AETNA BETTER HEALTH® of Michigan
Policy

Policy Name:	Rapid Dispute Resolution Process	Page:	1 of 4
Department:	Administration	Policy Number:	3100.16
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 and non-contracted hospital providers to resolve disputed claims **for approved services** when the parties cannot reach an agreement via the Accounts Receivable Reconciliation Group (ARRG) as set forth in Attachment C of the Medical Service Administration Bulletin 01-28 effective December 1, 2001.

STATEMENT OF OBJECTIVE:

This policy describes how Aetna Better Health meets the contract requirement in establishing a Rapid Dispute Resolution Process as it relates to the Hospital Access Agreement and Health Plan Obligation developed by the Department of Health and Human Services.

DEFINITIONS:

Accounts Receivable Reconciliation Group (ARRG)	Persons empowered to make decisions regarding outstanding bills and payments in non-contracting circumstances.
Aetna Medicaid Legal	Aetna Medicaid Legal provides oversight, support and resources to the Aetna Medicaid health plans including Aetna Better Health.
Medical Service Administration (MSA)	A division of the Michigan Department of Health and Human Services.
Department of Health and Human Services (DHHS)	Michigan State Regulatory Agency

LEGAL/CONTRACT REFERENCE:

- Section 1.022 (Y)(3), Comprehensive Health Care Program for the Michigan Department of Health and Human Services
- MDHHS Hospital Access Agreement (Attachment A)
- MDHHS Health Plan Obligation (Attachment B)
- MSA 01-28 Bulletin (Attachment C) effective 12/1/2001
- MSA-01-28 Definitions (Attachment D)
- Arbitration Agreement (Attachment E)
- MDHSS Medicaid Provider Manual

FOCUS/DISPOSITION:

Responsibilities

The chief operating officer (COO), in conjunction with the Compliance department, is responsible for oversight and enforcement of the Rapid Dispute Resolution Process.

Scope

A Hospital Access Agreement (HAA) (Attachment A) and Health Plan Obligation (HPO) (Attachment B) have been developed by the Department of Health and Human Services (DHHS) to acknowledge the responsibilities of Aetna Better Health and Hospitals where a hospital does not have a contract with Aetna Better Health. The HPO is an Amendment to the State's Medicaid Contract with Aetna Better Health. Each hospital is encouraged to execute the HAA; however, the execution of the agreement is voluntary on the part of each hospital. The HAA is not a contract with Aetna Better Health and each hospital that serves or has a contract to serve the same population of Medicaid beneficiaries will establish an ARRG as set forth in the HPO and HAA. The ARRG shall reconcile accounts receivable of non-contracting hospitals with accounts payable of Aetna Better Health. These groups will meet no less than every ninety (90) days.

Operational Practices

Upon receipt of notification from the DHHS advising of a request for Rapid Dispute Resolution, the notification will be forwarded immediately to Aetna Medicaid Legal for handling and coordination of participants:

- Hospitals and Health Plan agree to exhaust their efforts to achieve reconciliation solutions for outstanding accounts via internal means on a regular ongoing basis, including the use of an Accounts Receivable Reconciliation Group (ARRG), before pursuing the Rapid Dispute Resolution Process (RDRP).
- Where a disputed claim, or group of similar claims remains, either the Hospital or the Health Plan may submit a request to the DHHS for RDRP. Upon receipt of a request by either the Hospital or the Health Plan, the DHHS will advise the other party that the disputed claim or group of similar claims will be resolved in this manner.
- The DHHS will contact a mediator, selecting one at random from the list of available mediators that it has prepared, within fifteen (15) calendar days of election/agreement by both parties to proceed. The mediator will schedule the mediation session within fifteen (15) calendar days of contact by the DHHS. The mediator will issue his/her decision

within fifteen (15) calendar days of the mediation session. The mediators will be disinterested parties without conflict of interest with either the Health Plan or the Hospital.

- Hospitals and Health Plan agree that, should a Hospital or a Health Plan elect this process, the outcome, including any monetary award, will be binding. Both parties agree to assume the burden of cost for presentation of their positions before the mediator. The cost of the mediator will be borne proportionally.
- 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 DHHS 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 DHHS will enforce the decision through an adjustment of future Hospital payments and direct the disputed amount to the Health Plan.

OPERATING PROTOCOL:

Systems

- Claims payment application Systems

Measurement

- 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

- Mediation determination to MDHHS

INTER-/INTRADEPENDENCIES:

Internal

- Administration
- Claims

- Compliance
- Finance
- Medical Director
- Medical Management

External

- Hospitals/providers
- MDHHS
- Mediators

Aetna Better Health

Beverly Allen
Chief Executive Officer

Teressa Smith
Chief Operating Officer