Aetna Better Health® of New York 2023 Provider Manual

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Aetna Better Health® of New York
Managed Long Term Care Provider Manual

AetnaBetterHealth.com/NewYork
Contact our Provider Relations Department at **1-855-456-9126**

For the New York Managed Long-Term Care (MLTC) program, Aetna Better Health in New York serves the following counties:

▪ Nassau County	▪ Queens
▪ Suffolk County	▪ New York
▪ Kings	▪ Bronx

CHAPTER 1: INTRODUCTION

Welcome

Welcome to Aetna Better Health®. Aetna Better Health is proud to be one of the health plans approved by the New York State Department of Health to serve individuals enrolled in New York State's Partial Capitated Managed Long-Term Care program. Aetna Better Health's Managed Long-Term Care (MLTC) program provides Medicaid covered services to people 21 years and above who are chronically ill or have disabilities, and who need health and long-term care services to remain in their homes and communities as long as possible.

Our ability to serve our members well is dependent on the quality of our provider network. By joining our network, you are helping us serve the people in the state of New York by providing high-quality and accessible long-term care services and supports. You are one of the most critical components of our service delivery approach and Aetna Better Health is grateful for your participation.

This manual is intended to serve as an extension of the provider agreement. It includes valuable information to help you understand our program, provides key points on how to work with Aetna Better Health, and should be a helpful resource for you and your office staff. Please visit our website at **AetnaBetterHealth.com/NewYork** the most up-to-date information.

About Aetna Better Health

Aetna Better Health Inc. is a wholly owned subsidiary of Aetna Health Holdings, LLC, which is a wholly-owned subsidiary of Aetna Inc. Aetna Better Health combines the financial and administrative strength of Aetna with the depth of Medicaid experience and expertise of the Aetna Medicaid Business Unit. Aetna has more than 150 years of experience in meeting members' health care needs and Aetna Better Health, together with our parent and affiliates, has more than 25 years of Medicaid managed care experience.

About the Managed Long-Term Care (MLTC) Program

The Managed Long-Term Care (MLTC) program currently serves approximately 34,000 members in the State of New York. The MLTC program provides long-term home health care, dental, vision, and other health-related services to adults who are chronically ill or have disabilities. Non-covered services, such as physician and hospital care, are coordinated through an assigned Aetna Better Health Care Manager. This program is designed to link primary, specialty, and community-based services for New York's most vulnerable residents.

About this Provider Manual

This Manual will enable providers to easily access information on the majority of issues that may affect working with Aetna Better Health. If you have a question, problem, or concern that the Provider Manual does not fully address, please call **1-855-456-9126**.

Aetna Better Health will update the Provider Manual at least annually and will distribute bulletins as needed to alert you about any changes. Please check our website regularly at **AetnaBetterHealth.com/NewYork** for the most recent version of the Provider Manual and/or updates.

The Aetna Better Health Provider Manual is available in hard copy form at no charge by contacting our Provider Relations Department at **1-855-456-9126.** Otherwise, for your convenience Aetna Better Health will make the Provider Manual available for download on our website at **AetnaBetterHealth.com/NewYork**.

CHAPTER 2: CONTACT INFORMATION

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

Important Phone Numbers

Important Contacts	Phone Number	Fax	Hours of Operation	Days of Operations (excluding State holidays)
Aetna Better Health Administration	**1-855-456-9126** (follow the prompts)	NA	8 AM – 5 PM Eastern	Monday-Friday
Member Services (Eligibility Verification)	**1-855-456-9126** (follow the prompts)	Toll Free Fax: **1-855-863-6421**	8 AM – 5 PM Eastern	Monday-Friday
Provider Relations	**1-855-456-9126** (follow the prompts)	**1-860-754-2056** Toll Free Fax: **1-855-222-6621**	8 AM – 5 PM Eastern	Monday-Friday
NY Relay	Dial **711**	NA	24 hours / 7 days per week	24 hours / 7 days per week
LIBERTY Dental Plan (Dental)	**1-833-276-0853** TTY: **1-877-855-8039**	NA	8 AM –8 PM Eastern	Monday-Friday
EyeQuest (Vision) **eyeQuest@dentaQuest.com**	**1-855-873-1282**	**1-888-696-9552**	7 AM 7 PM Central	Monday-Friday
Transportation	**1-855-456-9126** (Member Services Department)	NA	8 AM – 5 PM Eastern	Monday-Friday

Reporting Complaints	Phone Number	Fax	Hours of Operation	Days of Operation (excluding State holidays)
Adult Care and Assisted Living Complaints http://www.health.state.ny.us/facilities/assisted_living/	**1-866-893-6772**	**NA**	8:30 AM - 4:30 PM Eastern	Monday-Friday Voicemail – After Hours
Complaints About Home Care Agencies The New York State Department of Health, Division of Home and Community-Based Care http://homecare.nyhealth.gov/about.php?p=help Mail Complaints to: Bureau of Home Care and Quality Indicators/Evaluation1 61 Delaware Avenue, Delmar, NY 12054	**1-800-628-5972**	**518-408-1636**	24 hours / 7 days per week	24 hours / 7 days per week
Nursing Home Complaints The New York State Department of Health, Division of Residential Services (DRS) http://www.health.state.ny.us/facilities/nursing/complaints.ht m Mail Complaint Forms to: NYSDOH DRS/SNHCP Mailstop: CA/LTC Empire State Plaza Albany, NY 12237	**1-888-201-4563**	**518-408-1157**	24 hours / 7 days per week	24 hours / 7 days per week
Aetna Better Health Special Investigations Unit (SIU)	**1-800-338-6361** follow the prompts	NA	24 hours / 7 days per week	24 hours / 7 days per week
Health Plan Compliance Hotline	**1-855-456-9125**	NA	24 hours / 7 days per week	24 hours / 7 days per week
NYS Office of Advocate for Persons with Disabilities http://cqc.ny.gov/	**1-800-624-4143**	NA	Online 24 hours/ 7 days per week	Online 24 hours / 7 days per week

NYC Mayor's Office for People with Disabilities **http://www.nyc.gov/html/mopd/html/home/home.shtml**	**212-788-2830** or TTY **212-788-2838**	**212- 341-9843**	NA	NA
Nursing Home Complaints The New York State Department of Health, Division of Residential Services (DRS) **http://www.health.state.ny.us/facilities/nursing/complaints.htm** Mail Complaint Forms to: NYSDOH DRS/SNHCP Mailstop: CA/LTC Empire State Plaza Albany, NY 12237	**1-888-201-4563**	**518-408-1157**	24 hours / 7 days per week	24 hours / 7 days per week
Aetna Better Health Special Investigations Unit (SIU)	**1-800-338-6361** (follow the prompts)	NA	24 hours / 7 days per week	24 hours / 7 days per week
Health Plan Compliance Hotline	**1-855-456-9125**	NA	24 hours / 7 days per week	24 hours / 7 days per week
NYS Office of Advocate for Persons with Disabilities **http://cqc.ny.gov/**	**1-800-624-4143**	NA	Online 24 hours / 7 days per week	Online 24 hours / 7 days per week
NYC Mayor's Office for People with Disabilities **http://www.nyc.gov/html/mopd/html/home/home.shtml**	**212-788-2830** or TTY **212-788-2838**	**212- 341-9843**	NA	NA

Important Addresses

Aetna Better Health (Provider Claim Disputes)	Aetna Better Health Attention: Provider Relations Manager PO Box 818089, Cleveland, OH 44181-8089.
Aetna Better Health (Claims Submission & Resubmission)	Aetna Better Health PO Box 982972 El Paso, TX 79998-2972

CHAPTER 3: PROVIDER RESPONSIBILITIES AND GENERAL INFORMATION

Aetna Better Health's network providers have many responsibilities that are referred to throughout this manual. This chapter describes provider responsibilities in detail, along with general information for all providers.

Provider Relations and Support

Provider Relations Representatives serve as liaisons between providers and Aetna Better Health, working to maintain open and ongoing communications. Providers can call **1-855-456-9126** to be connected with a knowledgeable Provider Relations Representative who will answer questions and assist them in meeting requirements and obtaining necessary information.

Provider Orientation

Aetna Better Health provide s initial orientation for newly contracted providers after they join our network. Aetna Better Health conducts the orientation either through group sessions, webinars, or during visits to individual provider offices. Sessions cover various topics, such as benefits, member and provider responsibilities, administrative processes, provider tools/resources, regulatory requirements, and Aetna Better Health contact information.

Adherence to the Provider Agreement & Terminations

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

Providers who have been excluded from participation in any federally or state-funded health care programs are not eligible to become network providers with Aetna Better Health.

Aetna Better Health is legally obligated to report to the appropriate professional disciplinary agencies within 30 days of the occurrence of any of the following:

- Termination of a provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.
- The voluntary/involuntary termination of contract/employment or other affiliation with such organization to avoid the imposition of disciplinary measures.
- The termination of a provider contract in the case of a determination of fraud or in a case of imminent harm to member wellbeing.

Aetna Better Health is also legally obligated to report to the appropriate professional disciplinary agency within sixty (60) days of obtaining knowledge of any information that reasonably appears to show that a provider is guilty of professional misconduct.

Aetna Better Health will follow the procedures outlined by the New York State Department of Health when terminating or electing not to renew a contract with a network provider. Upon termination, a written explanation will be sent to the provider outlining the reasons for termination along with information on how the provider can request a review hearing and the associated

timeframes. Aetna Better Health may immediately terminate a provider contract if the provider presents imminent harm to a member's wellbeing, has actions against his/her license, or in the case of fraud or malfeasance. Upon non-renewal, Aetna Better Health will provide a sixty (60) day notice to the provider. Non-renewal of a contract does not constitute a termination.

Additional Provider Responsibilities

- The provider must cover the services outlined in the MLTC program.
- The provider must provide services in accordance with generally accepted standards of professional/member services.
- The provider must adhere to the access standards set forth by Aetna Better Health.
- The provider may act as the member's advocate. Please note that Aetna Better Health will not terminate a provider contract if they advocate on behalf of a member, file a complaint against the plan, appeal a decision, request a hearing or review or provide information filed in a report to PHL 4406-c regarding prohibitions of plans.
- The provider must be in good standing with the New York State Department of Health's programs or applicable licensing/certification board.
- The provider may file a grievance on a member's behalf with the member's written consent.
- The provider must practice culturally competent care by understanding the disability, racial, ethnic, and cultural differences between the provider and member. The provider must alleviate barriers to accessing and receiving high-quality services and supports. The provider must also demonstrate a willingness and ability to make the necessary distinction between traditional and non-traditional treatment methods.
- The provider agrees not to bill any Aetna Better Health members for services covered under the MLTC Contract.
- The provider shall not unlawfully discriminate on the basis of age, race, color, gender, gender identity, creed, religion, disability, sexual orientation, source of payment, type of illness, condition or place of origin.
- The provider must comply with the following record retention requirements:
  - The provider must make records available to Aetna Better Health, MLTC program, NYSDOH, and HCFS, its members, and their authorized representatives within ten (10) working days of the record request.
  - The provider must maintain current records for each MLTC member, including documentation of all services provided to the member as well as verification of services coordinated by the Care Manager.
  - The provider must comply with all applicable laws and regulations pertaining to the confidentiality of member records, including, but not limited to, obtaining any requiredwritten member consents to disclose confidential records for complaint and appeal review.
  - The provider must retain member records for at least ten years after the last date of last service.

- The provider must disclose the required information; at the time of application; credentialing and/or recredentialing; and/or upon request in accordance with 42 C.F.R.§ 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP, and/or other Federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions; percentage calculations; and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.
- The providers must not hold members liable for payment of any fees that are the legal obligation of Aetna Better Health, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna Better Health to service such members, as long as the member follows Aetna Better Health's rules for accessing services described in the approved Member Handbook.
- If Aetna Better Health fails to pay the provider, the provider will not seek payment from the New York State Department of Health or our members.
- The provider must notify Aetna Better Health sixty days prior to terminating their agreement with Aetna Better Health.
- The provider must comply with marketing standards as set forth in 42 CFR§ 438.104 and applicable State Laws.
- The provider must notify the member's PCP and the Aetna Better Health Care Manager following any emergency procedures.

  Please note that an Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (b) serious impairment to such person's bodily functions; or (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Licensed Home Care Services Agencies (LHCSAs) Responsibilities

Licensed Home Care Services Agencies are responsible for providing part-time, intermittent personal care, attendant care, homemaker, or in-home respite services to members who require such assistance based on their individual care and service plan. Additional responsibilities include:

- Coordination with Aetna Better Health Care Managers
- Receiving service authorizations from Aetna Better Health Care Managers
- Obtaining physician orders required to meet member needs adhering to the care plan developed by Aetna Better Health's Care Managers
- Overseeing the activities of direct-service staff
- Ensuring staff is properly trained in meeting the Department of Health'srequirements

All LHCSAs who provide home care services such as attendant care, personal care, homemaker, and in-home respite are required to provide Aetna Better Health with a completed Non-Provision of Services Log for home care services each month. This log would be due to the Care Manager by the 10th day of the following month.

A gap in home care services is defined as the difference between the number of hours of home care services scheduled in each member's care plan and the hours of home care services that are actually delivered to the member.
Home care services received in the member's home are inclusive of such tasks as bathing, toileting, dressing, feeding, transferring to or from a bed or wheelchair, and assistance with similar daily activities. Please note that Licensed Home Care Services Agencies must provide home health services in accordance with applicable provisions of the regulations of the New York State Department of Health (10 NYCRR 505.23) and with federal regulations governing home health services (42 CFR§ 440.70 and Part 484).

Durable Medical Equipment (DME) and Other Medical Supply Providers' Responsibilities

- Obtaining proper physician orders for supplies prior to delivery to members.
- For members who have other health care coverage such as Medicare, covered DME supplies should be billed to the member's primary payer.
- For supplies not covered by another payer, ensure that a prior authorization request has been approvedby Aetna Better Health for any DME supplies provided.
- Follow the timeframe for delivering supplies to members.

After-Hours Care
Aetna Better Health requires network home care providers to have established after-hours care or have on-call arrangements with qualified providers on a 24-hours-a-day, 7-days-a-week basis. Provider's after-hours care cannot be offered by an answering machine in lieu of a live response.

Reimbursement
Aetna Better Health reimburses its contracted providers according to the Department of Health's fee schedule or other contracted rates. The type of reimbursement you receive and the services you are eligible to provide are part of your agreement. To view the state of New York's fee schedule for the Managed Long Term Care (MLTC) program visit **http://www.health.state.ny.us/facilities/long_term_care/reimbursement/**. Contact your Provider Relations Representative with any further questions.

Billing of Members
Providers may not collect copayments or deductibles from our Aetna Better Health members or bill members for covered services. If a member is requesting a non-covered service, the provider must advise the member, prior to initiation of service, that the service is uncovered and explain what the service will cost the member.

Availity Provider Portal
Aetna Better Health's HIPAA-compliant web portal is available 24 hours-a-day for providers.

Effective 1/19/2021 Aetna Better Health will begin using the Availity Provider Portal.
Provider Portal Benefits include:

- Payer Spaces
- CHC Claim Submission Link
- Contact Us & Messaging
- Claim Status Inquiry
- Grievance Submission
- Appeals Submission
- Grievance and Appeals Status
- PDM
- Ambient (Business Intelligence Reporting)
- Clear Claim
- ProPAT
- Provider Intake
- Dynamo (Case Management)
- CareBridge (ABHMI only)

Future functionality will be released throughout 2021 and until released in Availity these can be accessed using the current web portal. This includes:

- Prior Authorization submission and status lookup
- Eligibility & Benefits
- Enhanced G&A tool
- Panel Roster
- Remit PDF
- Enhanced (electronic) Remit Viewer

- If you are already registered in Availity, you will simply **log in** and select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

- If you are not registered, we recommend that you do so immediately.
  - Click here to learn more about Availity Portal Registration [**https://apps.availity.com/availity/Demos/Registration/index.htm**]
  - Click here to register [**https://www.availity.com/provider-portal-registration**]
  - For registration assistance, please call Availity Client Services at **1-800-282-4548** between the hours of 8 AM and 8 PM Eastern, Monday-Friday (excluding holidays)

Secure Provider Web Portal Log in: **AetnaBetterHealth.com/ny/providers/secure-portal**

For additional information, contact your Provider Relations Representative or call **1-855-456-9126**.

Mandated Reporting for Suspected Maltreatment of Members
As mandated by New York Public Health Law §§ 2801, 2803-d (2009), all persons who work or have any contact with Aetna Better Health MLTC program members are required to report any suspected incidents of physical abuse, neglect, mistreatment, and any other form of maltreatment.

Examinations to Determine Abuse or Neglect
When a State agency notifies Aetna Better Health of a potential case of neglect and/or abuse of a

MLTC program member, Aetna Better Health Care Managers will work with the agency and the Primary Care Practitioner (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health will also notify the appropriate regulatory agency.

Cultural Competency Training & Resources

Cultural competency refers to the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding toward enhancing the effectiveness of health care delivery to diverse populations.

Members are entitled to receive covered services without concern for race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, genetic information, medical history, or ability to speak English.

Aetna Better Health expects contracted providers to treat all members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication with different cultural groups, and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter.

Providers receive cultural competency education in topics such as:

- History of the disability rights movement and the progression of civil rights for people with disabilities
- Physical and programmatic barriers that can prevent people with disabilities from accessing meaningful care
- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices)
- The problem of health illiteracy and the need to provide members with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- Historical experience with American medicine and a reluctance to access services (e.g., the Tuskegee experiments, current racial disparities in health services)

Investigating Fraud and Abuse

If Aetna Better Health receives reports of potential fraud and abuse, our staff will document the information and issue a tracking number. Aetna Better Health will report the information to the Department of Health and other appropriate investigative and law enforcement agencies whether or not the fraud and abuse allegation has been resolved internally.

Special Investigations Unit (SIU)
Aetna's Special Investigation Unit SIU has a national toll-free fraud hotline: **1-800-338-6361** for members and providers who may have questions, seek information, or want to report potential fraud-related problems. The hotline has proven to be an effective tool and Aetna Better Health encourages Managed Long Term Care (MLTC) program members, providers, and contractors to use it.

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

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

Some examples of health care provider fraud and abuse include:

- Billing or charging members for services that Aetna Better Health covers
- Offering members gifts or money to receive treatment or services
- Offering members free services, equipment, or supplies in exchange for use of an Aetna Better Health member ID number
- Providing members with treatment or services that they do not need

Documentation and Audit of Records
Visits with our members, authorizations, contacts, member education, advance directives, or follow-up with members should be documented and maintained in the member's record. Notations regarding follow-up for canceled and missed services should also be evident. Records must be signed, dated, and legible. Providers must safeguard the member's Personal Health Information (PHI).

Records may be requested from a provider when Aetna Better Health is researching complaints, grievances, requests for a Department of Health Fair Hearing, or quality of care issues. It is important that these requests be responded to promptly and within the timeframes requested. See Chapter 10 for more information regarding member complaints, grievances, and the fair hearing process.

Aetna Better Health will conduct routine audits of records to see that documentation meets standard requirements. In addition, providers must grant the Department of Health or other governmental entities timely access to books, records, or other information for purposes of audits, investigations, inspections, or reviews.

See Chapter 3 for additional provider "record" responsibilities.

Credentialing/Re-credentialing
Aetna Better Health bases its credentialing and re-credentialing processes on nationally recognized accreditation standards as well as applicable state and federal requirements. Our credentialing/re-credentialing process includes primary source verification consistent with NCQA, Utilization Management Standards of the American Accreditation Healthcare Commission (URAC), and CMS standards as well as Aetna's national credentialing requirements. The Credentialing and Performance Committee credentials and re-credentials designated individual providers. Aetna Better Health conducts provider credentialing prior to participation and re-credentials providers every three years.

Upon request, application procedures and minimum qualification requirements will be made available to the provider.

Sample Forms
Aetna Better Health produces a number of forms for providers to expedite and standardize administrative functions. Provider orientation includes a review of these forms. If you have any questions or would like assistance in completing forms, please contact your Provider Relations Representative at **1-855-456-9126**.
For sample forms visit: **AetnaBetterHealth.com/NY/providers/forms**

Americans with Disabilities Act (ADA)
Title III of the Americans with Disabilities Act (ADA) mandates that all public accommodations be accessible to individuals with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

HIPAA Notice of Privacy Practices
Aetna Better Health maintains strict privacy and confidentiality standards for member records and member health care information in accordance with federal and state standards. Providers can access up-to-date Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices on our website at **AetnaBetterHealth.com/NY**. This includes explanations of members' rights to access, amend, request confidential communication, request privacy protection, restrict use and disclosure, and receive an accounting of disclosures of protected health information (PHI).

Confidentiality Requirements
Providers are required to comply with federal, state, and local laws and regulations governing the confidentiality of medical information, including laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses member records and confidential provider and member information, whether oral or written in any form or medium.

Member Rights and Responsibilities
Treating a member with respect and dignity is a good business practice and often can improve outcomes. Your agreement with Aetna Better Health requires compliance with member rights

and responsibilities, including treating members with respect and dignity. Aetna Better Health's Provider Relations Department is available to help you understand member rights and responsibilities and to answer your questions.

Understanding members' rights and responsibilities is important because you can help members to better understand their role in complying with treatment or care plans. Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

Member Rights

- Member have the Right to be treated with respect and dignity.
- Member have the Right to receive medically necessary care.
- Member have the Right to request to change their Care Manager.
- Member have the Right to timely access to care and services.
- Member have the Right to privacy about their medical record and when they get treatment.
- Member have the Right to get information on available treatment options and alternatives presented in a manner and language they understand.
- Member has the Right to get information in a language they understand; they can get oral translation services free of charge.
- Member has the Right to get information necessary to give informed consent before the start of treatment.
- Member has the Right to get a copy of their medical records and ask that the records be amended or corrected.
- Member has the Right to take part in decisions about their health care, including the right to refuse treatment.
- Member has the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Member has the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- Member has the Right to be told where, when and how to get the services they need from the managed long-term care plan, including how they can get covered benefits from out-of-network providers if they are not available in the plan network.
- Member has the Right to complain to the New York State Department of Health or their Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- Member has the Right to appoint someone to speak for them about their care

  and treatment. Member Responsibilities
- Learn and understand each Right they have under the Managed Long Term Care program.
- Ask questions if they do not understand their Rights.

- Know the name of their Primary Care Provider (PCP) and their Care Manager.
- Know about their health care and the process for gettingcare.
- Use providers who work with Aetna Better Health for covered services.
- Get approval from their Primary Care Provider, Care Manager or Care Management Team, as required, before getting a covered service.
- Know when they should and should not go to the emergency room.
- Contact their Care Management Team any time you use the Emergency Room, are hospitalized, get new prescriptions or receive a referral for another medical provider.
- Treat the health care professionals respectfully.
- Tell Aetna Better Health about care needs, concerns, questions, or problems.
- Give health care providers all the information they need.
- Ask for more information if member does not understand their treatment or health condition(s).
- Participate in managing their own health by telling their provider about their health care concerns and needs.
- Notify Aetna Better Health when they go away or out of town.
- Make all required payments to Aetna Better Health.
- Follow their Care Manager's advice or talk to their Care Manager if they are unable or are unwilling to follow the care plan.
- Protect their member ID card and show it when they get service.
- Tell Aetna Better Health about any other insurance they have.
- Tell Aetna Better Health if they are applying for other health care benefits.
- Contact their Care Management Team or Member Services toll free at **1-855-456-9126** right away if their address or phone number changes.

Home Care Worker Wage Parity Law

This law established a minimum wage requirement for home care aides in New Yok City, Nassau, Suffolk, and Westchester counties. Certified home health agencies (CHHAs), long-term home health care programs (LTHHCPs), licensed home care service agencies (LHCSAs), limited licensed home care service agencies (LLHCSAs), Consumer Directed Personal Assistance Services (CDPAS) and other organizations that employ home care aides in New York City or in Nassau, Suffolk or Westchester County are required to provide Aetna Better Health with quarterly written certification of your organization's compliance with the minimum wage requirement of the Hoe Care Work Wage Parity as required in Public Health Law of §3614-c. This certification must also be sent to New York State Department of Health Annually. This information can be found at **https://www.health.ny.gov/health_care/medicaid/redesign/2016/2016-02-17_wage_parity_alert.htm**.

Quarterly Certification are due to Aetna Better Health on March 1, June 1, September 1, and December 1 of each year. Certification should be sent to **NY_Prdocuments@aetna.com** or can be faxed to **860-607-8331**.

CHAPTER 4: BENEFITS

Under the Managed Long Term Care (MLTC) program, Aetna Better Health is responsible for administering the following covered services:

Covered Services*

Adult Day Health Care	Occupational Therapy
Audiology/Hearing Aids	Personal Care including: ▪ Assistance with Bathing, Eating, and Dressing ▪ Household Services ▪ Meal Shopping and Preparation
Care Management	Personal Emergency Response System (PERS)
Dental Services	Physical Therapy
Private Duty Nursing	Podiatry
Home Care including: ▪ Nursing ▪ Home Health Aide ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Pathology ▪ Medical Social Services	Durable Medical Equipment & Supplies including: ▪ Medical/Surgical Supplies ▪ Enteral and Parenteral Formula ▪ Hearing Aid Batteries ▪ Prosthetics ▪ Orthotics ▪ Orthopedic Footwear.
Home Delivered or Congregate Meals (provided through care management)	Respiratory Therapy
Non-Emergency Transportation	Social and Environmental Supports (provided through care management)
Nursing Home Care (Short Term Stay)	Social Day Care (provided through care management)
Nutrition	Speech Therapy
Vision Services including: ▪ Eyeglasses and Contact Lenses; and ▪ Visits with an Optometrist.	

*Some benefits have limitations set by the New York State. You can get the latest information on **http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-09.htm**

Aetna Better Health will only pay for covered services. Call our Member Services Department for information about exclusions and limitations. A list of covered services will also be available online via our website at **AetnaBetterHealth.com/NY**.

Transportation
Transportation services are offered to Aetna Better Health members. If a member has questions about transportation services, please instruct them to call our Member Services Department at **1-855-456-9126**.

Dental
Dental services are provided through LIBERTY Dental Plan. If a member has questions about their dental care benefits, please instruct them to call LIBERTY Dental Plan at **1-855-225-1727**

Vision
Vision service are provided through EyeQuest. If a member has questions about their vision care benefits, please instruct them to call EyeQuest at **1-888-696-9551**.

Medical Necessity
Services must meet medical necessity criteria and most services require prior authorization. Medical necessity criteria are guidelines that help Aetna Better Health make decisions about appropriate care for specific circumstances. When appropriate, Aetna Better Health uses evidence-based clinical guidelines.

You can view a current list of the services that require authorization on our website at **AetnaBetterHealth.com/NY/providers/information/prior**
Covered services must be provided in accordance with your agreement with Aetna Better Health. From time to time a covered service may be changed. If you have questions about covered services, visit our website at **AetnaBetterHealth.com/NY** or call **1-855-456-9126**. Aetna Better Health will give you at least 60 days advance notice of any changes to the Managed Long Term Care (MLTC) program, including new services, expanded services, or eliminated services. You will be notified by one or more of the following methods: provider newsletter, e-mail, updates to the Aetna Better Health website, letter (U.S. Mail), telephone call, or office visit.

Aetna Better Health works with the New York State Department of Health (NYSDOH) and its vendors to coordinate services that are covered by entities other than Aetna Better Health. If you have an Aetna Better Health member who needs one or more of these services and you are not sure how to reach an (NYSDOH) vendor, please contact our Member Services Department at **1-855-456-9126**.

CHAPTER 5: ENROLLMENT & ELIGIBILITY

Potentially eligible individuals who have been referred to Aetna Better Health, or who otherwise indicate that they are interested in enrolling in Aetna Better Health's MLTC program, will be contacted by a Member Services Representative who will arrange for an in-home assessment. An RN will conduct the assessment within 10 business days, using the state mandated SAAM tool (or any other instrument subsequently approved by the Commissioner of Health). During the assessment process, Aetna Better Health will also evaluate applicants to determine if they are capable (at the time of enrollment) of living in their home or community setting without jeopardizing their health or safety, based on criteria provided by the New York State Department of Health.

For additional member enrollment or eligibility criteria, please contact Provider Relations at **1-855-456-9126** or review the Member Handbook online at **AetnaBetterHealth.com/NY**.

CHAPTER 6: MEDICAL MANAGEMENT

Aetna Better Health's MLTC program focuses on relationship building; promoting choice among members and caregivers; and assisting in the coordination of the full continuum of physical; behavioral; social; financial; and environmental care and services. The objective is to assure that members receive care in the most integrated, least-restrictive community setting compatible with optimal functioning and personal preferences.

Identifying Members Needs

Once identified as a candidate or potential candidate for MLTC services, a clinically licensed and experienced Assessment Registered Nurse (RN) will conduct an initial face-to-face home visit to explain services in detail and obtain an Enrollment Agreement and complete a comprehensive evaluation of the individual in the community using the state-mandated SAAM instrument to determine eligibility (i.e., Medicaid-eligible with a need for long- term services and supports for at least 120 days) considering:

- The individual's overall health, functionality, and ability to perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Communication/sensory patterns
- Emotional and cognitive functioning, including orientation to surroundings and behavior (e.g., wandering, aggression)
- The individual's social, environmental, and financial circumstances
- The availability of informal supports
- Whether the individual is able to remain in his or her home or in a community setting without jeopardizing health or safety
- The need for referrals for physical and/or behavioral health care services in addition to long-term care services and supports

If the individual is determined eligible for the MLTC program and is enrolled with Aetna Better Health, the Care Management team will initiate the member-centric care/service planning process. The member will be assigned to a Care Management team that will utilize assessment tools to gain a perspective of the member's status. The case formulation and subsequent care plan will be developed through collaboration with the member, the assigned Care Management team, and caregiver. As appropriate, the Care Management Team will also consult with the member's PCP, specialist providers, and other relevant professionals involved in the member's care.

Aetna Better Health's assessment process is holistic, focusing on the individual's medical, social, cultural, financial, and environmental circumstances and long-term care needs.

If the individual is determined ineligible, Aetna Better Health will notify the individual, the Human Resources Administration, Local District Social Services (HRA/LDSS), and other appropriate entities and refer the member to other community resources for assistance.

Care Management Teams

Aetna Better Health's Care Management teams will be responsible for coordinating members' care throughout the continuum of covered and non-covered services. They will employ a number of strategies to accomplish this objective, including:

- **Communicating with Members and their Informal Support Systems**: Care Management teams will regularly communicate with members and members' families/caregivers telephonically, online, and during in-person visits to discuss an array of issues relating to the member's health and well-being, including physician visits, medications, therapies, nutrition, member safety, etc. As needed, Care Management teams will make referrals, schedule appointments, arrange out-of-network access, arrange transportation, and conduct follow-up discussions with the member and/or provider.
- **Communicating with Providers:** Ideally, Care Management teams will regularly confer with treating providers and other professionals involved in the delivery of covered and non-covered services to support their prescribed course of treatment and ensure that authorized long-term services and supports are consistent with the member's health-related needs and preferences. They will also collaborate with the member's physicians/practitioners in the development of the care/service plan and keep them up-to-date with any updates, modifications, and revisions to the member's plan of care and authorized services.
- **Telephonic or In-Person Visits**: The Care Management team will contact the member on a monthly basis. The Assessment RN will conduct an in-person visit every 180 days and as the member's condition requires. Aetna Better Health's Care Management team will conduct an evaluation of our members at their residences to perform assessments, confer with the member's informal supports, evaluate the residence for safety issues (e.g., rugs or step ladders that could contribute to falls), and ensure that the member's care plan remains responsive to the member's needs and preferences. Aetna Better Health's Managed Long-Term Care (MLTC) program provides necessary tools to evaluate and re-evaluate members in their home settings. The Care Management team may also consult with Aetna Better Health's Medical Director and the member's treating providers/practitioners about any health-related questions or concerns, schedule any necessary appointments and follow-up visits, and revise the member's plan of care/service as needed.

Authorization Requests from Members and Providers

Once a care and service plan has been implemented, members and providers may submit a request to their Care Management team to add a new service or support or to modify existing services and supports. If the request is to modify an existing service or support, the Care Management team will work with the member, the member's informal supports, and other stakeholders (e.g., requesting provider) to evaluate the medical necessity and appropriateness of the request. As needed and appropriate, Care Management teams may also consult with a Care Management Supervisor or Manager during this process.

For covered ancillary medical services not previously authorized in the member's care/service plan, the member's provider will submit a request for authorization. These services include nursing care, PT/OT/Speech, podiatry, audiology, and vision. Aetna Better Health's Medical Management staff will review the request for medical necessity and either approve or pend the request for further review, as appropriate. Only the Medical Director can deny a clinically related service authorization request or approve a reduction, suspension, or elimination of an existing medical service.

Aetna Better Health will process service authorization requests and issue written member and provider notifications within state-mandated timeframes or notify via telephonically, as follows:

Decision	**Decision/notification timeframe**	**Notification to**	**Notification method**
Expedited Prior Authorization	3 business days from request for service	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Standard Prior Authorization	Within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Standard Concurrent Review	Within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Expedited Concurrent Review	Within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services	Member	Telephonic and Written
		Provider if indicated	Electronic and Written
Post-service	30 calendar days from receipt of the request.	Member	Oral and Written
		Provider if indicated	Electronic and Written
Termination, Suspension, or Reduction of Service Authorization	At least 10 Calendar Days before the date of the action.	Member	Oral and Written
		Provider if indicated	Electronic and Written

In the case of a request for Medicaid-covered home health care services following an inpatient admission, the request will be processed within one (1) business day after receipt of necessary information, except when the day subsequent to the request for services falls on a weekend or holiday, in which case the request will be processed within seventy-two (72) hours after receipt of necessary information. In any event, the timeframe will be no more than three (3) business days after receipt of the request for services.

CHAPTER 7: QUALITY MANAGEMENT

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

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

Aetna Better Health's QM program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM process enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions and refining the interventions as necessary

The use of data in the monitoring, measurement, and evaluation of quality and appropriateness of care and services is an integral component of Aetna Better Health's quality improvement process. Aetna Better Health's QM program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization, and committees from the Board of Directors to the Member Advisory Council. This structure allows members and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. The Medical Director is supported in this effort by our QM Department and the Quality Management and Utilization Management (QM/UM) Committee.

Major functions of the QM/MM Committee are to:

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

Additional committees such as Service Improvement Committee (SIC), Credentialing, Appeals/Grievance, and Quality Management Oversight Committees (QMOC) further support our QM program. Aetna Better Health encourages provider participation on key medical committees. Providers may contact the Medical Director or inform their Provider Relations Representative if they wish to participate. You can reach Aetna Better Health by calling **1-855-456-9126**.

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

Aetna Better Health's QM Department is an integral part of Medical Management and internal operations. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards and recommend and promote improvements in the delivery of service to our members. Our QM and MM departments maintain ongoing coordination and collaboration regarding quality initiatives and care management activities involving the care of our members.

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

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

- **Formal Feedback from External Stakeholder Groups**: Aetna Better Health takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS), or focus groups with individuals, such as members and families, providers, and state and community agencies.
- **Findings from External Program Monitoring and Formal Reviews***:* Externally initiated review activities, such as an annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process assists Aetna Better Health in identifying specific program activities/processes needing improvement.
- **Internal Review of Individual Member or Provider Issues**: In addition to receiving grievances and appeals from members, providers, and other external sources, Aetna Better Health proactively identifies potential quality of service issues for review through daily operations (i.e. member services, prior authorization, and care management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services, and quality of care), Aetna Better Health is able to identify specific opportunities for improving care delivered to individual members.
- **Findings from Internal Program Assessments:** Aetna Better Health conducts a number of formal assessments/reviews of program operations and providers that are used to identify opportunities for improvement. This includes, but is not limited to: provider record reviews of contracted providers, credentialing/re-credentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment, and assessment of provider accessibility and availability.

- **Clinical and Non-Clinical Performance Measure Results:** Aetna Better Health uses an array of clinical and non-clinical performance standards (e.g., call center response times, and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results; Aetna Better Health is able to identify opportunities for improvement in clinical and operational functions. These measures include:
    - Adherence to nationally recognized best practice guidelines and protocols
    - Service authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals)
    - Provider availability and accessibility, including:
        - Length of time to respond to requests for referrals
        - Timeliness of receipt of covered services
        - Timeliness of the implementation of members' care plans
        - Availability of 24/7 telephonic assistance to members and caregivers receiving home care services
- **Data Trending and Pattern Analysis**: With our innovative information management systems and data mining tools, Aetna Better Health makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- **Other Service Performance Monitoring Strategies**: Aetna Better Health uses a myriad of monitoring processes to ensure effective delivery of services to all of our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health monitors include, but are not limited to:
    - High-cost, high-volume, and problem prone aspects of the long-term care services our members receive
    - Effectiveness of the assessment and service planning process, including its effectivenessin assessing a member's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization
    - Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services

Potential Quality of Care (PQoC) Concerns

Aetna Better Health has a process for identifying PQoC concerns related to Home and Community-Based Services (HCBS), researching and resolving these care concerns in an expeditious manner, and following up to make sure needed interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna Better Health tracks and trends PQoC cases and prepares trend reports that we organize according to provider, issue category, referral source, number of verified issues, and closure

levels. Aetna Better Health will use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Credentialing and Performance Committee, or identify the need for possible quality improvement initiatives.

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

- Target improvement in areas that will address a broad spectrum of key aspects of members' care and services over time
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Better Health enrollment in terms of demographic characteristics, prevalence of disease, and potential consequences (risks) of the disease

Our MM Department prepares PIP proposals that are reviewed and approved by our Medical Director, the QM/MM Committee, and the Quality Management Oversight Committee (QMOC) prior to submission to the New York State Department of Health for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health, as well as from providers who are members of our QM/MM Committee.

The QM Department also conducts an ongoing evaluation of the study indicator measures throughout the length of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance, Aetna Better Health immediately conducts additional analyses to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until Aetna Better Health achieves real and sustained improvement.

Peer Review
Peer review activities are evaluated by the Credentialing and Performance Committee. Providers who have been reviewed and disagree with the results are given an opportunity to appeal the committee's recommendation.
Written appeals stating the reasons why the provider does not agree may be submitted. At any time, the provider may request any and all profiling data that was used during the provider's performance evaluation.

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

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

Member Satisfaction Surveys
Aetna Better Health conducts an annual survey to assess the level of member satisfaction with Aetna Better Health's programs, customer service(s), and network. Aetna Better Health is responsible for reporting progress on improvement activities and/or corrective action plans to the QM Committee, QMOC, and Board of Directors if results are below Aetna Better Health goals, state-required goals, national benchmarks, or if results show a significant decline compared to previous years.

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

External Quality Review (EQR)
External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.S.C. 1396u–2] for states to contract with an independent external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness, and access to services. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

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

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

CHAPTER 8: ADVANCE DIRECTIVES

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

New York advance directives include:

- Living Will
- Health Care Proxy

Additionally, physicians can also assist members in the preparation of a Medical Orders for Life Sustaining Treatment form. The DOH 5003 MOLST (Medical Orders for Life Sustaining Treatment) form should be completed by a physician and can be accessed at the following links:

- **http://www.health.state.ny.us/forms/doh-5003.pdf**
- **http://www.health.state.ny.us/professionals/patients/patient_rights/molst/**

Do Not Resuscitate (DNR) orders are located at the following link:

- **http://www.health.state.ny.us/forms/doh-3474.pdf**

Provider Responsibility

Providers are required to comply with federal and state laws regarding advance directives, as well as contractual requirements regarding advance directives for adult members. In addition, Aetna Better Health requires that nursing home providers obtain and maintain advance directives information in the member's medical record.

Requirements for providers shall include (when appropriate):

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

Aetna Better Health provides information about advance directives to members in the Member Handbook, in the welcome packet, and through discussions with our Care Coordinators, including the member's right to make decisions about their medical care, advantages of having advanced directives, how to obtain assistance in completing or filing a living will, a MOLST, health care proxy, DNRs, and general instructions. For additional information or complaints regarding noncompliance with advance directive requirements, contact Aetna Better Health at 1-855-456-9126. In addition, you can find advance directive information and forms specific to New York at:

- **http://www.health.state.ny.us/professionals/patients/patient_rights/**
- **http://www.nyc.gov/html/doh/html/hca/advance-directives.shtml**
- **http://www.nylag.org/total_life.htm**
- **http://www.noah-health.org/en/rights/endoflife/adforms.html**

Note: Aetna Better Health is not responsible for the content or updating of these websites.

CHAPTER 9: BILLING PROCEDURES

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules, and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in Medicaid, or any program under federal law, or is not in good standing with the New York State Department of Health.

Provider Billing

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

Acceptable Claims Forms

Aetna Better Health requires providers to use one of the following forms when submitting claims:

- A CMS 1500 (formerly HCFA 1500) billing form is used to submit claims for professional services.
- Home health care, skilled nursing, and nursing home room and board must be billed on the UB-04 billing form.

Completing a CMS 1500

The CMS 1500 billing form is used to submit claims for professional services.

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

Completing the UB-04

The UB-04 form is used when billing for facilities services, including nursing home room and board.

Claims Submission

Providers can submit electronic claims to Change Healthcare by accessing

https://www.changehealthcare.com/

Note: use the following Change Healthcare Payer ID: 34734

Providers can submit hard copy claims directly to Aetna Better Health via mail to the following address:

Aetna Better Health
PO Box 982972
El Paso, TX 79998-2972

Aetna Better Health requires clean claim submissions for processing. 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. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Aetna Better Health requires that clean claims be submitted within 120 days from the date of service. Aetna Better Health will consider a claim for resubmission only if it is re-billed in its entirety.

Claims Payment Time Frames
Aetna Better Health processes clean claims according to the following time frames:

- 90% of clean EDI claims will be adjudicated within 30 days of receipt
- 99% of clean paper claims will be adjudicated within 45 days of receipt

If applicable, providers paid on a capitation basis will be paid according to the time period specified in your provider agreement with Aetna Better Health. Providers have a maximum of 120 days from the date of service for initial submission of a claim.

Claims Resubmission
Providers have 180 days from the date of remittance to resubmit a claim. Providers must include the nature of the request, member's name, date of birth, member identification number, service/admission date, location of treatment, service or procedure, documentation supporting request, copy of claim, and a copy of remittance advice on which the claim was denied or incorrectly paid. Providers must additionally stamp or write one of the following labels on the claim if resubmitting a paper claim:

- Resubmission
- Rebill
- Corrected bill
- Corrected
- Rebilling

For electronic resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid. Providers can resubmit hard copy claims directly to Aetna Better Health via mail to the following address:
Aetna Better Health
PO Box 982972
El Paso, TX 79998-2972

Important Requirements for Billing

Personal Emergency Response System
All bills for Personal Emergency Response Systems shall contain a dated certification by the provider that the care, services, and supplies itemized have in fact been furnished.

Home Health Agencies
No payment will be made unless the claim for payment is supported by documentation of the time spent providing services to each member.

Additional Billing Requirements as noted in Title 18, Section 540.7:
http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/0fe0d9931726c4f4852 56722007691a2?OpenDocument

Medicare and Other Primary Payer Sources
Eligible Aetna Better Health members can access services that are covered by Medicare through fee-for-service Medicare or a Medicare Advantage product. Generally, members with comprehensive third party insurance are considered to be an excluded population from the Aetna Better Health Managed Long-Term Care program.

For the Managed Long-Term Care (MLTC) program, Aetna Better Health is the payer of last resort for Medicaid- covered MLTC services. As applicable, providers must bill third party insurance before submitting a claim to Aetna Better Health. Aetna Better Health will pay the difference between the primary insurance payment and the Aetna Better Health allowable amount. Providers cannot balance bill members.

If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to Aetna Better Health for a coverage determination.

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

If a service is non-covered or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for members where third party insurance is indicated will be denied in most cases. Provider have a maximum of 365 days from the date of the EOB for Coordination of Benefits.

If assistance with the billing of third party payers is required, please contact a Provider Relations Representative at **1-855-456-9126**.

To prevent denials for coding mismatches, claims submitted to the primary carrier on a form that differs from Aetna Better Health's requirements should be clearly marked with "COB Form

Type Conversion."

Overpayment/Underpayment:
Aetna Better Health provides 30 days written notice to health care providers before engaging in overpayment recovery efforts, allowing the health care provider the opportunity to challenge the recovery, unless the recovery is for duplicate payment.

Claims Inquiries
Providers can check claims status through our HIPAA-compliant web portal, which is available 24 hours a day for providers and members at **AetnaBetterHealth.com/NY**. The portal supports the following functions and access to information related to:

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

Providers can also check the status of claims by contacting the Provider Relations Department at **1-855-456- 9126**.

Provider Claims Disputes
Providers can submit claims disputes directly to Aetna Better Health via mail to the following address:

Aetna Better Health of New York
PO Box 818089, Cleveland, OH 44181-8089.

The provider must include the following:

- A completed Provider Dispute Form (available on our website)
- Nature of the request (legal and factual basis for dispute)
- Member's name, date of birth, and member identification number
- Service/admission date
- Location of treatment, service, or procedure
- Clinical information and/or records/documentation supporting request
- Copy of claim
- Copy of remittance advice on which the claim was denied or incorrectly paid

Aetna Better Health has a procedure to resolve claim disputes. This process is described in Chapter 10 of this Manual regarding Grievances, Appeals, and State Fair Hearings.

CHAPTER 10: GRIEVANCE SYSTEM

Members can file a complaint/grievance, grievance appeal, appeal, State Fair Hearing, or State External Appeal if they are not satisfied. A network provider, acting on behalf of a member, and with the member's written consent, may file a complaint/grievance, grievance appeal, appeal, State Fair Hearing, or State External Appeal.

Upon completion of the appeal process, members or their representative may request a State Fair Hearing through the New York State Office of Temporary and Disability Assistance at 1-518-473-1090 within sixty (60) calendar days of the date of Aetna Better Health's Appeal Decision Letter. In addition, for Appeal Decisions that involve an issue of medical necessity or related to an experimental or investigational service, the member or the member's representative may request a State External Appeal within forty-five (45) calendar days of the date of Aetna Better Health's Appeal Decision Letter. If a member files for both a State Fair Hearing and an External Appeal, the decision of the Fair Hearing takes precedence.

Aetna Better Health informs members and providers of the Grievance System procedures for filing a grievance, a grievance appeal, appeal, State Fair Hearing, and State External Appeal in the Member Handbook and Provider Manual and on the Aetna Better Health website. When requested, Aetna Better Health will give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Grievances

Members or their representatives may submit a grievance in writing or orally to any Aetna Better Health staff. Upon receipt, the staff member who received the grievance will complete the appropriate documentation and make a good faith effort to resolve the matter immediately (Same Day Grievance) or forward it to the Grievance System Manager to research and resolve. Grievances that are resolved immediately do not require further acknowledgement but will be documented and tracked and trended consistent with our quality assurance process.

If the grievance is unable to be resolved immediately, the staff member who received the grievance will inform the member that further research is needed and that a written acknowledgment of the grievance will be sent within fifteen (15) business days following receipt of the grievance. If Aetna Better Health succeeds in resolving the issue before the written acknowledgment is sent, we will send one notice with the Acknowledgement and the Decision.

In most cases, the resolution of a Standard Grievance is reached within 45 calendar days of receipt of all necessary information, not to exceed sixty (60) calendar days from the date the grievance was received. The timeframe may be extended up to fourteen (14) calendar days at the request of the member or their representative, including a provider. If Aetna Better Health is unable to resolve a grievance within sixty (60) calendar days, we may ask to extend the grievance decision date by fourteen (14) calendar days. Aetna Better Health will send a written notice of the extension within the original sixty (60) calendar days to the member and the member's representative and, upon request, to New York State Department of Health (SDOH), explaining why the extension is in his or her best interest.

If Aetna Better Health determines, or the provider indicates, that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the grievance will be processed as an Expedited Grievance within forty-eight (48) hours of receiving all necessary information, but no more than seven (7) calendar days from the date the grievance was received. If Aetna Better Health is unable to resolve an expedited grievance within seven (7) calendar days, we may ask to extend the grievance decision date by fourteen (14) calendar days. Aetna Better Health will send a written notice of the extension within the original seven (7) calendar days to the member and the member's representative and, upon request, to SDOH, explaining why the extension is in his or her best interest.

Aetna Better Health will make reasonable efforts to issue an oral notice on expedited grievances and will issue written Notices of Decision within three (3) business days of the decision for all grievances. The Notice of Resolution will include the decision reached and the reasons for the decision and the telephone number and address where the member can speak with someone regarding the decision. The notice will also include instructions about the member's right to file a grievance appeal.

Grievance Appeal

Members have the right to file a grievance appeal within sixty (60) business days of receiving a Notice of Grievance Decision. The grievance appeal must be submitted to Aetna Better Health in writing either in a letter or on a standard form that we will provide to the member. Following receipt, Aetna Better Health staff will determine whether the appeal is standard or expedited. A member or a provider acting on the member's behalf can also request an expedited review of the appeal.

Aetna Better Health will send a written acknowledgment of the grievance appeal within fifteen (15) business days following receipt. If Aetna Better Health succeeds in resolving the issue before the written acknowledgment is sent, we will send one notice with the Acknowledgement and the Decision. Aetna Better Health will process the appeal as quickly as the member's condition requires, but no more than thirty (30) business days following the receipt of all necessary information for a Standard Grievance Appeal and no more than two (2) business days following the receipt of all necessary information for an Expedited Grievance Appeal.

Aetna Better Health will mail a written Notice of Decision to the member and provider (if applicable) within three (3) business days of the decision. The notice will include the reason for the determination, including the clinical rationale if the grievance appeal was clinical in nature. Members cannot further appeal Aetna Better Health's determination of a grievance appeal.

Appeal of an Action

In contrast to a "grievance appeal," an "appeal" is a request for a review of an action taken by Aetna Better Health. Members or their designated representative, including providers acting on behalf of the member with written consent, may submit an appeal orally or in writing within forty-five (45) calendar days of the postmarked date of Aetna Better Health's Notice of Action. If the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and the services were ordered by an authorized provider and the original period covered by the original authorization has not expired and the member requests extension of the

benefits, benefits will continue if the appeal was requested within ten (10) calendar days of Aetna Better Health's sending the notice of action or the intended effective date of our proposed action.

Aetna Better Health's Notice of Action informs the member of the following:

- Our decision and it's reasoning
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file an appeal by phone
- The procedures for exercising the rights to appeal or request a State Fair Hearing
- That the member may represent himself or designate a legal counsel, relative, friend, provider, or other spokesperson to represent them
- The specific regulations that support the decision, or the change in Federal or State law that requires the action
- An explanation that when a continuation of benefits is requested by the member:
    - Benefits will continue if the member files an appeal or a request for a State Fair Hearing within the time frames specified for filing
    - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member

Members may appeal the decision and request a further review of Aetna Better Health's actions. Examples of appeals include:

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

Members may file an appeal by:

- Calling Member Services at **1-855-456-9126** or the NY Relay **7-1-1**
- Writing Aetna Better Health at:

Aetna Better Health of New York
PO Box 81139,
5801 Postal Road
Cleveland, OH 4418

Aetna Better Health will send a written acknowledgment of the appeal within fifteen (15) calendar days of receipt. Oral appeals will be treated the same as written appeals to establish the earliest possible submission date. If submitted orally, Aetna Better Health will include a summary of the appeal in the written acknowledgment letter. If Aetna Better Health succeeds in resolving the issue before the written acknowledgment is sent, we will send one notice with the Acknowledgement and the Decision.

If the member requests that services continue while the appeal is being processed, Aetna Better Health will continue the services until sooner of:

- Appeal is withdrawn.
- The original authorization period has expired.
- If the appeal is denied, until ten (10) days after the appeal decision has been mailed, unless the member has requested a NYS Fair Hearing with continuation of services.

Expedited Appeal
Following receipt of the appeal, Aetna Better Health will make a determination as to whether a delay in processing poses serious jeopardy to the member's life or health or ability to attain, maintain, or regain maximum function. In this case, it must be treated as an expedited appeal. Aetna Better Health will further expedite all appeals relating to a concurrent review of a service authorization request.

Members may also request an expedited review of the appeal. If Aetna Better Health denies the member's request for an expedited review, our staff will make reasonable efforts to issue an oral notice of denial of an expedited review, and we will follow up with a formal written notice within two (2) calendar days of receipt of the expedited appeal request. The appeal will then be transitioned to our standard appeal processing time and the appeal will be decided as fast as the member's health condition requires, not to exceed thirty (30) calendar days. If the member objects to the denial for an expedited appeal, he or she may file a grievance (see above).

Aetna Better Health will process Expedited Appeals within two (2) business days following receipt of necessary information, not to exceed three (3) business days following receipt of the request for appeal. Members or the member's designated representative, including providers acting on behalf of the member with written consent, may request an extension for up to fourteen (14) calendar days. Aetna Better Health may ask to extend the appeal decision date by fourteen (14) calendar days if there is adequate justification of a need for additional information and the extension is in the member's interest. Aetna Better Health will send a written notice of the extension within the original three (3) business days to the member and the member's representative and, upon request, to SDOH, explaining why the extension is in his or her best interest.

Standard Appeal
Aetna Better Health will process Standard Appeals no later than thirty (30) calendar days following receipt of the appeal request. Members, or the member's designated representative, including providers acting on behalf of the member with the member's written consent, may request an extension for up to fourteen (14) calendar days.

Aetna Better Health may ask to extend the appeal decision date by fourteen (14) calendar days may if there is adequate justification of a need for additional information and the extension is in the member's interest. Aetna Better Health will send a written notice of the extension within the original thirty (30) calendar days to the member and the member's representative and, upon request, to SDOH, explaining why the extension is in his or her best interest.

Aetna Better Health will make reasonable efforts to issue an oral notice on expedited appeals and will issue written Notices of Decision within two (2) business days for all appeals. The notice will include an explanation of the member's right to request a State Fair Hearing as well as instructions for requesting a Fair Hearing, who can appear at the hearing on the member's behalf, and, as applicable, the member's right to request a continuation of services while the State Fair Hearing is pending (i.e., services continuing).

If members wish, and the matter relates to an issue of medical necessity or an experimental or investigational service, they may file for a State Fair Hearing and/or an External Appeal. If a member files both, the State Fair Hearing decision takes precedence.

Filing a State Fair Hearing or a State External Appeal will not negatively affect or impact the Aetna Better Health member or providers who treat the member. Aetna Better Health will ensure that punitive action is not taken in retaliation against a member or a provider acting on the member's behalf who requests a standard or expedited appeal or grievance.

Failure to Make a Timely Decision

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

State Fair Hearing

Upon completion of the appeal process, members may request a State Fair Hearing from NYS within sixty (60) days of the date of Aetna Better Health's Appeal Decision Letter. If applicable, members may also request a continuation of services while the State Fair Hearing is pending by checking a box on the State Fair Hearing request form and submitting the request within ten (10) calendar days of the date of the Notice of Decision or by the intended effective date of Aetna Better Health's action to reduce, suspend, or terminate the member's services, whichever occurs later. Under these circumstances, Aetna Better Health will continue the services until:

- The appeal is withdrawn
- The original authorization period for the services ends
- If the State Fair Hearing Officer upholds Aetna Better Health's action, Aetna Better Health may recover the cost of the services furnished to the member while the appeal and subsequent State Fair Hearing was pending.

If the State Fair Hearing Officer decides in the member's favor, Aetna Better Health will authorize the disputed services promptly and as soon as his or her health condition requires. If the member was receiving continued services pending the State Fair Hearing, Aetna Better Health will be responsible for payment.

To request a State Fair Hearing, members must submit a request for a State Fair Hearing to the NYS Office of Temporary and Disability Assistance:

- Online through their website; or
- Through the mail; or
- Call **1-518-473-1090** (Voice) or **1-877-502-6155** (TTY) toll free.

To submit a request in writing, members should mail the completed State Fair

Hearing form to: Fair Hearing Section
NYS Office of Temporary and Disability Assistance
PO Box 22023
Albany, NY 12201-2023

State External Appeals
Whether or not a member files for a State Fair Hearing, if the Appeal Decision Letter involves an issue of medical necessity or relates to an experimental or investigational service, the member may file at no charge for a State External Appeal within forty-five (45) calendar days of the date of Aetna Better Health's Appeal Decision Letter. External Appeals are reviewed by state-approved individuals with the appropriate credentials who do not work for either Aetna Better Health or the state.

Standard External Appeals are decided within thirty (30) calendar days, with a possible five (5) day extension if the reviewer requires additional information. The reviewer will issue a Notice of Decision to the member and Aetna Better Health within two (2) business days after the decision is reached.

A member's provider may also request an expedited External Appeal if a delay may cause serious harm to the member's life or health or ability to attain, maintain, or regain maximum function. Expedited External Appeals are decided within three (3) calendar days or less and the Notice of Decision will be issued to the member and Aetna Better Health immediately via phone or fax followed by a formal written notification.

Again, if a member files for both a State Fair Hearing and an External Appeal, the decision in the Fair Hearing takes precedence.

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

Aetna Better Health will inform providers about the dispute resolution process through the Provider Manual and other avenues, including newsletters, training sessions, provider orientation, and the website. Providers can also obtain information about the provider dispute process by calling their Provider Relations Representative. Aetna Better Health's Provider Relations Representatives are available to discuss a provider's dissatisfaction with a decision based on this policy and contractual provisions, inclusive of claim disputes.

In the case of a claim dispute, the provider must complete and submit the Provider Dispute Form and any appropriate supporting documentation to Aetna Better Health's Provider Relations Manager. The Provider Dispute Form is accessible on Aetna Better Health's website **AetnaBetterHealth.com/NY/providers/forms**, via fax, or by mail.

Following receipt, the Provider Relations Manager will assign the Provider Dispute Form to a Provider Relations Representative for research, analysis, and review. Claims disputes are delegated to the Claims Investigation Department for research, analysis, and review. Aetna Better Health will mail a written notice of its decision to the provider.

In the event the provider remains dissatisfied with the dispute determination, the provider will be notified that a complaint may be initiated. Aetna Better Health's Complaint System policy and the Aetna Better Health Provider Manual include a description of the process by which the provider can submit a complaint.

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

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

An acknowledgement letter will be sent within three (3) business days summarizing the complaint. The letter will include instruction on how to:

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

If the complaint requires research or input by another department, the Appeals and Grievance Manager will forward the information to the relevant department and work collaboratively to thoroughly research the issue using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures. The complaint and all related documents will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider from the same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will then consider all relevant information and render a decision.

Management of the Process
The Grievance and Appeals Department has the overall responsibility for the management of the member grievance and appeals process. This includes:

- Documenting individual grievances and appeals
- Coordinating resolutions
- Maintaining the appeals and grievance database

The Quality Management (QM) Department has oversight responsibility for the member grievance and appeals process. This includes:

- Reviewing individual grievances and appeals
- Tracking, trending, and reporting data
- Identifying opportunities for improvement

The Aetna Better Health Appeals and Grievance Manager will serve as the primary contact person for the grievance and appeals process, with the Aetna Better Health QM Coordinator serving as the back-up contact person.

The Member Services Department, in collaboration with the QM and Provider Relations Departments, is responsible for informing and educating members and providers about a member's right to file a grievance or appeal or request a State Fair Hearing and for assisting members in filing a grievance or appeal or in requesting a State Fair Hearing.

Members are advised of their grievance, appeals, and State Fair Hearing rights and processes at the time of enrollment and at least annually thereafter. Providers receive this information via the Provider Manual, during provider orientation, within the provider agreement, and on Aetna Better Health's website.

Appendix: I - III

I: Benefits

Covered Services, Authorizations, and Billing Requirements.

1.1 Medical Adult Day Health Care

Approval Needed	*Billing*
• Medical review – clinical documentation required • Aetna Better Health Prior Authorization Required • MD Script	• Claim Form: UB04

1.2 Audiology/Hearing Aids

Approval Needed	*Billing*
• Medical review – clinical documentation required • Aetna Better Health Prior Authorization Required • MD Script	• Claim Form: CMS 1500

1.3 Dental Services

Approval Needed	*Billing*
Dental services are provided through LIBERTY Dental Plan. If a member has questions about their dental care benefits, please instruct them to call LIBERTY Dental Plan at 1-855-225-1727	

1.4 Durable Medical Equipment & Supplies including

Approval Needed	*Billing*
• Medical review – clinical documentation required • Aetna Better Health Prior Authorization Required • MD Script	• Claim Form: CMS 1500
**For Dually eligible members an authorization is not required from Aetna Better Health when claim is for Coordination of Benefits requesting payment of the Medicare 20% Co-pay.* **Authorization is required for all other DME Equipment and Supplies*	

1.5 Home Care Aide Services

Including Home Health Aides (HHAs), Personal Care Aide (PCAs) and Consumer Directed personal Assistant Services (CDPAS)

Approval Needed	Billing
• Medical review – clinical documentation required • Aetna Better Health Prior Authorization Required • MD Script	• Claim Form: UB04
Home Care aide services are not approved and will not be authorized during the time a member is at Adult /Social day and Dialysis treatment	

1.6. Home Delivered or Congregate Meals

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required	• Claim Form: CMS 1500

1.7 Nursing Care: Skilled Nursing Facility

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required (when the plan is the Primary Payer)	• Claim Form: UB04

- The services covered in the Nursing Home per diem rates can be found at: https://www.health.ny.gov/facilities/nursing/all_services.htm
- The plan uses Code Set #2 of the Standard Nursing Home Managed Care billing codes

Standardized Nursing Home Managed Care Billing Codes

Service	Code Set #1	Code Set #2
Custodial Nursing Home Care	100	120
Discrete Specialty:AIDS	160	160
Discrete Specialty: Ventilator Dependent	169	101
Discrete Specialty: Neurobehavioral	124	124
Discrete Specialty: TBI	121	199
Discrete Specialty: Pediatric	123	123
Hospitalization Bed Hold	185	185
Other Leave of Absence Bed Hold	183	183
Therapeutic Bed Hold (authorized by medical professional)	189	189
Respite (Scheduled Short Term Care)	663	663

1.8 Nutrition Services (Nutritional Supplements)_

Approval Needed	*Billing*
• Medical review – clinical documentation required • Aetna Better Health Prior Authorization Required • MD Script	• Claim Form: CMS 1500

1.9 Optometry/Vision Services including: (*Eyeglasses and Contact Lenses; and visits with an Optometrist*)

Approval Needed	*Billing*

1.10 Personal Emergency Response Systems (PERS)

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required	• Claim Form: CMS 1500

1.11 Podiatry

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required	• Claim Form: CMS 1500
**For Dually eligible members an authorization is not required from Aetna Better Health when claim is for Coordination of Benefits requesting payment of the Medicare 20% Co-pay.* **Authorization is required for all other Podiatry Supplies*	

1.12 Rehabilitation Services *(including Occupational, Speech, and Physical therapies provided by a certified home health agency or licensed rehabilitation facility)*.

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required • MD Script • Medical review – clinical documentation required	• Claim Form: CMS 1500 or UB04
**For Dually eligible members an authorization is not required from Aetna Better Health when claim is for Coordination of Benefits requesting payment of the Medicare 20% Co-pay.*	

1.13 Respiratory Therapy

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required • MD Script • Medical review – clinical documentation required	• Claim Form: CMS 1500

1.14 Social Day Care

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required	• Claim Form: UB04

1.15 Social Day Care Transportation

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required	• Claim Form: CMS 1500
**1 Unit = 1 One-way trip* **2 units = Round Trip*	

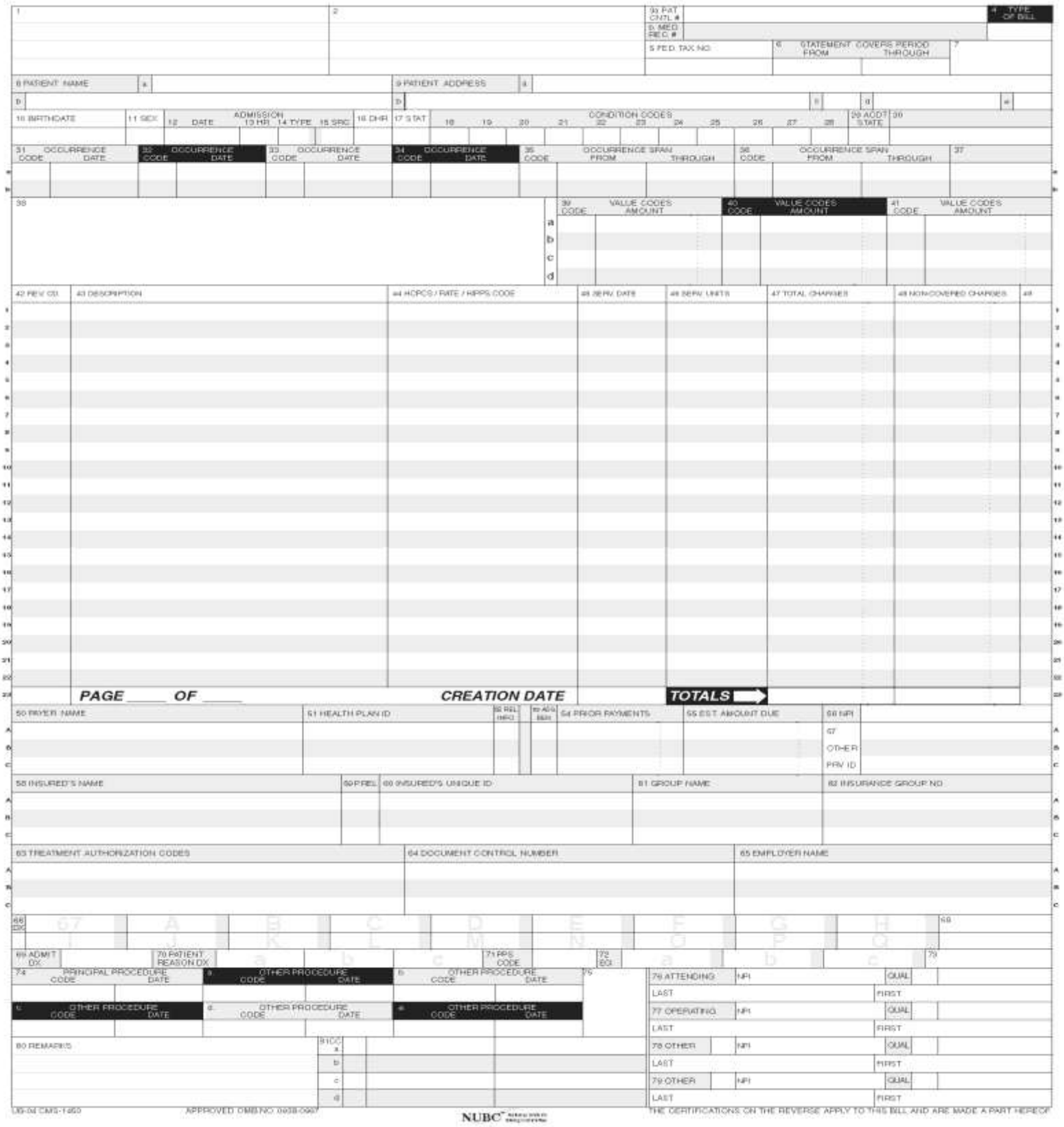
1.16 Skilled Nursing Care at Home

Approval Needed	*Billing*
• Medical review – clinical documentation required • Aetna Better Health Prior Authorization Required • MD Script	• Claim Form: UB04

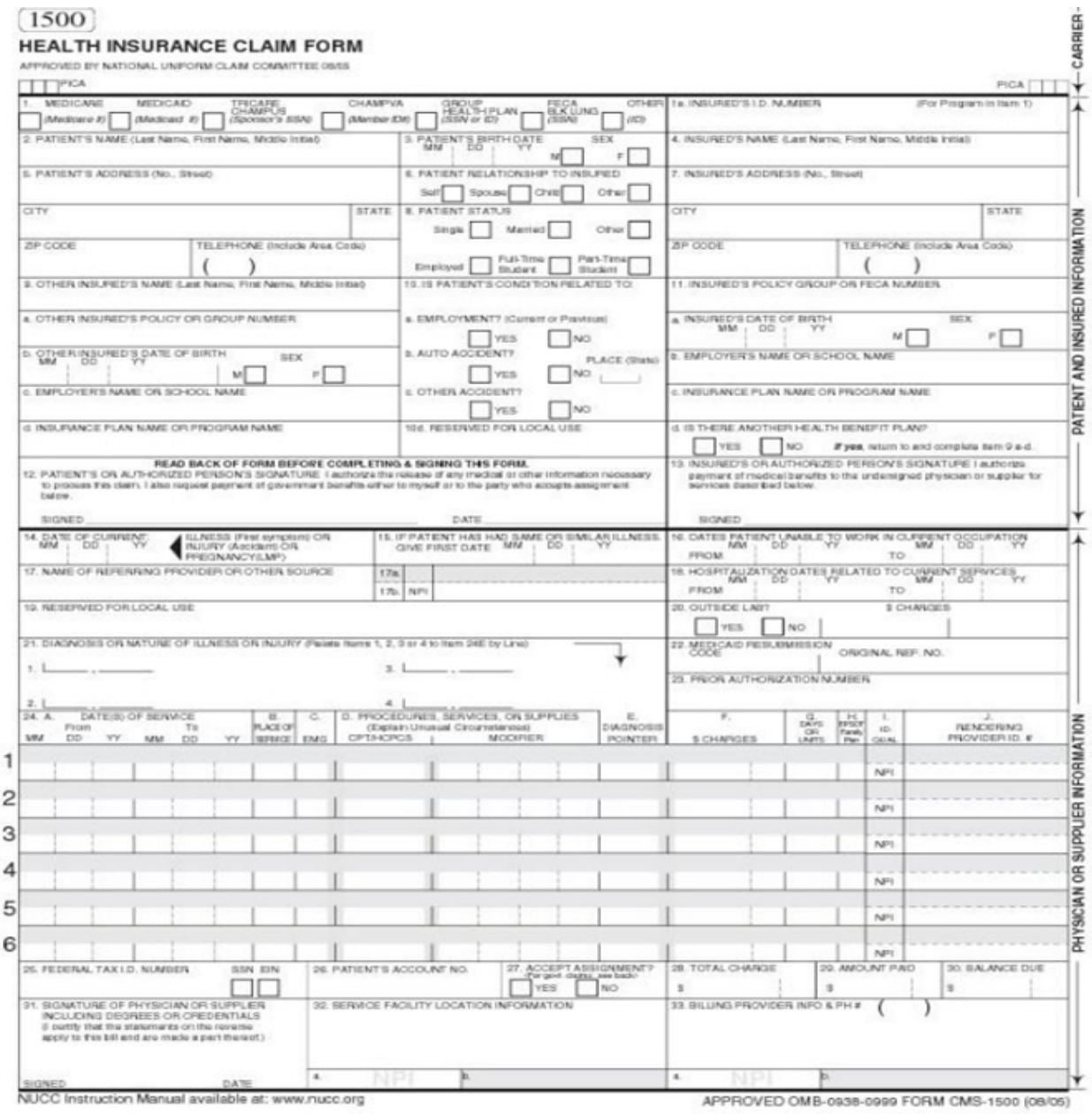
1.17 Social and Environmental Supports

Approval Needed	*Billing*
• Aetna Better Health Prior Authorization Required • MD Script • Medical review – clinical documentation required	• Claim Form: CMS 1500

II: Standard CMS Claim Forms
UB-04



CMS 1500 Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

III: Field Placement and Instructions

Attachment B – Field placement and Instructions			
Field	**Field description**	**Field type**	**Instructions**
1	Facility name, Address, Telephone Number, and Country Code	Required	This field contains the complete Servicing address (the address where the services are being performed/rendered) and telephone And/or fax number. This must be a Street address.
2	Pay-to Name and Address	Conditional	This field contains the address to which payment should be sent if different from the information in Field 1. Please be sure this matches what you submitted on You're credentialing documents.
3a	Patient Control Number	Conditional	Complete this field with the patient account number assigned by the provider that allows for the retrieval of individual patient Records.
3b	Medical/ Health Record Number	Conditional	In this field, report the patient's medical record number as Assigned by the provider.

4	Type of Bill	Required	This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient or outpatient. The **First digit** is a leading zero. The **Second digit** is the type of facility. The **Third digit** classifies the type Of care being billed. The **Fourth digit** indicates the sequence of the bill for a specific episode of care.

5	Federal Tax Number	Required	Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN).
6	Statement Covers Period "From" and "Through"	Required	Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.
7	Reserved for Assignment by the NUBC	Not Required	N/A
8a	Patient Identifier	Conditional	This field is for the patient's Identification number. Only required if the patient's ID on their identification card is different than the subscriber's.
8b	Patient Name	Required	This field is for the patient's last, middle initial and first name.
9a	Patient Address	Required	This field is for entering the Patient's street address. Please comply with US Postal service guidelines for all addresses.
9b	(unlabeled field)	Required	This field is for entering the Patient's city.
9c	(unlabeled field)	Required	This field is for entering the patient's state code as defined by The US Postal Service.
9d	(unlabeled field)	Required	This field is for entering the Patient's ZIP code.

9e	(unlabeled field)	Required	This field is for entering the Patient's Country Code.
10	Patient Birth date	Required	This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Sex	Required	Use this field to identify the sex of the patient.
12	Admission Date / Start of Care Date	Required	Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated.
13	Admission Hour Conditional	Required	For some accounts including all Medicaid claims. Enter the hour in which the patient is admitted for inpatient or outpatient care. **NOTE**: Enter using Military Standard Time (00 – 23) in top of- the-hour times only.
14	Priority (Type) of Visit	Conditional or Required for some accounts including all Medicaid claims.	Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section.
15	Source of Referral for Admission or Visit	Conditional Required for some accounts including all Medicaid claims	This field contains a code that identifies the point of patient origin for this admission or visit. See valid codes at the end of this section.
16	Discharge Hour	Conditional Required for some accounts	This field is used for reporting the hour the patient is discharged

		including all Medicaid claims.	from inpatient care. **NOTE**: Enter using Military Standard Time (00 – 23) in topof- the-hour times only.
17	Patient Discharge Status	Conditional Required for some accounts including all Medicaid claims.	Use this field to report the status of the patient upon discharge –required for institutional claims. See valid codes at the end of this section.
18 – 28	Condition Codes	Conditional	Use these fields to report conditions or events related to the bill that may affect the processing of it.
29	Accident State	Conditional	When appropriate, assign the two digit abbreviation of the state in which an accident occurred.
30	Reserved for Assignment by the NUBC	Not Required	N/A
31 – 34	Occurrence Codes and Dates	Conditional	The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.).
35 – 36	Occurrence Span Codes and Dates	Conditional	This field is for reporting the beginning and end dates of the specific event related to the bill.
37	Reserved for Assignment by the NUBC	Not Required	N/A

38	Responsible Party Name and Address	Required	This field is for reporting the name and address of the person Responsible for the bill.
39 - 41	Value Codes and Amounts	Conditional	These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is qualified by all payers.
42	Revenue code	Required	Use this field to report the appropriate *HIPAA* compliant numeric code corresponding to each narrative description **or** standard abbreviation that identifies a specific accommodation and/or ancillary service.
43	Revenue Description	Optional	This field contains a narrative description or standard abbreviation for each revenue code category reported on this claim. .
44	HCPCS / Rate / HIPPS Code	Conditional	This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system.
45	Service Date	Required	Indicates the date the outpatient service was provided and the date the bill was created using the six digit format (MMDDYY).

46	Service Units	Required	In this field, units such as pints of blood used, miles traveled and the number of inpatient days is reported.
47	Total Charges	Required	This field reports the total charges – covered and non-covered – related to the current billing period.
48	Non-Covered Charges	Conditional	This field indicates charges that are non-covered charges by the payer as related to the revenue code.
49	Reserved for Assignment by the NUBC	Not Required	N/A
50a, b, c	Payer Name	Conditional	If more than one payer is responsible for this claim, enter the name(s) of primary, secondary and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers.
51a, b, c	Health Plan Identification Number	Not Required	This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected.
52a, b, c	Release of Information Certification Indicator	Required	Enter the appropriate code denoting whether the provider has on file a signed statement from the patient or the patient's legal

			representative to release information. Refer to Attachment B for valid codes.
53a, b, c	Assignment of Benefits Certification Indicator	Conditional	Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.
54a, b, c	Prior Payments	Conditional	Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.

55a, b, c	Estimated Amount Due	Not required	Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.
56	National Provider Identifier- Billing Provider Conditional	Required	For some accounts including any Medicare and Medicaid plans. This field is for reporting the unique provider identifier assigned to the provider.
57	Other Provider Identifier – Billing Provider	Not Required	The unique provider identifier assigned by the health plan is reported in this field.
58a, b, c	Insured's Name (last, first name, middle initial)	Required	The name of the individual who carries the insurance benefit is Reported in this field. Enter the last name, first name and middle Initial. THIS MUST MATCH THE NAME ON THE INSURED'S IDENTIFICATION CARD
59a, b, c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.

60a, b, c	Insured's Unique Identification	Required	This is the unique number the health plan assigns to the insured individual. THIS MUST MATCH THE ID ON THE MEMBER'S IDENTIFICATION CARD.
61a, b, c	Group Name Preferred		Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured.
62a, b, c	Insurance Group Number	Conditional	Enter the plan or group number for the primary, secondary and tertiary payer through which the coverage is provided to the insured.
63a, b, c	Treatment *Authorization* Codes	Conditional	Enter the *authorization* number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized.
64a, b, c	Document Control Number	Not Required	from the Provider This number is assigned by the health plan to the bill for their internal control.
65a, b, c	Employer Name (of the Insured)	Conditional	Enter the name of primary employer that provides the coverage for the insured indicated in Field 58.
66	*Diagnosis* and Procedure Code Qualifier (*ICD* Version Indicator)	Required	This qualifier is used to indicate the version of *ICD*-9-CM being used. A "9" is required in this field for the *UB-04*. 10 should be used when *ICD*-10 is implemented as required by *CMS.*
67	Principal *Diagnosis Code*	Required	Required Enter the valid *ICD*-9-CM *diagnosis code*

			(including fourth and fifth digits if applicable) that describes the principal *diagnosis* for services rendered. *ICD*-10 should be used when implemented as required by *CMS*.
67 a - q	Other *Diagnosis Codes* / Present on Admission Indicator (POA)	Conditional	This field is for reporting all *diagnosis codes* in addition to the principal *diagnosis* that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The *ICD*-9 (*ICD*-10 when implemented) completed to its fullest character must be used. The present on admission (POA) indicator applies to *diagnosis codes* (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health Reporting. It is the eighth digit attached to the corresponding *Diagnosis code*.
68	Reserved for Assignment by the NUBC	Not Required	N/A

69	Admitting *Diagnosis*	Required	Enter a valid *ICD*-9-CM (*ICD*-10 when implemented) *diagnosis code* (include the fourth and fifth digits if applicable) that describes the

			diagnosis of the patient at the time of admission.
70 a – c	Patient's Reason for Visit	Conditional	The *ICD*-9-CM (*ICD*-10 when implemented) codes that report the reason for the patient's Outpatient visit is reported here.
71	Prospective Payment System (PPS) Code	Not required	This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan using DRG codes

72	External Cause of Injury (ECI) Code	Not Required	In the case of external causes of injuries, poisonings, or adverse effects, the appropriate *ICD*-9-CM *diagnosis code* is reported in this Field.
73	Reserved for Assignment by the NUBC	Not Required	N/A
74	Principal Procedure Code and Date	Conditional	This field contains the *ICD*-9-CM (*ICD*-10 when implemented) code for the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date on which the principal procedure was performed
74 a – e	Other Procedure Codes and Dates	Conditional	This field allows reporting up to five *ICD*-9-CM (*ICD*-10 when implemented) procedure codes to identify the significant procedure performed during the billing period and the related dates.

75	Reserved for Assignment by the NUBC	Not Required	N/A
76	Attending Provider Names and Identifiers	Required	This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim.
77	Operating Physician Name and Identifiers	Conditional	Report the name and identification number of the physician responsible for performing surgical procedure in this field.
78 – 79	Other Provider Names and Identifiers	Conditional	This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category.
80	Remarks	Not Required	This field is used to report additional information necessary to process the claim.
81 a – d	Code – Code	Conditional	This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the Institutional data set.

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Type of Bill Codes (Field 4)

This is a three-digit code; each digit is defined below.

First Digit -	
Leading Zero	0XXX
Second Digit –	**Description of Second Digit**
Type of Facility	**01**XX Hospital
	02XX Skilled Nursing
	03XX Home Health Facility
	04XX Religious Non-medical Health Care Institutions
	05XX Reserved for National Assignment by the NUBC
	06XX Intermediate Care (not used for Medicare)
	07XX Clinic (Requires Special Reporting for the Third Digit)
	08XX Special Facility or ASC Surgery (Requires Special Reporting for the Third Digit)
	09XX Reserved for National Assignment by the NUBC
Third Digit –	**Description of Third Digit**
Bill Classification	**Except for Clinics and Special Facilities**
	0X**1**X Inpatient (Including Medicare Part A)
	0X**2**X Inpatient (Medicare Part B Only) (Includes HHA Visits Under a Part B Plan of Treatment)
	0X**3**X Outpatient (Includes HHA Visits Under a Part A Plan of Treatment Including DME Under Part A)
	0X**4**X Laboratory Services Provided to Non-Patients, or Home Health Not Under a Plan of Treatment
	0X**5**X Intermediate Care Level 1 0X**6**X Intermediate Care Level II

	0X**7**X Reserved for National Assignment by NUBC
	0X**8**X Swing Beds
	0X**9**X Reserved for National Assignment by NUBC
Third Digit-	**Description of Third Digit**
Bill Classification	**Classification for Clinics Only**
	0X**1**X Rural Health Clinic
	0X**2**X Clinic – Hospital Based or Independent Renal Dialysis Center
	0X**3**X Freestanding
	0X**4**X ORF
	0X**5**X CORF
	0X**6**X CMHC
	0X**7**X Federally Qualified Health Center (FQHC) (effective April 1, 2010)
	0X**8**X Reserved for National Assignment by NUBC
	0X**9**X Other
Third Digit	**Description of Third Digit**
Bill Classification	**Classification for Special Facility Only**
	0X**1**X Hospice (Non-hospital based)
	0X**2**X Hospice (Hospital based)
	0X**3**X Ambulatory Surgery Center
	0X**4**X Freestanding Birthing Center
	0X**5**X Critical Access Hospital
	0X**6**X Residential Facility (Not used for Medicare)

	0X**7**X Reserved for National Assignment by NUBC
	0X**8**X Reserved for National Assignment by NUBC
	0X**9**X Special Facility - Other (Not used for Medicare)
Fourth Digit –	**Description of Fourth Digit**
Frequency of the Bill	0XX**0** Nonpayment / Zero Claim
	0XX**1** Admit through Discharge Claim
	0XX**2** Interim – First Claim
	0XX**3** Interim – Continuing Claim (Not valid for Medicare PPS Claims
	0XX**4** Interim – Last Claim (Not valid for Medicare Inpatient Hospital
	0XX**5** Late Charges Only Claim
	0XX**6** Reserved for National Assignment by NUBC
	0XX**7** Replacement of Prior Claim
	0XX**8** Void / Cancel of a Prior Claim

Sex Codes (Field 11)

Code Definition	F Female
	M Male
	U Unknown

Type of Admission Code (Field 14)

Code Definition	1 Emergency
	2 *Urgent*
	3 Elective
	4 Newborn
	5 Trauma Center

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