AETNA BETTER HEALTH® of Michigan
Policy

Policy Name:	Arbitration Process	Page:	1 of 4
Department:	Administration	Policy Number:	3100.14
Subsection:	Claims/Compliance	Effective Date:	09/28/2015
Applies to:	■ Medicaid Health Plans		

PURPOSE:

This policy confirms that Aetna Better Health provides a method for Aetna Better Health of Michigan and non-contracted hospitals and providers to resolve disputed claims when 1) The parties cannot reach an agreement via the Rapid Dispute Resolution Process (RDRP) or 2) The non-hospital provider or hospital provider, has not signed the Hospital Access Agreement, requests arbitration in accordance with Section 1.022 (Y)(3) Comprehensive Health Care Program for the Michigan Department of Health and Human Services.

STATEMENT OF OBJECTIVE:

The objective of this policy is to meet the contract requirement in establishing an Arbitration Process as it relates to the Hospital Access Agreement developed by the Department of Health and Human Services (DHHS):

- When a non-hospital provider or hospital provider has not signed the Hospital Access Agreement requests arbitration, Aetna Better Health is required to participate in a binding arbitration process.
- Providers must exhaust Aetna Better Health of Michigan's internal provider appeal process before requesting arbitration.

DEFINITIONS:

Aetna Medicaid Legal	Aetna Medicaid Legal provides oversight, support and resources to the Aetna Medicaid health plans including Aetna Better Health.
Department of Health and Human Services (DHHS)	Michigan State Regulatory Agency
Hospital Access Agreement	Agreement developed by the Department of Health and Human Services to acknowledge the responsibilities of Aetna Better Health of Michigan and Hospitals where a hospital does not have a contract with Aetna Better Health of Michigan.

LEGAL/CONTRACT REFERENCE:

- Section 1.022 (Y)(3) Comprehensive Health Care Program for the Michigan Department of Health and Human Services.
- Arbitration Agreement (Attachment E)

FOCUS/DISPOSITION:

Responsibilities

The chief operating officer (COO), in conjunction with the Compliance department, is responsible for oversight and enforcement of the Arbitration Policy.

Scope

Operational Practices:

Upon receipt of notification from the Department of Health and Human Services advising of a request for Arbitration, the notification will be forwarded immediately to Aetna Medicaid Legal for handling and coordination of participants:

- The Michigan Department of Health and Human Services will provide a list of neutral arbitrators available to resolve claims disputes. These arbitrators will be organizations with the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. A model agreement will be developed by MDCH that both parties to the dispute will be required to sign. This agreement will specify the name of the arbitrator, the dispute resolution process, a timeframe for the arbitrator's decision, and the method of payment for the arbitrator's fee.
- If the Hospital's position is granted, the Health Plan agrees to make payment for the disputed claim(s) within thirty (30) days. If the Health Plan fails to make payment within the required timeframe, the Department will enforce the decision through withhold of the disputed amount from the Health Plan's capitation payment and direct payment to the Hospital.
- If the Health Plan's position is granted and results in the Hospital obligated to reimburse the Health Plan, the Hospital agrees to make payment within thirty (30) days. If the Hospital fails to make payment within the required timeframe, the Department will enforce the decision through an adjustment of future Hospital payments and direct the disputed amount to the Health Plan.
- The Party found to be at fault will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

OPERATING PROTOCOL:

Systems

- Claims business application system

Measurement (example)

- Payment of disputed claim(s) to provider within thirty (30) days
- Reimbursement of disputed claim(s) to Aetna Better Health within thirty (30) days

Reporting

- As required per MDHHS

INTER-/INTRADEPENDENCIES:

Internal

- Administration
- Chief operations officer
- Claims
- Compliance
- Finance
- Medical Director
- Medical Management
- Operations

External

- Arbitrators
- Hospitals/Providers
- MDHHS

Aetna Better Health

Beverly Allen
Chief Executive Officer

Teressa Smith
Chief Operating Officer