced and made available the Getting Started with the **Sign-Up process guide** (PDF) guide to assist in general navigation and registration with Connect Center powered by Change Healthcare office.

- If you need help filling out a claim form, you can read detailed instructions **here**

What is a “Clean Claim”?

- To best ensure timely and accurate payment of your claim, submit a “clean claim”
- A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party.
- This does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity.
- Clean claims are processed according to the following timeframes:
  - 90% of clean EDI (electronic) claims adjudicated within 30 days of receipt
  - 90% of clean paper claims adjudicated within 90 days of receipt

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Corrected Claims & Claim Resubmissions

- Corrected claims require a resubmission code of “7” in Box 22, along with the original claim reference number.
- Failure to submit a corrected claim will result in a duplicate claim denial.
- Corrected claims must include all lines from the original claim, not just the line item(s) to be corrected.
- Corrections must be made within 120 days from the date of service.

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EFT & ERA Setup

Aetna Better Health of Michigan is partnering with Change Healthcare to introduce the new EFT/ERA Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

What is EERS?

EERS offers providers a standardized method of electronic payment and remittance

Providers will be able to use the Change Healthcare tool to manage ETF and ERA enrollments with multiple payers on a single platform.

How does it work?

If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers.

Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

Current users of Change Healthcare as a "clearinghouse" will still need to complete EERS enrollment.

Providers with pending applications will not need to resubmit.

Once enrolled, payees will have access to the Change Healthcare user guide to aid in navigation of the new system.

How and when do I enroll?

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit https://payerenrollservices.com/

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EFT (Electronic Funds Transfer) Payments

For faster payment with direct deposit into your bank account, we recommend that you sign up for electronic payments (EFTs).

The form can be found on **our website**

Please fax the form to Aetna Better Health Finance at **1-844-294-9321**

Providers who do not sign up for EFT payment may receive payment by VCC (Virtual Credit Card) as we transition away from paper checks.

These VCCs will be included with your explanation of payment. They will need to be manually keyed into a credit card machine for you to get access to your funds. Any applicable credit card fees will apply.

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Provider Dispute Process

What is a Provider Dispute?

A Provider Dispute is a request to review a denied service. Providers can dispute our decision if service was denied or reduced. Provider disputes must be received via Mail or Availity Web Portal within ninety (90) days of the action taken by Aetna Better Health Premier Plan, giving rise to the appeal. The dispute form can be found **here**.

Response Time?

- Disputes: average 30 business days
- Disputes are reviewed by a party not involved in original decision and not subordinate to the original decision maker

Please go through the dispute process first, before reaching out to your assigned Provider Representative for assistance.

Provider Disputes

If you are a Contracted Provider, you may use the Dispute Form found online to have your claim reconsidered. Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

Aetna Better Health of Michigan
P.O. Box 982963
El Paso , TX 79998-2963

For faster processing, you may also submit a dispute through the Availity Provider Web Portal.

You must select the appropriate reason for your Dispute (Incomplete or missing information may cause Dispute decision to be upheld or returned to Provider) including but not limited to:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed

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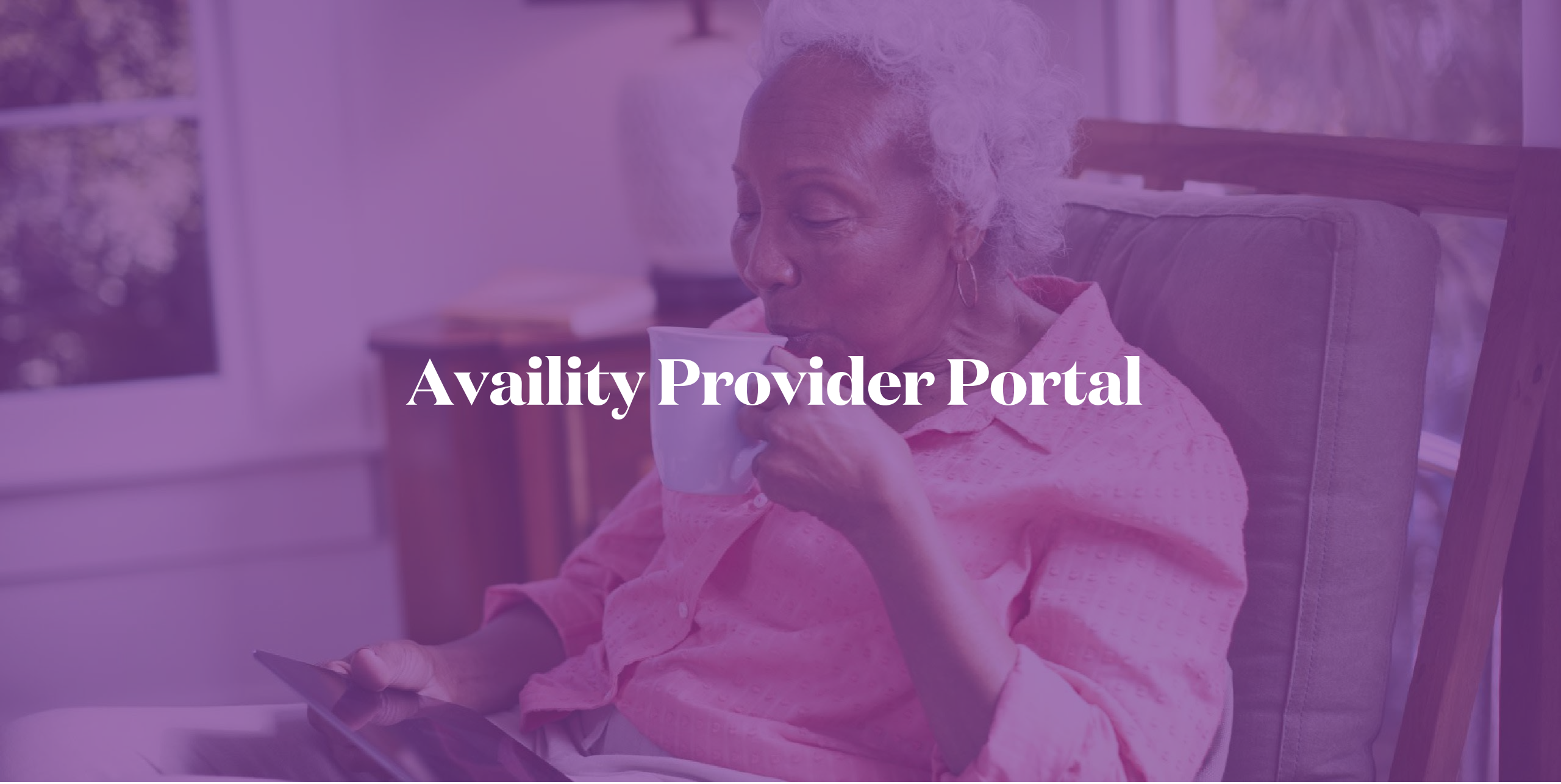

Availity Provider Portal

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Availity Secure Provider Portal

- If you are already registered with Availity, you will simply select Aetna Better Health Premier Plan MMP from your list of payers to begin accessing the portal and all the features
- If you are not registered, we recommend that you do so immediately under “Providers” at the link below:
- **https://www.availity.com/Essentials-Portal-Registration**
- For registration assistance, please call Availity Client Services at **1-800-282-4548** between the hours of 8:00am and 8:00pm Eastern, Monday – Friday (excluding holidays)

The Availity Secure Provider Portal allows providers to:

- Request portal access
- Verify member eligibility
- Check claim status
- File a dispute / submit supporting documentation

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Provider Resources

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Provider Relations

Our provider Relations staff is available to you Monday - Friday 8 AM - 5 PM to assist you on any facets of your relationship with Aetna Better Health Premier Plan.
You can reach Provider Relations via:

Aetna Better Health Premier Plan Phone Number: **1-855-676-5772**

Email: **MI-ProviderServices@Aetna.com**

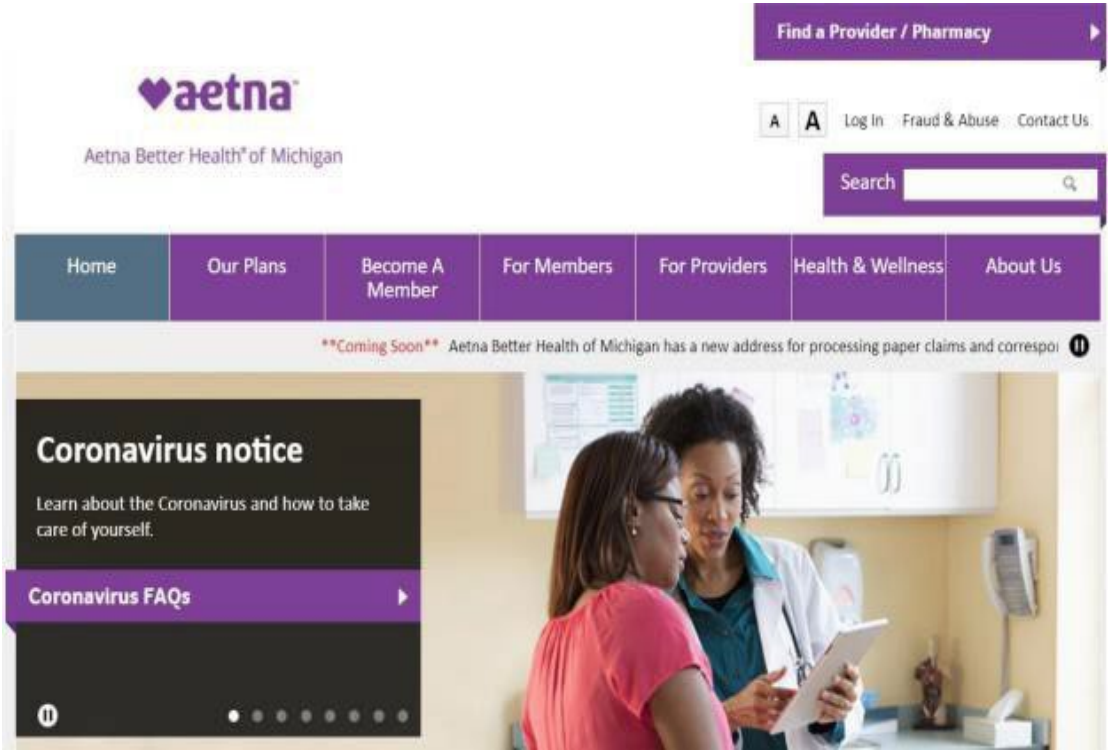
Each participating provider group is also assigned a Provider Relations Liaison who can assist with any escalated claim questions or other concerns.

Visit Our Website

Providers can access the Aetna Better Health Premier Plan website at
https://www.aetnabetterhealth.com/michigan/
There you'll find tools and resources to make doing business with us quick and simple.

We've listed a few of the tools and resources found on the "For Providers" tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Document Library
- Provider Education

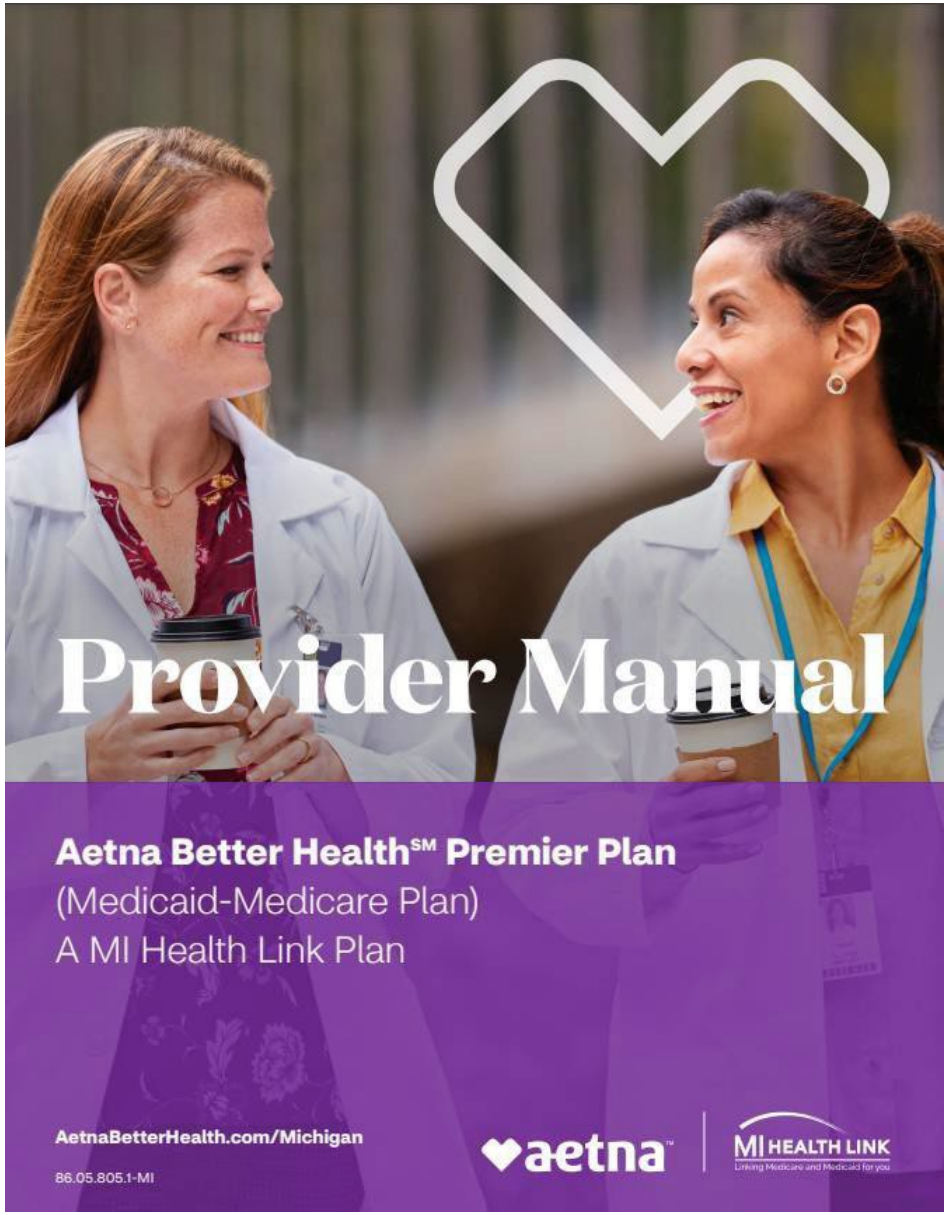


Provider Manual

The provider manual contains plan policies, procedures and benefits. You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available **here** on our website. Please note that the Premier Plan provider manual is different than the Medicaid provider manual.

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department.
Email: **MI-ProviderServices@Aetna.com**



MI Health and Human Services

- MI Choice Waiver Program: MI Choice Waiver Program
- Billing and Reimbursement: Billing and Reimbursement
- Electronic Billing: Electronic Billing

Provider Responsibilities

- Enrollee Privacy Rights
- Enrollee Privacy Requests
- Advanced Directives
- Provider Marketing
- Cultural Competency
- Health Literacy
- Alternative Formats
- Americans with Disabilities Act
- Abuse and Neglect
- Fraud, Waste, and Abuse

Provider Responsibilities (continued)

Enrollee Privacy Rights and Requests

- Uphold the privacy requirements of HIPAA when members exercise privacy requests.
- Make information available about Aetna Better Health Premier Plan's practices regarding their PHI.
- Maintain a process to request access, change, or restrict disclosure of PHI.
- Consistently respond to privacy requests within required time standards.
- Document requests and actions taken.

Advanced Directives

The advance directive must be prominently displayed in medical records. Must include:

- Providing written information on individual's rights under state law to make medical decisions.
- Written policies about advance directives (including conscientious objections).
- Documenting whether member's advance directive has been executed.
- Members may not be discriminated against due to advance directive decisions and providing unconditional care.

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Provider Responsibilities (continued)

Provider Marketing

- Aetna may not conduct sales activities in healthcare settings.
- Providers may discuss NJ Medicaid plans in response to an inquiry.
- Providers are encouraged to display enrollee materials of participating plans.
- Refer patients to 1-800-MEDICARE, Enrollment Broker, or CMS's website

Providers may:

- Educate on plan benefits and policies
- Refer to sources within Aetna
- Discuss participating status

Providers may not:

- Accept applications
- Induce enrollments
- Accept direct marketing compensation

Provider Responsibilities (continued)

Cultural Competency and Health Literacy

- Care without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.
- Treat all enrollees with dignity and respect.
- Participating providers are required to identify language needs and provide translation, oral or sign language interpretation.

  Aetna makes its language interpretation and sign language services available for free. Contact **1-855-676-5772** to access those services.
- Culturally and Linguistically Appropriate Services (CLAS) available at the **Think Cultural Health** site

Alternative Formats

- Large print, Braille, and alternative media for plan materials
- Contact Provider Services at **1-855-676-5772** or by email at **MI-ProviderServices@Aetna.com**

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Provider Responsibilities (continued)

Americans with Disabilities Act

- Obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities
- Waiting room and exam room furniture meets needs of all enrollees, including those with disabilities.
- Accessibility by public transportation routes
- Clear signage
- Appropriate accommodations such as large print materials
- Additional Resources at the **Americans With Disability** website

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Questions?

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