Aetna Better Health® of Oklahoma

Provider Engagement and Provider Relations
Orientation - 2024

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Orientation agenda

- Introduction
- Mission, vision and values
- Our members, your patients
- Value based services
- Care management
- Health risk screening
- Behavioral health
- How we connect with providers
- Credentialing
- Quality
- EPSDT
- Pharmacy
- Prior authorizations
- Concurrent review
- Access to care guidelines
- Abuse, neglect and exploitation
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- Claims, Availity and provider portal
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- Appeals & grievances
- Contacting **Aetna Better Health®**
- Resources
- **Aetna Better Health®** team
- Continue medical education
- Attestation

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Provider-Led Entity

Our **Aetna Better Health® Provider-Led Entity** (PLE) is comprised of a majority of key Local Oklahoma Provider Organizations (LOPOs) that reflect a fully integrated behavioral health, physical health, Tribal, foster care, urban and rural model. This Governing Body will have the ultimate responsibility and authority to oversee the Aetna PLE SoonerSelect contract with OHCA.

Aetna Better Health® recognizes the diversity of needs and barriers presented by a statewide contract in Oklahoma. Building a health plan to serve all of Oklahoma requires a flexible, field-based approach that adapts to address the unique needs, expectations, and requirements of our members.

Aetna Better Health® provides a Governing Body (our Aetna Provider-Led Entity (PLE) alongside Clinical and Quality Committees, **focused on the needs of every Oklahoma member**. Our Aetna PLE's Governing Body structure will ensure comprehensive oversight of our clinically integrated health plan, member benefit delivery, access to care, and improved quality and accountability in care delivery.

With deep roots in the Oklahoma health care system, they will advise on implementation strategy and conduct outreach with Oklahoma providers on the benefits of health care.

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Aetna Better Health® of Oklahoma's Mission

Aetna Better Health® is looking forward to serving Oklahomans and partnering with health systems, providers, FQHCs and community resources to bring quality healthcare to the state through our experience and dedication in serving SoonerSelect populations.

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

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

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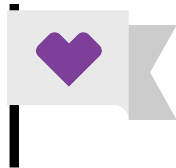
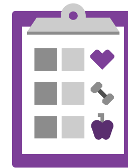
Oklahoma's SoonerSelect

Aetna Better Health® is proud to have been selected by OHCA to provide quality care and programs through SoonerSelect to qualified Oklahomans as one of the selected contracted entities.



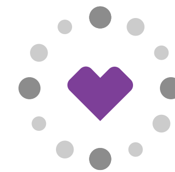
OHCA vision

Our vision is for Oklahomans to be healthy and to have **access** to quality health care services regardless of their ability to pay.



OHCA mission

Our mission is to responsibly purchase state and federally-funded health care in the most efficient and comprehensive manner possible; to analyze and recommend strategies for optimizing the accessibility and quality of health care; and, to cultivate relationships to improve the health outcomes of Oklahomans.



OHCA five key principles

- Passion for purpose
- Empowering and accountability
- Trust and transparency
- Best in class and outcome-driven
- Servant leadership

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General requirements

Provider agreements are executed in accordance with all applicable state and federal statutes, regulations, policies, procedures and rules.

Under the terms of provider agreements, participating providers shall agree that all applicable terms and conditions set in contracts, any incorporated documents, solicitations and all applicable State and federal laws, as amended, govern the duties and responsibilities of participating providers with regard to the provision of services to members.

The information included in this orientation is meant to support requirements detailed in contractual agreements, state and federal terms and conditions. Including but not limited to **Aetna Better Health®** provider manual, policy and procedures, websites, and other resources.

Note: There may be other training and education as required/requested by OHCA or any other State or federal agency.

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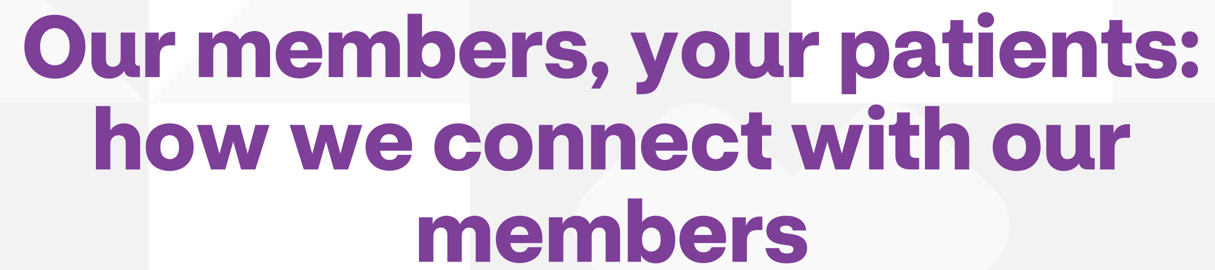
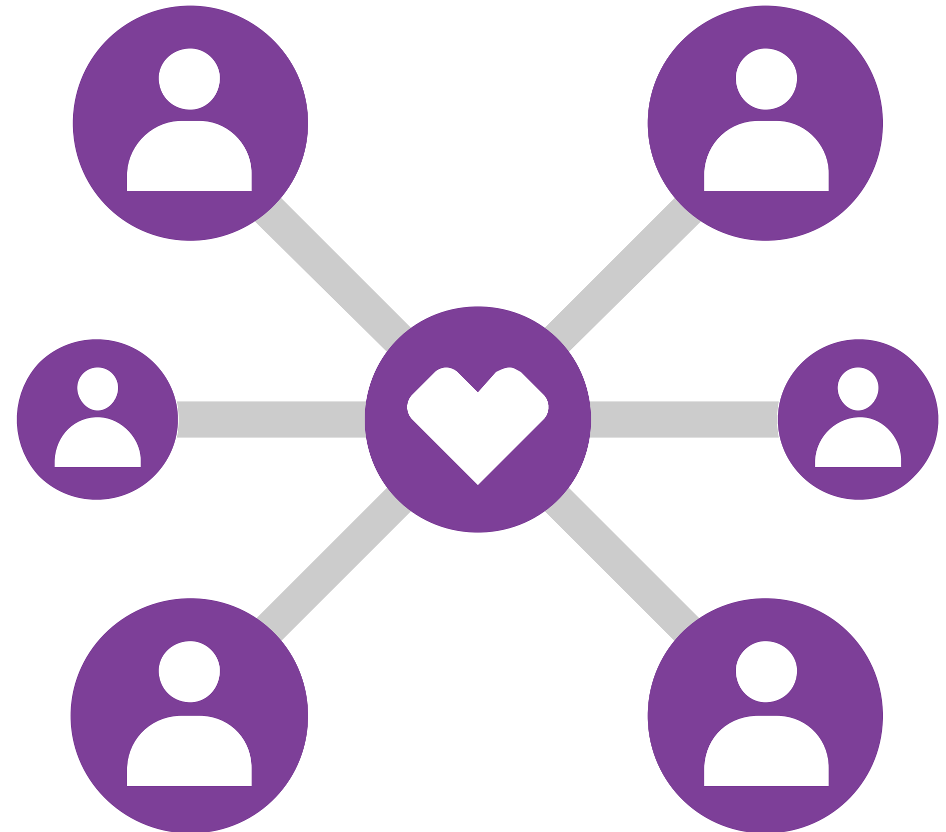

Our members, your patients: how we connect with our members

Member eligibility

Populations we serve:

- Children's Health Insurance Program (CHIP)
- Medicaid expansion
- General or Serious Mental Illness (GMH/SMI)
- Temporary Aid To Needy Families (TANF)
- American Indian/Alaska Natives
- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a care provider



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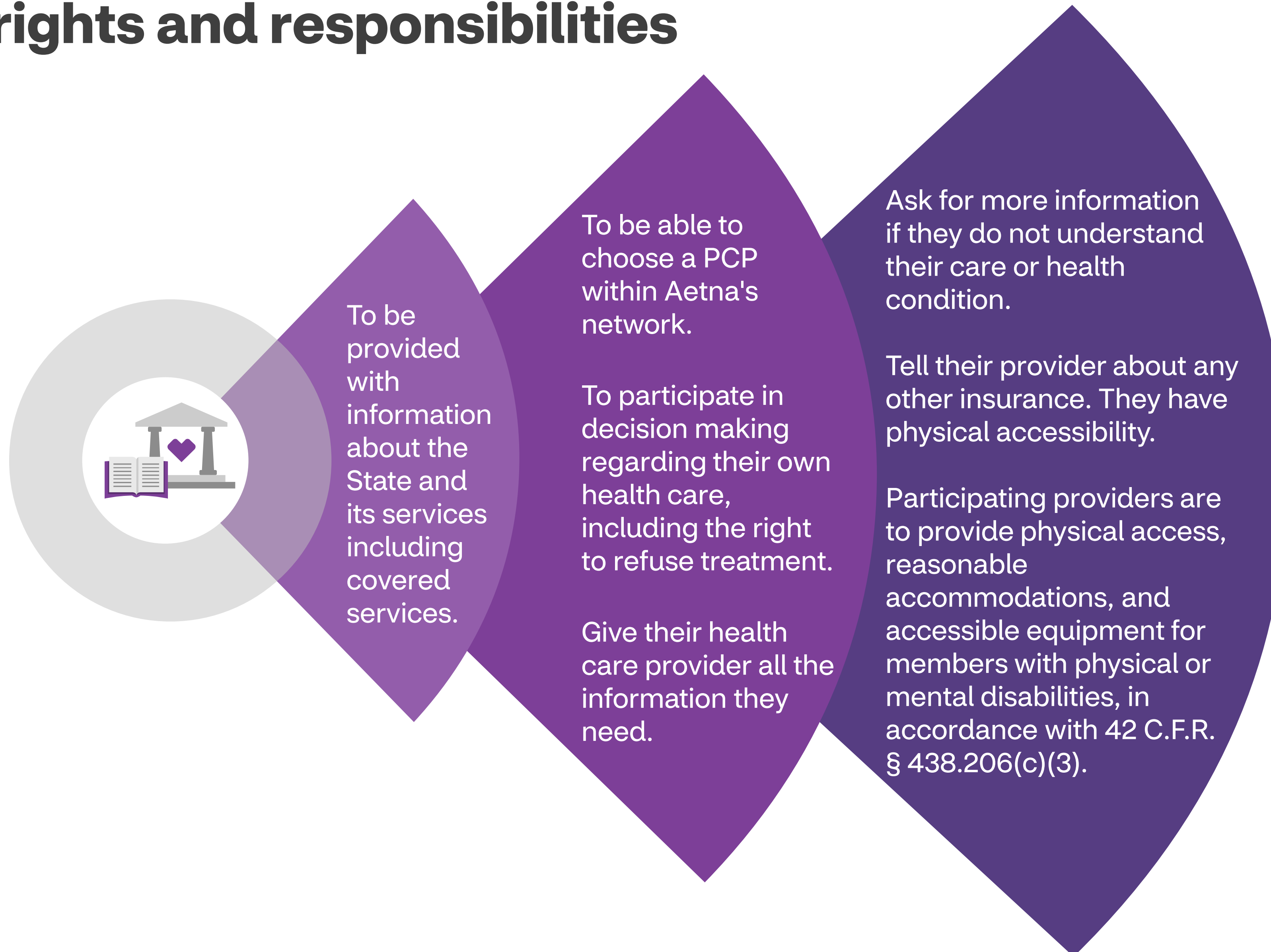
Member rights and responsibilities



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Member services and enrollment

Aetna Better Health® Member Services department is available to:

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

If you need help, call us (toll free) 24 hours a day, 7 days a week.
1-844-365-4385 (TTY 711)

You can also visit us online any time at
AetnaBetterHealth.com/Oklahoma

How can members enroll?

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

Online
Oklahoma.gov/ohca/individuals/mysoonercare/apply-for-soonercare-online/eligibility.html

Phone
SoonerCare Helpline
1-800-987-7767 or (711/TTY)

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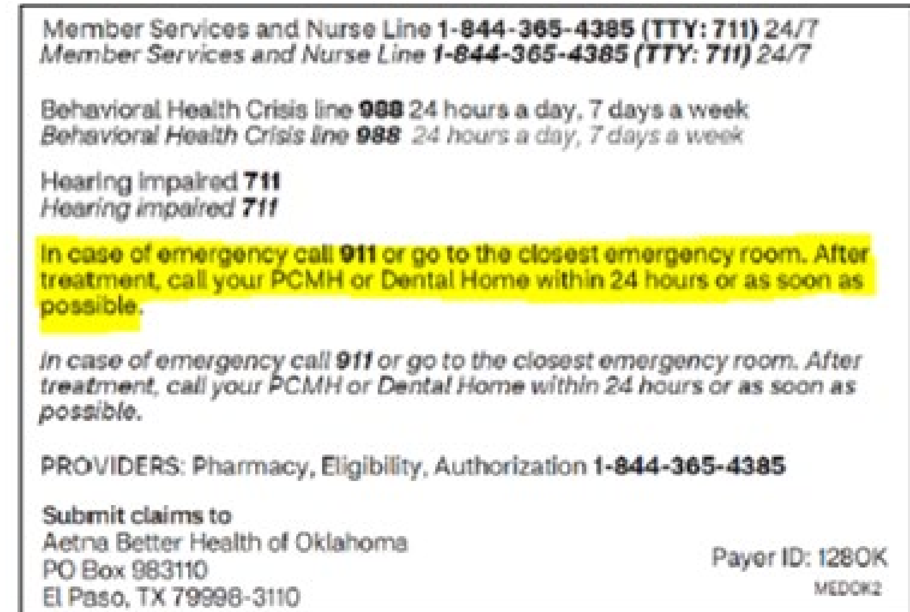
Aetna Better Health® of Oklahoma ID card

Aetna Better Health® bilingual ID card post PCP assignment:

Front post PCP assignment

Back



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Health equity & social determinants of health
(SDoH)

To contact our Health Equity Director, Terrainia Harris, please email:

HarrisT@aetna.com

Health equity is the goal

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

Social determinants of health are contributing factors

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

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

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What is health equity?

Our health equity definition: **Everyone has a fair and just opportunity to be as healthy as possible.**

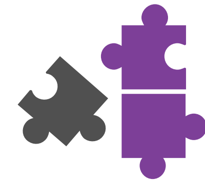
We must remember that achieving health equity means understanding the root causes of inequities.

Fair and just

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

Healthy

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



Recognition of racism and discrimination

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

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Cultural competency

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

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

Additional resources:

Provider manual: Page 32
AetnaBetterHealth.com/Oklahoma

YouTube.com/CVSHealth

ThinkCulturalHealth.hhs.gov

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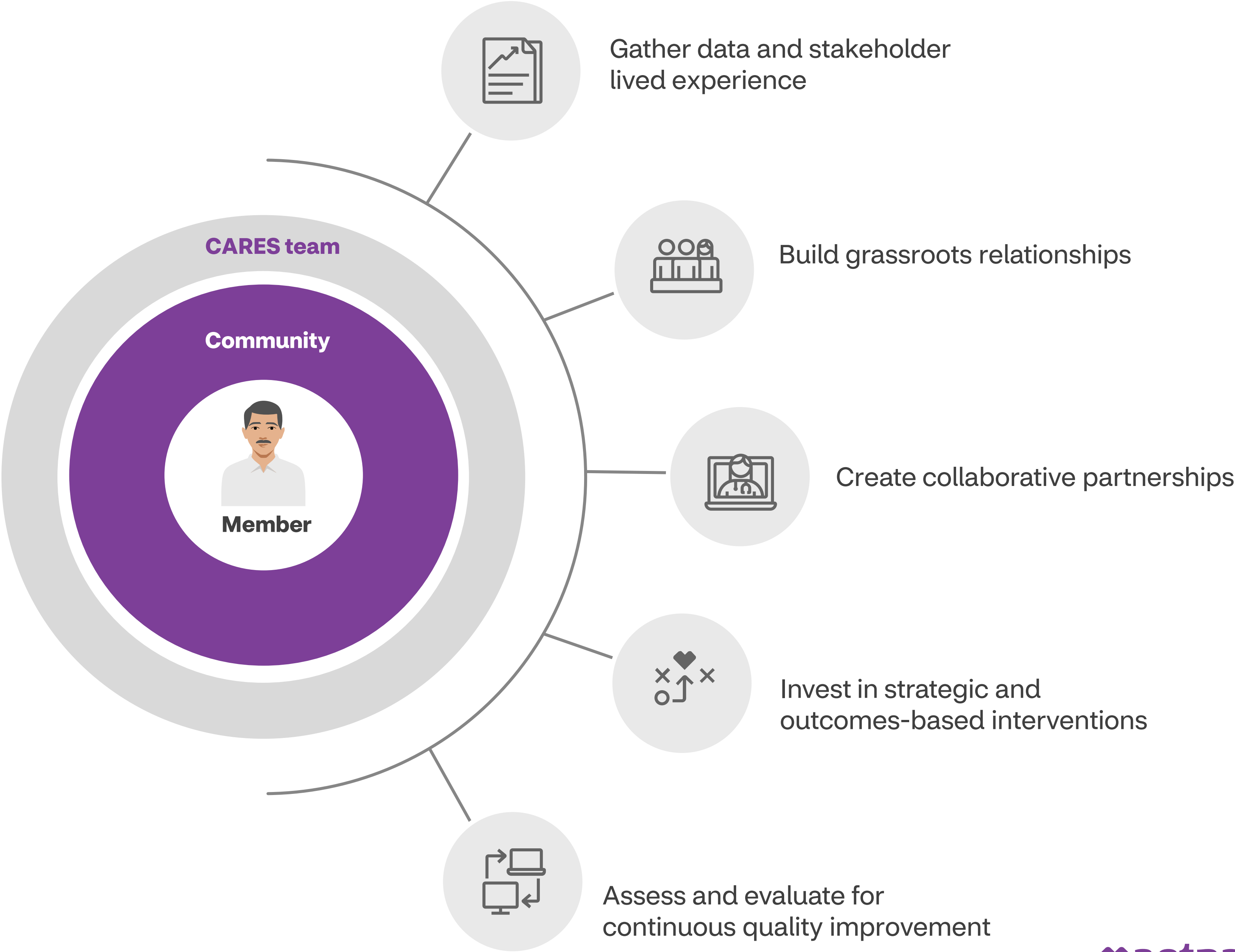
Better together: community CARES team

Our foundational approach to our program is to make the people and communities we serve healthier using data-driven, human-centered solutions that meet members where they are, reducing barriers to health, while continuously working to improve the collective health of the communities where our members live.

We know in order for any one person, family or community to focus on being the healthiest they can be they must ensure they have all basic needs met. **Here's how our CARES team works:**



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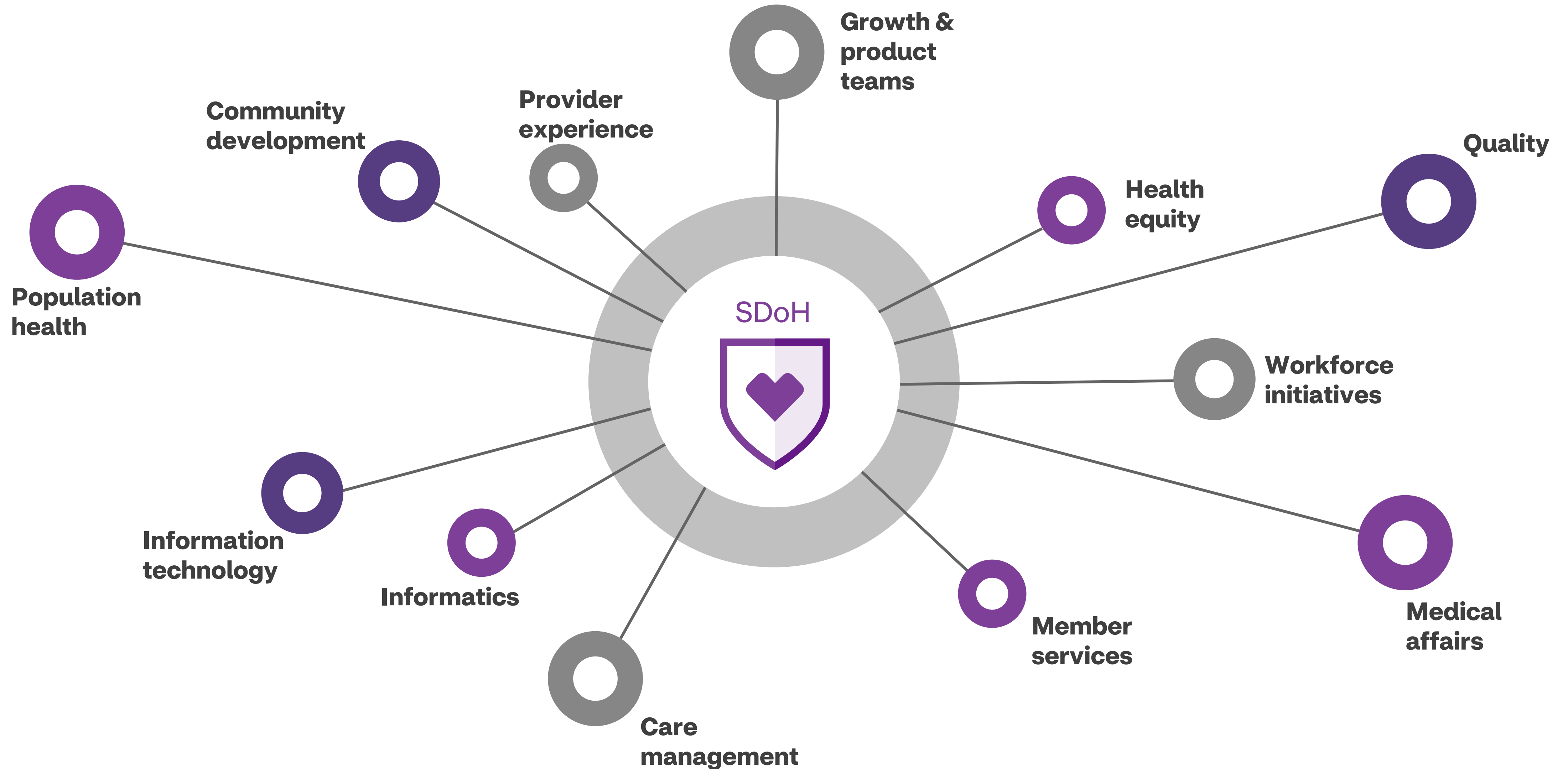
Better together: community CARES team

Better together: CARES teams will own and drive the work within markets and departments to address SDoH internally.



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Community health councils

Creating sustainable, effective social service solutions

At **Aetna Better Health®**, we're committed to ensuring that everyone has an equal opportunity to achieve their best health. That's why we've created our Community Health Councils (CHCs), an initiative to help address the most urgent social needs in your community.

What are CHCs?

CHCs are an important part of our **Better Together: Social Impact Solutions,** a suite of products and programs aimed at creating healthier members and communities. This gap-fill initiative engages stakeholders in a collaborative setting. An **Aetna Better Health®** partner will guide your group in identifying a focus area and pinpoint solutions to fill a specific social gap.

Why you should join?

We're local
We include local people, organizations and systems that impact health in our process.

We're impactful
We help fill gaps through public health programs planning and evaluation strategies.

We're data-driven
We rely on SDoH data as well as feedback based on stakeholder lived experience.

Learn more

To learn more about Better Together: Social Impact Solutions Community Health Councils, e-mail **Maggie Green**, Manager, Community Cares.

GreenM6@aetna.com
or (c) **405-978-4555**

Oklahoma CHC coming soon!

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Let’s make healthier happen together

The **Aetna Better Health®** REACH Team is dedicated to understanding and assisting with your needs. We can connect you to programs that may be able to offer:

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

Call us anytime.

833-316-7010

Member REACH Team
Real Engagement and Community Help

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Aetna Better Health®
of Oklahoma

Aetna Better Health® of Oklahoma Tribal affairs

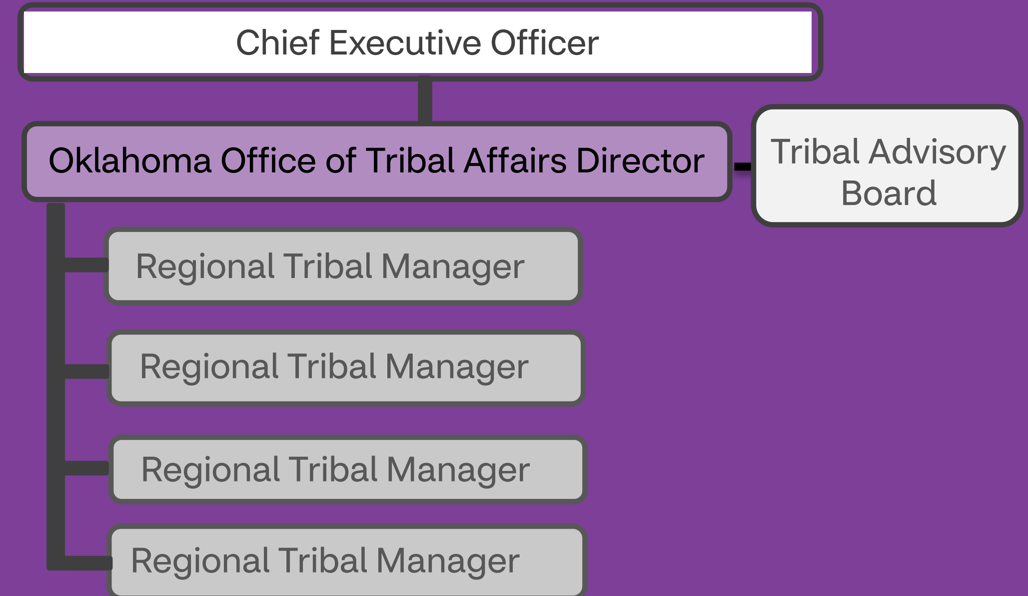
A **Tribal Advisory Board** will be developed as a resource to drive collaboration and provide a pathway to engage with Tribes and ensuring Tribal priorities are identified and addressed.

- 39 federally recognized Tribes
- 75 Indian Health Services, Tribal Health Providers, Urban Indian Health Providers clinics
- 9 Indian Health Services, Tribal Health Providers, Urban Indian Health Providers hospitals

Aetna will:

- **Listen** – leverage focus groups to enhance plan offerings
- **Act** – solicit feedback, address concerns and provide resolution
- **Resolve** – use our expertise to address health disparities

To contact our Tribal Government Liaison and team, please email: **ABHOKTribalAffairs@aetna.com.**



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Tribal health advisory board

Aetna Better Health® recognizes the vital importance of elevating the voices of Tribal Nations and communities in shaping and improving managed care for all Oklahomans.

In alignment with this commitment, **Aetna Better Health®** proposes to establish a Tribal Advisory Board with the Southern Plains Tribal Health Board (SPTHB).

This board will serve as a pivotal resource, ensuring the integration of American Indian and Alaskan Natives' perspectives and resulting in meaningful outcomes for **Aetna Better Health®** wellness initiatives within Oklahoma. The Tribal advisory board will consist of up to 16 members with a mix of Indian Healthcare Providers and American Indian/Alaskan Native **Aetna Better Health®** members.

The purpose of the Tribal Advisory Board is to provide a structured platform for Tribal Nations and community members to actively engage and provide invaluable feedback regarding the quality, efficiency, and amenability of **Aetna Better Health®** managed care plan to meeting the comprehensive health needs of American Indians and Alaskan Natives in Oklahoma.

The primary objectives of the advisory board include:

1. Collaboration: Facilitate collaboration between Indian Healthcare Providers, Aetna AI/AN members and **Aetna Better Health®** to enhance health plans to include more meaningful and impactful value-added benefits.

2. Feedback Mechanism: Serve as a venue for Tribal Nations, communities, and individuals with lived experience to provide valuable feedback and promptly escalate and resolve concerns.

3. Expertise Utilization: Establish avenues to request expertise from **Aetna Better Health®** to assist with utilization i.e., billing, coding, case management, and social services.

4. Health Equity and Outreach: Ensure health equity is a priority by addressing health disparities throughout Native American communities by supporting community-led outreach initiatives.

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Anti-discrimination policy and Americans with Disabilities Act (ADA)

It is our policy <u>not</u> to discriminate against members based on:

- Race
- Sex
- Sexual orientation
- National origin
- Creed
- Color
- Age
- Gender/gender identity
- Religion
- Health status
- Physical/mental disability
- Other basis prohibited by law

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

- Race
- Sex
- Sexual orientation
- National origin
- Creed
- Religion
- Age
- Physical/Mental disability
- Color
- Gender/Gender identity

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

If we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be taken. The ADA guarantees equal opportunity for individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

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Value added benefits

Value-added benefits (VABs)

What extra benefits do I get as a member of Aetna Better Health®?

- Members receive several **value-added services** and **extra benefits** which will be outlined in the Member Handbook
- **Aetna Better Health®** selected benefits/services are designed to:
  - Encourage **family** interactions
  - Increase **engagement** with your provider
  - Support **health** and **wellness**
  - **Assist** with complicated/complex health conditions
  - Inspire **self-care**

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Value Added Benefits for members (VABs)

Go/Get outside

Members may receive $40 annually to use toward the Oklahoma City Zoo, the Tulsa Zoo or to get an Oklahoma state park pass. This is a benefit for the family to get outside for recreation, education and social activities.

Enhanced transportation

Need help getting a ride? We can help. If members can’t make other arrangements when needed, we can help them access job interviews, job trainings, shopping for work type clothing, food banks or grocery stores, WIC offices, and other community and social services.

Over the counter (OTC)

We offer each household $25 per month to purchase certain OTC items such as vitamins and health products mailed right to our member's home.

Adult vision

$150 every two years to cover glasses/contacts and $75 towards an annual exam.

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Value Added Benefits for members (VABs)

Diabetes care program nephropathy

Members will receive $15 for completing a nephropathy screening.

Diabetes care program healthy foods

Eligible members can receive $50 per month to use towards healthy foods.

Diabetes care program Diabetic retinal eye exam

Members will receive $15 for completing a diabetic retinal eye exam.

Diabetes care program A1c testing

Members will receive $15 for completing an A1c test.

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Value Added Benefits for members (VABs)

Substance use disorder technology app

Members have access to an app that connects them to support and services in their recovery journey.

Pyx Health

Members 13 years or older will have access to a mobile app that focuses on helping them with loneliness and social isolation.

Mental health coaching

Members 13 years or older will have access to an app that assists in strengthening emotional health. The app provides access to tools and support for:

- Depression
- Substance abuse
- Tobacco cessation
- Early pregnancy

We want to help members with healthy outcomes.

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Value Added Benefits for members (VABs)

Diaper club

Members ages 0-2.5 have access to $45 to use for a monthly allotment of diapers.

Health living for children

Members ages 8-16 years old, diagnosed with obesity, will receive $50 towards home exercise, sports supplies and after school programs. In addition, they will receive two family nutritional counseling sessions. Caregivers will also earn $20 incentives for completing each nutritional counseling session and will qualify for an annual allowance of $100 for youth sports & fitness fees.

After school engagement

Members ages 5-18 can get up to $50 per year for activities at YMCAs, Boys and Girls Clubs, Boy Scouts or Girl Scouts, and other sports and afterschool programs.

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Value Added Benefits for members (VABs)

Notification of pregnancy

Members who are pregnant and complete their Notice of Pregnancy form in their first trimester will receive a $25 gift card.

Initial prenatal

Members who complete their initial prenatal visit will receive a $25 gift card.

Subsequent prenatal

Members who are pregnant can earn an additional $10 for each prenatal visit.

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Value Added Benefits for members (VABs)

Postpartum

Members can receive $25 for their first visit before 21 days post-delivery. They can receive an additional $25 for their second visit within 22-84 days post-delivery.

Maternal dental visits

Members who are pregnant can receive $10 for their first dental visit and another $10 for their second visit.

Well-child

Members ages 3-20 years old can receive $25 for completing their well-child exam.

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Value Added Benefits for members (VABs)

Postpartum doula visits

If eligible and based on provider, members may have access to extra postpartum doula visits.

Asthma home care

Members with an asthma diagnosis can receive hypoallergenic bedding, deep carpet cleaning and pest control services each year. Adults receive up to $150 to use towards these services in addition to the bedding.

Childcare financial support

Members with a high-risk pregnancy can receive up to $150 per quarter for childcare.

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Value Added Benefits for members (VABs)

Career & life skills training/GED support

Members ages 16 years or older have access to a job skills platform. Members can discover new career paths, earn credentials and certifications. In addition to trade skills, members can earn their GED. After passing the GED online prep course, they'll receive a voucher that will pay for the GED exam fee.

TED E. Bear, M.D. Club

Ted E. Bear M.D. Club provides children up to age 13 with health education regarding diet, exercise, and daily hygiene. Cub Club materials are specialized for children and provide member rewards for completion of challenges, activities and program graduation.

Non-traditional medicine/traditional healing

American Indian and Alaskan Native members receive up to $400 per year for traditional healing practices and services.

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Value Added Benefits for members (VABs)

"Keeping kids safe" opioid lockbox program

Members prescribed an opioid and have children in the home have access to a lockbox to secure medications.

Behavioral health follow-up visit

Members ages 6 years and older are eligible for a $20 incentive for each follow up visit completed with a mental health practitioner within 7 days following an acute behavioral health inpatient hospitalization.

Alternative to opioids

Members ages 21+ with a chronic pain diagnosis can receive $500 to use towards services for acupuncture, massage therapy, dry-needling and yoga.

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Member healthy rewards program (example)

We've got your back
Healthy rewards program

The healthy rewards incentive program lets members earn $10-$50 gift cards when they complete wellness activities such as vaccines yearly checkups and diabetic exams.

Eligible members	Reward amount	Wellness activity
6+ years	$20	Behavioral health follow-up visit
Ages 3 - 20	$25	Yearly well child checkup
Eligible members	Varies	Post-discharge meals
21+ years	$500 per member, per year	Chronic pain care management
Pregnant members	$25	First prenatal visit
	$25	Notifying health plan of pregnancy
	$10	Subsequent pre-natal visits ($100 max)
	$25	First post-partum visit
	$25	Second post-partum visit
	Varies	Postpartum doula visits (only Tulsa Birth Equity members)
Members with diabetes	$15	Yearly HbA1c blood test
	$15	Retinal eye exam
	$15	Nephropathy screening

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Advisory committee

This group is made up of **Aetna Better Health®** staff, members, individuals and providers with knowledge of and experience with serving the older population and individuals with disabilities, representatives from community agencies and community advocates.

This committee meets quarterly and discusses how to improve **Aetna Better Health® of Oklahoma** policies. The advisory committee is responsible for:

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

We encourage you to become a part of this group. Or if you have a member that would be interested, email **MemberAdvocateOK@aetna.com**

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Member advisory committee (MAC)

The objectives of the MAC are implied to obtain member input regarding **Aetna Better Health®** member education and outreach programs and quality improvement activities.

The MAC serves a critical role in representing the values and concerns of **Aetna Better Health®** members and is responsible for:

- Strengthening member participation in their health care
- Collaborating with **Aetna Better Health®** personnel to verify that **Aetna Better Health®** services attend to the holistic needs of each member
- Working with **Aetna Better Health®** personnel to increase responsiveness to the needs of a culturally diverse population
- Advising on issues and areas of improvement in member access to and responsiveness of **Aetna Better Health®** services
- Improving readability and responsiveness of the **Aetna Better Health®** website and other member materials

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Behavioral Health advisory committee (BHAC)

The objectives of the BHAC are to obtain both provider and member input regarding **Aetna Better Health®** member education, policy development, outreach programs, and quality improvement activities as they relate to the delivery of Behavioral Health and Substance Use Disorder services. The BHAC will consist of Oklahoma SoonerSelect Behavioral Health providers, community peer support specialists, members who are consumers of behavioral health services, and member representatives along with key **Aetna Better Health®** leaders.

The BHAC serves a critical role in representing the values and concerns of **Aetna Better Health®** members and is responsible for:

- Strengthening member participation in their health care
- Collaborating with **Aetna Better Health®** personnel to verify that **Aetna Better Health®** services attend to the holistic needs of each member
- Working with **Aetna Better Health®** personnel to increase responsiveness to the needs of a culturally diverse population
- Advising on issues and areas of improvement in member access to and responsiveness of **Aetna Better Health®** services
- Understanding the perspective and being responsive to the diverse needs of Oklahoma SoonerSelect enrollees with Behavioral Health and Substance Use Disorder needs
- Improving readability and responsiveness of the **Aetna Better Health®** website and other member materials

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Care management

Medical management: care management

The Integrated Care Management (ICM) program is a member-centered approach that addresses physical and behavioral health, psychosocial needs and collaboration with the members' system of care and relationships.

Care management programs include, but aren't limited to:

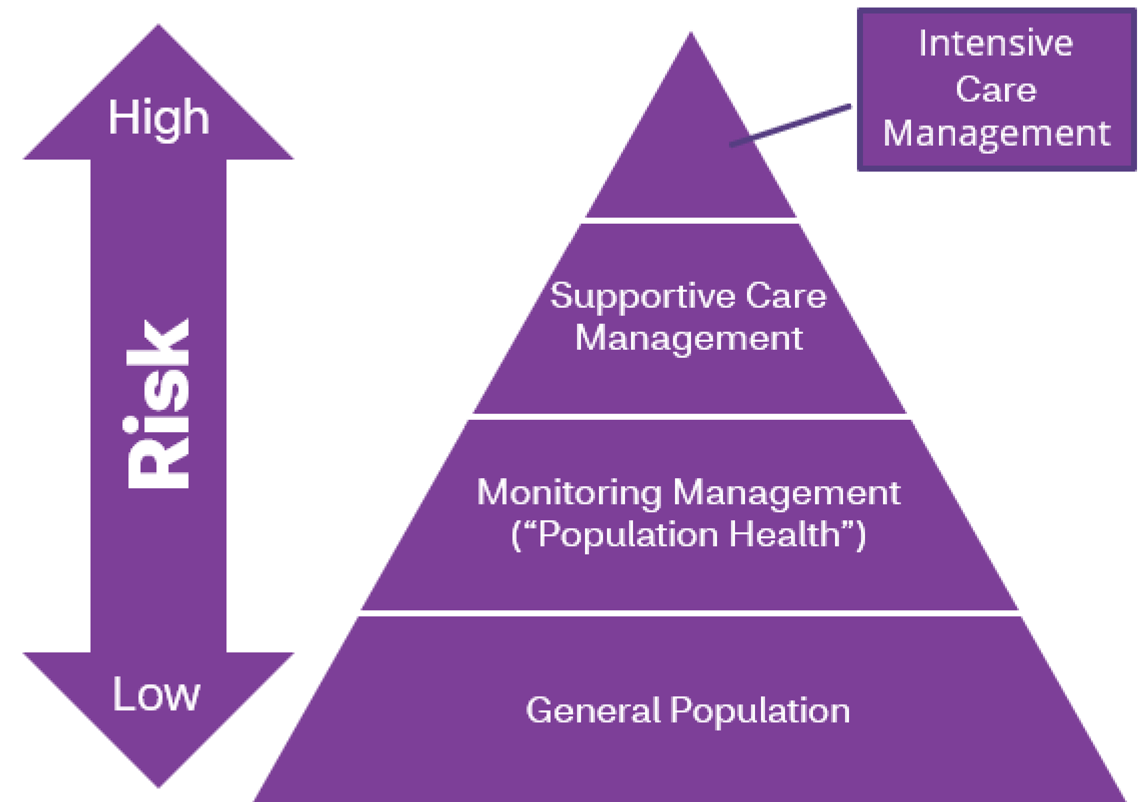
- Pregnancy outreach
- Special health care needs
- Chronic health conditions
- Behavioral health and substance use

How to refer to care management

Phone: **1-844-365-4385 (TTY: 711)**

Fax: **1-833-898-6542**

Email: **AetnaBetterHealthOKCM@aetna.com**



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How to refer to care management and coordination

When a member is enrolled in CM, the member's PCPs receive a welcome letter advising them of their member's enrollment in CM.

The PCP will receive a copy of the care plan and be included in the member's ICT, if the member chooses.

Referral process

Phone: **1-844-365-4385 (TTY: 711)**

Fax: **1-833-898-6542**

Email: **AetnaBetterHealthOKCM@aetna.com**

Forms can be found here: **AetnaBetterHealth.com/Oklahoma**

Aetna Better Health of Oklahoma
777 NW 63rd Street, Suite 100
Oklahoma City, OK 73116

Aetna Better Health of Oklahoma

Case Management Referral Form

Member Name:	**DOB:**	**Referral Date:**
Insurance Plan:	**Member ID Number:**	**COB:** ☐ Yes ☐ No
Member's Current Phone Number:	**POA/Guardian Name & Phone Number:**	**Member aware of Referral?** ☐ Yes ☐ No
Referred by:	☐ BH UM ☐ BH CM ☐ Member Advocate ☐ Medical CM ☐ Medical Director	☐ MS ☐ PA ☐ Medical UM ☐Provider ☐ Pharmacy ☐ Other
Referral to:		☐ Adult Team – CM ☐ Peds Team – CM ☐ Perinatal CM ☐ Other: Specify

Concerns leading to referral: (check all that apply)

☐Transplants ☐Chronic Pain ☐Cancer (new Dx or treatment) ☐Complex/multiple surgery ☐HIV/AIDS ☐Lead Exposure ☐Sickle Cell Anemia ☐Children in Foster Care or in Foster Adoption Subsidy ☐Suicidal/Homicidal Ideation/Hx of ☐Unable to Navigate System on own ☐Court Ordered Treatment ☐Pregnancy with Serious Mental Illness/Substance Abuse	☐Cardiovascular/Stroke complications ☐Respiratory failure/complications ☐Dementia with current complications ☐Pregnancy ☐Diabetic ☐Child w/ Special needs – Specify: ☐Anxiety Disorders ☐Member transitioning onto/off of the plan (transition of care) ☐Serious Mentally Ill Diagnosis ☐Lack of Support and/or Resources ☐Eating Disorder	☐TBI/Seizure disorder ☐Eating Disorder with medical complications ☐Complex Medical Treatment ☐Medical trauma/burns ☐Hepatitis ☐Pervasive Developmental Disorders ☐Pervasive Developmental Disorders ☐Domestic Abuse ☐Substance Abuse ☐Mental Health/Substance Abuse ☐Repeated non-compliance with Meds or Tx Pain ☐Excessive ER use

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Updated: 06/22/2023

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Health risk screening

Health risk screening

As an **Aetna Better Health®** provider, it is expected that you perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has an OCS eligible medical condition. This information must be included in the member's medical records and supplied to **Aetna Better Health®** or its regulators upon request.

Care management completes the initial health risk screening within thirty (30) days of the member's enrollment to obtain basic health and demographic information, identify any immediate needs and place member in an appropriate level of care management, if appropriate.

The health risk screening will assist us in identifying members with special health care needs or having a need for Long-Term Services and Supports (LTSS). If these needs are identified, we will follow-up with a comprehensive assessment to identify any ongoing special condition(s) of the member that require a course of treatment or regular care monitoring. The comprehensive assessment assesses a member's physical health, behavioral health, community, and social support needs.

Members are may complete the questionnaire in-person, by phone or electronically via **Aetna Better Health®** member portal.

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Health risk screening & triggers

Screening includes but is not limited to:

- Demographic information for verification purposes
- Current and past physical health and behavioral health conditions
- Identifying members with special health care needs and specialized treatment or equipment
- Services or treatment the member is currently receiving, including from out-of-state providers
- Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another plan
- Most recent ER visit, hospitalization, physical exam, and medical appointment
- Current medications
- Questions to address social determinants of health, including food, shelter, transportation, utilities, and personal safety

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Aetna Better Health® of Oklahoma comprehensive assessment

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

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Women's health and family planning

Female members:

- Have direct access to Women's Health Care Provider (WHCP) services
- Have the right to select their own women's health care provider, including nurse midwives participating in the **Aetna Better Health®** network
- Can obtain maternity and gynecological care without prior approval from a PCP
- WHCP services are an addition to primary care providers

Family planning services do not require prior authorization.

Members may access family planning services from any qualified provider without a referral.

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Behavioral health

Behavioral health

Basic behavioral health services

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

Physical and behavioral health integration

Aetna Better Health® promotes early intervention and health screening for identification of behavioral health problems and member education. To that end, **Aetna Better Health®** providers are expected to:

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

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Behavioral health - continued

Aetna Better Health® covers behavioral health services including:

- Behavioral health services in coordination with PCP
- Psychiatric testing
- Out-patient counseling
- Substance use disorder treatment
- Psychiatric evaluation & medication management
- Applied behavioral analysis (ABA) services
- Certified community behavioral health clinic (CCBHC) services
- Partial Hospitalization Program (PHP)
- Inpatient programs

- Participating providers providing inpatient psychiatric services to members are required to schedule the member for out-patient follow-up care prior to discharge from the inpatient setting with the out-patient treatment occurring within seven (7) calendar days from the date of discharge.
- Providers must notify **Aetna Better Health®** of all discharge medications PRIOR to member's planned discharge from inpatient (IP) stay:
    - IP mental health
    - IP detox
    - Residential

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Care advocate team

Our care advocate team members are subject matter experts in:

- Children and adult systems of care
- Recovery and resiliency
- Workforce development
- Housing and community specialists
- Crisis services
- Veteran wellness

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Behavioral health resources

Screening, brief interventions, & referral to treatment (SBIRT)

- **Screening**: assess member for risky substance use behaviors using standardized screening tools
- **Brief intervention**: healthcare professional engages member in a short conversation, providing feedback and advice
- **Referral to treatment**: healthcare professional provides referral to brief therapy or additional treatment for members whose screening demonstrates the need for additional services

Additional resources:
Screening, brief intervention, and referral to treatment (SBIRT): **Samhsa.gov/sbirt**
- CMS Health insurance reform for consumers (MH Parity Act of 2008):
CMS.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf

Milliman Care Guidelines Behavioral Health Guidelines
Effective September 1, 2016, OHCA implemented the Milliman Care Guidelines Behavioral Health Guidelines (MCG BHG) as the primary medical necessity criteria for behavioral health.

- MCG BHG is nationally recognized, evidence-based clinical guidelines used for determining medical necessity, appropriate levels of care: **MCG.com/content/behavioral-health-care**
- Depression screening: **APA.org/depression-guideline/member-health-questionnaire.pdf**
- Unhealthy drug use screening: **USPreventiveServicesTaskforce.org/uspstf/recommendation/drug-use-illicit-screening**
- Anxiety screening: **ADAA.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf**
- Post-partum mood disorders: **Samhsa.gov/resource/dbhis/edinburgh-postnatal-depression-scale**
- Pediatric ADHD: **Nichq.org/sites/default/files/resource-file/NICHQ-Vanderbilt-Assessment-Scales.pdf**
- OHCA recommended behavioral health screeners: **Oklahoma.gov/content/dam/ok/en/okhca/docs/providers/types/behavioral-health/pcmh/Behavioral%20Health%20Screening%20Tools.pdf**

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Advance directives

Members have the right to discuss, clarify preferences, and proactively provide direction for care should they become unable to personally provide information at a future point in time.

The types of conditions that may render members unable to provide real-time direction for their care include:

- Coma
- Brain injury
- Behavioral health conditions
- Conditions requiring life support
- Anytime there is a potential for resuscitative or supportive actions such as artificial feeding

Additionally, each member has the right to designate the person(s) of their choosing to speak on their behalf in such circumstances.

Conversations with members should employ sensitivity and be done with respect for individual and cultural differences.
Below are the links to Oklahoma specific Advance Directive for Health Care, Medical Power of Attorney and Psychiatric Advance Directive (PAD).

- **PowerOfAttorney.com/wp-content/uploads/2013/07/oklahoma-medical-power-of-attorney.pdf**
- **NRC-pad.org/images/stories/PDFs/oklahomapadform.pdf**
- **Oklahoma.gov/content/dam/ok/en/okdhs/documents/okdhs-publication-library/87-07W_AdvanceDirectiveforHealthCare_as_12292020.pdf**

NOTE: The State of Oklahoma requires that Advance Directives be incorporated into member's case file within the **Aetna Better Health®** Care Management system and provider's member medical record, as applicable.[1]

[1] In accordance with OAC 317:30-3-13(a)(3)), Advance Directives shall be incorporated into the Enrollee's Case File within the Care Management system as well as the Enrollee's medical records, as applicable. The Advance Directive becomes operative when it is communicated to the attending physician and the Enrollee is no longer able to make decisions regarding administrative of life sustaining treatment, in accordance with 63 O.S. § 3101.5. The Health Care Power of Attorney becomes effective when the attending physician determines that the Enrollee is no longer able to make their own health care decisions, unless the Enrollee elected to have the Agent's authority take effect upon execution of the Health Care Power of Attorney, in accordance with 60 O.S. § 3111.5.

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Additional services provided

Modivcare
Solutions

Transportation

Members/Providers

1-877-718-4208

Vision

Available to members by calling

1-866-4-EYEMED

Pharmacy benefits manager

RX prior authorizations

1-833-847-2987

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Language services

Language services can be accessed via Member Services at 1-844-365-4385 (TTY 711), 24 hours a day, 7 days a week.

Interpretation (face to face)

- Nationwide network of qualified interpreters offering interpretation in 15+ languages, including American Sign Language (ASL)

Interpretation (over the phone)

- Access to interpreters supporting 200+ languages via telephone

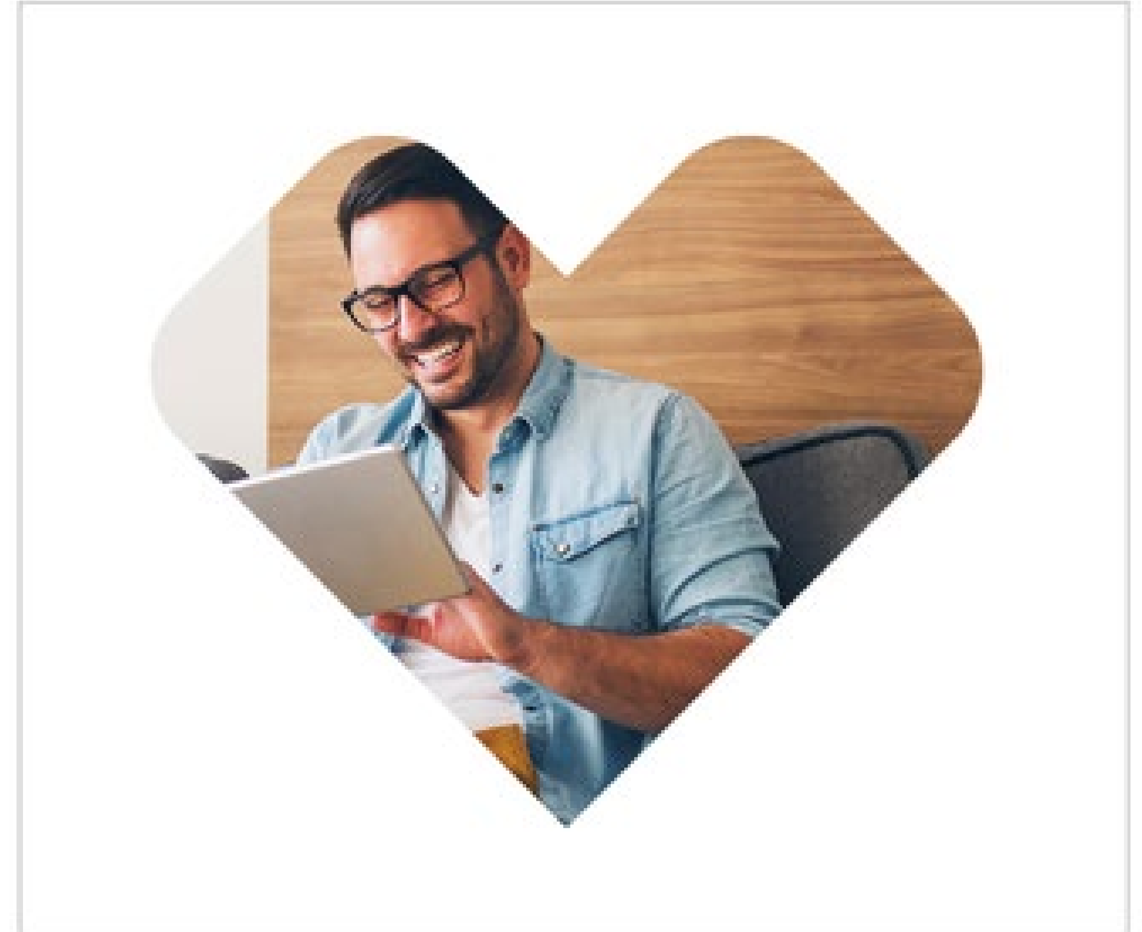
Additional resources:

Interpreter quality standards guidance

NCIHC.org/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf

Office for Civil Rights

HHS.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html



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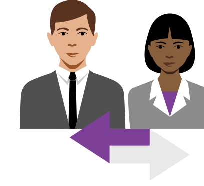
Credentialing

Credentialing



Physicians/Mid-Levels

- Each new provider must be credentialed before s/he can render care to an **Aetna Better Health®** Member.
- **Aetna Better Health®** will accept approved providers actively enrolled with OHCA without requiring full credentialing until all three CEs establish a consolidated provider enrollment and credentialing process.
- It is important for **all providers** to keep the state portal and CAQH updated with current information.

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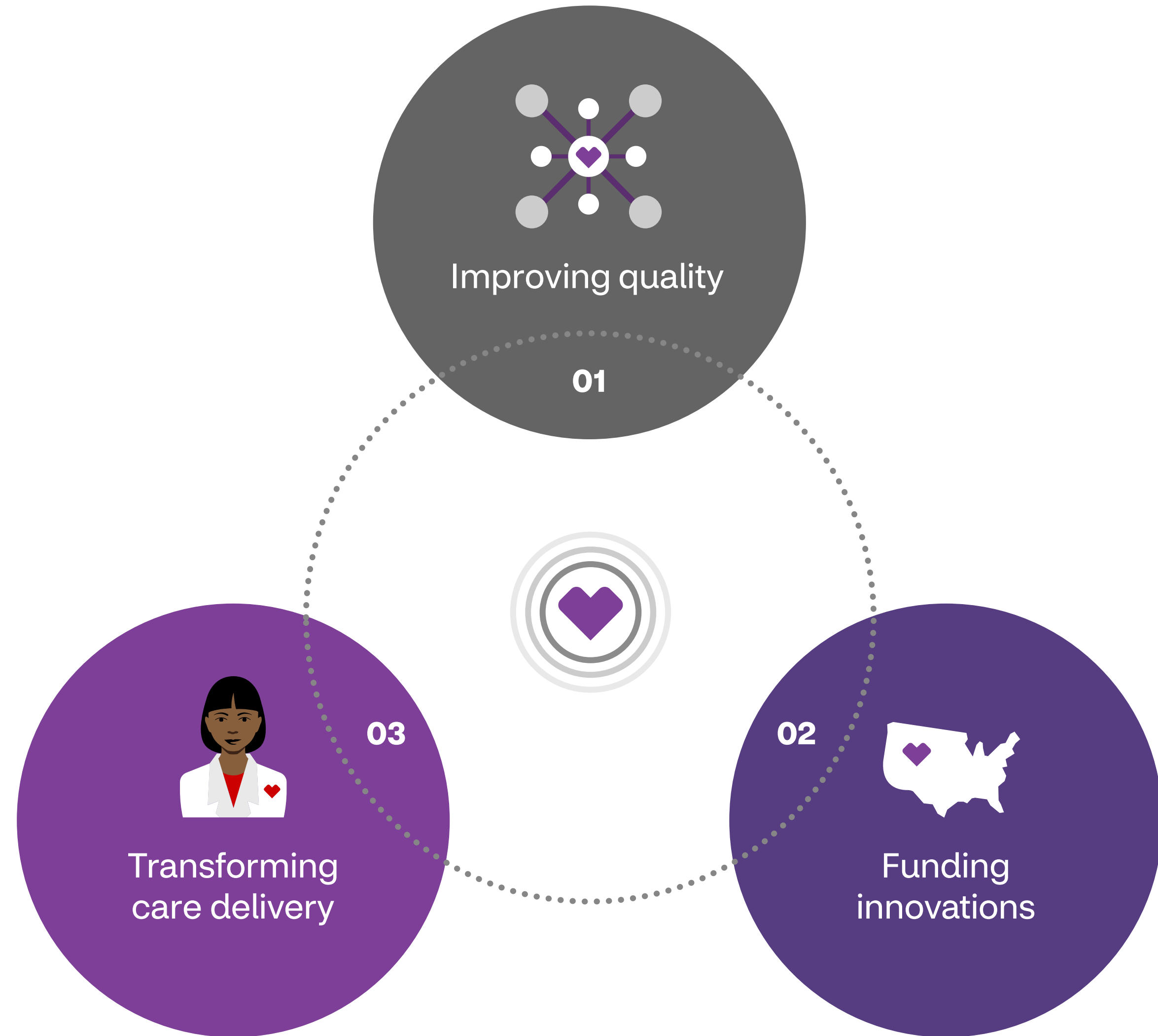
Value-based services



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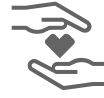
Overview of value-based services (VBS)

Our offer

Various incentive arrangements

- Pay for quality with designated incentive pool
- Shared savings models
- Shared risk models
- Full risk models slash capitation models



We look for

Participating providers in

- Primary care
- Pediatric care
- Obstetrics and gynecology

Interested?

Please contact

- Valerie Smith – Lead Director, Value-Based Services
- Email: SmithV3@Aetna.com

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Quality

Quality management program

QM Program is a **continuous quality improvement** process that includes comprehensive quality assessment and performance improvement activities. The process enables us to:

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

Medical records standards

- Our **Aetna Better Health®** standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).
- All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the **Aetna Better Health®** provider manual.

Healthcare Effectiveness Data and Information Set (HEDIS)

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

What is our ultimate goal?

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

Please see HEDIS tips for PCPs located on our website:
AetnaBetterHealth.com/Oklahoma

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Early and periodic screening,
diagnostic and treatment
(EPSDT)

Early and periodic screening, diagnostic and treatment (EPSDT)

What is EPSDT?

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

Provider responsibilities:

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

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Early and periodic screening, diagnostic and treatment (EPSDT) - continued

EPSDT Services

Screening services must include, at a minimum:
- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory tests (including blood lead level assessment appropriate for age and risk factors)
- Health education (including anticipatory guidance)

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

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

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

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

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Pharmacy

Pharmacy

Aetna Better Health® covers prescription medications and certain over-the-counter (OTC) medicines when you write a prescription for a member.

We use CVS Caremark® for Pharmacy Benefit Management (PBM) services.

Online formulary search tool provides the list of covered drugs and indicates whether a drug requires step therapy (ST), has a quantity limit (QL) or requires prior authorization (PA)

CVS Caremark® Mail Order Pharmacy network.

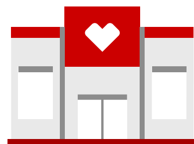
Pharmacy PA:

- Submit PA by telephone : **1-844-365-4385** (TTY: 711)
- Fax: **1-888-601-8461**
- Through a direct link on our website, you can view:
  - OHCA PA criteria
  - PA forms

Electronic PA:

Use SureScripts or CoverMyMeds® to:

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



Visit our provider page for more information
AetnaBetterHealth.com/oklahoma/providers/pharmacy.html

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Prior authorizations

Utilization management

You may submit PA requests by:
Phone: **1-844-365-4385**
Secure: Availity **Apps.Availity.com/availity/web/public.elegant.login**

Service authorization decision timeframes	Turnaround times
Non-urgent preservice decision (approvals and denials)	72 hours from receipt of the request
Urgent pre-service decision (approvals and denials)*	24 hours from receipt of request
Urgent concurrent request (approvals and denials)	24 hours from receipt of request
Inpatient behavioral health	24 hours from receipt of the request

Documentation requirements for authorization request:
- Member information
- Diagnosis code(s)
- Treatment or procedure code(s)
- Anticipated start and end dates of service(s)
- All supporting clinical documentation to support medical necessity

Include:
- Office/department contact name
- Telephone
- Fax number

Forms can be found here:
AetnaBetterHealth.com/Oklahoma

***Note:** Includes DME requests within 5 days of discharge from acute.

***Note**: Includes member transfer from acute to post-acute level of care (LTAC, SNF, Rehab)

****Additional timeframes and authorization information, can be found in the Provider Manual****

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Referrals

Aetna Better Health® members are not required to obtain a written referral from their PCP to obtain services from a participating provider.

Members can self-refer to a provider for services. However, members should be informed that there are possible consequences, including but not limited to, experiencing a delay in accessing the services needed during this process.

Members can self-refer for the following services:

- Behavioral health services, including SUD treatment
- Vision services
- Emergency services
- Family planning services
- Prenatal care
- Department of health providers, including mobile clinics
- Services provided by IHCPs to AI/AN members

Authorization denials

If you receive an authorization denial you may request a peer-to-peer review. To request a peer-to-peer review, call **1-833-459-1998**.

Resources:

AetnaBetterHealth.com/Oklahoma

Provider Manual: Chapter 5
AetnaBetterHealth.com/Oklahoma

Forms can be found here:
AetnaBetterHealth.com/Oklahoma

ProPat -
AetnaBetterHealth.com/Oklahoma

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Concurrent review

Concurrent review

Concurrent review process

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

What does that mean?

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

Second medical opinions

Members have the right to receive a second opinion as an option for an illness, surgery, and/or confirming a treatment of care a provider has told a member needs. Members are asked to contact their provider or Member Services for help to get a second opinion. If an appropriate provider for the second opinion is not available within the **Aetna Better Health®** network, we will arrange for the second opinion outside of our network. When approved by us, out-of-network second opinions are provided at no more cost than if the service was provided in-network.

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Access to care guidelines: how we remain compliant

Access to care guidelines

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

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

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

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Access to care guidelines - continued

<table>
<tr><th>PCP</th><th>OB/GYN</th><th>Specialty</th><th>Mental health</th><th>Substance Use</th></tr>
<tr><td>Within 30 days from date of request for a routine appointment.
Within 72 hours for non-urgent sick visits.
Within 24 hours for urgent care.
Each PCP shall allow for at least some same-day appointment to meet acute care needs</td><td>Within 30 days from date of request for a routine appointment.
Within seventy-two (72) hours for non-urgent sick visits.
Within twenty-four (24) hours for urgent care

*See below for prenatal care</td><td>Specialty care consultation, including nonurgent 60 days and within 24 Hours for Urgent Care or as clinically indicated.</td><td>Within 30 days from date of request for a routine appointment.
Within 7 days of residential care and hospitalization.
Within 24 hours for urgent care.
For mental health emergencies, please call the Oklahoma Mental Health Lifeline at 988.</td><td>Within 30 days from date of request for a routine appointment.
Within 7 days of residential care and hospitalization.
Within 24 hours for urgent care.</td></tr>
<tr><td colspan="5">*Prenatal care -- Members will be seen within the following timeframes:
• First trimester visit within 14 calendar days
• Within the second trimester within 7 calendar days
• Within their third trimester within 3 business days
High-risk pregnancy – Within three (3) business days of identification of high-risk to Aetna Better Health® or maternity provider or immediately if an emergency exists.</td></tr>
</table>

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

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Your demographics – provider web form

Use our new provider 'contact us' form to tell us more about your specific request or inquiry.

This form allows you to share the right information from the start, so you don't have to spend valuable time tracking down the help you need. As an added benefit for us both, we have ensured that any request or inquiry made through this form is routed to the appropriate department.

How it works

To access the form, visit **AetnaBetterHealth.com/oklahoma/providers.** Start by selecting the reason for your inquiry, then share the appropriate contact at your practice and add essential information like your tax ID, NPI and more.

You can also include up to five files with your inquiry, if needed.

Use this form when submitting demographic changes, or terms, new provider adds to existing groups, terminating providers due to office closures, retirement, and leaving medical groups, large add/change/term files and W-9.

Once the form is submitted an email confirmation will be generated with details about your request.

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Abuse, neglect and exploitation

Abuse, neglect and exploitation

As mandated by state of Oklahoma, all providers who work or have any contact with **Aetna Better Health®** members, are required as "mandated reporters" to report any suspected incidences of physical abuse, neglect, mistreatment, financial exploitation and any other form of maltreatment of a vulnerable member to the appropriate state agency.

Children

Providers must report suspected or known child abuse and neglect to the Oklahoma Department of Human Services (OKDHS) Statewide 24-hour Child Abuse and Neglect Hotline at 1-800-522-3511 or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable adults

Oklahoma law defines a vulnerable adult as an individual who is an incapacitated person or who, because of a physical or mental disability, including persons with Alzheimer's disease or other dementias, incapacity, or other disability, is substantially impaired in the ability to provide adequately for the care or custody of himself or herself, or is unable to manage his or her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect himself or herself from abuse, verbal abuse, neglect, or exploitation without assistance from others.
Providers must report suspected or known physical abuse, neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to: Oklahoma Department of Human Services (OKDHS) 1-800-522-3511 or through this link: **OurOkDhs.org/s/reportabuse**.

Domestic abuse & sexual assault

Providers treating a competent adult victim of domestic abuse or sexual assault must make a report to law enforcement if requested to do so by the victim. Details for the reporting requirements and exceptions are in Oklahoma Statute §22-40.3A and §22-58.

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Fraud, waste and abuse

Fraud, waste and abuse

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

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

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

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

- By phone to the confidential **Aetna Better Health® 1-844-365-4385**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**

You can also report provider fraud to OHCA, at **1-855-817-3728** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services **at 1-800-HHS-TIPS** (**1-800-447-8477**).

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Claims, Availity and provider
portal

Claims and claim submission

Clearinghouse & clean claims
Aetna Better Health® accepts clearinghouse electronic claim submissions through the Office Ally clearinghouse.

To seamlessly submit your electronic claims, ensure that your current clearinghouse is aware that Aetna Better Health® claims need to be routed through the Office Ally clearinghouse.

Payer ID: 128OK
EDI claims received directly from Office Ally & processed through pre-import edits to:
- Evaluate data validity
- Ensure HIPAA compliance
- Validate member enrollment
- Facilitate daily upload to **Aetna Better Health®** system

Claims submissions
Aetna Better Health® requires clean claims submissions for processing. To submit a clean claim, the participating provider must submit:
- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure code

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

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

Providers may resubmit a claim that was originally denied because of:
- Missing documentation
- Incorrect coding
- Incorrectly paid or denied because of processing errors

How to submit a claim:
Mail: **Aetna Better Health of Oklahoma Inc.**
PO Box 983110
El Paso, TX 79998-3110

Phone: **1-844-365-4385 (TTY:711)**
Online: **CMS.OfficeAlly.com**

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Claim submission resources

Claim submission assistance/links

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

How to fill out a CMS 1500 form:

CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

Sample CMS 1500 form:

CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf

How to fill out a CMS UB-04/1450 form:

CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

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Billing & encounters

Refer to chapter 15 : billing and claims in the provider manual for complete and detailed information

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

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of CMS Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in our Claims Processing System. Important notes: The ICD10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four- digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.

Aetna Better Health® uses an Encounter Management System (EMS) that warehouses claim data and formats encounter data to OHCA requirements. The EMS also warehouses encounter data from vendors, and formats it for submission to OHCA. We use our state-of-the-art EMS to monitor data for accuracy, timeliness, completeness, and we then submit encounter data to OHCA. Our EMS processes CMS1500, UB04 (or UB92), Dental, Pharmacy and Long-Term Care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II).

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Provider dispute resolution processing timeframe

Description		Turnaround time frame
Deadline for market receipt of provider disputes	Dispute related to an individual claim, billing dispute, or contractual dispute; OR Dispute related to a demonstrable and unfair payment pattern by the market	Deadline: 365 days after the most recent action, or in the case of inaction, 365 days after time for contesting or denying claims has expired
	Dispute regarding a market notice of overpayment	Deadline: Within 30 working days of receipt of the market notice of overpayment of a claim
	Amended provider dispute	Deadline: Within 30 working days of the date of the provider's receipt of a returned dispute with written market notice

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Provider dispute resolution processing timeframe - continued

Description		Turnaround timeframe
Time period for acknowledgement	Electronic provider dispute (directly into the system)	Provided within 2 working days of the date of receipt of the electronic provider dispute
	Paper provider dispute (mail, fax, e-mail, physical delivery)	Provided within 15 working days of the date of receipt of the paper provider dispute
Time period for resolution and written determination	Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Market's goal is to resolve, and issue written determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
Past due payments and interest and penalties	Resolution of a dispute involving a claim, which is determined in whole or part in favor of the provider, shall include the payment of any outstanding monies determined to be due and all interest due.	Market goal is to issue payment with the resolution letter and in all cases, payment will be made no later than within 5 working days of the issuance of the written determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.

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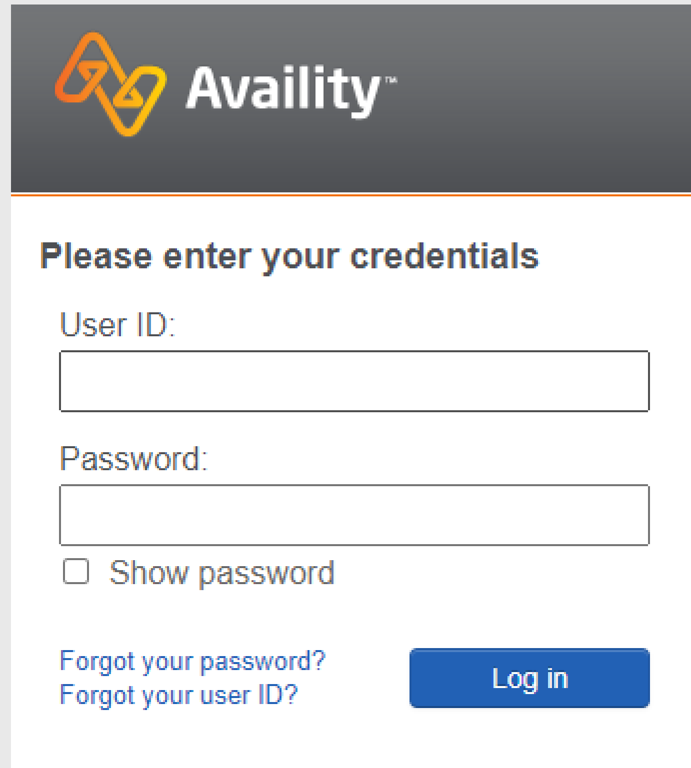

Availity (provider secure web portal)

We are thrilled to announce that Aetna Better Health® will be using Availity for our provider portal.

Apps.Availity.com/availity/web/public.elegant.login

We are excited to support you as you provide services to our members. Our communications will be via email. Keeping our providers informed is our priority.

Some highlights of increased functionality include:

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

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Provider preventable conditions (PPC)

Provider preventable conditions (PPCs)

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

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

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

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

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Provider preventable conditions (PPCs) - continued

Aetna Better Health® will not reduce payment for a PPC to a provider when the condition (defined as a PPC for a particular member) existed prior to the initiation of treatment for that member by that provider.

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

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

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

Aetna Better Health® will ensure that non-payment for PPCs does not prevent access to services for SoonerSelect beneficiaries.

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Appeals & grievances

Appeals & grievances (A&G)

Member grievance system overview
Members or their designated representative can file a request for reconsideration or express dissatisfaction with **Aetna Better Health®.**

Orally or in writing.

- A representative is someone who acts on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney.
- Representatives must be designated in writing.

Requests for *reconsideration* are classified as an *appeal*.
All other *expressions of dissatisfaction* are classified as a *grievance*.

- When the grievance is received by phone and can be resolved by the next business day, and it is not related to reconsideration or an appeal it is classified as an exempt grievance.

Aetna Better Health® informs members and providers of the grievance system processes for exempt grievances, grievances, appeals, IMRs and State Fair Hearings.

Display notices of member rights to grievances, appeals and state fair hearings. Require that the participating provider display notices in public areas of the participating provider's facility/facilities in accordance with all State requirements and any subsequent amendments.

How to file an appeal or grievance

Phone: **1-844-365-4385 (TTY: 711)**

Fax **1-833-805-3310**

Online: Member portal & Availity -
Apps.Availity.com/availity/web/public.elegant.login

Email: OKAppealandGrievance@aetna.com

Mail:
Aetna Better Health of Oklahoma
Attn: Appeal and Grievance Manager
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

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Additional information on A&G

Provider dispute

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

Provider grievance

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

Provider appeal

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

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Additional information and resources

Contacting Aetna Better Health® of Oklahoma

Visit: AetnaBetterHealth.com/Oklahoma

Provider/Member services line:
1-844-365-4385 (TTY: 711)

- 24/7 medical/behavioral advice line
- Care coordination
- Claims
- Eligibility

Our website

Provider
tools

List
of participating
providers

24/7
secure provider portal

Screeners for
BH

Education
for providers

Clinical
guidelines forms

Screening, brief interventions, &
Referral to treatment (SBIRT) information & training
SBIRT Training

Pharmacy search tool

Website:
AetnaBetterHealth.com/Oklahoma

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Available resources

- Claims inquiry & research (CICR) team
- Provider enrollment team
- Online provider manual: AetnaBetterHealth.com/oklahoma/providers/manual
- Online provider portal: AetnaBetterHealth.com/oklahoma/providers/portal
- Dedicated network relations manager
- Quick reference guide

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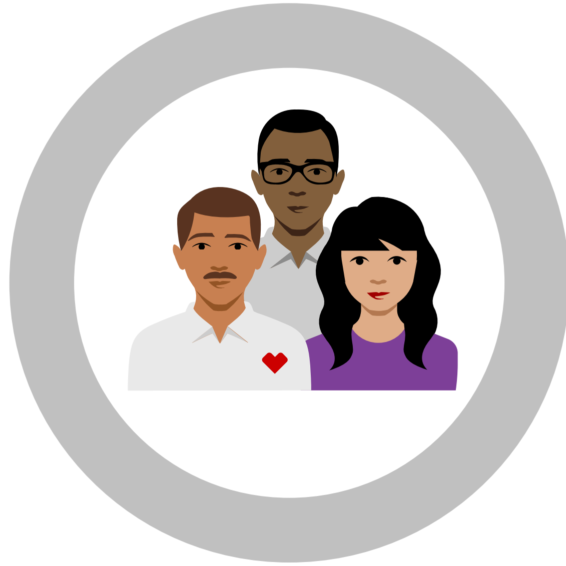

Your Aetna Better Health® provider experience team

Email: ABHOKProviderEngagement@AETNA.com

Phone: **1-844-365-4385** (TTY: 711)

Director, provider experience

Rita Hanson

Provider experience specialist:

- Michelle Dillard
- Karen Green
- Courtney Smallwood
- Leslie Sanchez
- Michele Wanko

Your provider experience manager primary point of contact:

- Arleta Barnes
- Regina Brandt
- Aneesah Evans
- Deiona Looney
- Jade Mitchell
- Tia Philpot
- Justin Smith
- Robby Wolfe

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Provider engagement counties & staff

Manager, Arleta Barnes: (Analyst, Courtney Smallwood)
Hillcrest Hospital and Clinics **Counties**: Tulsa (Central), Osage, Washington, Pawnee, Nowata, Creek (North)

Manager, Regina Brandt: (Analyst, Karen Green)
Healthcare System: St. John's Hospital and Clinics, OSU Medical Clinics **Counties:** Wagoner, Delaware (South), Cherokee, Adair

Manager, Aneesah Evans: (Analyst, Michele Wanko)
OU Medical, Children's Hospital and Clinics **Counties**: N. OKC, McClain, Grady, Garvin, Comanche, Carter, Jefferson, Cotton, Stephens, Murray

Manager, Deiona Looney: (Analyst, Leslie Sanchez)
Norman Regional Hospital and Clinics Variety Care Clinics (Mid-Del, Norman and Southwest OK) **Counties:** Pottawatomie, Seminole, Hughes, Pontotoc

Manager, Jade Mitchell: (Analyst, Karen Green)
Bethany Children's Hospital (NW OKC) **Counties**: Kingfisher, Garfield, Grant, Logan, and Cleveland

Manager, Dana Northrup: (Analyst, Courtney Smallwood)
OSDH Tribal Jurisdiction and Clinics, Varity Care Clinics (OKC Metro) **Counties**: S. OKC, Noble, Kay, Payne, Creek (South)

Manager, Tia Philpot: (Analyst, Michelle Dillard)
St. Francis Hospital and Clinics **Counties:** Tulsa (North), Rogers, Craig, Mayes, Ottawa, Delaware (North)

Manager, Justin Smith: (Analyst, Michelle Dillard)
Integris Hospital and Clinics **Counties**: Canadian, Caddo, Custer, Dewey, Blaine, Washita, Roger Mills, Beckham, Kiowa, Greer, Jackson, Tillman

Manager, Robby Wolfe: (Analyst, Leslie Sanchez)
Mercy Hospital and Clinics **Counties**: Cimarron, Custer, Texas, Beaver, Harper, Woods, Ellis, Major, Alfalfa, Woodward

***Manager Pending*:**
Atoka, Choctaw, Coal, Bryan, Johnston, Love, Marshall, McCurtain, Okfuskee, Pushmataha

Manager Pending:
Counties: Sequoyah, McIntosh, Haskell, Pittsburgh, Latimer, LeFlore, Okmulgee, Coal

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Continuing medical education

Provider CME opportunity: suicide prevention

Time Commitment	1 hour/month 8 months total	50 min/session 3 sessions total	3 hour/ course 4 courses total
Engagement Level	Didactic and case-based discussion	Video modules and video-guided discussions	Online course and case study
Credits Available	CME Credit Track 2 (With QI): 25 MOC Part 4 Credits	3 CME Credits	11.5 CE Credits 8.5 CME Credits
Who Is This For?	Pediatric Primary Care*	Primary Care*	Behavioral Health Providers

* Anyone in the practice can participate

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Food as medicine free continuing medical education (CME)

5.5 hours total:

- Introduction to lifestyle medicine module (1 hour)
- Food as medicine: nutrition for prevention and longevity module (3 hours)
- Food as medicine: nutrition for treatment and risk reduction module (1.5 hours)

How to enroll

Select 'register now' at **LifestyleMedicine.org/essentials**

Scroll to the bottom of the page and login or create an ACLM account. Proceed to check out.

Enter promo code: **ESS-ABHOK**

To contact our Medical Director and team, please email: **SchumannS@aetna.com.**

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Attestation

Thank you!

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[1] In accordance with OAC 317:30-3-13(a)(3)), Advance Directives shall be incorporated into the Enrollee's Case File within the Care Management system as well as the Enrollee's medical records, as applicable. The Advance Directive becomes operative when it is communicated to the attending physician and the Enrollee is no longer able to make decisions regarding administrative of life sustaining treatment, in accordance with 63 O.S. § 3101.5. The Health Care Power of Attorney becomes effective when the attending physician determines that the Enrollee is no longer able to make their own health care decisions, unless the Enrollee elected to have the Agent's authority take effect upon execution of the Health Care Power of Attorney, in accordance with 60 O.S. § 3111.5.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

The information provided herein and during the presentation are for convenience only and do not take the place of or supersede the requirements of the SoonerSelect program or the provider agreement, if any, with Aetna Better Health of Oklahoma.

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