Aetna Better Health of Florida

Provider Orientation - 2025

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Rev. 04.2025

Orientation Topics

- Welcome!
- Health Equity
- Member Reach Team
- Cultural Competency
- Anti-Discrimination Policy and Americans with Disabilities Act (ADA)
- Member Rights & Responsibilities
- Expanded Benefits (all LOB)
- Member Advisory Committee
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- Member Sample ID Cards
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Aetna Better Health of Florida's Mission

WELCOME

Aetna Better Health of Florida (ABHFL) is looking forward to serving Floridians and partnering with health systems, providers, FQHCs and community resources to bring quality healthcare to the state through our experience and dedication in serving Medicaid populations.

Our Plan is led by our CEO, **Jennifer A. Sweet**. Members of the Aetna Better of Florida team will be based within the state to better serve the healthcare community and its members. Aetna Better Health of Florida will support our healthcare partners through interactive onboarding, virtual and in-person ongoing education, value based contracting opportunities, enhanced secure provider portal, and claims management assistance. Additionally, we will provide useful resources and tools to help ease the administrative burden.

Together, we will collaborate on a healthier future for your patients, our members.

Contacting Aetna Better Health of Florida

MMA: 1-800-441-5501 (TTY: 711)

FHK: 1-844-528-5815 (TTY:711)

LTC: 1-844-645-7371 (711)

Visit Aetna Medicaid Florida (https://www.aetnabetterhealth.com/florida)

- 24/7 Medical/Behavioral Advice Line
- Care Coordination
- Claims
- Eligibility

Health Equity

What is health equity?

Our health equity definition:

Everyone has a fair and just opportunity to be as healthy as possible.

We must remember that achieving health equity means understanding the root causes of inequities.

Fair and just

Regardless of race, ethnicity, gender, sexual orientation, gender identity, preferred language, religion, geography, income or disability status.

Healthy

A complete state of physical, mental and social well-being that is impacted by clinical and non-clinical drivers of health, including access to quality health care, education, housing, transportation and jobs.

Recognition of Racism and Discrimination

Key drivers of health outcomes, and the importance of working with communities to remove barriers to health.

Health Equity & Social Determinants of Health

Health Equity is the Goal

Everyone has a fair and just opportunity to be as healthy as possible.

Social Determinants of Health are Contributing Factors

The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.

Health Equity & SDoH are closely related concepts, but they are not the same. Health Equity is the goal, and SDoH are factors that influence whether we achieve that goal.

Member Reach

Member REACH Team

The Member REACH (Real Engagement And Community Help) team is here to support Aetna Better Health of Florida members by addressing their social care needs so they can focus on their overall health and wellbeing.

Aetna's REACH Team is dedicated to understanding and assisting member's individual needs and can connect them to local community programs that may be able to offer financial assistance, food assistance, educational services, housing assistance, legal services, employment services, support groups, baby supplies, clothing, and more.

Member REACH Team
Real Engagement and Community Help

Let's make healthier happen together.

Aetna's REACH Team is dedicated to understanding and assisting with your needs. We can connect you to programs that may be able to offer:

- Financial assistance
- Food assistance
- Educational services
- Housing assistance
- Legal services
- Employment services
- Support groups
- Baby supplies
- Clothing

Call us anytime.
833-316-7010

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Aetna Better Health®

Member REACH Team
Real Engagement and Community Help

Cultural Competency

ADA

Anti-Discrimination Policy and Americans with Disabilities Act (ADA)

It is our policy not to discriminate against members based on:

- Race
- National Origin
- Creed
- Color
- Age
- Gender/Gender Identity
- Sexual Preference
- Religion
- Health Status
  - Physical/Mental Disability
- Other Basis Prohibited by Law

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

If we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be taken.

The **ADA** gives civil rights protections to individuals with disabilities like those provided to individuals based on:

- Race
- National Origin
- Creed
- Sexual Preference
- Religion
- Age
- Physical/Mental Disability
- Color
- Gender/Gender Identity

The ADA guarantees equal opportunity for individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

Member Rights and Responsibilities

Member Rights

Members have the right to:

- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. • Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you

Member Rights

Members have the right to:

- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a complaint or grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results

Member Rights

Members have the right to:

- Freely exercise your rights without the Plan or its network providers treating you badly
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation
- Receive information on beneficiary and plan information
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS))
- A right to make recommendations regarding the organization's member rights and responsibilities policy.

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive services in a home-like environment regardless where you live Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the services, you need
- To be able to take part in decisions about your health care
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

Member Responsibilities

Members have the responsibilities to:

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions for care, and ask questions
- Keep your appointments, and notify your provider if you will not be able to keep an appointment
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- A responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff and case manager with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies

Member Responsibilities

Members have the responsibilities to:

- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-Term Care program
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Expanded Benefits

MMA Expanded Benefits

Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services to ask about getting expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization
After School Activities	Members ages 5-18 have access to a $50 stipend per year for after-school activities. No prior authorization required.	Ages 5-18, $50 per year.	No
Asthma Home Care	Members with an asthma diagnosis have access to hypoallergenic bedding and a $150 stipend for carpet cleaning and pest control. Prior authorization required.	One set of bedding per year, $150 per year for carpet cleaning and pest control.	Yes
Baby Item Stipend	Members may get $150 stipend per pregnancy for baby items such as crib, stroller and car seat. Prior authorization required.	$150 per pregnancy.	Yes
Behavioral Health Integration Service	Care management services provided by doctors.	As medically necessary.	No

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Blue Jeans for Teens	Members ages 13-21 may get a $150 stipend per year for clothing with a qualifying well-visit with their primary care doctor. Prior authorization required.	Ages 13-21, $150 per year.	Yes
Calming Comfort Collection	Members may get one calming box per year that includes items to support mental health concerns and trauma. Prior authorization required.	One box per year.	Yes
Career Closet	Members 18+ may get a $100 clothing stipend to support workforce development. One time only. Prior authorization required.	Members 18+, $100 per lifetime.	Yes
Childcare Support	Members may get $150 per quarter to pay for childcare during pregnancy, up to 12 months. Benefit may be extended through postpartum period. Prior authorization required.	$150 per quarter, up to 12 months.	Yes

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Developmentally Delayed Stipend	Members 18+ may get a $500 stipend to cover expenses related to the following: · Education/job training · Pursuing volunteer opportunities or faith-based activities · Services that provide improvements for the home · Supports that address barriers to access to care (transportation or provider consultations not otherwise covered by Medicaid). Prior authorization required.	Members 18+, $500 per year.	Yes
Diaper Club	Infants up to 30 months may get a $45 diaper stipend per month. No prior authorization required.	$45 per month for each child under 30 months.	No
Doula Services	Members may get unlimited doula services to support prenatal and postpartum care. No prior authorization required.	No limit for pregnant female members 14 to 55 years of age.	No
Durable Medical Equipment	Members ages 10+ may get one blood pressure monitor per year. Prior authorization required.	Members ages 10+, one per year.	Yes

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Food Assistance: Food as Medicine	Members with certain chronic conditions may get a $50 food stipend per month. Prior authorization is required.	Members with certain chronic conditions; $50 per month.	Yes
Food Assistance: Home Delivered Meals Post-Discharge	Members may get three meals per day for up to 12 weeks after discharge from a facility. Prior authorization is required.	Three meals per day for up to 12 weeks after discharge from a facility.	Yes
GED Support and Job Skills Training	Members ages 18+ (16-17 with parental, custodial or legal guardian consent and school district permission) may access a job skills training platform. The platform has GED preparation courses, preparation materials, and practice tests to help members with a GED. The costs of GED tests may be covered. No prior authorization required.	Members ages 18+ (16-17 with parental, custodial or legal guardian consent and school district permission). One per year.	No

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Grooming and Hygiene Stipend	Members ages 18+ with a qualifying well visit with their primary care doctor will receive a $50 stipend per quarter to support workforce activities. Prior authorization required.	Members ages 18+ with a qualifying well visit with their primary care doctor, $50 per quarter.	Yes
Hearing Benefits for Adults	Members ages 21+ get one annual hearing exam and a set of hearing aids every two years. No prior authorization required.	Members ages 21+, one annual hearing exam and a set of hearing aids every two year.	No
Home Delivered Meals – Hurricane Preparedness	Home and Community-Based members may request three home-delivered, shelf-stable meals per day for up to 12 weeks to prepare for hurricane season. Prior authorization required.	Home and Community-Based members, three meals per day for 12 weeks, may be requested May through November.	Yes
Housing Assistance: Hardship Grants	Members 18+ may get a $1000 stipend per year for crisis events that impact housing stability or maintenance. Prior authorization required.	Members 18+, must have a qualifying crisis event, $1000 per year.	Yes

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Housing Assistance: LTSS Housing/Utility Stipend	Members 18+ needing help may get a $500 stipend per year for housing issues such as utility payments. Prior authorization required.	Members 18+, $500 per year.	Yes
Housing Assistance: Legal Services	Members 18+ who are tenants may get $500 to use toward legal services related to housing issues such as eviction or repairs. No prior authorization required.	Members 18+, one per year.	No
Laundromat Stipend	Members 18+ with a qualifying well visit with their primary care doctor may get a $25 stipend per quarter for laundromat services. Prior authorization required.	Members 18+ with a qualifying well visit with their primary care doctor, $25 per quarter.	Yes
Medication Lockbox	Members who are prescribed a medication and have children in their home may get one lockbox per year to secure medications. No prior authorization required.	Members who are prescribed a medication and have children in their home, one lockbox per year.	No

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Newborn Circumcision	Infants up to 28 days old may get newborn circumcision. No prior authorization required.	Infants up to 28 days old, one per lifetime.	No
Non- Emergency Transportation	Members ages 18+ may get ten one-way trips per month to access resources such as food banks, local organizations, faith-based groups, and other activities. No prior authorization required.	Members ages 18+, ten one-way trips per month	No
Occupational Therapy for Adults	Members ages 21+ may get occupational therapy, including: · Evaluation and re-evaluation every year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years Prior authorization required.	Members ages 21+ · One evaluation and one re- evaluation per year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years	Yes
Over-the- Counter (OTC) Benefit	Members may get $65 per household per month for OTC products. No prior authorization required.	$65 limit per household per month on select OTC items	No

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Over-the- Counter Period Stipend	Female members ages 11+ may get $20 per month for menstrual products. No prior authorization required.	Female members ages 11+, $20 per member per month on select OTC items.	No
Physical Therapy for Adults	Members ages 21+ may get physical therapy, including: · Evaluation and re-evaluation every year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years. Prior authorization required.	Members ages 21+ · One evaluation and one re-evaluation per year · Up to seven therapy treatment units per week · Wheelchair fitting once every two years.	Yes
Prenatal/ Postpartum Services – Breast Pump	Members may get a breast pump.	One hospital grade breast pump per year for rent, one non-hospital grade breast pump every two years.	Yes, prior authorization required.
Prenatal/ Postpartum Services –Visits	Members may get expanded prenatal and postpartum visits. No prior authorization required.	Up to 14 prenatal visits for low-risk pregnancy and 18 visits for high-risk pregnancy before baby is born. After baby is born, three visits within 90 days of delivery.	No

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Primary Care Visits for Adults	Members 21+ have access to unlimited primary care visits. No prior authorization required.	Members 21+	No
Tutoring for Children and Teens	Members ages 6-18 may get individualized tutoring and mentoring sessions. No prior authorization required.	Members ages 6-18	No
Vision and Hearing Flex Card	Members ages 21+ may get $400 stipend every two years for extra vision and hearing services. No prior authorization required.	Members ages 21+, $400 every two years	No
Vision Services for Adults	Members ages 21+ may get a six-month supply of contact lenses with prescription, eyeglasses with prescription, and one eye exam per year. No prior authorization required.	Members ages 21+, six-month supply of contact lenses with prescription, eyeglasses with prescription, and one eye exam per year.	No

MMA Expanded Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Waived Copayments	Members have access to unlimited waived copayments on all Medicaid covered services. Prior authorization required for non-participating providers.	No limit	No prior authorization required for participating providers. Prior authorization required for non-participating providers.
Young Adult Life Coaching Services	Members ages 16-30 may have access to online education for support with developing life skills. No prior authorization required.	Members ages 16-30	No

FHK Expanded Benefits

Service	Description	Coverage/Limitations
Transportation to Specialist	Transportation for a member and a family relative or guardian to a specialist or dentist located between forty (40) and seventy (70) miles away from the member's home when no comparable specialist or dentist is located closer	Four (4) round trips per year per Member
CVS ExtraCare Card	One (1) CVS ExtraCare Health Card to each member's household by mail upon enrollment. The CVS ExtraCare Health Card provides a twenty percent (20%) discount on CVS brand over-the-counter health-related items available in CVS retail stores or online	One (1) CVS ExtraCare Health Card per household
After School Engagement	Reimbursement for member's membership fees, up to thirty- five dollars ($35) per year, for the YMCA, 4-H, Boys & Girls Clubs of America, Boy Scouts of America, Girl Scouts of the United States of America, and other established community organizations, afterschool programs or organized team sport programs	$35 per year

FHK Expanded Benefits

Service	Description	Coverage/Limitations
Swim Lesson Benefit Program	Insurer shall cover the cost of swimming lessons with drowning prevention practices, up to $50 per Enrollee lifetime. Reimbursement will be made directly to the Enrollee's YMCA or other certified swimming school or organization.	$50 per enrollee lifetime
Weight Management Program	Weight management program for children. Program will include the following for qualified participants: • A wearable Bluetooth® fitness tracker; • Up to three (3) nutritional counseling visits per year; • Program participation incentives including $20 gift cards at three (3) months and six (6) months of program participation	Members will be enrolled in the weight management program through case management

FHK Expanded Benefits

Service	Description	Coverage/Limitations
Tobacco/ Vaping Cessation Program	Tobacco/vaping cessation program which shall include the up to two (2) $20 gift cards as incentives. The first $20 gift card shall be available after three (3) months of case management support and medication. The second $20 gift card shall be available after an additional three (3) months of continued case management engagement and possible therapy from a behavioral health network Provider and the attending physician who will determine the need for continued medication	Limited to a six (6) month period
Prenatal and Post-partum Incentive Program	One (1) home diaper delivery for members who have completed a minimum of seven (7) prenatal visits (or the number of visits recommended by the American College of Obstetricians and Gynecologists from the date of enrollment) and a post-partum visit between 21 and 56 days after delivery.	One (1) home diaper delivery, limited to two (2) boxes per pregnancy and a maximum value of $5

FHK Expanded Benefits

Service	Description	Coverage/Limitations
Substance Use Program	The first gift card is available after ninety (90) days of sobriety as indicated by: • Verification of a minimum of three (3) visits to an intensive outpatient program or group meetings • Case manager verified attendance at psychosocial rehabilitation • Participation in care management for a minimum of ninety (90) days • Negative urine toxicology screen at ninety (90) days The second gift card is available after one hundred eighty (180) days of sobriety as indicated by: • Verification of continuous participation in an intensive outpatient program or group meetings with a minimum of one (1) per month • Case manager verified attendance at psychosocial rehabilitation • Participation in care management for a minimum of one hundred eighty (180) days • Negative urine toxicology screen at one hundred eighty (180) days	Limited to a six (6) month period; limited to a $40 total value

FHK Expanded Benefits

Service	Description	Coverage/Limitations
Expanded Asthma Program	The following additional benefits for members with an asthma diagnosis will be provided: • $60 lifetime benefit to purchase hypoallergenic bedding • An additional peak flow meter and spacer	One-time benefit
Health Risk Assessment Incentive	A fifteen-dollar ($15) gift card will be provided to members that complete an HRA and a well-child visit within the first ninety (90) Calendar Days of enrollment. If a member does not require a well-child visit within the first ninety (90) Calendar Days of enrollment because of a recent well-child visit, the previous visit satisfies the well-child visit requirement	One-time benefit

Member Advisory Committee

Member Advisory Committee

Member Advisory Committee

This group is made up of ABHFL staff, members, individuals and providers with knowledge of and experience with serving the older population (LTC) and individuals with disabilities, representatives from community agencies and community advocates.

This committee discusses how to improve ABHFL policies and is responsible for:

- Providing input on cultural and linguistic needs
- Providing feedback on member materials so they are more effective and user-friendly
- Suggesting ways to contact hard to reach members
- Suggesting ways to improve telephone services
- Suggesting ways to better communicate proper ER usage and transportation services
- And more...

We encourage you to become a part of this group. Or if you have a member that would be interested, call 1-844-645-7371.

Care Management

Medical Management: Care Management

Integrated Care Management Program (ICM)

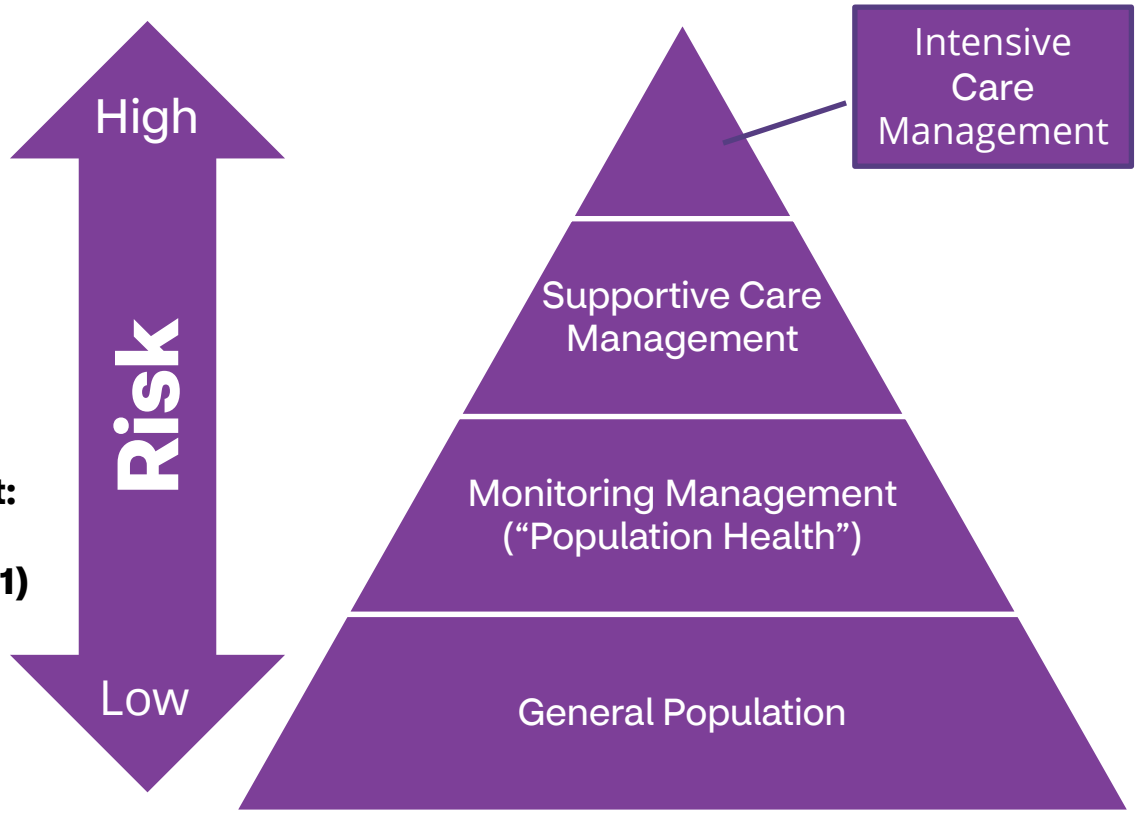
A member-centered approach that addresses physical and behavioral health, psychosocial needs and collaboration with the members' system of care and relationships.

Specialized Care markets for:

- COPD
- Asthma
- Depression
- Heart Failure
- Diabetes
- Hypertension

How to Refer to Care Management:

- **Phone: 1-800-441-5501 (TTY 711)**
- **Fax: 959-888-4124**



How to Refer to Care Management

Referral Process:

If you have a complex condition, care management can help. It gives you the personal support of a case manager and one-on-one health coaching. Case managers are nurses or social workers who understand your health conditions. To learn more, just contact us and ask to talk to a case manager.

Phone:

- **Managed Medical Assistance (MMA): 1-800-441-5501**
- **Florida Healthy Kids (FHK): 1-844-528-5815**
- **Long-Term Care (LTC): 1-844-645-7371**

Behavioral Health

Behavioral Health

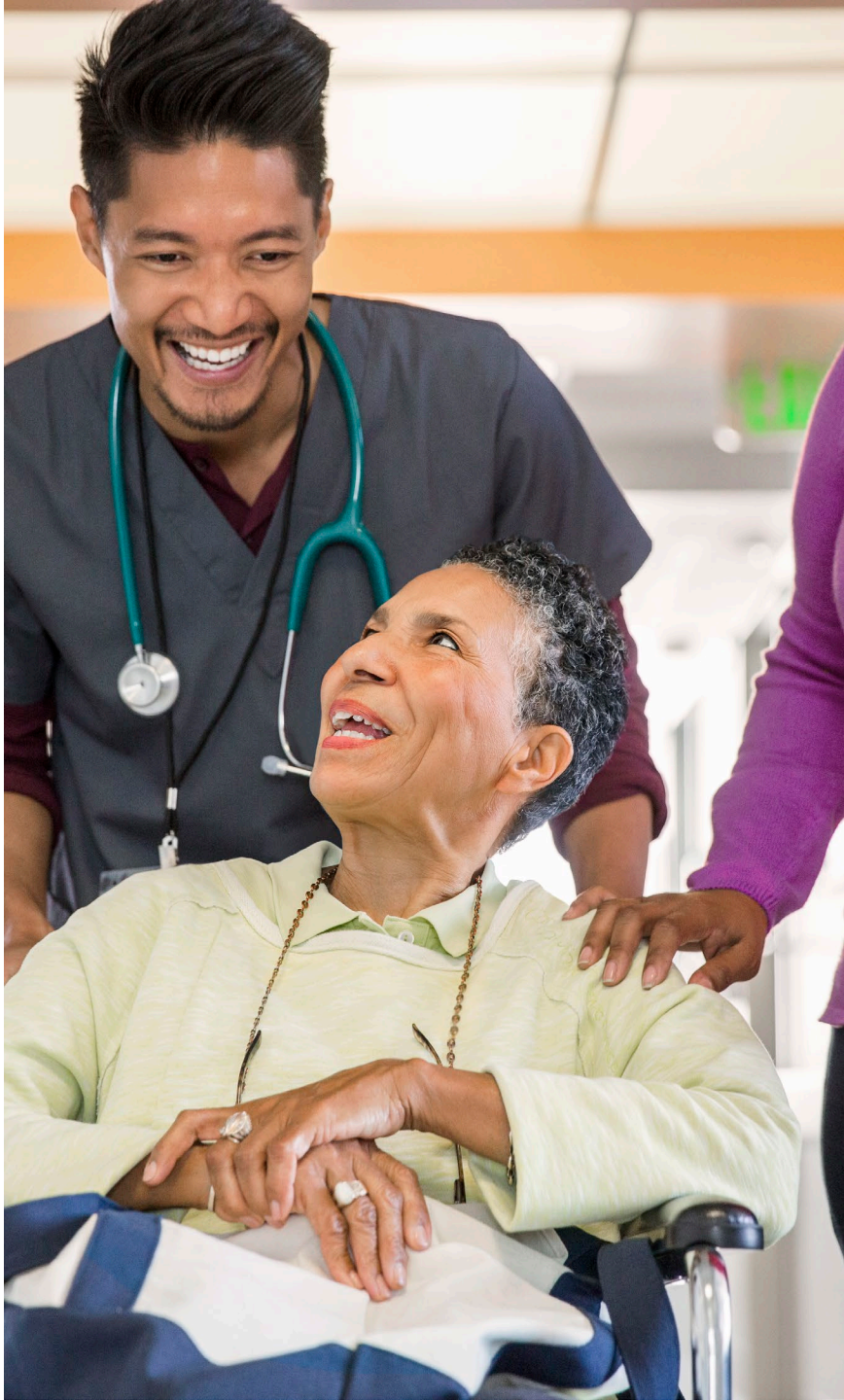
Basic Behavior Health Services

- Services provided for the assessment and treatment of problems related to mental health and substance use disorders.
  - Substance use disorders include abuse of alcohol and other drugs.
- Inpatient behavioral health services are reimbursed in accordance with your contract.

Primary Care Provider Referral

ABHFL promotes early intervention and health screening for identification of behavioral health problems and patient education. To that end, ABHFL providers are expected to:

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



Behavioral Health

Multiple Access Points for Behavioral Health Services

- Mild to Moderate Impairment
- Moderate to Severe Impairment
- Substance Use Disorder

Responsibility of Aetna Better Health of Florida, includes Mild to Moderate Impairment:

- PCP
- Psychiatric Testing
- OP Counseling
- Psychiatric Evaluation & Medication Management
- ABA Services
- Intensive Outpatient Program (IOP)

- Participating Providers are required to provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within twenty-four (24) Hours of assessment.

- Participating Providers providing inpatient psychiatric services to Enrollees are required to schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven (7) Calendar Days from the date of discharge.

- Providers must notify ABHFL of all discharge medications PRIOR to member's planned discharge from inpatient (IP) stay:
  - 1) IP Mental Health
  - 2) IP Detox
  - 3) Residential

Behavioral Health - Resources

Screening, Brief Interventions, & Referral to Treatment (SBIRT)

Screening: assess patient for risky substance use behaviors using standardized screening tools

Brief Intervention: healthcare professional engages patient in a short conversation, providing feed back and advice

Referral to Treatment: healthcare professional provides referral to brief therapy or additional treatment for patients who screening demonstrates the need for additional services

Additional Resources:

SBIRT

https://www.aetnabetterhealth.com/florida

Resources and Materials:

Members have access to behavioral health education and resources on the:

- Member behavioral health page
- Member local resources and services page, which includes the community resource tool
- Depression Screening
- Unhealthy drug use screening
- Early and Periodic Screening, Diagnostic and Treatment info
- Cognitive Health Assessment for Members 65 years of age or older

Member Eligibility & Enrollment

Member Eligibility

Populations We Serve:

- Aged, Blind, and Disabled (ABD)
- Children's Health Insurance Program (CHIP)
- Long Term Services and Supports (LTSS)
- Medicaid Expansion
- Developmentally Disabled (DD)
- General or Serious Mental Illness (GMH/SMI)
- Temporary Aid To Needy Families (TANF)
- Native Americans and those who qualify for services from an Indian Health Center
- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a care provider.

Member Rights and Responsibilities:

To be provided with information about the State and its services, including Covered Services.

To be able to choose a Primary Care Provider within Aetna's network.

To participate in decision making regarding their own health care, including the right to refuse treatment.

Give their health care provider all the information they need.

Ask for more information if they do not understand their care or health condition.

Tell their provider about any other insurance they have.

Physical Accessibility. Participating Providers are to provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3)

Member Services and Enrollment

Overview

- ABHFL Member Services Department is available to:
  - Answer questions about members health and covered services
  - Help choose primary care provider (PCP)
  - Tell member where to get needed care
  - Offer interpreter services if primary language is not English
  - Offer information in other languages/formats
  - Assist with access and questions regarding the Member Web Portal

If you need help, call Aetna Better Health of Florida (toll free) 24 hours a day, 7 days a week.

MMA- Medicaid -1-800-441-5501 or 1-844-645-7371

You can also visit us online any time at **https://www.aetnabetterhealth.com/florida/index.html**

How Can Members Enroll?

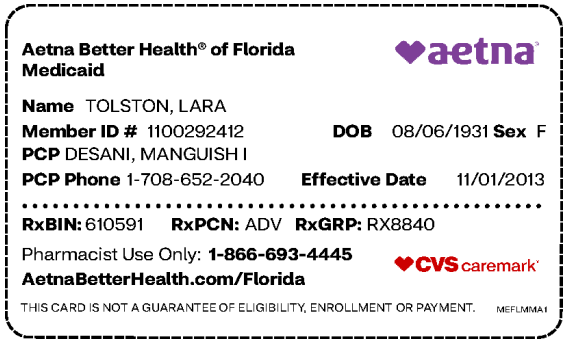
The State is responsible for determining eligibility and members can contact them enroll:

Online	Phone
https://ahca.myflorida.com/Medicaid/statewide_mc/smmc_ltc.shtml.	1-877-711-3662 TDD 1-866-467-4970

Member Sample ID Cards

Member Sample ID Card(s)

Medicaid - MMA



Aetna Better Health® of Florida
Medicaid

aetna

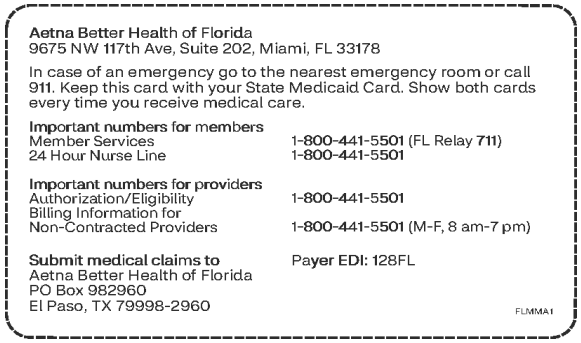
Name TOLSTON, LARA
Member ID # 1100292412 **DOB** 08/06/1931 **Sex** F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 **Effective Date** 11/01/2013

RxBIN: 610591 **RxPCN:** ADV **RxGRP:** RX8840

Pharmacist Use Only: **1-866-693-4445**
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLMMA1



Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

Important numbers for members
Member Services 1-800-441-5501 (FL Relay 711)
24 Hour Nurse Line 1-800-441-5501

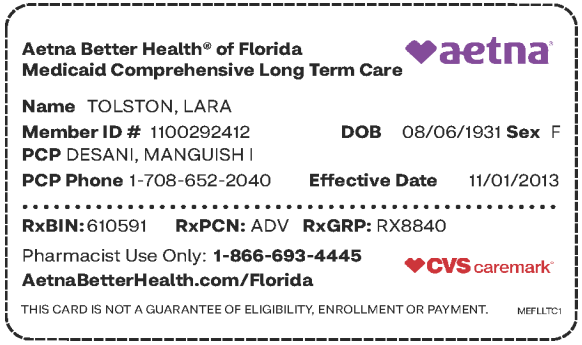
Important numbers for providers
Authorization/Eligibility 1-800-441-5501
Billing Information for Non-Contracted Providers 1-800-441-5501 (M-F, 8 am-7 pm)

Submit medical claims to
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

Payer EDI: 128FL

FLMMA1

Medicaid – Comprehensive Long-Term Care



Aetna Better Health® of Florida
Medicaid Comprehensive Long Term Care

aetna

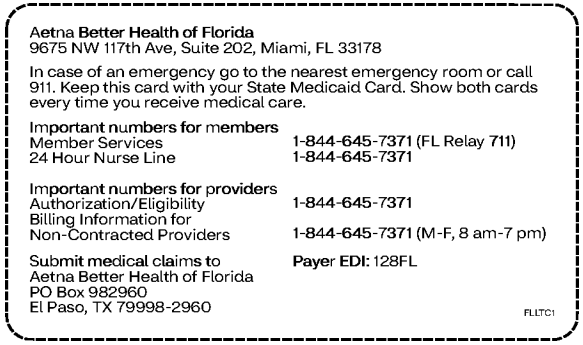
Name TOLSTON, LARA
Member ID # 1100292412 **DOB** 08/06/1931 **Sex** F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 **Effective Date** 11/01/2013

RxBIN: 610591 **RxPCN:** ADV **RxGRP:** RX8840

Pharmacist Use Only: **1-866-693-4445**
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLLTC1



Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

Important numbers for members
Member Services 1-844-645-7371 (FL Relay 711)
24 Hour Nurse Line 1-844-645-7371

Important numbers for providers
Authorization/Eligibility 1-844-645-7371
Billing Information for Non-Contracted Providers 1-844-645-7371 (M-F, 8 am-7 pm)

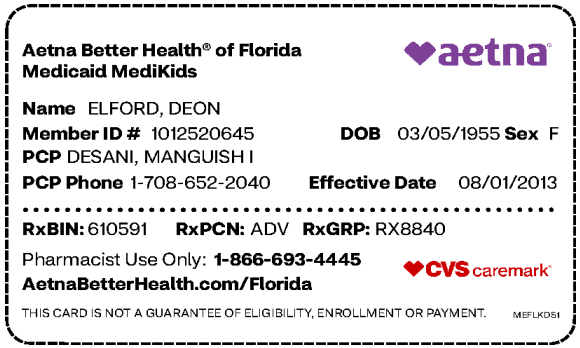
Submit medical claims to
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

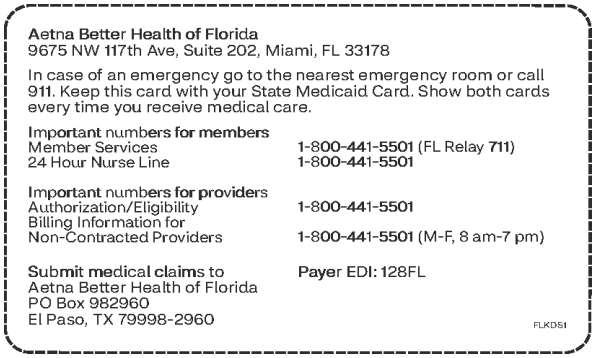
Payer EDI: 128FL

FLLTC1

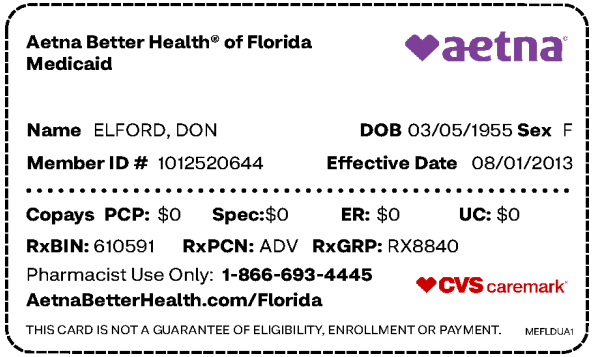
Member Sample ID Card(s)

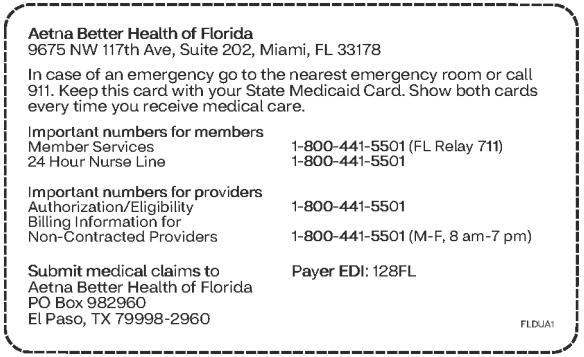
MediKids





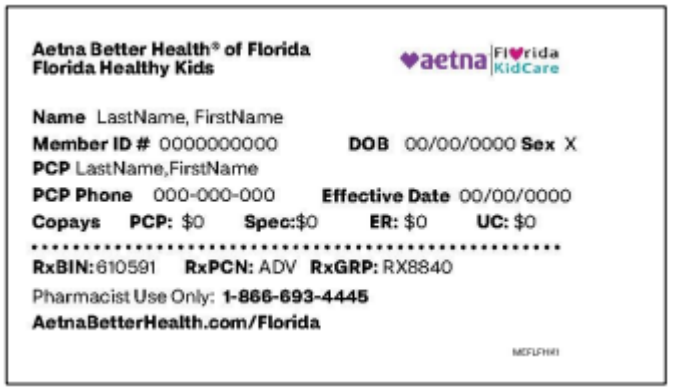
Dual Eligible

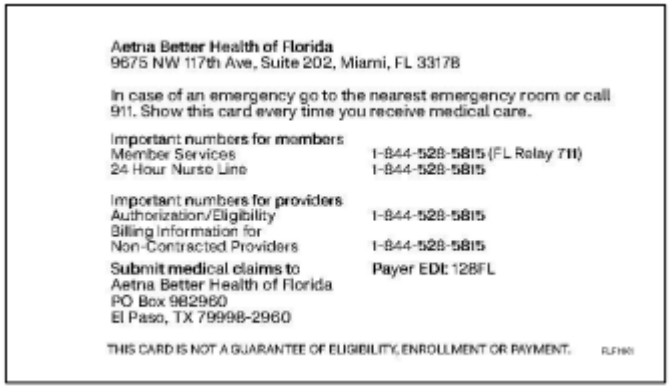




Member Sample ID Card(s)

Florida Healthy Kids





Language Services

Language Services

Language Services can be accessed via Member Services at MMA 1-800 -441-5501 (TTY 711), LTC 1-844-645-7371 (TTY 711)

- **Interpretation (Face to Face)**
  - Nationwide network of qualified interpreters offering interpretation in 15+ languages, including American Sign Language (ASL)
- **Interpretation (Over the Phone)**
  - Access to interpreters supporting 200+ languages via telephone

For members who are hearing impaired, the health plan will utilize the 711 Telecommunications Relay Service (TRS).

Additional Resources:

Interpreter Quality Standards Guidance
https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf

Office for Civil Rights
https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Vendors

Vendors

Aetna Better Health of Florida uses the following network vendors for certain services, areas and products. To find participating providers in areas not serviced by the below vendors please visit our provider search tool at: aetnabetterhealth.com/florida.

Specialty	Provider	Service Area	Product/ Program	Website	Phone Number
High-tech Imaging	eviCore Healthcare MSI	Statewide	Medicaid, Healthy Kids	http://www.evicore.com/	1-888-693-3211
Laboratory	LabCorp	Statewide	Medicaid, Healthy Kids	http://www.labcorp.com/	1-800-877-5227
Laboratory	Quest Diagnostics	Statewide	Medicaid, Healthy Kids	http://www.questdiagnostics.com/	1-866-697-8378
Oncology Chemotherapy Regimens -Adults	Eviti Connect	Statewide	Medicaid	http://connect.eviti.com/	1-888-482-8057
Ophthalmology & Optometry	iCare Health Solutions	Statewide	Medicaid, Healthy Kids	http://www.myicarehealth.com/	1-866-770-8170
Pain Management	eviCore Healthcare MSI	Statewide	Medicaid, Healthy Kids	http://www.evicore.com/	1-888-693-3211
Sleep Studies	United Health Systems, Inc.	Dade, Broward, Palm Beach	Medicaid, Healthy Kids	http://www.unitedhealthsystems.net/	1-954-382-0001
Specialty Medications	CVS Specialty Pharmacy	Statewide	Medicaid, Healthy Kids	https://www.cvsspecialty.com/	1-800-237-2767

Vendors

*Credentialed by Aetna Better Health of Florida

Specialty	Provider	Service Area	Product/ Program	Website	Phone Number
*Chiropractic	Doctor's Professional Services Consultants	Statewide	Medicaid, Healthy Kids	http://www.dpscinc.com/	1-386-615-0801
*Dermatology	Dermatology Network Solutions	Statewide	Medicaid, Healthy Kids	http://www.providernetworksolutions.com/	1-888-959-8714 1-844-222-3535
*Orthopedic	Orthopedix Network Solutions	Dade and Broward	Medicaid, Healthy Kids	http://www.providernetworksolutions.com/	1-888-959-8714 1-844-222-4545
*Podiatry	Podicare	Statewide (Healthy Kids is limited to region 9 & 11 only)	Medicaid, Healthy Kids	http://www.podicare.net/	1-866-293-3666
PT/OT/ST	Health Network One	Statewide	Medicaid, Healthy Kids	http://www.mytnfl.com/	1-888-550-8800
*Transportation (Non- Emergent)	ModivCare formerly LogistiCare Solutions	Statewide	Medicaid,	http://www.modivcare.com/	MMA & LTC Reservation: 1-866-799-4463 Ride Assist: 1-866-799-4464 Health Kids / CHIP Reservation: 1-866-824-1563 Ride Assist: 1-866-824-1564

Value-Based Services (VBS)

Overview of Value-Based Services (VBS)

Our Offer — Various Incentive Arrangements

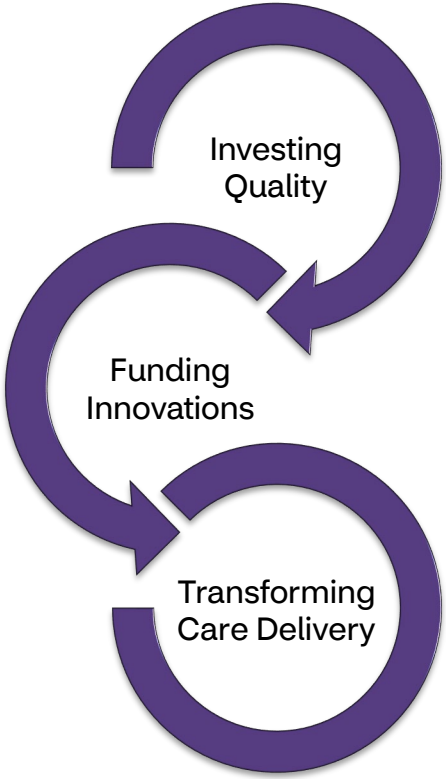
- Pay for Quality with designated incentive pool
- Shared Savings Models
- Shared Risk Models
- Full Risk Models/Capitation Models

We look for — Participating providers in

- Primary Care
- Pediatric Care
- Obstetrics and Gynecology

Interested? — Please Contact:

- Patricia A. Gardner – Lead Director, Value-Based Services
- Email: Gardnerp@aetna.com



Credentialing

Credentialing

Adding a New Provider to Existing Practice

- Each new provider must be credentialed before s/he can render care to an ABHFL Member, including Nurse Practitioners.
- Mid-levels must have a supervising physician.
- Background screening
- Utilize CAQH for credentialing
- CAQH ProView
    - Complete Attestation & Documentation
    - Authorize ABHFL to view CAQH Profile
- Contact the Credentialing Department with the applicable CAQH number.

Authorizations

Medical Prior Authorizations (PA)

You may submit PA Requests by:

Phone	Secure	Fax
1-800-441-5501 (TTY: 711)	Availity	1-860-607-8056

Service Authorization Decision Timeframes	Turnaround Times
MMA Urgent	**2** calendar days
MMA Elective	**7** calendar days
FHK Urgent	**72** hours from receipt of the request
FHK Elective	**14** calendar days

Additional timeframes and authorization information, is in the Provider Manual

Documentation requirements for authorization request:

- Member Information
- Diagnosis Code(s)
- Treatment or Procedure Code(s)
- Anticipated Start and End Dates of Service(s)
- All Supporting Clinical Documentation to Support Medical Necessity
- Include:
  - Office/Department Contact Name
  - Telephone
  - Fax Number

Forms can be found here: **https://www.aetnabetterhealth.com/florida/providers/prior-authorization.html**

Concurrent Review

Concurrent Review Process

Overview

Aetna Better Health of Florida conducts concurrent utilization review on **each** member admitted to an inpatient facility, including skilled nursing facilities (SNF) and freestanding specialty hospitals.

What does that mean?

- Admission certification
- Continued stay review
- Conducted before the expiration of the assigned length of stay
  - Providers will be notified of approval or denial of stay
- Review of the member's medical record to assess medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines
- The nurses work with the medical directors in reviewing medical record documentation for hospitalized members

Pharmacy

Pharmacy

Aetna Better Health of Florida covers prescription medications and certain over-the-counter medicines when you write a prescription for a member.

We use CVS/Caremark for pharmacy benefit management services.

Online formulary search tool includes formulary status and indicates whether a drug requires step therapy (ST), has a quantity limit (QLL) or requires Prior Authorization (PA)

CVS Caremark Mail Order Pharmacy

Pharmacy PA:

- Submit PA by telephone 1-800-441-5501 (TTY 711), fax 1-855-799-2554 or online.
- Through a direct link on our website, you can view:
  - PA criteria
  - PA forms

Visit our provider page for more information at:

https://www.aetnabetterhealth.com/florida/providers/pharmacy-prior-authorization.html

Electronic PA:

Use Provider Portal ® to:

- Submit prior authorization (PA)
- Check member eligibility and coverage status
- Check medication history, and formulary information

Quality Management Program

Quality Management Program

Overview

- QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. The 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

Medical Records Standards

- ABHFL's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).
- All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the ABHFL Provider Manual

Quality Management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

- Two ways data is collected for HEDIS measures.
    - Administrative- measures use claims/encounters for hospitalizations, medical office visits and procedures or pharmacy data only.
    - Hybrid- measures use data obtained directly from the member's medical record in addition to administrative data.

What is Our Ultimate Goal

- For providers to submit claims/encounters with coding that administratively captures all required HEDIS data via claims. This decreases or removes the need for medical record (hybrid) review.

Please see HEDIS Tips for PCPs located on our website at **AetnaBetterHealth.com/Florida**

Early and Periodic Screening Diagnostic, and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

What is EPSDT?

- It is a federally defined health program for children under age 21 who are enrolled in Medicaid.
- The EPSDT benefit is more robust than the ABHFL benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.
- The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

Provider Responsibilities:

- ✓ Complete the required screenings according to the current American Academy of Pediatrics "Bright Futures" periodicity schedule and guidelines
- ✓ Fully document all elements of EPSDT assessments, including anticipatory guidance and follow-up activities
- ✓ Report EPSDT visits by submitting the applicable CPT codes on claim submission

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - continued

EPSDT Services

Screening services must include, at a minimum,

- comprehensive health and developmental history (including assessment of both physical and mental health development);
- comprehensive unclothed physical exam;
- appropriate immunizations;
- laboratory tests (including blood lead level assessment appropriate for age and risk factors);
- health education (including anticipatory guidance).

Vision services - diagnosis and treatment for defects in vision, including eyeglasses

Dental services – dental screening/oral health assessment must be performed as part of every periodic assessment; referred for treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

Hearing services - diagnosis and treatment for defects in hearing, including hearing aids.

Other necessary health care, diagnostic services, treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services

Health Risk Screening

Health Risk Screening

As an Aetna Better Health provider, it is expected that you perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has an OCS eligible medical condition. We rely on you, our network providers, to complete the Initial Health Risk Screening within thirty (30) days of the members enrollment to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care.

The Health Risk Questionnaire for will assist us in identifying enrollees with special health care needs. If identified, we will follow-up with a Comprehensive Assessment (CA) as a part of the Risk Stratification Level Framework. This information must be included in the patient's medical records and supplied to Aetna Better Health of Florida or its regulators upon request.

Three (3) documented outreach attempts:

- Enrollee to complete the questionnaire in-person, by phone, electronically via ABHFL member portal, or by mail

Health Risk Screening Questionnaire & Triggers

Questionnaire include but is not limited to:

a. Demographic information for verification purposes;

b. Current and past physical health and behavioral health conditions;

c. Identifying Enrollees with Special Health Care Needs and specialized treatment or equipment;

d. Services or treatment the Enrollee is currently receiving, including from out-of-State Providers;

e. Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another plan;

f. Most recent ER visit, Hospitalization, physical exam, and medical appointments;

g. Current medications; and

h. Questions to address Social Determinants of Health, including food, shelter, transportation, utilities, and personal safety.

Health Risk Screening

ABHFL Comprehensive Assessment

a. Demographic intake;
b. Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content and memory;
c. Functional or adaptive deficits/needs (e.g., ADLs, IADLs);
d. Behavioral health, including previous psychiatric, addictions and/or substance abuse history, and a behavioral health, depression, and substance abuse screen;
e. Medical conditions, complications, and disease management needs;
f. Trauma, abuse, neglect, violence and/or sexual assault history of self and/or others, including Department of Human Services involvement;
g. Disability history;
h. Educational attainment, skills training, certificates, difficulties, and history;
i. Family/caregiver and social history;
j. Medication history and current medications, including name, strength, dosage, and length of time on medication;
k. Social profile, community, and social supports (e.g., transportation, employment, living arrangements, financial, community resources) and support system, including peer and other recovery supports;
l. Advance directives;
m. Present living arrangements;
n. Enrollee strengths, needs and abilities;
o. Home environment; and
p. Enrollee cultural and religious preferences.

Access Care Guidelines

Access to Care Guidelines

Appointment Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Provider Relations will routinely monitor compliance and seek Corrective Action markets (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the Agency for Health Care Administration(AHCA) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

~~A~~ppointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), and high-volume Participating Specialist Providers (PSPs).

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

Access to Care Guidelines - continued

PCP	OB/GYN	Specialty	Mental health	Substance Use
Within **30 days** from date of request for a routine appointment. Within **48 hours** for urgent care.	Within **30 days** from date of request for a routine appointment. Within **48 hours** for urgent care *See below for prenatal care	Specialty care consultation, including nonurgent **60 days** Within **48 Hours** for Urgent Care or as clinically indicated.	Within **7** days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment Within **14** days for initial outpatient behavioral health treatment	Within **30 days** from date of request for a routine appointment. Within **7 days** of residential care and hospitalization. Within **24 hours** for urgent care.
***Prenatal Care -- Members will be seen within the following timeframes:** **• First trimester visit within 14 calendar days** **• Within the second trimester within 7 calendar days** **• Within their third trimester within 3 business days** **High-Risk Pregnancy – Within three (3) business days of identification of high-risk to ABHFL or maternity provider or immediately if an emergency exists.**				

Please Note: Participating Providers are required to meet State standards for timely access to care and services, as specified in this Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i).

Telephone Accessibility Standards

Telephone Accessibility Standards

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.
- Providers must comply with telephone protocols for all the following situations:
- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

Telephone Accessibility Standards - continued

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable:	Unacceptable:
• Telephone is answered by provider, office staff, answering service, or voice mail. • The answering service either: ○ Connects the caller directly to the provider ○ Contacts the provider on behalf of the caller and the provider returns the call ○ Provides a telephone number where the provider/covering provider can be reached • The provider's answering machine message provides a telephone number to contact the provider/covering provider.	• The answering service: ○ Leaves a message for the provider on the PCP's/covering provider's answering machine ○ Responds in an unprofessional manner • The provider's answering machine message: ○ Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. ○ Instructs the caller to leave a message for the provider. • No answer • Listed number no longer in service • Provider no longer participating in the contractor's network • Answering Service refuses to provide information for after-hours survey • Telephone lines persistently busy despite multiple attempts to contact the provider

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

Abuse, Neglect and Exploitation

Abuse, Neglect and Exploitation

As mandated by state of Florida, all providers who work or have any contact with an Aetna Better Health of Florida members, are required as “mandated reporters” to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency.

Children

Providers must report suspected or known child abuse, and neglect to the Florida Department of Children and Families **Statewide 24-hour Child Abuse and Neglect Hotline at 1-800-962-2873** or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable Adults

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

•The Florida Domestic Violence Hotline at **1-800-799-SAFE** (7233)

•Reporting Agencies

•Florida Department of Children and Families Abuse Hotline **1-800-962-2873** or through this link: **https://www.myflfamilies.com/services/child-family/child-and-family-well-being**

Fraud, Waste and Abuse

Fraud, Waste, and Abuse

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste

Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse

Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

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

- By phone to the confidential Aetna Better Health of Florida
- By phone to our confidential Special Investigation Unit (SIU) at **1-855-415-1558**

You can also report provider fraud to Florida Agency for Health Care Administration (AHCA), at 1-(888) 419-3456 or online at https://apps.ahca.myflorida.com/mpi-complaintform/

Claims

Claims

Clearinghouse & Clean Claims
We accept both paper and electronic claims via Availity and is the preferred clearing house for electronic claims

- **Payer ID: 128FL**

EDI claims received directly from Office Ally through Availity & processed through pre-import edits to:

- Evaluate Data Validity
- Ensure HIPAA Compliance
- Validate Member Enrollment
- Facilitate Daily Upload to ABHFL System

Claims Submissions
ABHFL requires clean claims submissions for processing. To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure code

New Claim Submissions

- Submitted within 180 calendar days from the date the service unless there is a contractual exception.
- For hospitals inpatient claims (date of service means the entire length of stay for the member).
- For FQHC and RHC providers, please list the rendering provider on your claims.

Claim Resubmission
Corrected claims must be submitted within 180 days from the determination date.

- Providers may resubmit a claim that was originally denied because of:
  - Missing documentation
  - Incorrect Coding
  - Incorrectly Paid or Denied because of Processing Errors

How to Submit a Claim:

Mail
Aetna Better Health of Florida Inc.
PO Box 982960
El Paso, TX 79998-2960

Phone
1-800-282-4548

Online
Availity

Provider Dispute Resolution Processing Timeframe

DESCRIPTION		TURNAROUND TIME FRAME
DEADLINE FOR MARKET RECEIPT OF PROVIDER DISPUTES	Dispute related to an individual claim, billing dispute, or contractual dispute; OR Dispute related to a demonstrable and unfair payment pattern by the market	Deadline: 365 days after the most recent action, or in the case of inaction, 365 days after time for contesting or denying claims has expired.
	Dispute regarding a market notice of overpayment	Deadline: Within 30 working days of receipt of the market notice of overpayment of a claim
	Amended Provider Dispute	Deadline: Within 30 working days of the date of the provider's receipt of a returned dispute with written market notice

Provider Dispute Resolution Processing Timeframe (con't)

DESCRIPTION		TURNAROUND TIME FRAME
TIME PERIOD FOR ACKNOWLEDGEMENT	Electronic Provider Dispute (directly into the system)	Provided within 2 working days of the date of receipt of the date of receipt of the electronic provider dispute
	Paper Provider Dispute (mail, fax, e-mail, physical delivery)	Provided within 15 working days of the date of receipt of the date of receipt of the paper provider dispute
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	Resolution and issuance of written determination for each provider dispute or amended provider dispute.	market's goal is to resolve and issue written determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
PAST DUE PAYMENTS AND INTEREST AND PENALTIES	Resolution of a dispute involving a claim, which is determined in whole or part in favor of the provider, shall include the payment of any outstanding monies determined to be due and all interest due.	market goal is to issue payment with the resolution letter and in all cases payment will be made no later than within 5 working days of the issuance of the written determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs)

The Patient Protection and Affordable Care Act-Section 2702, requires that state Medicaid programs implement non-payment policies for Provider Preventable Conditions (PPCs), including Health Care-Acquired Conditions (HCACs) (in an acute inpatient setting) and Other Provider-Preventable Conditions (OPPCs) (in any health care setting).

ABHFL uses a claims business application system that is designed to stop automatic processing of PPC claims identified for clinical review. ABHFL uses this process to pend processing of claims received with PPC related diagnosis codes.

Pended claims are referred to a concurrent review nurse to initiate the investigation process. In addition, associates involved with the concurrent review process may identify potential PPCs during the course of utilization management evaluation.

ABHFL will not pay any Provider claims nor reimburse a PPC, in accordance with 42 C.F.R. § 447.26(b). ABHFL asks all contracted Providers to report all PPCs in the form and frequency required.

Provider Preventable Conditions (PPCs)

ABHFL will not reduce payment for a PPC to a provider when the condition (defined as a PPC for a particular patient) existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- The identified PPCs would otherwise result in an increase in payment.
- The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPCs.

Payment will not be available for any State expenditure for PPC conditions.

ABHFL will ensure that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

Grievance & Appeals

Grievance & Appeals

Member Grievance System Overview

- Members or their designated representative can file a request for reconsideration or express dissatisfaction with Aetna Better Health of Florida.
- Orally or in writing.
  - A representative is someone who acts on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney.
  - Representatives must be designated in writing.
- Requests for *reconsideration* are classified as an *appeal*.
- All other *expressions of dissatisfaction* are classified as a *grievance*.
  - When the grievance is received by phone and can be resolved by the next business day, and it is not related to reconsideration or an appeal it is classified as an exempt grievance.
- ABHFL informs members and providers of the grievance system processes for exempt grievances, grievances, appeals, IMRs and State Fair Hearings.
- Display Notices of Enrollee Rights to Grievances, Appeals and State Fair Hearings. Require that the Participating Provider display notices in public areas of the Participating Provider's facility/facilities in accordance with all State requirements and any subsequent amendments.

How to file an Appeal or Grievance:

- Phone: 1-800-441-5501
- Fax: 1-860-607-7894
- Online: Availity & Member Portal

  https://www.aetnabetterhealth.com/florida/providers/portal.html
- Email: FLAppealsandGrievances@AETNA.com
- Mail:

  Aetna Better Health of Florida
  Attn: Appeal and Grievance Manager
  PO Box 81040
  5801 Postal Road
  Cleveland, OH 44181

Grievance & Appeals

Provider Dispute

- Network providers may file a payment dispute verbally or in writing direct to ABHFL to resolve billing, payment and other administrative disputes for any reason including but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the provider; or any other reason for billing disputes. Provider Payment Disputes do not include disputes related to medical necessity.

Provider Grievance

- Both network and out-of-network providers may file a formal grievance in writing directly with ABHFL in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action within ABHFL from when they became aware of the issue.

Provider Appeal

- A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with ABHFL from the Aetna Better Health Florida Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

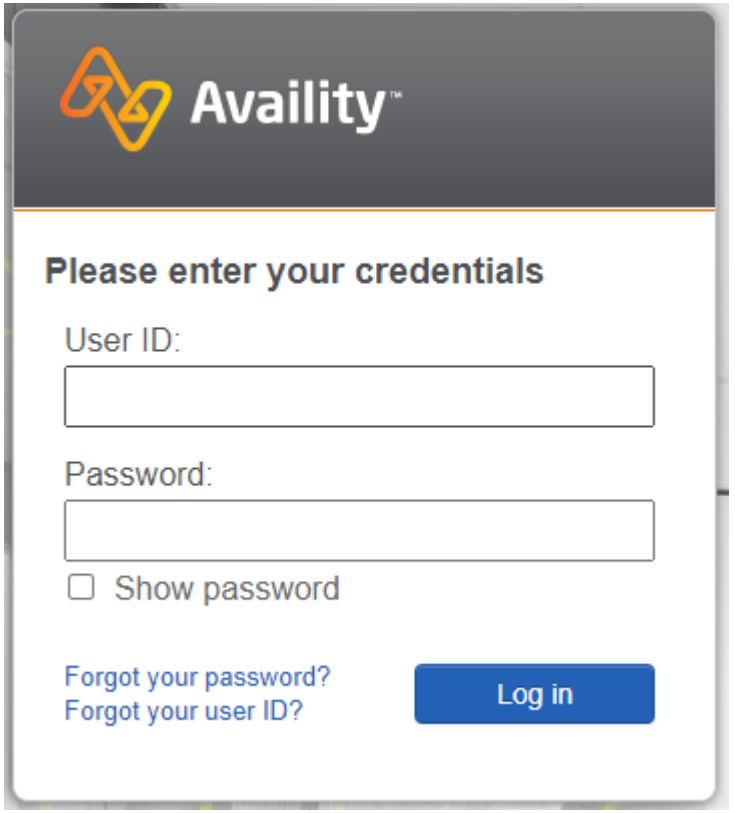
Availity

Availity (Provider Secure Web Portal)

We are thrilled to announce that Aetna Better Health Florida will be using Availity for our provider portal. We are excited to support you as you provide services to our members. Our communications will be via email. Keeping our providers informed is our priority.

Some highlights of increased functionality include:

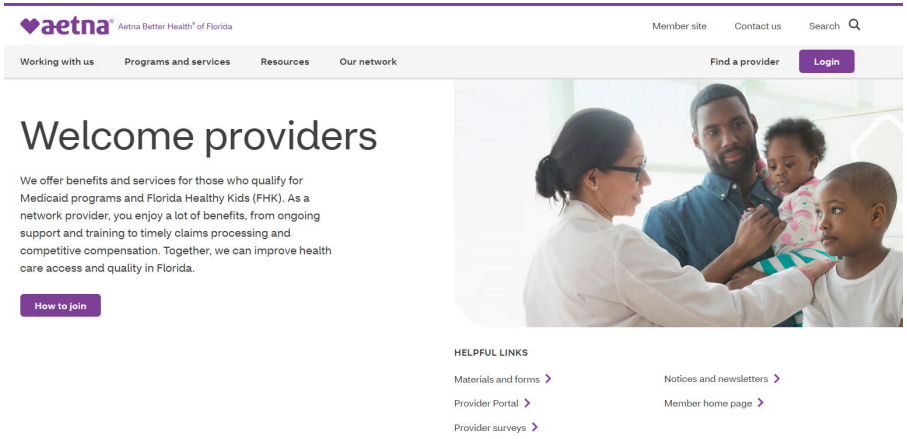
- Claims look up
- Online claim submission
- Prior authorization submission and look up
- Grievance and Appeals submission
- Panel searches
- A new robust prior authorization tool
- Review of Grievance and Appeals cases
- Eligibility and member look up

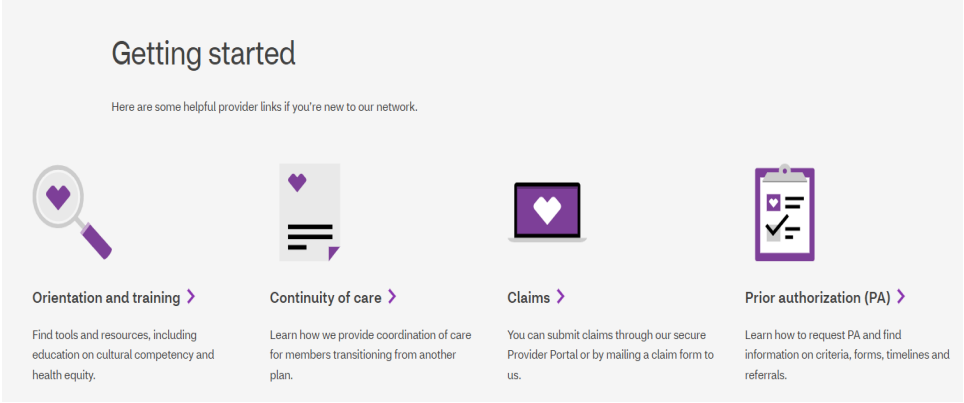


Availity

ABHFL Website

Our Website





Tools

[Prior Authorizations]

[Pharmacy Search Tool]

[Provider Manual]

[Availity]

[24/7 Secure Provider Portal]

[Clinical Guidelines Forms]

[Provider Education]

[Notices and Newsletters]

[Claims]

[Continuity of Care]

Website:
https://www.aetnabetterhealth.com/florida

Resources

Resources

ABHFL Provider Site:
https://www.aetnabetterhealth.com/florida/providers/index.html

Materials and Forms:
https://www.aetnabetterhealth.com/florida/providers/materials-forms.html

Provider Quick Reference Guide:
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_quick_reference_guide.pdf

Provider Manuals:
https://www.aetnabetterhealth.com/florida/providers/materials-forms.html

Contact List:
Provider Engagement (PE) Team Contact List

Email: FLProviderEngagement@aetna.com

Attestation

Attestation

As required by Aetna Better Health Florida, please complete and forward a copy of the attestation form located on our website to our Provider Engagement team to acknowledge completion of this orientation: FLProviderEngagement@aetna.com

ATTESTATION DIRECT LINK:

- **https://www.aetnabetterhealth.com/florida/providers/training-orientation.html**

Thank you for you time and partnership!