2024 Provider Manual

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Aetna Better Health® of Michigan

AetnaBetterHealth.com/ Michigan

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CHAPTER 1 – WELCOME TO AETNA BETTER HEALTH OF MICHIGAN

Welcome to Aetna Better Health® of Michigan Inc. (Aetna or Aetna Better Health), a Michigan corporation. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By participating in our network, you are helping us serve those Michiganders who need us most.

Aetna

Aetna Medicaid Administrators LLC (Aetna Medicaid), a CVS Health company, has over 30 years of experience managing the care of the most medically vulnerable, using innovative approaches and a local presence in each market to achieve successful health care results and effective cost outcomes. Aetna Medicaid has expertise serving high-need Medicaid members, including those who are dually eligible for Medicaid and Medicare. Currently, Aetna Medicaid owns and or administers Medicaid-managed health care plans under Aetna Better Health and other affiliate names. Together, these plans serve approximately 2.5 million people in 15 states, including Arizona, Florida, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Texas, Virginia, and West Virginia.

Experience and Innovation

We use predictive modeling, care management, and state-of-the-art technology to achieve cost savings and help members attain the best possible health through various service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on dramatic improvements in preventive care by facing health literacy challenges and personal barriers to healthy living. In addition, we provide care management services to hundreds of thousands of high-cost, high-need Medicaid members. We also utilize various delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

At Aetna Better Health, we understand that our holistic approach to managing a member's health is the best way to achieve expected goals. By assessing the member's physical, mental, sociological, economic, linguistic, and cultural needs, we can identify and prioritize the member's needs, removing or minimizing barriers to goals wherever possible. As a result of this understanding, we embrace and support an integrated model of care approach. We have extensive experience in engaging the entire Integrated Care Team (ICT), including the member, their PCP, and as applicable, their mental health provider, and other service providers when managing care. We routinely engage our member's PCP

to communicate and collaborate on member needs, conducting biweekly and monthly collaborative rounds with our behavioral health partners to discuss and coordinate care between the member's physical and behavioral health needs. Our ICT, which includes bachelor's-prepared social workers, community health workers, and other staff, is essential in assisting us in connecting identified members with available community resources, screening for depression, and coordinating with behavioral health providers when indicated.

Model of Care

Our model of care offers an integrated care management approach. The approach means enhanced assessment and management for enrolled members. The processes, oversight committees, provider collaboration, care management, and coordination efforts applied to address member needs result in a comprehensive and integrated care plan for members.

Our combined provider and care management activities improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across healthcare settings and providers
- Promote appropriate utilization of services and cost-effective service delivery

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:

- Review of network for adequacy and resolve unmet network needs
- Clinical studies and proactive discharge planning activities
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards preventing complications and preventive care services

Our integrated care management program influences member health. These include:

- Comprehensive member health assessment, clinical review, proactive discharge planning, transition management, and education towards obtaining preventive care. These care management elements reduce avoidable hospitalization and nursing facility placements/stays
- When appropriate, identify individualized care needs and authorization of required home care services/assistive equipment. These services promote improved mobility and functional status and allow members to reside in the least restrictive environment possible
- Care plans that identify a member's personal needs to direct education efforts that prevent medical complications and promote active involvement in personal health management

- Case Manager referral and predictive modeling software used to identify members at increased risk, functional decline, hospitalization, and emergency department visits

Service Area

Our service area for Medicaid, MI Child, CSHCS, and Healthy Michigan products includes the following counties:

Regions	Counties within Region
Region 8	Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
Region 9	Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
Region 10	Macomb, Oakland, Wayne

About This Provider Manual

Our Provider Manual serves as a resource and outlines operations for Aetna Better Health. Through the Provider Manual, you should be able to locate information on the majority of issues that may affect working with us. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Experience Department at **1-866-314-3784 (TTY: 711)**.

Our Provider Experience Department updates this Provider Manual at least annually and distributes update bulletins as needed to incorporate any revisions/changes. Please check our website at **www.aetnabetterhealth.com/Michigan** for the most recent version of the Provider Manual. The Provider Manual is available in hard copy form or electronic form, at no charge, by contacting our Provider Experience Department at **1-866-314-3784 (TTY:711)**. Otherwise, for your convenience, we will make the Provider Manual available on our website at **www.aetnabetterhealth.com/michigan/providers/manual**.

References throughout the Provider Manual to "Aetna" or "Aetna Better Health" or the "health plan" represent Aetna Better Health of Michigan.

Disclaimer

We expect our Providers to adhere to your Aetna Better Health provider agreement terms, including requirements described in this manual and all Federal and State regulations. While this manual contains basic information about Aetna Better Health and the Michigan Department of Health and Human Services (MDHHS), providers must fully understand and apply MDHHS requirements when administering covered services. Please refer to **www.michigan.gov/mdhhs/** for further information on MDHHS.

CHAPTER 2 – CONTACT INFORMATION

Important Contact Information

Providers with additional questions can refer to the following contact information for assistance:

Important Addresses	
Office Location	Aetna Better Health of Michigan 28588 Northwestern Hwy, Suite # 380B Southfield, MI 48034
Electronic Payor ID **Paper Claims and Claims Correspondence**	Electronic Payor ID: 128MI Aetna Better Health of Michigan P.O. Box 982963 EL Paso, TX 79998-2963
Resubmissions: Reconsiderations and Corrections (Contracted Participating Providers)	Aetna Better Health of Michigan P.O. Box 982963 EL Paso, TX 79998-2963
Appeals (Non-Contracted Providers)	Aetna Better Health of Michigan P.O. Box 81040 5801 Postal Road Cleveland, OH 44181
Returned Checks and Refund	Aetna Better Health of Michigan Attention: Angela Chambers 4750 S 44th Place Phoenix, AZ 85040

Aetna Better Health of Michigan Important Contacts	Phone Number	Hours and Days of Operation
Toll-Free Hotline	**1-866-316-3784 (TTY: 711)** (follow the prompts to reach the appropriate departments)	8 AM - 5 PM EST. Monday-Friday Our office is closed on: • New Year's Day • MLK Day • Memorial Day • Independence Day • Labor Day • Thanksgiving Day • Christmas Day
Compliance Hotline (Reporting Fraud, Waste or Abuse)	**1-855-421-2082 (TTY: 711)**	24-hours-a-day, 7-days-a- week through Voice Mail inbox
Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)	**1-855-421-2082 (TTY: 711)** To report fraud to MDHHS OIG, call **1-855-643-7283**	24-hours-a-day, 7-days-a-week
Nurse Line	**1-866-711-6664 (TTY: 711)**	24-hours-a-day, 7-days-a-week

Aetna Better Health of Michigan Departments	Phone Number	Fax Number
Member Services	**1-866-316-3784 (TTY: 711)**	1-866-506-1350
Claims Inquiry and Claim Research	**1-866-316-3784 (TTY: 711)**	N/A

Aetna Better Health of Michigan Departments	Phone Number	Fax Number
Provider Experience **Email: AetnaBetterHealth-MI-PR-Medicaid@aetna.com**	**1-866-316-3784 (TTY: 711)**	1-866-602-1251
Medical Prior Authorization	**1-866-874-2567 (TTY: 711)**	1-866-603-5535
Pharmacy Prior Authorization	**1-866-316-3784 (TTY: 711)**	1-855-799-2551
Appeals & Grievances	**1-866-316-3784 (TTY: 711)**	1-866-889-7517
Behavioral Health Crisis Line	**1-866-827-8704 (TTY: 711)**	1-866-603-5535
Disease Management/	**1-866-316-3784 (TTY: 711)**	1-866-889-7572
Provider Claim Resubmissions: Reconsiderations and Corrections	**1-866-316-3784 (TTY: 711)**	N/A

Contractors	Phone Number	Hours and Days of Operation
DentaQuest (Dental Vendor) **www.dentaquest.com**	1-866-316-3784	8 AM - 5 PM EST Monday-Friday
Interpreter Services The language interpretation contractor offers sign language, special services for the hearing impaired, oral translation, and oral interpretation.	Contact our Member Services Department at **1-866-316-3784 (TTY: 711)** (For more information on how to schedule these services in advance of an appointment)	8 AM - 5 PM EST Monday-Friday
Vision Services Plan Insurance Co. (VSP) (Vision Vendor) **www.vsp.com**	**1-800-877-7195**	Monday – Friday 8 AM – 9 PM EST Saturday/Sunday 10 AM - 8 PM EST

Contractors	Phone Number	Hours and Days of Operation
Access2Care (Non-Emergent Transportation Vendor) **www.access2care.net**	**1-866-316-3784**, Option 6	Monday through Friday, 6 AM to 10 PM EST; Saturday, 8 AM to 4 PM EST; closed Sundays.
Mail Order Prescription- CVS	**1-800-552-8159**	Monday – Friday 8 AM - 8 PM EST
Specialty Pharmacy CVS	**1-800-237-2767**	Monday - Friday 7:30 AM - 9 PM EST
Pharmacy Electric Prior Authorization Requests	Call CoverMyMeds® toll-free at **1-866-452-5017** Call SureScripts toll-free at	Visit the CoverMyMeds® website: **www.covermymeds.com/main**
	1-866-797-3239	Visit the SureScripts website: **surescripts.com/enhance-prescribing/prior-authorization**

CHAPTER 3 – PROVIDER EXPERIENCE DEPARTMENT

Provider Experience Department Overview

Our Provider Experience Department is a liaison between our health plan and our provider community. Our staff assists with provider training, problem identification and resolution, provider office visits, and accessibility audits. Our Provider Experience Department also supports network development and contracting with multiple functions, including evaluating the provider network and compliance with regulatory network capacity standards.

In addition to the Provider Experience Department, we also have a Claim Investigation Claims Research (CICR) team available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where our Claims Inquiry and Claims Research Department can help:

- Assist with claims questions, inquiries, resubmissions, appeals and grievances
- Review claims or remittance advice information
- View recent updates
- Locate forms
- Assist with prior authorization questions
- Receive reports of suspected fraud, waste, or abuse

For questions, please call our Claims Inquiry and Claims Research Department at **1-866-316-3784 (TTY: 711).**

Provider Experience

Our Provider Experience Department assists providers by offering education and assistance regarding various topics such as:

- Providing education/training to provider offices
- Providing support on Medicaid policies and procedures
- Clarifying provider contract provisions
- Assisting with demographic changes, terminations, and initiation of credentialing
- Obtaining secure web portal or member care login information

Our Provider Experience Department maintains a solid commitment to meeting the needs of our providers. By assigning Provider Experience representatives to specific groups of participating providers, we can become familiar with our providers and form a solid working relationship. Your designated representative understands our internal operations and is well versed in the managed care program.

Your assigned Provider Experience representative will visit or phone your provider offices periodically to ensure a seamless experience with us. Representatives meet routinely with you and or your office staff and are available upon request. Provider newsletters, electronic messages, and specialized mailings are sent to providers periodically, including updates to the provider manual, changes in policies or benefits, and general news and information of interest to our provider community. To contact your dedicated Provider Experience representative, please call **1-866-314-3784 (TTY: 711)** or email us at **AetnaBetterHealth-MI-PR-Medicaid@Aetna.com.**

Joining the Network

Providers interested in joining the Aetna Better Health of Michigan network should contact our Provider Experience Department at **1-866-314-3784 (TTY: 711)** for additional information regarding contracting and credentialing.

Provider Orientation

We provide initial orientation for newly contracted providers after joining our network. We provide a variety of forums for ongoing provider training and education, such as routine office site visits and individual or group training sessions on select topics (i.e., member benefits, Aetna Better Health website navigation). Provider newsletters, bulletins, reminders, and online resources are available via our website at **aetnabetterhealth.com/Michigan**.

Informed Health® Line (IHL)

Informed Health Line – The Informed Health Line is available 24 hours a day, seven days a week. Members can call or send a secure message to a registered nurse to seek medical information and advice. Members will receive a response within 24 hours. Informed Health Line is free of charge for our members. Informed Health Line utilizes clinical triage services consisting of a package of information services, call center services, triage, and other services. In providing the clinical triage services, the program uses algorithms, clinical tools, and supporting software designed to enable Registered Nurses to assess a member's level of health risk based on the presenting symptoms and route them to an appropriate level and timing of care.

Services are provided based on the answers to the questions in the algorithms. The nurses can then help the member decide if they need to go to the hospital, urgent care facility, or their doctor, or if they can care for themselves or a family member at home. The Informed Health Line does not provide benefit information.

Our Informed Health Line call center is open seven (7) days a week, twenty-four (24) hours a day, including holidays. Members can call **1-866-711-6664 (TTY: 711)** to speak to a nurse.

CHAPTER 4 – PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

Provider Responsibilities Overview

This chapter outlines general provider responsibilities. These responsibilities are the minimum requirements to comply with contract terms and applicable laws. Our providers are contractually obligated to adhere to and abide by the terms of the Michigan Medicaid program, their Aetna Better Health provider contract, and the requirements in this manual. We may or may not specifically communicate such terms in forms other than the provider contract, this manual, and website bulletins.

Our providers must act lawfully in the scope of treatment, management, and discussion of the medically necessary care and advise or advocate appropriate medical care with or on behalf of our members. In addition, our providers must provide information regarding the nature of treatment options, risks of treatment; alternative treatments; or the availability of alternative therapies, consultation, or tests that may be self-administered, including all relevant risks, benefits, and consequences of non-treatment.

We also expect our providers to use the most current diagnosis and treatment protocols and standards established by the medical community and relevant regulatory agencies. All advice must be given in the best interest of the member. In addition, our providers may not refuse treatment to individuals with disabilities. Refusal of treatment includes individuals with the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

Those providers appearing as excluded from participation in any federally or state-funded health care program are no longer eligible to participate in our network and must notify us immediately.

State of Michigan Medicaid Provider Enrollment

Providers who deliver services to our members must be enrolled in the state's Community Health Automated Medicaid Processing System (CHAMPS) and credentialed by us before providing care to our members. To learn how to register with the State of Michigan, please refer to the department's website at:
https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_85441---,00.html

National Provider Identifier (NPI) Number

A National Provider Identifier (NPI) number is a ten (10) digit number provider-specific and assigned by CMS. To obtain your NPI or learn more, please visit the National Plan/Provider Enumeration System (NPPES) website https://nppes.coms.hhs.gov/#/ To submit a claim with us, providers must have a valid NPI number. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information.

Access and Availability Standards

Our providers must schedule appointments for our members following minimum appointment availability standards and based on the severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Experience Department will routinely monitor provider compliance with minimum appointment availability standards and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from those providers not meeting accessibility standards.

Providers are contractually required to adhere to the Michigan Department of Health and Human Services (MDHHS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of the need for the services.

The tables below show appointment availability standards by provider type:

Availability Standard
Availability Standard for hours of operation for PCPs: • Twenty hours per week per practice location

Physician type	Appointment Type	Availability Standard
Primary Care Physician (PCP)	Non-Urgent Symptomatic Care	Within 7 business days of request
	Urgent Care	Within 48 hours
	Routine	Fourteen (14) business days
Specialty Care	Routine	6 weeks
Acute Specialty Care	Routine	5 business days
Behavioral Health	Non-Life-Threatening Emergency	Within six (6) hours
	Urgent Care	Within 48 hours
	Routine Care	Within ten (10) business days
Prenatal	First (1st) Trimester	Thirty (30) business days
	Initial Second (2nd) Trimester	Seven (7) business days
	High Risk	Three (3) business days from the date of referral
Dental	Initial Appointment	Within 8 weeks of Request
	Routine Care	Within 21 business days of request
	Preventive Services	Within 6 weeks of request
	Urgent Care	Within 48 hours
	Emergency	24 hours/day seven days per week

Notes:

- Primary Care Provider (PCP) is defined as Family Practice, Internal Medicine, Pediatrics, and General Practice.
- We determine high Volume Specialists through annual High Volume Specialist Reports. OB/GYN providers are considered mandatory High Volume Specialist providers and added to the yearly High Volume Specialist listing.
- When developing the network, we consider the linguistic and cultural preferences of health plan Membership.
- PCP providers must be available to members 24 hours a day, seven days a week. Providers are required to locate another physician to cover your services when necessary.

Telephone Accessibility Standards

Providers are responsible for arranging after-hours coverage per applicable rules and regulations, either by being available or having on-call services with other qualified participating Aetna Better Health providers.

Our policy does not allow network providers to utilize an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage responses for routine, urgent, and emergent health care issues are held to the same accessibility standards regardless of after-hours coverage managed by the PCP, current service provider, or the on-call provider.

All Providers must have a published after-hours telephone number and maintain a system that provides access to primary care 24 hours a day, 7-days-a-week. In addition, we encourage providers to offer open-access scheduling, expanded hours, and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. We routinely measure provider compliance with these standards as follows:

- Medical and provider management teams continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention
- Compliance and provider management teams evaluate member, caregiver, and provider grievances regarding after-hour access to care to determine if a PCP or specialist fails to comply

Providers must comply with telephone protocols under the following conditions:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a

member
- Identifying and rescheduling broken and no-show appointments
- Identifying member's needs while scheduling their doctor's appointments (e.g., wheelchair and interpretive linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental staff to provide covered services within regular working hours. Protocols should be in place to provide coverage in a provider's absence

We require our providers to offer our members the same hours of operation as non-Medicaid patients.

Providers must provide covered services to our members on a twenty-four (24) hour, seven (7) days per week basis. Further, you must meet Michigan state standards for timely access to care and services, considering the urgency of the need.

Monitoring of Standards

To monitor compliance with the Access and Availability Standards, the Aetna Better Health will:

- Review at least annually results of the Geo-mapping reports, completed by utilizing industry-standard software, to monitor compliance with the time and distance standards
- Review the Consumer Assessment of Health Plans Study (CAHPS), a member satisfaction survey, to monitor compliance with the Accessibility standards.
- Routinely monitor member complaints
- Routinely monitor after-hour telephone accessibility through member complaints and member and provider surveys or after-hours phone audits to ensure that the physician or an associate is available 24 hours per day, seven days per week

Covering Providers

If another provider covers your panel, you must notify us. Notification must occur in advance of the provision of any authorized services. Reimbursement to a covering provider follows the Michigan Medicaid Fee Schedule, which depends on their enrollment as a provider in our network and the State of Michigan Medicaid program. Failure to notify our Provider Experience Department of covering providers may result in claim denials.

Verifying Member Eligibility

All providers must verify a member's enrollment status regardless of contract status before delivering non-emergent, covered services. We will not reimburse providers for services rendered to members who lost eligibility.

Verify member eligibility by:

- Logging into the State of Michigan CHAMPS website
- Searching our secure provider portal
- Calling the Aetna Better Health's Member Services Department at **1-866-316-3784 (TTY: 711)**

The State of Michigan Medicaid Eligibility Line **1-800-292-2550** will also have helpful information regarding the member's eligibility status.

Secure Web Portal

The Aetna Better Health Secure Web Portal is a web-based platform that allows us to communicate member healthcare information directly with our providers. Providers can perform many functions within this web-based platform. The following features are available through our Secure Web Portal:

- Member Eligibility– Verify current eligibility of members
- Panel Roster – View the list of Members currently assigned to the provider as the PCP
- Provider List – Search for a specific provider by name, specialty, or location
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates **Note**: Only claims associated with the user's account provider ID are displayed
- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates.
- Only remits associated with the user's account provider ID will be displayed
- Authorization List – Search for provider authorizations by Member, provider, authorization data, or submission/service dates **Note**: Only prior-authorizations associated with the user's account provider ID are displayed.
- Submit Authorizations – Submit an authorization request on-line
- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member's compliance with any of the HEDIS measures. Indicators identify if each member has any gaps in care. A "Yes" means the member has measures that they are not compliant with; a "No" means that the Member has met the requirements
- Secure messaging to various departments at Aetna Better Health

To register for the Secure Web Portal, go to **www.availity.com/provider-portal-registration .** Please contact Availity Client Services for assistance with registration at **1-800-Availity (282-4548)** Monday – Friday 8 AM to 8 PM EST.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Member Care Web Portal

Our Member Care Web Portal is another web-based platform that allows members access

to services and information 24 hours a day. For additional information regarding the Member Care Web Portal, please access the Member Care Web Portal Navigation Guide located on our website.

The portal supports the functions and access to information related to:

- Prior authorization submission and status
- Claim payment status
- Member eligibility status
- E-Referrals to other registered providers
- Member and provider education and outreach materials

If you're interested in using this secure online tool, register on our "For Providers" page at **aetnabetterhealth.com/Michigan**. You can also contact our Provider Experience Department to sign up by calling **1-866-316-3784 (TTY: 711).** To submit your registration via fax, you can download the form from our website or request a copy from our Provider Experience Department. Please note that you must have a valid e-mail address and access to the internet to register.

Provider groups must first register a principal user known as the "Provider Representative." Once registered, the "Provider Representative" can add authorized users within each entity or practice. For instructions to add authorized users, go to **aetnabetterhealth.com/Michigan/providers/portal** and select Provider Secure Web Portal Navigation Guide.

Overview of Features for Members

Members can register for their own secure member portal accounts at **aetnabetterhealth.com/Michigan**. We have customized the Member portal to meet their needs better. Members will have access to:

- Health and Wellness Appraisal – This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. If applicable, the results will summarize the member's overall risk and protective factors and compare current results to previous results. The tool is available annually and is accessible via electronic and print formats
- Educational resources and programs – Members can access self-management tools for specific topics such as smoking cessation and weight management
- Claim status – Members and their providers can follow a claim from the beginning to the end, including the current stage, the amount approved, paid, and the date paid
- Pharmacy benefit services – Members can find out if a drug is covered, learn how to request an exception for a non-covered drug, request a refill for mail-order medications, and find an in- network pharmacy by zip code. They can also figure out drug interactions, side effects, and risks for medications and get the generic substitute for a drug

- Personalized health plan services information – Members can request a member ID card, change PCPs, and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain referrals and information on prior authorization requirements and find benefit and financial responsibility information for a specific service
- Innovative services information – Members will be asked to complete a personal health record and request an enrollment screening to see if they qualify for any disease management or wellness programs
- Informed Health Line – The Informed Health Line is available 24 hours a day, seven days a week. Members can call or send a secure message to a registered nurse to seek medical information and advice. Members will receive a response within 24 hours
- Wellness and prevention information – We encourage healthy living. Members will receive reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources, and automated outreach efforts with references to web-based self-management tools

We encourage providers to promote the use of the Member Portal during interactions with your patients. Members can sign up online **aetnabetterhealth.com/Michigan**. Or they can call our Member Services Department at **1-866-316-3784 (TTY: 711).**

Educating Members

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. We will not prohibit, or otherwise, restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of your patient:

- For member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- For any information, the member needs to decide among all relevant treatment options
- For the risks, benefits, and consequences of treatment or non-treatment
- For member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions

Further, we will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each member can request and receive a copy of their medical records, including any amended or corrected as specified in 45 CFR Part 164.

Primary Care Providers (PCP)

PCPs are physicians who specialize in:

- Family practice
- General practice
- Internal medicine
- Pediatrics
- Obstetrics/Gynecology
- Physician Assistant
- Other physician specialists when appropriate for a member's health condition.
- Certified Nurse Practitioners (CNP, under the direct supervision of a physician)
- Certified Nurse Midwife (under the supervision of a physician)

The PCP's Role is to:

- Manage and coordinate the overall health care of members
- Make appropriate referrals to participating providers and relevant community-based organizations
- Obtain prior authorization for any referrals to non-participating providers
- Provide or arrange for on-call coverage 24 hours/day, seven days/week
- Accept new members
- Follow all notification requirements as outlined in this Provider Manual
- Maintain comprehensive and legible medical records
- Complete section four of the Health Risk Assessment for Healthy MI members, and fax the completed form to toll- free number listed on the form

The Specialist's Role is to:

- Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment authorized by the PCP
- Communicate any assessments or recommended treatment plans to the PCP
- Obtain prior authorization for specified non-emergent inpatient and determined outpatient covered services
- Maintain comprehensive and legible medical records

Specialist Providers Acting as PCP

A member may select a physician specialist to serve as their PCP. In these instances, the specialist must demonstrate the ability to provide comprehensive primary care. Specialists are required to enroll with the State of Michigan as a PCP. Please contact our Provider Experience Department for additional assistance and approval.

Emergency Services

We do not require prior authorizations for emergency services. If you cannot provide services to a member who needs emergent care or calls after hours, instruct the member

to go to the nearest emergency room department. For more information, please reference the prior authorization requirements for inpatient admissions from the emergency room.

Urgent Care Services

Providers serve the medical needs of our members and are required to adhere to all appointment availability standards. In some cases, it may be necessary to refer members to a network urgent care center (after hours). Please reference our online directory located on our website. Select an "Urgent Care Facility" in the specialty drop-down list to view a list of participating urgent care centers located in the network.

We periodically review "unusual" urgent care and emergency room utilization. Trends will be shared with you and may increase appointment availability monitoring.

Skilled Nursing Facility (SNF) Providers

Skilled Nursing Facilities (SNFs) provide services to members who need consistent rehabilitation care but are not hospitalized or require daily care from a physician. Many SNFs may offer additional services to meet the unique needs of our members.

Skilled nursing facility (SNF) admissions require prior authorization. As part of the discharge planning process, our concurrent review nurse will coordinate the prior authorization of SNF admissions.

Following an admission, the concurrent review nurse will review the stay via the telephone with the facility Case Manager or designated facility review staff. A provider may also request a review by contacting our Utilization Department at **1-866-874-2567 (TTY: 711)**.

Home and Community-Based Services (HCBS)

Home and Community-Based Services often provide services to members in their homes. There may be times when an interruption of service may occur due to unplanned hospital admission or short-term nursing home stay for a member. While services may have been authorized for caregivers and agencies, providers should not bill for any days that fall between the facility admission and discharge dates or any day during which services were not provided. Submitting a claim could be considered fraudulent billing. HCBS providers may be required to work with Aetna Better Health Case Managers.

Medical Home

The National Center for Medical Home Implementation defines a medical home as a community-based primary care setting that provides and coordinates high-quality, planned, family-centered, health promotion, acute illness care, and chronic condition management. Performance/care coordination requirements of a medical home include the ability to:

- Provide comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited to electronic communications and ongoing care

coordination and health maintenance tracking

- Provide primary health care services for members and appropriate referral to other health care professionals or behavioral health professionals as needed
- Focus on the ongoing prevention of illness and disease
- Encourage active participation by a member and the member's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development
- Facilitate the partnership between members, their PCP, and, when appropriate, the member's family
- Encourage the use of specialty care services and supports

Self-Referral/Direct Access

We have an open-access network, where members may self-refer or directly access services without notice from their PCP. We encourage all providers to discuss specialty care with their members and coordinate services as needed.

Our members must receive services from network providers. However, there are exceptions to this; emergency, family planning, federally qualified and rural health centers, and tribal clinic services do not require prior authorization for in-network or out-of- network providers. Members may access these services from a qualified provider enrolled with the State of Michigan Medicaid program.

Second and Third Opinions

Members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. A member may request a second opinion from a provider within our network. If requested, providers must refer the member to another network provider within an applicable specialty for a second opinion.

Members have the right to a third opinion when the recommendation of the second opinion fails to confirm the primary diagnosis, and there is a medical need for a specific treatment, and if the member desires the third opinion.

Members will incur no expenses other than standard co-pays, if applicable, for a second and or third opinion provided by a participating network provider, as appropriate under the Member Handbook. Out-of-network services must receive prior authorization and are approved only when an in-network provider cannot perform the service. If our member has questions about second or third opinions, please have them call our Member Services Department at **1-866-316-3784 (TTY: 711).**

Procedure for Closing a PCP Panel

A PCP who no longer wishes to accept new Aetna Better Health members must submit a written notification to our Provider Experience Department to close their panel. In this

situation, any new member who is not an established patient will not be able to select that provider as a PCP.

To re-open a “closed” panel a written notification to our Provider Experience Department is required. This change will be made on the first of the month following submission of the request, no less than thirty days (30) from receipt of the request.

When a member chooses a PCP, who has a “closed” panel, our Member Service Department will notify the member of the physician’s panel status. Please contact our Member Services Department if you decide to make an exception on a “closed” panel situation.

PCP Transfer/Non-Compliant Members

Providers are responsible for delivering appropriate services to facilitate members' understanding of their health care needs. Providers should strive to manage members and ensure compliance with treatment plans and scheduled appointments. We will assist in resolving member-specific compliance issues by providing comprehensive member education and following case management protocols, discuss the problem and any potential solution with the member, or employ the plan's internal grievance procedures. Do not hesitate to contact our Provider Experience Department for additional assistance in resolving member issues.

The PCP may request removal of a Member from their panel upon submission of supporting documentation verifying circumstances that warrant removal. Circumstances that may warrant a disenrollment request include, but are not limited to:

- Failure to follow a recommended health care treatment plan. This can occur after one (1) verbal or one (1) written warning of the implication and possible effect of non-compliance
- Documented chronic missed appointments
- Documented behavior, which is consistently disruptive, unruly, abusive, or uncooperative
- Documented behavior which constitutes a threat or danger to the office staff or other patients
- Travel distance substantially limits the member’s ability to follow PCP services/referrals
- The PCP has documentation to establish fraud or forgery or evidence of unauthorized use/abuse of the service by the member. (Note: Fraud and abuse investigation protocols are activated accordingly to investigate all identified potential cases)

Member Transfer from Provider Guidelines

The PCP must adhere to the following guidelines to remove a member from their panel:

1. The provider must notify our Provider Experience Department of their desire to transfer a member in writing within thirty (30) days before terminating services
2. Provider is to notify the Member in writing within thirty (30) days by certified mail, of reason for termination and to choose another PCP

3. The provider must maintain responsibility for providing services to the member until our Provider Experience Department confirms the transfer is complete
4. Provider is required to manage care for emergent services during this time period
5. The PCP must provide:
   - A detailed accounting of the reason(s) for the transfer
   - A detailed accounting of the attempts made to resolve the issue with the member. Before beginning the transfer request process, the PCP must make serious efforts to resolve the problem presented by the member, including warning them that their continued behavior may result in a transfer
6. Provide documentation that, despite reasonable efforts to accommodate the member's medical conditions (physical and behavioral) through service coordination, the member continues to have behavior that is disruptive, unruly, abusive, or uncooperative to the point that their continuing participation in managed care seriously impairs the ability of the PCP and the Health plan to furnish services to either the member or others.
7. Submit documentation that the member's behavior was evaluated to determine if the behaviors are due to a mental illness and whether the condition/behaviors can be treated/controlled through appropriate interventions; or

Requests to transfer due to an adverse change in the member's health or unfavorable health status are not allowed. Removing a member from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid members.

Approval Review Requirements

Upon request, we will provide documentation showing the attempts made to resolve the reason for the transfer request through contact with the member or their legal representative, the PCP, or other appropriate sources.

We will document attempts to accommodate the member's needs and information supporting Aetna's and the PCP's ability to do so in a reasonable manner. Documentation will include information about:

- The reasonable efforts made to locate another PCP within our network;
- The PCP has demonstrated that they do not have the requisite skills and training to furnish the care and that s/he has made reasonable efforts to attempt to enlist additional consultation; and
- The PCP is unable, based on objective evidence, to establish a relationship with a member.

We will assist our PCPs and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for members with special needs, e.g., HIV/AIDS.

Processing Procedure for PCP Transfer Requests

1. The following procedure applies when a PCP requests a transfer:
    - The PCP must contact our Provider Experience Department and provide documentation of the reason(s) for transferring to another PCP. Aetna Better Health will be responsible for investigating and documenting the reason for the request
    - Aetna Better Health will review the documentation and conduct any additional inquiry to establish the reason(s) for transfer
    - Aetna Better Health will contact the member to assist them in voluntarily changing PCP. If we are unsuccessful in reaching the member or the member will not voluntarily change their PCP, the request will be submitted to MDHHS directly. If the transfer request is for a lock-in member, we will forward the request to MDHHS. We will attempt to contact the member to inform them that they must call MDHHS to change their lock-in PCP and assist them in finding a new PCP
    - Aetna Better Health will submit the transfer request to MDHHS within ten days of the request
    - MDHHS approves or denies the transfer request within five working days and responds directly to Aetna Better Health
    - MDHHS will then notify the member, PCP, and Aetna Better Health of the approval or denial of the transfer. The member and PCP will receive a letter and Aetna Better Health via fax
    - Aeta Better Health will auto-assign a new PCP for the member if the request is approved. If the transfer request is for a lock-in member, Aetna Better Health lists the member's PCP as "unassigned" until notified by MDHHS that the PCP transfer is complete

Interim PCP Assignment

Aetna Better Health is responsible for assigning an interim PCP in the following situations:

1. The PCP has terminated their participation with Aetna Better Health (e.g., PCP retires, leaves the practice, dies, no longer participates in managed care)
2. The PCP is still participating with Aetna Better Health but is not participating at a specific location (i.e., change in a location only) or
3. A PCP/plan-initiated transfer has been approved, but the member does not select a new PCP

Aetna Better Health is responsible for ensuring a smooth transition for the member through the assignment of an Interim PCP.

Aetna Better Health will immediately notify the member; by mail that the member is being temporarily assigned to another in-network PCP and that the new PCP will be responsible for meeting the member's health care needs.

Member Notification

The notification sent to the member will be made by Aetna Better Health by the later of 30 calendar days prior to the effective date of the new PCP assignment, or 15 calendar days after receipt or issuance of the PCP termination notice resulting in the change. Member notification will include the following information:

1. Member name, address, and Medicaid number
2. Reason for the change
3. Name, address, and telephone number of the new PCP

Exception: Aetna Better Health will treat PCPs as terminated if they move out of state or are no longer within coverage distance to the member.

Medical Records Review

We have adopted the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative's (QARI) medical record standards. In addition to the requirements of the Michigan Department of Health and Human Services, these are the minimum acceptable standards within our provider network. Below is a list of the medical record review criteria. Consistent organization and documentation of inpatient medical records are components of our Quality Management initiatives and are required to maintain continuity and quality of patient care.

All providers must adhere to national medical record documentation standards. NCQA considers 6 of the 21 elements as core components to medical record documentation. Core elements are indicated by an asterisk (*). Below are the minimum medical record documentation and coordination requirements:

Medical Record Documentation	
1	Each page in the record contains the patient's name or ID number
2	Personal biographical data include the address, employer, home and work telephone numbers and marital status
3	All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials
4	All entries are dated
5	The record is legible to someone other than the writer
6*	Significant illnesses and medical conditions are indicated on the problem list
7*	Medication allergies and adverse reactions are prominently noted in the record. If the

Medical Record Documentation	
	patient has no known allergies or history of adverse reactions, this is appropriately noted in the record
8*	Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses
9	For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history)
10	The history and physical examination identify appropriate subjective and objective information pertinent to the patient's presenting complaints
11	Laboratory and other studies are ordered, as appropriate
12*	Working diagnoses are consistent with findings
13*	Treatment plans are consistent with diagnoses
14	Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed
15	Unresolved problems from previous office visits are addressed in subsequent visits
16	There is review for under - or overutilization of consultants
17	If a consultation is requested, there a note from the consultant in the record
18	Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans
19*	There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
20	An immunization record (for children) is up to date, or an appropriate history has been made in the medical record (for adults)
21	There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines

The Quality Management (QM) Department will audit PCP clinics for compliance with the documentation standards noted above and provide the PCP with the results.

The Provider Experience Department will provide routine Medical Record Review (MRR) education to practitioners and their respective clinics. Education may include, but is not limited to, articles in our Provider Newsletter on the MRR process, highlights of low compliance, the adaptation of any universal forms by Aetna Better Health, and any changes within the process and standards. Tools utilized to implement and maintain education may include emails, fax alerts, provider website, provider manual, provider

newsletters, and mailings.

Providers may not bill or require members to reimburse them for expenses related to providing copies of patient records or documents to any local, State, or Federal agency. Including records requests from:

- Local, State, or Federal agencies, including the Centers for Medicare and Medicaid Services ("CMS") or such agencies' subcontractors
- Review organizations conducting Quality Management, Utilization Reviews, and Risk Management Programs, including the collection of HEDIS data
- Aetna Better Health when deciding whether a service is a covered service for which payment is due

All records, books, and papers of providers about members, including without limitation, records, books, and documents relating to professional and ancillary care provided to members and financial, accounting, and administrative records, books, and papers, must be open for inspection and copying by Aetna Better Health, its designee and authorized State or Federal authorities during provider's regular business hours. Providers must release a member's medical records to Aetna Better Health upon the provider's receipt of a member consent form or as otherwise required by law. Providers must acknowledge that the member has consented to release such records to Aetna Better Health.

Medical Record Audits

Aetna Better Health or MDHHS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we respond to an inquiry on behalf of a member or provider, administrative responsibilities, or quality of care issues. Providers must respond to these requests promptly. Medical records must be made available to Aetna, Michigan Department of Health and Human Services, and CMS for quality review upon request.

Providers must follow HIPAA (Health Insurance Portability and Accountability Act of 1996) guidelines when scoring member records.

Access to Facilities and Records

Federal and local laws, rules, and regulations require that providers retain and make available all records pertaining to any aspect of services furnished to a member or pertaining to their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of ten (10) years from the end of the contract with Aetna Better Health
- The date the State of Michigan or their designees complete an audit
- The period required under applicable laws, rules, and regulations

Documenting Member Appointments and Eligibility

When scheduling an appointment with a member, providers must verify eligibility and document the member's information in their medical record. Please access the Aetna Better Health website to electronically verify eligibility or call our Member Services Department at **1-866-316-3784 (TTY: 711).**

Missed or Cancelled Appointments

Providers should:

- Document in the member's medical record and follow-up on missed or canceled appointments
- Document if the Members contact information has changed and the reason the Member is unable to be contacted/reached
- Conduct affirmative outreach to a member who misses an appointment by performing minimum reasonable efforts to contact the member
- Notify our Member Services Department when a member continually misses appointments

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has many provisions affecting the health care industry, including transaction code sets privacy and security provisions. HIPAA impacts entities, specifically providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information and standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **http://www.hhs.gov/ocr/hipaa/**.

For additional training or Q&A, please visit
http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm.

Member Privacy Rights

Aetna Better Health's privacy policy affords members the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations and applicable contractual requirements. Our privacy policy conforms with 45 CFR (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

This policy also assists our personnel in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy requests, including:

- Making information available to members or representatives about Aetna Better Health practices regarding their PHI

- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") per federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Request amendments/corrections to records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

The member or member's authorized representative must submit a privacy request. A member's representative must provide documentation or written confirmation that he/she is authorized to make the request on behalf of the member or the deceased member's estate.

Advance Directives

Advance directives can include Living Will and Health Care Power of Attorney and are written instructions relating to the provision of health care when the individual is incapacitated.

Providers must comply with federal and state laws regarding advance directives for adult members and display their advance directives prominently in their medical records. Requirements include:

- Providing written information to adult members regarding their rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections)
- Documenting in the member's medical record whether or not the adult member received advance directive information and if executed
- Not discriminating against a member because they decide to execute or not execute an advance directive and not making it a condition for the provision of care

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand a community's social, linguistic, moral, intellectual, and

behavioral characteristics and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay, or speaking English. As federal law requires, Aetna Better Health expects providers to treat all members with dignity and respect. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on 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 communication skills within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on members diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter. We develop and implement proven methods for responding to those challenges.

Providers may receive education about such vital topics as:

- How can a member religious and or cultural beliefs affect health outcomes (e.g., belief in non- traditional healing practices)
- Health illiteracy and providing patients with understandable health information (e.g., simple diagrams, vernacular communication, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care
- How certain cultures are reluctant to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment

Our Provider Experience staff may conduct cultural competency training during provider orientation meetings, which helps providers:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with patients to help obtain better health outcomes

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

We must ensure members with Limited English Proficient (LEP) have meaningful access to health care services as required by the State and Title VI of the 1964 Civil Rights Act which established national standards for culturally and linguistically appropriate health care services.

Due to language differences and inability to speak or understand English, persons identified with LEP are often excluded from eligible programs, experience delays or denials of services, or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay, or speaking English. According to federal law, providers must treat all members with dignity and respect. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Providers must identify members language needs and provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health provides free telephonic language interpretation service to help providers facilitate member interactions. These services are accessible to the member and provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services from the Member Services Department, a representative will assist the provider via a three-way call to communicate in the Member's native language
- A Member Services representative will contact the language interpretation service to initiate a conference with a member and the interpreter for outgoing calls
- For face-to-face meetings, Aetna Better Health staff (e.g., Case Managers or Member Services representatives) can conference with an interpreter to communicate with a member in their home or another location
- When providers need interpreter services and cannot access them from their office, they can call the Member Services Department to link with an interpreter

Aetna Better Health provides alternative communication methods for visually impaired members, including large print and other formats. Alternative forms of communication are also available for deaf and hard-of-hearing members, including accessing the state Relay line (711). Contact the Member Services Department for more information on accessing alternative formats/services for the visually or hearing impaired.

Aetna Better Health requires professional interpreters rather than family or friends. Further,

we provide member materials in alternate formats to meet the member's specific needs.

Providers must also deliver information in a manner that the member understands. If a member declines interpreter services, the provider must document this in the member's medical record. This documentation could be necessary if a member decides that the interpreter does not have complete knowledge of their medical history, treatment, or health education. During the credentialing process for Aetna Better Health, we capture languages spoken in the office to meet members' special language needs.

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician office be accessible and flexible to those with disabilities. No qualified individual with a disability may be excluded from participation in or be denied the benefits of a public entities' services, programs, or activities. Non-compliance may result in discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also provide appropriate accommodations such as large print materials and easily accessible doorways. Our Provider Experience staff will conduct site visits to ensure those network providers are compliant.

Receipt of Federal funds, Compliance with Federal Laws, and Prohibition on Discrimination

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act), and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164

In addition, network providers must comply with all applicable CMS laws, rules, and regulations. Providers may not discriminate against members based on health status.

Providers must provide covered services to members. Covered services are to be delivered promptly, consistent with professional, clinical, and ethical standards, the same

way non-Medicaid members receive them. Providers must accept Aetna Better Health members as new patients on the same basis as accepting non-Medicaid beneficiaries as new patients. Provider shall not discriminate against a member on the basis of age, race, color, creed, religion, gender, sexual preference, national origin, health status, use of covered services, income level, or on the basis that Member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary. Out-of-Network Services
If Aetna Better Health cannot provide necessary covered medical services within our network of contracted providers care coordinate of these services will be facilitated with an out-of-network provider for as long as Aetna Better Health is unable to provide the services. A Care Manager will provide any necessary information for the member to help arrange the service. The member will not incur additional costs for seeking these services from an out-of-network provider.

Clinical Practice Guidelines

Aetna Better Health has clinical practice guidelines and treatment protocols available to providers to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to members and the general community. Providers should not use these guidelines to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member
- Constitute procedures for or the practice of medicine by the party distributing the guidelines
- Guarantee coverage or payment for the type or level of care proposed or provided

Clinical Practice Guidelines are available on our website at:

- Clinical Practice Guidelines | Aetna Better Health of Michigan
- Clinical guidelines are adopted from the Michigan Quality Improvement Consortium and are also available at Clinical Practice Guidelines | Michigan Quality Improvement Consortium .
- For Kidney Health clinical guidelines, visit the National Kidney Foundation of Michigan website Clinical Practice Guidelines | National Kidney Foundation of Michigan

Financial Liability for Payment for Services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. Network providers may collect deductibles, co-insurance, or co-payments from members per the Member's Member Handbook terms. Providers must make sure that they are:

- Agreeing not to 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 Aetna has authorized to service such members, as long as the

member follows Aetna's rules for accessing services described in the approved Member Handbook

- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members before rendering services
- Agreeing to advise a member, before furnishing a non-covered service, of the member's responsibility to pay the total cost of the services
- Agreeing that when a provider refers a member to another provider for a non-covered service, provider must ensure that the member is aware of their obligation to pay in full for such non-covered services

Health Care Acquired Conditions (HCAC)

Procedures performed on the wrong side, wrong body part, wrong person, or wrong procedure are referred to in this policy as "Wrong Site/Person/Procedure," or WSPPs. The Centers for Medicare and Medicaid Services (CMS) has adopted a national payment policy that all WSPP procedures are never reimbursed to facilities. CMS prohibits providers from passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse providers for WSPPs or any WSPP- associated medical services. In addition, Aetna Better Health prohibits passing these charges on to patients.

HCACs are preventable conditions that are not present when patients are admitted to a hospital but become present during the patient's stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria:

- Conditions are high cost or high volume or both
- Condition results in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
- The condition could have been reasonably prevented through the application of evidence-based guidelines

Subject to CMS policy, Aetna Better Health will not reimburse hospitals for the extra care resulting from HCACs. In addition, providers are prohibited from passing these charges on to patients.

General Reminders to all Providers

- Obtain prior authorization from Aetna Better Health for all services requiring a prior authorization
- Referrals to non-participating providers, regardless of the level of care, must be pre-authorized unless exempted explicitly from authorization, such as family planning and emergency services
- Authorization approval does not guarantee authorized services are covered benefits
- Benefits are always contingent upon member eligibility at the time of service

- Understand that Aetna Better Health approves authorization requests based on the present information made available to us. Payment for previously authorized, covered services is subject to compliance with Aetna Better Health's Utilization policies

Management Program, contractual limitations and exclusions, and coordination of benefits.

- Accept medical necessity and utilization review decisions (refer to the Grievance and Appeal section of this provider manual if a provider disagrees with a review decision or a previously processed claim)
- Agree to collect only applicable copayments, coinsurance, or deductibles from members. Except for collecting copayments, coinsurance or deductibles, providers shall look only to Aetna Better Health for compensation for medically necessary covered services
- Agree to meet credentialing and re-credentialing requirements of Aetna Better Health
- Providers must safeguard the privacy of any information that identifies a particular Member according to federal and state laws and maintain the member records in an accurate and timely manner
- Providers must provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care
- Providers must render or order only medically appropriate services
- Providers must obtain authorizations for all hospitalizations, confinements, and services specified in this manual and other provider communications requiring prior approval
- Providers must fully comply with the terms of their agreement and maintain an acceptable professional image in the community
- Providers must keep their licenses and certifications current and in good standing and cooperate with Aetna Better Health's re-credentialing program
- Providers must notify Aetna Better Health of any material change in the provider's qualifications affecting the continued accuracy of the credentialing information submitted
- Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/re-credentialing process.
- Providers must furnish Aetna Better Health with evidence of coverage upon request and must provide the plan with at least fifteen (15) days' notice before the cancellation, loss, termination, or transfer of coverage
- Providers must ensure the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna Better Health, including the required medical records data, and ensure that the information presented on the applicable

claim forms is accurate

- Providers must follow the termination process outlined in this provider manual if terminating their agreement with Aetna Better Health
- Providers must submit demographic or payment data changes at least sixty (60) days before the effective date of the change
- Providers must submit changes in provider roster, address, and telephone number immediately upon effect of the change.
- Providers must be available to Aetna Better Health members as outlined in the provider manual Access and Availability Standards section
- Providers must arrange 24-hour, on-call coverage for their patients by providers that participate in the Aetna Better Health network, as outlined within this manual
- Providers must become familiar and, to the extent necessary, comply with members' rights as outlined in the "Members Rights and Responsibilities" section of this manual
- Providers must honor all Aetna Better Health members' rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records about their care, and actively participating in decisions regarding health and treatment options
- Providers must comply with the quality improvement, utilization review, peer review, grievance procedures, credentialing and re-credentialing procedures, and any other policies that Aetna Better Health may implement, including amendments to this manual and mentioned policies and programs
- Providers of all types may be held responsible for the cost of service(s) where prior-authorization is required but not obtained or when the place of service does not match prior authorization; providers must not bill the member for applicable service(s).

Aetna Better Health encourages providers to contact our Provider Experience Department if they require further details on requirements of participation.

Civil Rights, Equal Opportunity Employment, and Other Laws

Providers are required to comply with all applicable local, State, and Federal statutes and regulations regarding civil rights laws and equal opportunity employment, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Providers must recognize that the Michigan Fair Employment Practice Act prohibits a Provider, in connection with its provision of services under this Amendment, from discriminating against any employee or applicant for employment, with respect to hiring, tenure, terms, conditions, or privileges of employment because of race, color, religion, sex, disability, or national origin. Providers must guarantee compliance with the Michigan Fair Employment Practice Act. Additionally, Providers must comply with the Elliott-Larsen Civil Rights Act,

the Persons with disabilities Civil Rights Act and Executive Directive 2019—09. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and Prohibited Relationships

Aetna Better Health does not contract with providers listed on the non-procurements portion of the State of Michigan's General Services Administration's "Lists of Parties Excluded for Federal Procurement or Non-procurement Program." This list contains the names of parties debarred, suspended, or otherwise excluded by State agencies and contractors declared ineligible under State statutory authority. Upon entering an agreement with Aetna Better Health, providers attest that they do not appear on this list. Should a provider's status on this listing change, providers must notify Aetna Better Health immediately.

Aetna Better Health does not contract with providers excluded from federal health care programs under either section 1128 or section 1128A of the Social Security Act. Should a providers exclusion status change, providers must notify Aetna Better Health immediately. Further, providers must not employ or contract with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Aetna Better Health does not maintain relationships with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, including Executive Order No. 12549 and No. 12549. Aetna Better Health does not maintain relationships with "affiliates" under the Federal Acquisition Regulation. Should a provider status change to an "affiliate," providers must notify Aetna Better Health immediately.

Federal Sanctions

For Aetna Better Health to comply with federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106), we must obtain specific information regarding the ownership and control of entities with which we contract for services and for which payment falls under the Medicaid or Medicare program. We collect ownership and control information on our Controlling Interest Worksheet included in the provider application packet. This form must be completed, signed, and dated when returned from the provider.

Medically Necessary Services

All services provided to members must be medically necessary and reflect:

- Health care services and supplies which are medically appropriate
- Basic health needs of the member
- Rendering in the most cost-efficient manner and setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or government agencies

- Consistent with the diagnosis of the condition
- Provision of services required for means other than the convenience of the member and their provider
- A provision that is no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Provision of services of demonstrated value
- Provision of services that is no more intense level of service than can be safely provided

New Technology

Emerging technologies are a daily occurrence in health care. Aetna Better Health has a Medical Technology Committee (MTC) to review new and emerging technology. The committee uses evidence-based clinical research when determining the latest technologies. We share with our provider information about these new technologies approved for coverage by Aetna's MTC via routine communications, including the Provider Newsletter, bulletins, and ongoing provider relations.

Notice of Provider Termination

We will make a good faith effort to give written notice of termination of a contracted provider, within thirty (30) days after receipt or issuance of the termination notice, to each member who received their primary care from the terminated provider. The providers responsibility is to provide timely notification as indicated in the provider contract if they request a termination from the Aetna Better Health network.

Prohibition on Payments Outside the United States

Effective January 1, 2011, Section 6505 of the Patient Protection and Affordable Care Act prohibits Aetna Better Health from making payments for Medicaid items or services to financial institutions or entities outside the United States. This act includes payments to physicians, hospitals, and ancillary healthcare providers for items or services provided to Medicaid members through the Aetna Better Health contract with the State of Michigan. Payment will not be remitted if you or your organization are located outside or utilize a financial institution outside of the United States. Establishing a new relationship with an entity located in the United States will allow for payment.

Provider Satisfaction Survey

Annually, Aetna Better Health conducts a provider satisfaction survey. If you have any questions or would like to participate, please contact the Provider Experience Department at **1-866- 316-3784 (TTY: 711).**

Provider Responsibilities to Members

This section outlines the providers responsibilities to Aetna Better Health members. This

information is provided to providers to understand the requirements in place for the Medicaid Program. Establishing an early primary care physician relationship is the key to ensuring that every Member has access to necessary health care and provides continuity and coordination of care. The member will already have chosen a primary care physician when their enrollment is effective. If necessary, Aetna Better Health will assign a primary care physician if the member makes no selection.

PCP Qualifications and Responsibilities

Providers must be Medicaid-enrolled providers and agree to comply with all pertinent Medicaid regulations. In addition, providers must:

- Sign a contract with Aetna Better Health as a PCP which explains the PCP's responsibilities and compliance with the following Managed Medicaid requirements:
- Treat Managed Medicaid Members in the same manner as other patients
- According to the Enrollment Report, provide the covered services to all members who choose or are assigned to the PCP's practice and comply with all requirements for referral management and prior authorization
- Provide members with a medical home including, when medically necessary, appropriately coordinate referrals to services that typically extend beyond those services provided directly by the PCP (This includes but is not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community-based agency services)
- Work cooperatively with specialists, consultative services, and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.
- Provide continuous access to PCP services and necessary referrals of urgent or emergent services available 24-hour, seven days per week, access by telephone to a live voice (an employee of the PCP or answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours
- Not refuse an assignment or transfer a member or otherwise discriminate against a member solely based on age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when another provider type can better treat that illness or condition
- Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the member's unique needs
- Request transfer of the member to another PCP only for reasons identified in Michigan Medicaid policy and continue to be responsible for the member as a

patient until another PCP is assigned

- Maintain a medical record for each member and comply with the requirement to coordinate the transfer of medical record information if the member selects another PCP
- Communicate with agencies including, but not limited to, local public health agencies to participate in immunization registries and programs, e.g., Vaccines for Children, communications regarding the management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in the State
- Provide information to MDHHS as required
- Inform members about all treatment options, regardless of cost or whether the Michigan Medical Assistance Program covers such services
- Provide accurate information to Aetna Better Health promptly to exchange information with MDHHS

Provider Reminders – Member Demographic Updates

We encourage our providers to remind members how important it is to maintain their demographic information. If a member updates their phone number, email, or address with your practice, please remind them to report the updates to the Michigan Department of Health and Human Services (MDHHS). Members can update their demographics by going to the MI Bridges website at **www.michigan.gov/mibridges**. If the member does not have an account, they will need to create an account by selecting "Register." Once the member is in their account, please remind them to make the update in both the profile section and the Report Changes area when reporting the demographic changes. The Report Changes area is what the local office will use to update the address for their case.

Advanced Directives

Aetna Better Health is committed to ensuring that adult members understand their rights to make informed decisions regarding their health care. Aetna Better Health educates providers on advance directives processes to ensure our members have the opportunity to designate advance directives. Aetna Better Health's Advance Directives Medicaid Policy and Procedure guides us on our obligations for educating members and providers It describes the provision of health care when the member is incapacitated. These policies ensure the member's ability to make known their preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health's policy defines advance directives as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (statutory or as recognized by the courts of the State) relating to the provisions of health care when the individual is incapacitated. The Advance Directives policy details our obligation for Advance Directives with respect to all adult individuals receiving medical

care by or through the health plan. These obligations include, but are not limited to:

- Providing written information to all adult individuals concerning their rights under state law to make decisions concerning their medical care, accept or refuse medical or surgical treatment and formulate Advance Directives for health care
- Documenting in a prominent part of the individuals medical record whether the individual has executed an Advance Directive
- Not conditioning the provision of care or otherwise discriminating against an individual based on whether that individual has executed an Advance Directive.
- Ensuring compliance with requirements of state law concerning Advance Directives
- Educating Health Plan staff and providers on Advance Directives

Aetna Better Health's policies provide guidance on their obligation for ensuring the documentation of any Advance Directive decisions in the providers member records and monitoring provider compliance with advance directives, including the right of the Member to note any moral or religious beliefs that prohibit the member from making an advance directive.

The Aetna Better Health Provider Experience staff will educate network providers of their responsibilities regarding advance directives through the Provider Contract, Provider Manual, Provider newsletters, and during Provider Experience on-site office visits.

Aetna Better Health Network Management is responsible for:

- Ensuring provider contracts contain requirements that support members to formulate advance directives
- Ensuring the provider manual contains guidance on advance directives for Aetna Better Health members

Aetna Better Health's Quality Management (QM) staff distributes Medical Record Documentation Standards annually to the providers. Providers must place a copy of the members advance directives in their medical records. If the member does not have an executed advance directive, the medical history should denote a discussion regarding advance directives between the provider and the member.

At the time of enrollment, Aetna Better Health distributes written information to members on advance directives (including Michigan State law) through the Member Handbook. The information in the materials includes:

- Description of member's rights under State law
- Our policies on the implementation of member rights
- Details on how a member can file a complaint with the State

Our Case Managers educate Aetna Better Health of Michigan members and offer

advance directives information when appropriate. Additionally, providers are audited during on-site reviews to ensure policy and procedure compliance.

CHAPTER 5 – CREDENTIALING AND PROVIDER CHANGES

Requests for Participation

All potential providers who request to participate within the Aetna Better Health provider network are subject to the same process. Our process ensures consistency amongst all providers who apply.

Aetna Better Health will only accept as participating providers those providers/practitioners:

1. For which there is a network need
2. That willingly accept the terms of the negotiated contracts, including reimbursement rates
3. Successfully pass the health plan's credentialing standards
4. Who has registered with CHAMPS.

Once a request is received for provider/practitioner participation within the Health Plan network(s) it will be reviewed for network need.

- If determined there is a network need, the provider will be contacted to begin the contracting and credentialing process
- If determined there is not a network need, the requestor will be notified by in writing that there is no current need in his/her specialty area and/or in his/her service area. The requestor is also informed that they may request application to the network one year from the date of the notification letter

Council for Affordable Quality Healthcare (CAQH)

Aetna Better Health uses current National Committee for Quality Assurance (NCQA) standards and guidelines for reviewing, credentialing, and re-credentialing of providers. In addition, we use the CAQH Universal Credentialing Data Source, developed by America's leading health plans collaborating through the Council for Affordable Quality Healthcare, or CAQH, for all provider types. The Universal Credentialing Data Source is the top industry-wide service to address one of the provider's most redundant administrative tasks: the credentialing application process.

The Universal Credentialing Data Source Program allows practitioners to use a standard application and a shared database to submit one application to one source and update it on a quarterly basis to meet the needs of all health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contact the practitioner for the same standard information. To maintain data accuracy, providers update their information every quarter. CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide. All new providers, except

for hospital and ancillary providers, including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process and be approved by the Credentialing Committee. Please note that non-credentialed provider types will not be required to complete the CAQH application; please contact our Provider Experience Department for further information.

Providers are re-credentialed every three (3) years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and Drug Enforcement Administration (DEA) certificates are also required. Please note that providers may NOT treat members until a provider is fully credentialed and assigned a final effective date. Providers may be required to be board certified.

Additions or Provider Terminations

Providers in good standing are required to notify Aetna Better Health about any terminations or additions to their agreement at least ninety (90) days prior to the change. Providers are required to continue providing services to members throughout the termination period.

Providers are responsible for notifying our Provider Experience Department of any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes to your in-office team may result in the need for additional training. Please contact your assigned Provider Experience representative to discuss staff training needs.

Aetna Better Health provides written notice of a termination of a network provider at least thirty (30) days prior to the termination effective date to all members (patients) who are seen regularly by the provider being terminated. Providers are required to notify their panel of any know termination.

Continuity of Care

Providers terminating their contracts with Aetna Better Health without cause must provide written notice in accordance with the terms of their contract to the Provider Experience Department.
Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Providers may also contact the Case Management Department for assistance with continuity of care needs.

Facility Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation annually or as otherwise requested

Credentialing /Recredentialing

Aetna Better Health utilizes credentialing and re-credentialing procedures to exercise reasonable care in selecting, evaluating, and retaining competent, participating providers. Our primary objectives in credentialing providers are to:

- To establish minimum standards for participation of network providers
- To provide a sufficient number of providers by specialty/type to service our members
- To review, through appropriate application of credentialing standards, on a scheduled basis, at least every three years, providers credentials to assure that minimum standards for participation are maintained
- To apply standards for participation in a uniform and consistent manner
- To initiate and maintain contractual requirements by which providers must notify us of any changes in status relevant to the credentialing process
- To provide a means whereby issues concerning providers and data concerning the level of member satisfaction with our providers may be brought to our attention and used during the re-credentialing process
- To evaluate and recommend the approval or denial of all-new provider applications
- To assess the performance and accuracy of credentialing information that changes over time

Application Requirements for Ancillary/Facility Providers

Our Provider Experience Department manages all ancillary and facility application requests. The applicant must provide a completed, signed, and dated Aetna Better Health application for use in verify the providers qualifications. Please note that ancillary provider locations may require a facility review if they do not hold an acceptable accreditation. In addition to the application, please submit the following items:

- Signed Participating Provider Agreements (if applicable)
- Completed Facility Application
- List of licensed services offered
- Copy of current Michigan or appropriate License
- Copy of DEA (federal) certificate, if applicable
- Copy of another applicable narcotic certificate (if applicable)
- Copy of professional liability insurance or malpractice coverage
- Copy of accreditation certificate(s)
- A completed Ownership Disclosure form
- Completed Cultural Competency form
- Copy of accreditation organization's letter indicating accreditation level
- Copy of CMS certificate or state audit report
- Copy of full CMS audit report

- Copy of completed IRS W-9 form
- A complete listing of the service area, including cities and counties

Site Review

Aetna Better Health will perform site reviews in response to member complaints, quality reviews, or unaccredited ancillary/facility providers. The site review includes but is not limited to the following areas:

- Physical access
- Physical appearance
- Office hours
- Adequacy of waiting and examining areas
- Availability of appointments
- Emergency and safety
- Adequacy of equipment
- Emergency medication
- Medical record review

Providers who fail a site review may receive a corrective action plan.

Credentialing Policy

Aetna Better Health's credentialing policy incorporates the highest industry standards, a combination of URAC/NCQA/CMS plus applicable state and federal requirements. Exceptions to these standards are reviewed and approved based on local access issues determined by the local health plan. We will follow and apply the provisions of state statutes, federal requirements, and accreditation standards that apply to credentialing activities.

Statement of Confidentiality

Provider information obtained from any source during the credentialing/re-credentialing process is considered confidential and used only to determine the provider's eligibility to participate in our network; and carry out the duties and obligations of our operations, except as otherwise required by law.

Provider information is shared only with those persons or organizations who have the authority to receive such information or who perform credentialing- related functions. We store all credentialing records in secured/locked cabinets and limit access to credentialing to authorized personnel only. Individual computer workstations are locked when employees leave their workstations. All employees are trained in and acknowledge training pursuant to Federal HIPAA regulations.

Non-Discrimination

Aetna Better Health does not discriminate against any provider on the basis of race, color, creed, ancestry, religion, age, disability, sex, national origin, citizenship, sexual orientation, disabled veteran, or types of procedures performed or types of patients the practitioner specializes, or veteran status, in accordance with Federal, State, and Local laws.

Aetna Better Health does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under state law, solely on the basis of the license or certification.

Aetna Better Health maintains a Compliance Hotline at **1-855-421-2082 (TTY: 711),** which is available 24 hours per day, 7 days to facilitate the reporting of compliance concerns. All Aetna Better Health employees, members and providers are encouraged to contact the compliance line if they suspect discrimination.

Verification Activity

Aetna Better Health utilizes a source verification checklist to monitor compliance. The following activities are validated:

- Complete Application
- Current State Licensure (Primary Source)
- Specialty Board Certification (ABMS)
- Residency Program Completion (Primary Source)
- Medical School of Graduation (Primary Source)
- Attestation statements signed and dated (within 180 days of the credentialing date)
- Completeness and Correctness of Application & Release of Information (Attestation)
- Verify liability insurance coverage is current (Secondary source, Ins. Carrier face sheet)
- Liability Insurance Coverage in the minimum amount of $100,000/300,000 (secondary source, Ins. Carrier face sheet)
- History of loss of admitting facility privileges or disciplinary activity (Attestation)
- Inability to perform essential functions of the position (Attestation)
- Lack of present illegal use of drugs (Attestation)
- History of loss of license or felony convictions if applicable (Attestation)
- NPDB for malpractice history and state and federal sanctions
- DEA or CDS/BNDD (NTIS or Copy of certificate)
- OPM
- Review of work History for previous five years for gaps of 6 months or more
- Hospital privileges, Secondary (Application)
- Ownership/Controlling Interest
- Cultural Competency training

For any questions regarding the credentialing or re-credentialing status of a provider, please contact our Provider Experience Department at **miaetnacontractingrequest@aetna.com**

FQHC/RHCs Application Status

Within 30 days of receiving and validating an application for completeness, Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) will receive notification directly from the Centralized Verification Organization (CVO) that their credentialing application is under review. In the event you did not receive notice from the CVO, please get in touch with our Provider Experience Department to validate your status by emailing **miaetnacontractingrequest@aetna.com**

Important FQHCs & RHCs Information

Claim Information:

- FQHCs and RHCs should expect claims to be adjudicated as usual in that provisions are in place to allow claims to be processed and paid under the MDHHS Provider Manual guidance. Should FQHC/RHC experience any issues, they should contact Aetna's Claims Inquiry Claims Research (CICR) team for assistance at **1-855-676-5772**.

Direct Access:

- Members may receive services from an FQHC or RHC without prior approval

Reporting:

- FQHCs and RHCs must adhere to the responsibilities outlined in this manual, including any information and data sharing expectations

Applicant Notification and Rights

Practitioners are notified of their credentialing rights when applying for network participation which include the following:

- Each applicant is notified in writing if there is a delay in the credentialing process
- Practitioners have the right to review the information submitted in support of their Credentialing application. This review is at the practitioner's request and, as applicable, is facilitated by the Network Operations staff or Medical Director

Aetna may disclose to the practitioner information obtained from any outside primary source, including but not limited to, malpractice insurance carriers and state licensing boards

- Aetna will not disclose to the practitioner information prohibited by law, references, recommendations, or other information that is peer review protected
- Network Operations staff will notify practitioners in writing of any information obtained during the Credentialing process that varies significantly from the information provided to the Health Plan by the practitioner

- Practitioners have the right, upon request, to be informed of the status of their credentialing application, the process is as follows:
- Practitioners may contact the Credentialing staff via telephone or in writing and inquire as to the status of their application
- Credentialing staff will respond to the practitioner's request for information either via telephone or in writing of the status of their application
- Practitioners have the right to correct erroneous information submitted by another party, i.e., information obtained from other sources, that varies substantially from that of the practitioner. When discrepancies are identified, the process is as follows:
- The practitioner will be notified in writing, within thirty (30) days, from the date Aetna receives this information. CVO will not reveal the source of the information if the information is not obtained to meet organizational credentialing verification requirements or if law prohibits disclosure
- The practitioner will submit any corrections in writing, within fifteen (15) calendar days, to the Network Operations staff
- The Network Operations staff will document in the applicants file the date the information was received by Aetna
- All documentation and correspondence relative to this topic will be kept in the applicant's credential file
- The following is how practitioners are notified of their right to correct erroneous information:
  - Practitioner Application/Practitioner Reappointment Application
  - Aetna Better Health of Michigan website **aetnabetterhealth.com/Michigan**
  - Guidance throughout the Provider Manual

Annual Monitoring of Provider Credentialing Systems and Data Exchange

Aetna Better Health of Michigan's process for monitoring system security controls covers delegates that store, create, modify or use credentialing or recredentialing data on its behalf. Aetna Better Health is committed to ensuring the integrity of all credentialing data is secure by taking the following measures:

- Monitoring the delegate's credentialing system security controls in place to protect data from unauthorized modification, as outlined in CR 1, Element C (Credentialing System Controls), factor 4, at least annually.
- Ensuring that the delegate monitors, at least annually, that it follows the delegation agreement or its own policies and procedures.

Aetna Better Health monitors the delegate's system security controls as part of the delegation oversight requirements.

The delegate should provide documentation (e.g., a report or other type of evidence) that it completed the monitoring process at least annually during the specified review period.

Delegate's monitoring of its system security controls. The delegate provides documentation of modifications that did not comply with its policies and procedures or with the delegation agreement at least annually during the look-back period.

Documentation of monitoring must be provided regardless of system functionality (e.g., the system prevents changes to the original record under any circumstances, but allows creation of a new record to modify dates; allows date modifications only under specific circumstances; uses alerts or flags to identify noncompliance), with the exception of advanced system controls capabilities.

Advanced system controls capabilities. If the credentialing system has advanced system control capabilities, the following are provided in lieu of monitoring reports or other monitoring evidence:

- A description of system functionality that ensures compliance with established policies and procedures with the delegation agreement.
- Documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modifications criteria; the system must have both capabilities.

Aetna Better Health may also Chose Auditing as the method for monitoring.

- If the credentialing system can identify noncompliant modifications, all noncompliant modifications must be reviewed.
- Sampling is allowed only if the credentialing system cannot identify all noncompliant modifications.

Aetna Better Health is not required to conduct an audit if it determines that the delegate adequately monitored and reported noncompliant modifications; the organization reviews the delegate's findings in the audit report instead of conducting its own audit of the delegate's system controls. The organization provides documentation (e.g., a report, meeting minutes, other evidence) that it reviewed and agreed with the delegate's findings.

If Aetna Better Health determines that the delegate did not adequately monitor noncompliant modifications, we may decide to conduct our own audit of the delegate's system controls.

Delegate files may be audited using one of the following methods:

- 5% or 50 files, whichever is less, to ensure that information is verified appropriately.
    - At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
- The NCQA "8/30 methodology" may also be utilized in the review of credentialing files. Details on the "80/30 methodology" are available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual file audits.

CHAPTER 6 – MEMBER BENEFITS

Aetna Better Health believes that the essence of a successful Medicaid program is that members understand their benefits and how to access them. We also go beyond simply educating members about covered services and implementing incentive programs to encourage benefit utilization.

Covered Services

General areas of covered services under Aetna Better Health include:

- Health Fitness benefits
- Ambulance and specific emergency medical transportation
- Breast pumps; personal use, double-electric
- Outpatient mental health services
- Blood lead testing under the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Centering Pregnancy Program services
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Community Health Worker services
- Dental services
- Doula services
- Diagnostic laboratory, x-ray, and other imaging services
- Durable medical equipment (DME) and supplies, including those that a pharmacy may supply
- Emergency services
- End-Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by the member)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 days

- Maternal and Infant Health Program (MIHP) services
- Medically necessary weight reduction services (Weight Watchers)
- Non-emergent medical transportation (NEMT) to medically necessary, covered services
- Out-of-state services authorized by the Aetna Better Health
- Parenting and birthing classes
- Pharmacy services
- Over-the-Counter medications and supplies
- Podiatry services
- Practitioners' services
- Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS
- Prosthetics and orthotics
- Restorative or rehabilitative services in a place of service other than a nursing facility
- Remote Patient Monitoring for members with Chronic Conditions
- Sexually transmitted infections (STI) treatment
- Tobacco cessation treatment, including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational, and therapies to support activities of daily living), excluding services provided to persons with developmental disabilities, and billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts
- Transplant services
- Vision services
- Well-child/EPSDT for persons under age 21 Aetna Better Health
- Long-Term acute hospital services (LTACH)
- Dental services for adults 21 and older and pregnant women
- Continuous glucose monitoring system (for some individuals with Type 1 Diabetes)

The covered services provided to Healthy Michigan Plan members include all those listed above and the following additional services:

- Additional preventive services required under the Patient Protection and Affordable Care Act as outlined by MDHHS
- Habilitative services

Enhanced Services

In conjunction with the provision of covered services, Aetna Better Health will:

- Place strong emphasis on programs to enhance the general health and well-being of members to maintain a healthy diet, engage in regular exercise, get an annual physical examination, and avoid all tobacco use
- Make health promotion programs available to the members
- Collaborate with community partners to resolve social determinates of health and health care related needs
- Promote the availability of health education classes for members
- Provide education for members with, or at risk for, a specific disability or illness
- Provide education to members, member's families, and other health care providers about early intervention and management strategies for various illnesses and, or exacerbations related to that disability or disabilities
- Upon request from MDHHS, collaborate with MDHHS on projects that focus on improvements and efficiency in the overall delivery of health services

Copayments

There are no co- payments, deductibles, or any other out-of-pocket cost for covered services.

Members may be required to pay for services if they ask to receive services that Aetna Better Health does not cover.

Member Communications

Aetna Better Health communicates information about covered services with our members in several ways. We write all member communication materials at a sixth-grade reading level. Some of these materials are available in alternate formats and non-prevalent languages. The documents include:

- Member Handbook - A comprehensive members document that explains all covered benefits and services and exclusions and limitations
- Public Website - General information and Member Handbook are available online
- Member online portal – The portal provides members easy access to health care information and materials.
- The member portal is a secure, password-protected site that ensures confidential information is only available to the member
- Member Newsletter - Newsletters feature health plan news, health, and wellness information, tips, and tools for members, and more. Aetna Better Health also communicates covered benefits and services to members
- Member Services - Representatives are trained and dedicated to responding to members benefit questions.

- Appeals and Grievances - The Member Handbook outlines how to file appeals and grievances. The grievance and appeals team also assist members through the process
- Care Management - Aetna Better Health offers a Care Management program to help members with health needs. When needed, our care management programs are updated to meet the needs of our membership. Care coordinators educate members about their health needs
- Prior Authorization – The Member Handbook outlines which services require prior authorizations and which services do not. Members can also contact our Member Services Department for more details
- Community Health Workers (CHW) - Assist members in addressing Social Determinants of Health (SDoH) to foster improved health outcomes
- Outreach Coordinators - Work with community partners to support our members understanding of Medicaid, drive brand awareness, align on common health improvement community goals
- Network Providers - Provider Directory outlined which providers are in network. It is available on our website and can also be mailed.
- Member Advisory Board - Aetna members, staff, and stakeholders committee meeting regularly to learn about covered benefits and services and provide feedback on materials, providers, and services

Interpretation Services

Aetna Better Health provides interpreter services for members with Limited English Proficiency (LEP), deaf, and hearing or visual impairments. Aetna Better Health will provide, upon request, alternative formats of all member-related materials.

To promote the delivery of quality health care services to all LEP members, providers and members may inquire about interpretive services in their community by contacting our Member Services Department at **1-866-316-3784 (TTY: 711).**

Aetna Better Health offers deaf and hard-of-hearing members a TTY line (TTY: 711). Our Member Services Department can establish interactions with other TTY lines or be available to mediate a TTY line call to a health care provider by contacting us at **1-866-316-3784 (TTY: 711)**.

When a member prefers that available family or friend interpret for them or decides not to utilize Aetna Better Health's hearing-impaired support service line, the provider must note this in the member's medical record. Refer to the Interpretation Services section in the Provider Responsibilities and Important Information chapter for additional requirements.

Transportation

For Medicaid members, transportation is available for all covered services by Aetna Better Health of Michigan. Transportation includes public transportation, ambulance, gas reimbursement, and transportation by wheelchair van. Aetna Better Health covers air travel for critical medical needs. Transportation services are a covered benefit for eligible Aetna Better Health members when necessary to receive non-emergent medically necessary health services.

Guidelines to determine transportation necessity:

- Members must be eligible with Aetna Better Health on date of the scheduled appointment
- Members are asked to give a three-day notice when requesting non-urgent transportation

Providers or members may contact the transportation vendor to arrange for transportation for medically necessary non-emergent health services by calling 1-866-316-3784, Option 6. Non-emergent transportation arrangements may be made twenty- four (24) hours a day.

Criteria for non-emergent transportation

- Transportation is a covered benefit for covered non-emergent medical appointments, trips to the pharmacy, and specified Aetna Better Health of Michigan/Care Management outreach events
- More than one (1) additional passenger will require Member Service Supervisor approval
- If the Member is a single caregiver with more than one minor child in his/her care the Plan authorizes vendor to transport the additional minor children
- Members under age 16 must be accompanied by an adult at least 21 years or older, with the exception of pregnant members whose trip will not require Member Service Supervisor approval
- Transportation is a covered benefit for mental health visits
- Trips to a PCP that exceed 30 miles or trips to a specialist that exceed 50 miles one way require prior approval from Aetna Better Health of Michigan Member Service Supervisor
- Trips to see a provider that exceed 40 miles or 40 minutes (one way) in rural communities require prior approval
- Out-of-state trips require approval from the health plan. Please reach out to Member Services at 1-866-316-3784 (TTY: 711).

Pharmacy

The Aetna Better Health pharmacy benefit follows the Michigan Department of Health and

Human Services (MDHHS) Single Pharmacy Drug List (SPDL) and Common Formulary. The SPDL is a listing of drugs that are covered by Michigan Medicaid. There are two categories of coverage, preferred and non-preferred. The link to the complete PDL can be found on our website at **aetnabetterhealth.com/Michigan/providers/Medicaid/pharmacy**. The link provides access to the pharmacy management procedures.

Additional drugs are covered on the Michigan Medicaid Common Formulary (CF). The Common Formulary includes drugs that are covered as a pharmacy benefit and contains requirements such as quantity limits, age limits, prior authorization criteria and step therapies that all Medicaid Health Plans in Michigan are required to follow. The Aetna Better Health pharmacy benefit follows these requirements and also includes medications that are not required to be covered by the common formulary. A link to the common formulary may also be found on our website.

Please review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health of Michigan patient such as quantity limits and step therapy protocols. Drugs not listed on the PDL/CF will require a prior authorization for an exception and should include an explanation of why a non-formulary drug is needed and include relevant medical records. MDHSS has a list of PDL/CF criteria that which can be found on our website. The complete PDL can be found on our website **aetnabetterhealth.com/michigan/providers/medicaid/pharmacy**

Aetna Better Health pharmacy benefit is intended to cover medically necessary prescription products for self- administration in an outpatient setting. The pharmacy benefit provides for outpatient prescription services that are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. There are some medications that are not on the formulary because they are covered as a medical benefit. These medications may be those that are physician-administered injectable drugs, vaccines, and intrauterine devices.

There are medications that are carved out and not covered by the Aetna Better health pharmacy benefit. These medications are paid directly to a pharmacy by the MDHHS fee-for service program. This list can be found at **https://michigan.fhsc.com/Providers/DrugInfo.asp**. For these medications, pharmacies are required to bill Magellan Medicaid Administration for payment.

Except for medications that are carved out, the Aetna Better Health pharmacy benefit allows for a provider to request for any prescribed medically appropriate product identified on the Medicaid Pharmaceutical Product List (MPPL). This list may be found at **https://michigan.fhsc.com/Providers/DrugInfo.asp**. Medications that are listed on the MPPL but are not listed on the Common Formulary are available through a non-formulary prior authorization process.

Aetna Better Health formulary is a key component of the benefit design. The goal of our formulary is to provide cost-effective pharmacotherapy based on prospective, concurrent, and retrospective review of medication therapies and utilization. The principal consideration in the selection of covered drugs is to provide safe and effective medications for all disease states. Providers may request an exception to Aetna Better Health Formulary by contacting the pharmacy help line at **1-855-432-6843 (TTY: 711)**.

Vision

Aetna Better Health of Michigan maintains a network of providers through its vision vendor VSP, for the delivery and reimbursement of routine vision services, such as optometric exams. Non-routine vision related services medical in nature should be billed directly to Aetna.

Aetna Better Health provides optical services for eligible members. Contact our Member Services Department at **1-866-316-3784 (TTY: 711)** to verify member eligibility for optical services.

Benefits include, but are not limited to the following:

- One (1) routine eye exam every twelve (12) months (authorization is not required)
- Lenses and frames may be replaced every twenty-four (24) months
- Lens changes can be made more frequently than the benefit permits if the MDHHS guideline for diopter change is met
- Vision therapy requires prior authorization
- Contact lenses are covered only if medically necessary, for specific diagnoses

For a complete listing of all participating vision providers, please refer to the Aetna Better Health Provider Directory or Aetna Better Health website at **aetnabetterhealth.com/Michigan.**

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with DentaQuest to provide your dental benefits. If you have any questions about your dental services, please contact DentaQuest at **1-844-870-3976 (TTY: 711)**.

Covered dental services include:

Aetna Better Health covers adult dental services including but not limited to:

- Preventive dental services
- Routine cleanings

- X-Rays
- Extractions
- Fillings
- Crowns
- Root Canals
- Dentures

For more information on dental services and prior approval requirements, call Aetna Member Services.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at **1-800-642-3195** for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: **1-800-936-0935**

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (**deltadentalmi.com**)
Phone: **1-866-696-7441**

Medicaid Members ages 21 and up and Healthy Michigan Plan Members: Ages 19-64

- Benefits are covered through DentaQuest Dental
- Members call: **1-844-870-3976**
- Providers call: **1-844-870-3977**

Emergency Services

Prior approval by the member's primary care physician and medical/surgical plan is not required for receipt of emergency services. Education of the member is necessary to ensure they are informed regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the member to contact the PCP and plan before accessing emergency services. Our Member Services Department and Medical Management team will also assist in educating members regarding emergency services.

An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity, (including severe pain), that a prudent layperson, who

possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency

Emergency services shall not be subject to prior authorization. Aetna Better Health must be notified within one (1) business day following an emergency admission, service, or procedure to request certification and/or continuation of treatment for that condition. Aetna Better Health will reimburse non-participating Providers for the evaluation and/or stabilization of emergency conditions.

Members that inappropriately seek routine and/or non-emergent services through emergency department visits will be contacted by Aetna Better Health and educated on visiting their PCP for routine services and/or treatments. Use of ground ambulance transportation under the prudent lay persons definition of emergency will not require authorization for the ambulance service.

24 Hour Informed Health Line

Aetna Better Health of Michigan provides a free 24-hour Informed Health Line for members. Informed Health Line services are provided based on the answers to questions in algorithms, the nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or to their doctor or if the member can care for him or herself or family member at home. The Call Center is staffed seven (7) days a week, twenty-four (24) hours a day, including holidays and can be reached at 1-866-711-6664.

Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists, within our network. Providers must follow the policies for emergency room care, second opinion, and noncompliant members.

It is not always possible to complete all components of the full medical screening service. For example, immunizations may be medically contraindicated or refused by the caregiver. The caregiver may also refuse to allow their child to have a lead blood level test performed. When this occurs, an attempt should be made to educate the caregiver with regards to the importance of these services. If the caregiver continues to refuse the service, the child's medical record must document the reason the service was not provided. By fully documenting in the child's medical record the reason for these services was not provided, the Provider may bill a full medical screening service even though all components of the

full medical screening service were not provided.

Telehealth Services

To reduce barriers in accessing and enhancing healthcare, providers may choose to conduct assessments or professional services leveraging telemedicine and e-visits. Aetna Better Health supports the use of simultaneous audio/visual telehealth service delivery as a primary method of telehealth service; however, in situations where the beneficiary cannot access services via a simultaneous audio/visual platform, either due to technology constraints or other concerns, the provision of audio-only services for a specific set of procedure codes is allowed. Refer to the Michigan Medicaid Provider Manual for additional guidelines for audio-only telehealth services.

Providers must ensure the privacy of the beneficiary and the security of any information shared via telehealth. Aetna Better Health requires either direct or indirect beneficiary consent for all services provided via telehealth. This consent must be properly documented in the beneficiary's chart in accordance with applicable standards of practice.

Direct Access to Women's Health Specialist

Aetna Better Health provides female members direct access to women's health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to prenatal care, breast exams, mammograms, and pap tests. Direct access means that Aetna Better Health cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent Aetna Better Health from requesting or requiring notification from the practitioner for data collection purposes. They may also seek these services from a participating provider of their choice, if their primary care provider is not a women's health specialist.

Women's health specialists include, but are not limited to, obstetricians, gynecologists, nurse practitioners, doulas, and certified nurse-midwives.

Direct Access for Family Planning Services

Aetna Better Health members have direct access for family planning services without a referral and may also seek family planning services at the provider of their choice (in or out of network).
The following services are included:

- Annual gynecological exam
- Annual pap smear
- Lab services
- Contraceptive supplies, devices, and medications for specific treatment
- Contraceptive counseling

Direct Access for Treatment for STDs

Aetna Better Health members can access any participating provider or Michigan Medicaid provider for treatment of a sexually transmitted disease without prior approval from Aetna Better Health.

Direct Access for American Indians

Aetna Better Health members who are American Indian or Alaska Native may receive services from a tribal clinic or Indian Health Services without prior approval.

Maternity Services

Medicaid covers maternity care and delivery services. A Member may initiate the first visit to an in-network maternity provider without obtaining prior authorization. Members should have a prenatal care checkup in their first trimester and a postpartum care visit 7 to 84 days after delivery.

Once an Aetna Better Health Member is determined to be pregnant, the Provider is requested to notify Aetna Better Health. Members having an established relationship with a non-par maternity provider may see that provider without obtaining prior authorization.

Aetna Better Health generally authorizes forty-eight (48) hour admission stays for a routine vaginal delivery and ninety- six (96) hour admission stays for an uncomplicated cesarean delivery. The attending physician and mother may determine that an earlier discharge is in the best interest of the family.

Aetna Better Health's goal is to have healthy mothers and babies. In an effort to meet that goal, Aetna Better Health works closely with the Members obstetrical provider and various Maternal Infant Health Programs to ensure the best start for the mother and baby.

Maternal, Infant Health Programs (MIHP) is a home-visiting program for Medicaid eligible women and infants to promote healthy pregnancies, positive birth outcomes and healthy infant development. All MIHP's are certified by MDHHS and include service such as:

- Plan of care development.
- Professional intervention services of a multidisciplinary team consisting of a qualified: Social Worker, Nutritionist, Nurse, and Infant Mental Health Specialist (if available).
- Arranging transportation as needed for health, substance abuse treatment, support services, and/or pregnancy-related appointments.
- Referral to community services (e.g., mental health, substance abuse, chronic kidney disease).
- Coordination with medical care providers.
- Childbirth classes or parenting education classes.
- Dispute Resolution including grievance and appeal resolution

Services consist of social work, nutrition, nursing services (including health education), counseling/social casework, and beneficiary advocacy services. MIHP services are reimbursed by fee-for-service Medicaid.

MIHP services are voluntary. Members must be provided an opportunity to select and change their MIHP provider organization. If the member does not choose an MIHP provider organization at the time of MIHP eligibility determination, Aetna Better Health will assign an MIHP provider organization within one month of the effective date of MIHP eligibility determination. Aetna Better Health must provide members an opportunity to change their MIHP provider organization among those who maintain agreements and to decline MIHP screening and services. If a member is currently receiving services from an MIHP provider at the time of enrollment with Aetna Better Health and Aetna Better Health does not have an agreement with that MIHP provider, Aetna Better Health must pay the MIHP provider Medicaid FFS rates until case closure.

Newborns

Charges for newborn services must be billed on a separate claim from the mothers claim. Claims received with mother and baby charges submitted on the same claim will be rejected and be sent back to the provider as denied for inconsistency with member's age or sex. The provider would then need to resubmit separate claims for the mother and the baby.

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

MDHHS 2018 EPSDT Bulletin

Early and periodic screening, diagnosis, and treatment (EPSDT) is a federally mandated comprehensive child health program for Medicaid members. Aetna Better Health provides or arranges for EPSDT services for Aetna Better Health Medicaid members under the age of 21.

EPDST care provides comprehensive, periodic evaluations of the member's health, development, nutrition, vision, hearing, and dental status. EPDST services are provided by health departments and Primary Care Providers (PCPs) such as pediatricians, family practice physicians, and general practice professionals, as well as by community health and head-start agencies. The goal of preventive health care is to recognize and treat health conditions that could have significant developmental consequences for children and adolescents.

Aetna Better Health educates members about EPSDT through the Member Handbook, the member newsletter, and a member reminder system.

Network providers are subject to Aetna Better Health's documentation requirements for EPSDT services. EPSDT services shall also be subject to the following additional

documentation requirements:

- The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule
- Documentation of a comprehensive screening shall at a minimum, contain a description of the components described below.
- Aetna Better Health recommends that providers send reminders to parent when screenings, immunizations, and follow-up services are due

Screenings

Providers should use the following guidelines to provide comprehensive EPSDT services to Aetna Better Health members.

Comprehensive, periodic health assessments or screenings, from birth through age 20 at intervals, which meet reasonable standards of practice, as specified in the EPSDT medical periodicity schedule established by MDHHS. The medical screening shall include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development
- A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection, and nutritional assessment
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations must be administered
- Appropriate laboratory tests at participating lab facilities
- The following recommended sequence of screening laboratory examinations should be provided by Aetna Better Health participating providers; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary:
- Hemoglobin/hematocrit
- Urinalysis
- Tuberculin test
- Health education/anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected
- EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:
  - Neonatal exam
  - Under 6 weeks
  - 2 months

- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- 3 years
- 4 years
- 5 years
- Bi-annually from age 6 through 20 years for Medicaid

- Blood lead testing using blood level determinations should be completed during scheduled periodic health visits according to the following schedule:
- Lead Testing at 12 months **and** at 24 months of age
- Lead Testing between 36 and 72 months of age children who were not previously tested must be tested at least once
- **An elevated Blood Lead Level (EBLL) is ≥3.5 ug/dl,** if an Aetna member has an elevated blood lead level there are several considerations and treatment plans that can be considered. Ensure a venous blood retest is completed within 1-3 months to ensure BLL is not rising. You can refer the family to MDHHS' Lead Safe Home Program to determine eligibility for environmental investigation and abatement
- All screenings shall be done through a blood lead level determination
- Results of lead screenings, both positive and negative results, shall be reported to MCIR – Michigan Care Improvement Registry
- The following questions are intended to assist physicians and nurse practitioners in determining if further lead testing is necessary in addition to that completed at the mandated ages:
  - Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? (this could include day care, preschool, or home of a relative)
  - Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
  - Does the child have a brother or sister (or playmate) with lead poisoning?
  - Does the child live with an adult whose job or hobby involves lead?
  - Does the child's family use any home remedies that may contain lead?
- You may also refer a member with elevated blood lead levels for Care Management services by calling **1-866-316-3784 (TTY: 711)**

For further information on lead screening, please contact the Centers for Disease Control (CDC) at 1-800-232-4636. Publications and other materials concerning blood lead screening may be obtained from the Michigan Department of Health and Human Services Childhood Lead Poisoning Prevention Program.
https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2983---,00.html

Vision Services

Participating providers should perform periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to DHHS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening of an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done. For members with vision problems, Aetna' Member Handbook and other materials are available in large print and Braille. The Aetna website also has buttons to make print larger.

Hearing Services

All newborn infants will be given a hearing screening before discharge from the hospital. Those infants who do not pass the newborn hearing screening, those who are missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Children should be tested using an appropriate test such as the Hear Kit, Weber, Rinne, or Puretone Audiometric evaluation along with history from the parent or guardian. The Michigan Department of Health and Human Services (MDHHS) requires hearing screening of all Medicaid-covered newborns. **https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_21429-141509--,00.html**

Participating providers should perform periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in DHHS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids.

Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

Providers are expected to provide adequate access to all covered services to those with limited English proficiency, deaf or hard of hearing, physical or mental disabilities, Children's Special Health Care Services (CSHCS) and persons with special healthcare needs.

Dental Services

Dental services are available for all beneficiaries enrolled in Healthy Michigan Plan, as well as Medicaid enrollees ages 21 and older. For questions regarding dental coverage (D codes) please refer to our dental provider, DentaQuest at 855-898-1478. A referral to a dentist at or after one year of age is recommended. A referral to a dentist shall be mandatory at three years of age and annually thereafter through age 20 for Medicaid members.

Oral examination includes visual and tactile examination of all intra-oral hard and soft tissues and teeth for all children for obvious abnormalities, such as cavities, inflammation, infection, or malocclusion.
Children should be referred to dentists for the following reasons:

- Over the age of three (3) years
- Evidence of infection, inflammation, discoloration, malformation of the dental arches, malformation, or decay of erupted teeth

Oral Health Screening and Fluoride Varnish

This program is intended for medical providers, such as pediatricians, family practitioners, and nurse practitioners who treat beneficiaries aged 0 – 35 months. This program will help aid in early identification of caries and help provide a risk assessment and intervention for medical providers in order to help reduce the risk of early childhood caries.
www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_6226-449061--,00.html

The State's Oral Health Program has developed an online training program and fluoride varnish manual for use in medical practices. Medical providers are required to complete the training and submit verification of the completion to the Oral Health Program. The Oral Health Program will distribute a certificate to the medical providers upon completion. In addition, the Oral Health Program will keep an updated list and monitor the practices that receive a completion certificate.
Varnish! Michigan Free Fluoride Varnish Program for Medical Providers

If your office is interested or you have questions, please contact:
oralhealth@michigan.gov

Additional Training materials can be found on the MDHHS website, **www.michigan.gov/medicaidproviders** >>Billing and Reimbursement >> Provider Specific Information >> Dental.

Billing and Reimbursement for Fluoride Varnish

Topical application of fluoride varnish is for beneficiaries up to age 20. Fluoride varnish can be applied to teeth up to four times a year for ages 0 through 5 and one time per six

months for ages 6 through 20. For ages 6 through 20, topical application of fluoride varnish cannot be combined with topical application of non-varnish fluoride in the same six months. The procedure code for fluoride varnish application is D1206. This code can be billed on the CMS 1500 or the 837 4010A1 Professional claim format. The fluoride varnish application is a separate reimbursement. The oral health screening is part of the well-child visit performed by the medical provider. There is no additional reimbursement for the screening.

Other Services

Participating providers should perform such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Sterilizations

Age Requirement: The Michigan Department of Health and Human Services (MDHHS) is prohibited from paying for sterilization of individuals who are:

- Under the age of 21 on the date the member signs Form MSA-1959; or
- Legally incapable of consenting to sterilization

Coverage Conditions:

MDHHS covers sterilizations only when:

- The sterilization is performed because the member receiving the service made a voluntary request for services
- The member is advised at the outset and before the request or receipt of his/her consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized
- Members whose primary language is other than English must be provided with the required elements for informed consent in their primary language
- The member must be mentally competent at the time the surgery is performed.
- The waiting period from the time the Consent Form is signed to the day of the surgery must allow for a full thirty (30) day waiting period but not exceed one hundred eighty (180) days from the consent date
- The member must be eligible with Aetna Better Health on the date of service.
- Reimbursement cannot be made to the physician if the State requirements are not met

Procedure for Obtaining Services: Non-therapeutic sterilizations are covered by Aetna Better Health of Michigan only when:

- Legally effective informed consent is obtained on Form MSA-1959, "Consent Form," from the

- Member on whom the sterilization is to be performed. The surgeon shall submit a properly completed and legible Form MSA-1959 to Aetna Better Health before payment of claims can be considered; and
- The sterilization is performed at least 30 days following the date informed consent was given. To calculate this time period, day 1 is the first day following the date on which the form is signed by the member. Day 31 in this period is the first day on which the procedure could be covered by MDHHS. The consent is effective for 180 days from the date Form MSA-1959 is signed. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the member must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MSA-1959.

Informed Consent

Informed consent means the voluntary, knowing assent of the member who is to be sterilized after s/he has been given the following information:

- A clear explanation of the procedures to be followed
- A description of the attendant discomforts and risks
- A description of the benefits to be expected
- Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure
- An offer to answer any questions concerning the procedures; and
- An instruction that the individual is free to withhold or withdraw his/her consent to the sterilization at any time before the sterilization without prejudicing his/her future care and without loss of other project or program benefits to which the member might otherwise be entitled

This information is shown on Form MSA-1959, which must be completed by the member. The consent form must be submitted with the claim form.

Sterilization Consent Forms

Form MSA-1959, "Sterilization Consent Form," is included in this manual, please see the Forms Section. It may also be ordered by the physician directly from the Michigan Department of Health and Human Services, Division of Medicaid and Long-Term Care, or from the local HHS office. The surgeon shall submit a properly completed and legible Form MSA- 1959 to Aetna Better Health before payment of claims can be considered. For additional information, contact the Prior Authorization Department at 1-866-874-2567.

Hysterectomies

Aetna Better Health covers hysterectomies when medically necessary. For payment of claims for hysterectomies (hospital, surgeon, assistant surgeon, anesthesiologist), the surgeon shall submit to Aetna Better Health, Form MSA- 2218, "Informed Consent Form," properly signed and dated by the member in which member states that member was informed before the surgery was performed that this surgical procedure results in permanent sterility before claims associated with the hysterectomy can be considered.

Exception: Aetna Better Health does not require informed consent if:

- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility
- In the case of a post-menopausal individual, the Department considers the individual to be sterile. All claims related to the procedure must indicate that the member is post- menopausal
- The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life- threatening emergency situation in which s/he determined prior acknowledgment was not possible. The physician must also include certification of the emergency

A copy of the physician's certification regarding the above exceptions must be submitted to Aetna Better Health before consideration for payment for claims associated with the hysterectomy can be submitted. For additional information, contact the Pre-Authorization Department at **1-866-874-2567 (TTY: 711)**.

Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

Abortions

Medicaid payments for abortion services are limited to cases in which the life of the member would be endangered if pregnancy were continued and cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the member or is to terminate a pregnancy that resulted from rape or incest. Physicians must make such certification on a completed Certification for Induced Abortion form (MSA-4240). The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist,

hospital, laboratory) that would submit claims for services related to the abortion.

Vaccines For Children (VFC) Program

Aetna Better Health of Michigan facilitates the payment of allowable fees for the administration of childhood immunizations to see that vaccines administered to enrolled and eligible members under the Vaccines For Children (VFC) program are appropriately reimbursed. Aetna Better Health will reimburse participating providers for administration costs for vaccines provided to eligible members under the VFC program. Please check VFC program eligibility with the State of Michigan.

What is the Vaccine for Children Program?
VFC helps families by providing free vaccines to doctors who serve eligible children. The program is administered at the national level by the CDC through the National Immunization Program (NIP). CDC contracts with vaccine manufacturers to buy vaccines at reduced rates.

States and eligible U.S. projects enroll physicians who serve eligible patients up to and including age 18 years, providing routine immunizations with little to no out-of-pocket costs.

Why does Aetna Better Health of Michigan require all Primary Care Providers who serve pediatric and adolescent members to participate in the Vaccine for Children Program?
One stop service – Immunization specific pediatric "best practices" have included the administering of a child's immunizations in their medical home. In other words, it is best for your patients to have access to needed vaccines at their medical home where well child and medical services are rendered.

What are the advantages to your being a VFC Provider?

- Reduction of your out-of-pocket costs because you don't have to buy vaccines with your own money
- Allows you to charge an administrative fee to offset your cost of doing business. Refer to the
- HEDIS Cheat Sheet you received earlier this year
- Covers all ACIP recommended vaccines
- Enhances all services you provide relative to EPSDT and access to care
- You no longer must refer patients to public health to get their vaccines
- Helps to build your business by providing badly needed government services to patients in need
- Facilitates immunization documentation and compliance through the Michigan Care Improvement Registry (MCIR), an electronic web-enabled statewide childhood immunization registry that is accessible to both private and public providers. Busy

practices have found that MCIR can assist them in the challenges of assessing ever-changing and complex immunization requirements and schedules involving different vaccine manufacturers and combination vaccines. MCIR can also help you manage your vaccine supply, and assist with reporting requirements. For more information, please contact your local Region 1 Michigan Care Improvement Registry Regional Office (for Southeastern Michigan, including the City of Detroit; and counties of Livingston, Macomb, Monroe, Oakland, St Clair, Washtenaw, and Wayne) at 1-888-217-3900.

- Links you to a vast source of quality resources, such as the CDC's Recommended Childhood and Adolescent Immunization schedule for 2015. Go to the following website to retrieve forms, various patient educational materials, and the invaluable AFIX service: **https://www.cdc.gov/vaccines/schedules/index.html**

For more information about the VFC Program, and how to join, please contact Local Region 1 Michigan Care Improvement Registry Regional Office at **1-888-217-3900** or access the following Webpage:

www.cdc.gov/vaccines/programs/vfc/providers/questions/qa-join.html

Children's Special Health Care Services (CSHCS)

CSHCS is a State of Michigan program that serves children, and some adults, with special health care needs. Aetna Better Health of Michigan members who have CSHCS get additional benefits.

- Help from Local Health department with:
  - Community resources, schools, community mental health, respite care, financial support, childcare, Early on and the Women, Infants and Children program (WIC)
  - Transitioning to adulthood services
- Help from the Family Center for Child and Youth with Special Health Care Needs– Call the CSHCS toll- free Family Phone Line at **1-800-359-3722**, Monday - Friday from 8 a.m. to 5 p.m.
  - Parent-to-parent support network
  - Parent/Professional training programs
- Financial help to go to conferences about CSHCS medical conditions and "Relatively Speaking," a conference for siblings of children with special needs
- Help from Children's Special Needs Fund (CSN). The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. Members may see if they qualify for help from the CSN Fund by calling **1-517-241-7420**.
- Examples of help include:
  - Wheelchair ramps
  - Van lifts and tie downs
  - Therapeutic tricycles
  - Air conditioners

- Adaptive recreational equipment
- Electrical surge upgrades for eligible equipment

- Services that are not covered by Aetna Better Health and are only covered by CSHCS include:
  - Orthodontia services provided for certain diagnosis*
  - Respite Services*
  - Certain over-the-counter medications
  - Hemophilia drugs
  - Certain Orphan drugs

*These services will be coordinated by the Local Health department

Foster Care Program

Foster care policy provides general health requirements for supervising agencies to ensure that each child has:

- A physical examination (well child visit, including behavioral health screening) within 30 days of initial foster care placement
- A dental exam within 90 days of placement if the child is 4 years old or older
- Current immunizations

There are also policy requirements to document all medical, dental, and mental health services received, including information regarding prescriptions, and to maintain a medical passport for each child that is provided to caregivers. Documentation of a child's present health status and medical needs is required from the onset of a child's placement into foster care.

We need your assistance in ensuring timely access to care within your office for these children. If you are asked to provide an exam for a child in Forster Care and are unable to meet the above stated guidelines, please contact our Member Services Department at **1- 866-316-3784 (TTY:711)**, Monday – Friday, 8am -5pm. We will work with the caregiver to have the child seen at another provider's office.

Adult Health Screening Preventive Health Care Guidelines

Adult Health Screenings are annual preventive exams that should be performed once per year on Medicaid recipients that are 21 years of age or older. The goal of adult health screenings is to prevent illness, disease, disability, or progress thereof, and to promote physical and mental health.

Clinical Practice and Disease Management Guidelines consistent with nationally recognized recommendations, are available through the Health Services department. Adherence with these guidelines leads to improved outcomes, and a better quality of life for each patient. Refer to the Michigan Quality Improvement Consortium (MQIC at https://www.mahp.org/michigan-quality-improvement-consortium/) and the

American Academy of Family Physicians (AAFP at **www.aafp.org**).

Tobacco Cessation Treatment

Aetna Better Health does not require a prior authorization on tobacco cessation treatment or set a limit to the type, duration, or frequency of tobacco cessation treatments. Aetna Better Health provides tobacco cessation treatment that includes the following services:

- Intensive tobacco cessation treatment through an MDHHS-approved telephone quit- line
- Individual tobacco cessation counseling/coaching (separate from the routine outpatient mental health services covered by Aetna Better Health) in conjunction with tobacco cessation medication or without
- Non-nicotine prescription medications
- Prescription inhalers and nasal sprays
- The following over-the-counter agents:
  - Patch
  - Gum
  - Lozenge
- Combination therapy – the use of a combination of medications, including but not limited to the following combinations
  - Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)
  - Nicotine patch and inhaler
  - Nicotine patch and bupropion SR

Members can get more information by calling the Tobacco Quit Line at: **1-800-784-8669.**

Here are other resources to help members quit:

- Go to **smokefree.gov**
- Call the Michigan Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669) and talk to someone on how to quit
- Go to **cancer.org** and enter "Tobacco and Cancer" for more resources on quitting

Home Care Services and Durable Medical Equipment

Home Health Care, DME, Home Infusion and Orthotics/Prosthetic Services may require prior authorization. All services should be coordinated with the Member's PCP or the referring physician specialist in accordance with his/her plan of treatment based on medical necessity, available benefit, and appropriateness of setting and network availability.

Community Health Workers (CHWs)

Aetna Better Health will provide or arrange for community health worker (CHW) or peer-support specialist services to members who have significant behavioral health issues and complex physical co- morbidities who will engage with and benefit from CHW or peer-

support specialist services. CHWs address social determinants of health by arranging social service needs, conduct home visits to assess barriers to healthy living and promote health education by advocating for enrollees with their providers.

Behavioral Health and Substance Abuse

Aetna Better Health is responsible for providing routine outpatient behavioral health visits for members. Specialty and inpatient behavioral health services are not covered by Aetna Better Health and should be coordinated by the local Prepaid Inpatient Health Plans (PIHP's) through the Community Mental Health (CMH) service providers. Providers, members, or other responsible parties should call **1-866-827-8704** for Aetna Better Health covered behavioral health services.

Aetna Better Health does not cover substance abuse treatment services. These services for both inpatient and outpatient occurrences are coordinated and covered solely by the local PIHP's/CMHs, as directed by MDHHS. However, inpatient substance abuse will be covered for emergency admissions until the member is stabilized medically.

When a Provider makes a referral for behavioral health, the member should be encouraged to sign a Universal Consent Form. This will allow for communications between the member's PCP and Behavioral Health Provider.

To refer members to Behavioral Health Services beyond routine outpatient visits and substance abuse treatment services (i.e., Inpatient mental health services, intensive mental health treatment, substance abuse treatment and developmental disability services), contact the PIHP's in our service area as follows:

- Detroit Wayne Mental Health Authority **1-800-241-4949**
- Macomb County Community Mental Health Services **1-855-996-2264**
- Oakland County CMH Authority **1-800-231-1127**
- Southwest Michigan Behavioral Health (Covering Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties) **1-800-781-0353**
- CMH Partnership of Southeast Michigan (Covering Lenawee, Livingston, Monroe, and Washtenaw counties) **1-888-644-5005** or **1-800-886-7340**
- Mid-State Health Network (Covering Hillsdale and Jackson counties) **1-844-405-3095**

Services Prohibited or Excluded under Medicaid

- Elective cosmetic surgery
- Services for treatment of infertility
- Experimental/investigational drugs, biological agents, procedures devices, or equipment
- Elective abortions and related services

CHAPTER 7 – MEMBER ELIGIBILITY AND ENROLLMENT

Member Services

Our Member Services Department provides information for members on eligibility, benefits, grievances, education, and available programs. Member Services representatives can provide services for members having trouble with their health care needs, finding providers, filing grievances or appeal, as well as assist providers with non-compliant members and/or discharges. Our Member Services Department can be reached at **1-866-316-3784 (TTY: 711)**.

Eligibility

Eligibility determinations are made by the State of Michigan Medicaid program prior to enrollment with a managed care plan, including Aetna Better Health of Michigan. Any coverage prior to the enrollment effective date with Aetna Better Health of Michigan is also determined by the State of Michigan Medicaid program.

Michigan operates a program of mandatory participation in a managed care program for the following groups of members:

- Children in foster care
- Families with children receiving assistance under the Financial Independence Program (FIP)
- Persons under age 21 who are receiving Medicaid
- Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
- Persons receiving Medicaid for the blind or disabled
- Persons receiving Medicaid for the aged
- Pregnant women
- Medicaid eligible persons enrolled under the Healthy Michigan Plan

Within the groups identified above, the following groups of members are currently excluded from managed care:

- Persons without full Medicaid coverage
- Persons with Medicaid who reside in an Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or a State psychiatric hospital
- Persons receiving long term care (custodial care) in a licensed nursing facility
- Persons being served under the Home & Community Based Elderly Waiver
- Persons with commercial HMO/PPO coverage
- Persons in PACE (Program for All-inclusive Care for the Elderly)
- Deductible clients (also known as Spend down)
- Children in Child Care Institutions

- Persons in the Refugee Assistance Program
- Persons in the Repatriate Assistance Program
- Persons in the Traumatic Brain Injury program
- Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
- Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Aetna Better Health's plan
- Persons incarcerated in a city, county, State, or federal correctional facility
- Persons authorized to receive private duty nursing benefits

Enrollment

Upon initial eligibility determination and during the annual enrollment period for Medicaid, members wishing to select a managed care program can contact the enrollment broker for the State of Michigan.

Verification of Eligibility

Member eligibility and enrollment can and should be confirmed by utilizing one of several methods:

- Contact the MDHHS Provider Inquiry at **1-800-292-2550** to verify eligibility
- Provider web portal eligibility search
- Our Member Services Department at **1-866-316-3784 (TTY: 711)**

State of Michigan-Automated Eligibility Information

Providers may obtain Medicaid eligibility and plan assignment information for Members by accessing Michigan's eligibility system, CHAMPS Line at **1-800-292-2550**, or via the online system (with proper access rights).

Change Health Care - Member Eligibility Information

Aetna Better Health has partnered with Change Health Care to provide our physicians access to helpful information for administration services. The Internet site allows the provider to check eligibility, submit claims, obtain authorizations, check claim status, and receive remittance advices and payments through electronic fund transfers for Aetna Better Health members. In addition, a new functionality has been added which allows claim disputes to be processed electronically. This feature allows for a more convenient and timely method of handling disputed claim payments. If you are interested in obtaining a user name and password to obtain access to this site, please contact your Provider Experience representative or call Change Health Care at **1-877-469-3263**.

Identification Cards

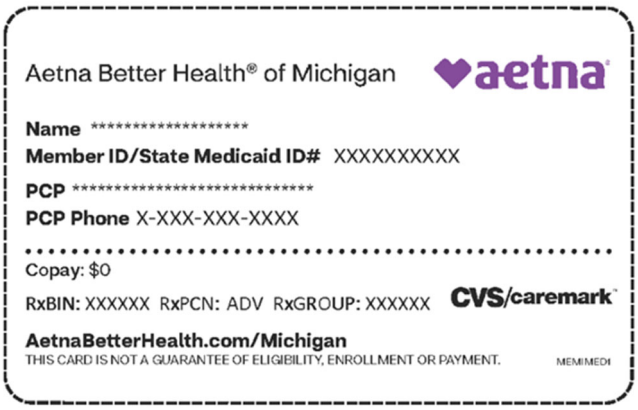
Members are provided an ID card from the State of Michigan. Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in the

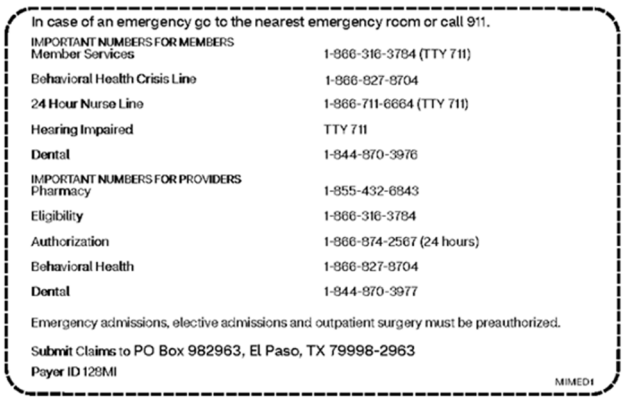
Aetna Better Health of Michigan plan. An ID card will be mailed to each new member when a PCP is selected or assigned.

Members are encouraged to keep the identification card with them at all times. If the card is lost or stolen, the member should call our Member Services Department immediately to get a new card. Should a Member present without a card or present with a State of Michigan Medicaid ID card, services should not be denied. To confirm the Aetna Better Health Member's PCP selection, call our Member Services Department at **1-866-314-3784 (TTY: 711)**.

The Aetna Better Health of Michigan identification card will include the following information:

- Aetna Better Health name
- Member name
- Member/State Medicaid ID number
- Primary care provider name
- Primary care provider telephone number
- Toll free hotline for our Member Services Department
- Claim submission information
- 24-hour Informed Health Line telephone number
- Behavioral Health/Crisis telephone number
- Each product line will be identified by:
  - Medicaid
  - Healthy Michigan





There is one of two Member product identifiers in the lower right-hand corner of each card:

- MI Medicaid - MEMIMED1
- Healthy Michigan - MEMIHEAL1

Member Rights and Responsibilities

Members of Aetna Better Health of Michigan have the right to:

- Get information about one's health, PCP, our providers and Aetna Better Health services and members' rights and responsibilities
- Request information on the Plan's structure, operations, and services
- Be treated with respect and dignity
- Be assured personal information is kept private and confidential
- Seek advice and help
- Discuss all treatment options for their condition, regardless of cost or benefit coverage
- Voice grievances, complaints, appeals and offer suggestions about Aetna Better Health and/or the services we provide
- Make recommendations about our members' rights and responsibilities policy
- Choose a Primary Care Provider (PCP) as a personal medical provider
- Work with doctors in making decisions about their health
- Know about diagnosis, treatment, and prognosis
- Get prompt and proper treatment for physical and emotional problems
- Receive discharge planning
- Receive guidance and suggestions for more medical care if health care coverage is ended
- Access their medical records in accordance with state and federal law
- Get information about how their PCP is paid
- Request an emergency PCP transfer if their health or safety are threatened
- Receive culturally and language appropriate services
- Request and get a copy of their medical records and request for records to be amended or corrected
- Participate in decisions regarding their health care, including the right to refuse treatment and express desires about treatment options.
- Be free to exercise their rights without adversely affecting their treatment by Aetna Better Health, its providers, or the State
- Be free from any form of restraint or seclusion used as a means of force, disciplines, convenience, or retaliation
- Be provided health care services consistent with the contract and State and Federal regulations
- Be free from other discrimination prohibited by State and Federal regulations

Aetna Better Health's staff and participating providers will comply with all requirements concerning member rights.

Members of Aetna Better Health also have Responsibilities. The responsibilities of an Aetna Better Health of Michigan member are to:

- Give information to the Plan, its Practitioners and Providers needed for our staff to take care of the member
- Follow the instructions given by your doctors
- Understand one's health condition and share in health care decisions
- Treat Aetna Better Health staff and doctors with respect and dignity
- Keep all appointments and call to cancel them when unable to make them
- Understand what medicine to take
- Give us feedback about one's health rights and responsibilities
- Let us know of any changes in name, address, or telephone number

Members have a responsibility to follow Aetna Better Health of Michigan rules. Aetna Better Health of Michigan may ask for members to be dis-enrolled if they do not follow the rules. Our Member Rights and Responsibilities statement is updated each year. Aetna Better Health of Michigan does not take action against members who exercise their rights.

Persons with Special Health Care Needs

The Aetna Better Health is required to do the following for members identified by MDHHS as persons with special health care needs:

- Conduct an assessment in order to identify any special conditions of the member that require ongoing case management services
- Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs
- For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the member

PCP Assignment

Each Aetna Better Health of Michigan member is assigned a PCP. Members are allowed to select a PCP at the time of enrollment and may change their PCP voluntarily at any time by contacting our Member Services Department. For involuntary termination of a PCP, please see Non-Compliant Members/PCP Transfer in Provider Responsibilities and Important Information chapter.

PCP Selection

Primary care physicians include physicians in the following specialties: Internal Medicine, Pediatrics, General Practice, Family Practice, Physician Assistant, or Nurse Practitioner. Every family member enrolled in the Plan must choose a primary care physician, although it does not have to be the same physician. All members have the option of changing their primary care physician. Members may request to change their PCP following the initial visit without cause. PCP change requests made are made effective on the same day requested.

- Aetna Better Health members are given the opportunity to select a Primary Care Provider (PCP). Michigan Medicaid policy allows members who lose eligibility/enrollment and are reinstated within ninety (90) days to be prospectively re-enrolled into the Health Plan and reassigned to the last PCP of record
- If a member has NOT selected a PCP upon enrollment, Aetna Better Health shall assign one for them. Aetna Better Health shall consider factors such as age, gender, language(s) spoken, location, and special needs
- Upon notice of the current automatically assigned PCP by Aetna Better Health Michigan, the member has the opportunity to request a PCP change if not satisfied with the assigned PCP
- A list of PCPs is made available to all Aetna Better Health members. Member service representatives are available to assist members with selecting a PCP
- Members have the freedom to select participating PCPs based on age/gender limit restrictions
- Members are encouraged to choose a PCP that is geographically convenient to them, however, members are not restricted by any geographic location

Aetna Better Health members may change their PCP at any time, by contacting our Member Services Department at **1-866-316-3784 (TTY: 711)**.

Members with a disabling condition and/or chronic illness may request that their PCP be a specialist. These requests will be reviewed by the Aetna Better Health Medical Director to ensure that the specialist requested agrees to accept the role of PCP and assume all the responsibilities associated with this role. Members need to contact our Member Services Department directly for such requests. Member Services representatives will route the
request directly to the Medical Director for review.

Aetna Better Health of Michigan may initiate a change in a member's primary care physician under the following circumstances:

- The member's primary care physician ceases to participate in Aetna Better Health of

Michigan's network
- The physician/patient relationship will not work to the satisfaction of either the physician or the patient
- The physician requests the patient to select another primary care physician and has sent written notification to the member, giving a minimum of 30-day notice to Aetna Better Health of Michigan

Members are advised to get to know and maintain a relationship with their primary care physician. They are instructed to always contact their primary care physician before obtaining specialty services or going to the emergency room. It is the responsibility of all primary care physicians to manage the care of each patient, directing the patient to specialty care services as necessary. It is the responsibility of the specialist physician to work closely with the primary care physician in the process.

Newborn Enrollment

Newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health by the Medical Service Administration. Unless the member selects a different Medicaid Managed Care Plan, newborns born during the member's Aetna Better Health enrollment are eligible to receive services from Aetna Better Health. The state enrollment process must be completed to ensure timely and accurate claims processing of newborn claims. Any service payment issues related to newborn care should be directed to the Provider Experience Department.

NEWBORN CLAIMS WILL BE DENIED UNTIL A VALID STATE OF MICHIGAN RECIPIENT ID NUMBER IS ON FILE FOR THE NEWBORN.

Hospital social service coordinators or Local Department of Human Services (DHS) caseworkers usually initiate the process of educating and facilitating the member of an Aetna Better Health newborn, to complete the Medicaid enrollment process.

Newborns are retrospectively enrolled with Aetna Better Health back to the date of birth by the State. Delayed newborn enrollment may cause a delay in claim reimbursement for Providers. Once the file is received from the state with the newborn enrolled, claims previously denied and resubmitted will be processed.

If the member has not selected a PCP for the newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member.

Member Disenrollment from Aetna Better Health

The MDHHS has sole authority for dis-enrolling Members. MDHHS may dis-enroll Members for any of the following reasons:

- Loss of eligibility
- Placement of the member in a long-term nursing facility, state institution or intermediate care facility for the mentally retarded for more than thirty (30) days.
- Member selection of a different Medicaid Managed Care Plan
- Member change of residence outside of the Aetna Better Health service area
- Profound noncompliance of a Member to follow prescribed treatments or requirements that are consistent with state and federal laws and regulations when agreed upon by the MDHHS
- Abuse of the system, threatening or abusive conduct/behavior that is disruptive and unruly which seriously impairs Aetna Better Health ability to provide service to either the Member or others
- Commitment of intentional acts to defraud Aetna Better Health and/or MDHHS for covered services

The provider must provide written notification that a Member has demonstrated one or more of the above behaviors, in addition to the following supportive documentation:

Violent or Life-Threatening Behavior:

- Police Report
- Incident Report from staff involved or threatened
- Copy of Member's chart that documents Member was previously counseled on the behavior by the PCP (if applicable)
- Any other documentation to support request for disenrollment

Fraud or Misrepresentation:

- Police Report
- If no police report, documentation as to why it was not reported
- If no police report, documentation that indicates the case was referred to the Department of Health and Human Services, Office of Inspector General Beneficiary Fraud Unit at **1-855-643-7283**
- Incident Report on the fraudulent activity
- Copies of altered prescription and/or copies of original prescription
- Copy of Patient Signature Log from the Pharmacy
- Pharmacy Profile
- Copies of any Member correspondence (i.e., PCP dismissal letter to the Member, letter from Aetna Better Health to the Member must include reason and Aetna Better Health internal grievance process, etc.)

- Additional documentation to support request for disenrollment, especially if there is no police report to show patterns of past questionable behavior (i.e., drug seeking behavior, abusive behavior, changing doctors, etc.)

Member Education

Educational and informational materials are frequently sent to our Members. Aetna Better Health Members are sent a welcome packet upon enrollment. The welcome packet contains the following:

- Welcome letter
- Member Handbook which contains, but is not limited to, an explanation of Rights and Responsibilities as an Aetna Better Health member, benefits, and information on how to make appointments
- Certificate of Coverage which contains a comprehensive explanation of covered services, limitations, and exclusions
- Notice of Privacy Practices which contains Aetna Better Health protocols relative to ensuring member privacy of records

Member identification cards are sent separately via first class mail service prior to the mailing of a new Member welcome packet. Aetna Better Health identification cards indicate the PCP's name and telephone number.

Medicaid beneficiaries must sign a Medical Release of Information Form when they enroll with the Michigan Medicaid Program. This release authorizes the release of medical records to Aetna Better Health and any representative of Aetna Better Health to promote:

- Continuity of care
- Assist in the coordination of care
- Clinical review
- State and Federal sponsored audit
- Accreditation Agency

Member Outreach Activities

The Aetna Better Health Member Outreach Department's function within Quality Management is responsible for contacting members to assist with coordinating gaps in care. The Member Outreach Department frequently coordinates activities within the community to provide member education and information regarding Aetna Better Health member initiatives.

Advanced Directives

Please see the Provider Responsibilities and Important Information chapter for additional information.

Member Appeal and Grievance Process

Members have the right to file a complaint (grievance) or to dispute an adverse determination (appeal). The health plan asks that all providers cooperate and comply with all Aetna, Medicaid, and/or CMS requirements regarding the processing of member appeals and grievances, including the obligation to provide information within the timeframe reasonably requested for such purpose. For further guidance on the member appeal and grievance processes, please contact our Member Services Department.

Member Handbook

A Member Handbook is provided to actively enrolled Aetna Better Health of Michigan members upon enrollment. Changes to any program or any service site changes are provided to members in a timely manner. The Member Handbook includes information about covered and non-covered services. The Member Handbook covers key topics such as: how to choose and change a PCP, copays, and guidance to emergency care. The Member Handbook is available electronically on the Aetna Better Health of Michigan website.

CHAPTER 8 – MEDICAL MANAGEMENT

Integrated Care Management process

We designed our Integrated Care Management (ICM) to identify our most complex and vulnerable members with whom we can make a significant difference. We engage these members in integrated care coordination programs to remove or lessen barriers that limit their ability to manage their own health and well-being. We provide education about their chronic conditions and help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness, and availability of family or other supports.

We encourage autonomy and active self-management of acute and chronic conditions where clinically appropriate with tools and education directed at each member's unique needs and health literacy. A well-trained care manager serves as the single point of contact for the member.

We collaborate with the member/member supports/integrated care team to create a Care Plan that includes mutually agreed upon member-centered goals and actions for the member/member supports. The Care Manager and the care team coordinate both covered and non-covered services for the member. Members will receive person-centered outreach and follow-up, from those who are very healthy to those who are very sick or most at-risk due to their medical, behavioral, and social comorbidities.

The Integrated Care Management program reflects our belief that care coordination must address the member's medical, behavioral, and social needs in an integrated fashion and must address the continuum of acute, chronic, and supports needed. Care Management staff assist members in coordinating medical and behavioral health services as well as those available in the community. Based on the member's needs, Care Managers use condition-specific assessments and interventions to assist with condition management.

Members with diabetes, COPD, heart failure, asthma, depression, chronic kidney disease, bipolar disorder, schizophrenia, arthritis, hepatitis C, cancer, HIV and coronary artery disease are identified by our predictive modeling engine's tool, claims, health risk assessments, care coordination assessments, concurrent review/prior authorization referral, as well as member and provider referrals. Any psychosocial issues and cognitive limitations are incorporated into the individualized service plan as are the cultural practices and beliefs that are most important to the member. We specifically address barriers to improving health and root causes of poor health outcomes to help both the care manager and the member better understand what has prevented full engagement with a suggested clinical treatment. Once the member identifies these issues and the care team is informed, individualized and collaborative service planning

can begin.

The Integrated Care Management program manages the unique needs of each member's experience. Whether they have short term acute needs, longstanding chronic health issues, need information, resources, or care coordination; we tailor the program to each specific member's situation. Using available information, we employ clinical algorithms and care management clinical judgment to recommend a level of Integrated Care Coordination best suited to address the member's needs.

The purpose of Complex Case Management is to identify, assess and provide intervention in cases that, due to their chronicity, severity, complexity, and cost, require close management to affect an optimal member outcome cost-effectively. Aetna Better Health's Care Management Program is a collaborative process of biopsychosocial assessment, planning, facilitation, care coordination, evaluation, and advocacy for service and support options to meet members' comprehensive care needs.

Providers may request Complex Case Management evaluations by contacting our Case Management Department at 1-866-316-3784 (TTY: 711) or by faxing a referral to 1-866- 889-7572.

Maternity Program

A healthy pregnancy begins with the timely identification of pregnant women, an initial comprehensive assessment and ongoing assessment of risk, and interventions designed to address identified risks. Providers play a key role in this process. Providers are encouraged to notify Aetna Better Health of Michigan when they are aware of a member's pregnancy. This occurs through the completion of the Notification of Pregnancy (NOP) Form. After the level of risk is determined, our team of highly skilled clinicians will work with your team, nurses, doulas, perinatologists, other specialists, and the member to ensure that members at greatest risk for an adverse pregnancy outcome have access to the care, resources and supports they need. Women who are less at risk will also receive care coordination commensurate with their needs. Members always have the right to decline or elect to discontinue care management services at any time.

Disease Management and outreach programs

Aetna Better Health implements a population-based approach to specific chronic diseases or conditions. Based on claims data, Aetna Better Health members with identified conditions are auto enrolled in the program. Members that do not wish to participate can call our Member Services Department and notify a representative of their

desire not to participate.

All members receive educational material to promote a better member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care, and testing supported by evidence-based practices and tools. We incorporate our Disease Management Program within the Care Management Program, and the same staff will provide member outreach, engagement, and education.

Case Managers reach out to members with significant gaps in care to educate and assist the members in obtaining needed services, including lifestyle modifications and health resource access.

Aetna Better Health currently has Disease Management programs for Asthma, Diabetes, Coronary Heart Disease, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Depression, Sickle Cell Disease, and Chronic Kidney Disease (CKD). Our programs guide members and support their physician/clinical providers per the Clinical Practice Guidelines adopted by Aetna Better Health.

Our goal is to assist our members in better understanding their chronic conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Our Disease Management programs reinforce the providers' treatment plans. Providers can contact our Case Management Department at **1-866-316- 3784 (TTY: 711)** and follow the prompts to refer a member to our Case/Disease Management programs.

Members of Aetna Better Health are automatically enrolled when we identify them for one or more of the chronic conditions covered by our disease management programs. Please let us know if you would like to refer any of your Aetna Better Health patients into any of the programs. The program offers the following services:

- Support from health plan nurses and other health care staff to ensure that patients understand how to best manage their condition and periodically evaluate their health status
- Periodic newsletters to keep them informed of the latest information on conditions and their management
- Educational and informational materials that assist patients in understanding and managing medications prescribed by practitioners, how to plan for visits to see practitioners effectively, and reminders as to when those visits should occur
- Support from Community Health Workers (CHW) who are a trusted, knowledgeable, frontline care management support staff who are of and from the communities they serve

Membership in our Disease Management programs is voluntary, which means members can request a withdrawal from the program at any time.

Lead Program (Elevated Blood Lead Level – EBLL)

Children are at risk if they are exposed to lead. There is no safe level of lead in the blood and even low levels of lead in blood put children at risk of developmental delays, difficulty learning, and behavioral issues. Lead can be found in paint, pipes, soil, and drinking water of older homes. It has been found in clay products, toys, cosmetics, household items, and food. All children should be tested for lead exposure by 1 and 2 years of age. All children over 3 years who have not been tested should be tested. Children should also get a lead screening at least once between 3 and 6 years of age. Those children who are at risk of lead exposure will need to be checked more often. These children should be tested at least once per year. Children with a history of lead poisoning and those who live in older homes or apartments are at high-risk of lead exposure. Our program provides the lead level testing, identifies and tracks children with a 3.5 micrograms per deciliter (µg/dL) lead level testing results, and ensure they have follow-up care from their Primary Care Provider (PCP). We also work collaboratively with local health departments to provide resources and services to children and families that address the source of the lead and its removal.

CHAPTER 9 – PHARMACY

Aetna Better Health covers prescription medications and certain over-the-counter medicines when you write a prescription for enrolled Members. Pharmacy is administered through CVS Caremark. CVS Caremark is responsible for pharmacy network contracting, mail order delivery, and network Point-of- Sale (POS) claim processing. Aetna Better Health of Michigan is responsible for formulary development, drug utilization review, and prior authorization.

Prescriptions, Drug Formulary and Specialty Injectables

The Michigan Department of Health and Human Services (MDHHS) implemented a Single Pharmacy Drug List (SPDL). This change is due to a MDHHS policy change and affects all Michigan Medicaid Health Plans including Aetna. The SPDL is a listing of drugs that are covered by Michigan Medicaid. There are two categories of coverage, preferred and non-preferred. The complete PDL can be found on our website **www.AetnaBetterHealth.com/Michigan/providers/medicaid/pharmacy**
Not all covered drugs are listed on the PDL, MDHSS still covers drugs through the Michigan Medicaid Common Formulary. The common formulary may also be found on our website.

Aetna Better Health also covers diabetic supplies. The preferred Glucose meters and Test Strips are J&J One Touch products. The preferred pen needles are BD. Please review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health of Michigan patient. Drugs that are not covered on the PDL or are listed as non-formulary will require a prior authorization. MDHSS has a list of PDL criteria that can be found on our website. Drugs that are listed under the common formulary have criteria may also be found on our website.

Carve-out Drugs

MDHSS carves out specific classes of drugs. These drugs are covered by MDHSS Fee-for- service (FFS) using the Magellan Pharmacy Benefit Manager. For more information about MDHSS Fee-for-service carve outs please click here. For confirmation of carved out agents use the FFS drug search tool.

We are committed to making sure our providers receive the best possible information, and the latest technology and tools available. We have partnered with CoverMyMeds® and SureScripts to provide you a convenient way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (EPA) program. With Electronic Prior Authorization (EPA), you can look forward to:

- Time saving
- Decreasing paperwork, phone calls and faxes for requests for prior authorization

- Quicker Determinations
- Reduction in average wait times, resolution often within minutes
- Accommodating & Secure transactions
- HIPAA compliant via electronically submitted requests

There is no cost required and getting started is easy. Choose from multiple to ways to enroll:
- Visit the CoverMyMeds® website or call toll-free at **1-866-452-5017**
- Visit the SureScripts website or call toll-free at **1-866-797-3239**
- Pharmacy Billing Information:
  BIN: 610591 PCN: ADV
  Group: RX8826

Check the current Aetna Better Health of Michigan formulary before writing a prescription for either prescription or over-the-counter drugs. If the drug is not listed, it may be carved out and only covered by Medicaid Fee-for-service.

Pharmacy Prior Authorization Request form must be completed before any non-formulary or non-preferred drug will be considered. Please also include any supporting medical records that will assist with the review of the prior authorization request. Pharmacy Prior Authorization forms are available on our website and requests may be made telephonically at **1-866-316-3784 (TTY: 711)** or via fax 1-855-799-2551.

Aetna Better Health of Michigan members must have their prescriptions filled at a network pharmacy to have their prescriptions covered at no cost to them.

Prior Authorization Process

Aetna Better Health of Michigan's pharmacy prior authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy PA process will support the MDHSS PDL and Common formulary programs including applying state approved PA criteria. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:
- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State's Medicaid program
- Prescriptions that do not conform to Aetna Better Health of Michigan's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when a "A" rated generic equivalent is available

Aetna Better Health of Michigan's Medical Director is in charge of generating adverse decisions, including a complete denial or approval of a different medication. Using specific, evidence-based PA pharmacy review guidelines Aetna Better Health of Michigan's Medical Director may require additional information prior to deciding as to the

medical necessity of the drug requested. This information may include, but is not limited to, evidence indicating:

- Formulary alternatives have been tried and failed or cannot be tolerated (i.e., step therapy)
- There are no therapeutic alternatives listed in the formulary
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the Federal Drug Administration (FDA) or as accepted by established drug compendia)
- For brand name drug requests, a completed FDA MedWatch form documenting failure or intolerance to the generic equivalents is required

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Medical Director may contact the prescriber to discuss the case or consult with a board-certified physician from an appropriate specialty area such as a psychiatrist.

Aetna Better Health of Michigan will fill prescriptions for a seventy-two (72) hour supply if the Member's prescription has not been filled due to a pending PA decision.

Step Therapy and Quantity Limits

The step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs. Drugs having step therapy are identified on the formulary with "STEP". Certain drugs on the Aetna Better Health of Michigan formulary have quantity limits and are identified on the formulary with "QLL".

The QLLs are established based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat.

To request an override for the step therapy and/or quantity limit, please fax a Pharmacy Prior Authorization Request form and any supporting medical records that will assist with the review of the request to **1-855-799-2551**.

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis, and rheumatoid arthritis, which are not often available at local pharmacies. Specialty medications require prior authorization before they can be filled and delivered. Providers can call **1-866-316-3784 (TTY: 711)** to request prior authorization or complete the applicable prior authorization form and fax to 1-855-799-2551.

Specialty medications can be delivered to the provider's office, Member's home, or other location as requested.

Mail Order Prescriptions

Aetna Better Health of Michigan offers mail order prescription services through CVS Caremark. Members can access this service in one of three ways.

- By calling CVS Caremark, toll free at **1-800-552-8159 (TTY: 711).** Monday to Friday between 8 AM and 8 PM, Eastern Time. They will help the Member sign up for mail order service. If the Member gives permission, CVS Caremark will call the prescribing provider to get the prescription
- By going to CareMark Portal the Member can log in and sign up for Mail Service online. If the Member gives permission, CVS Caremark will call the prescribing provider to get the prescription**https://www.caremark.com/**
- By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then the Member calls CVS Caremark and asks CVS Caremark to mail them a Mail Service order form. When the Member receives the form, the Member fills it out and mails CVS Caremark the prescription and the order form.
  Forms should be mailed to:

  CVS CAREMARK
  PO BOX 94467
  PALATINE, IL 60094-4467

CHAPTER 10 – CONCURRENT REVIEW

Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Hearst Corporation's MCG evidence-based care guidelines (formerly Milliman Care Guidelines). Admission certification is normally conducted within one business day of receiving medical information but no later than three (3) days of notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of additional days. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

Medical Criteria

Aetna Better Health uses the Hearst Corporation's MCG evidence-based care guidelines to ensure consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. These guidelines are updated regularly as each new version is published. A free copy of individual guidelines pertaining to a specific case is available for review upon request by phone **1-866-874-2567**.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the Member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating of discharge planning for members with complex and/or multiple discharge needs
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers)
- Informing hospital staff and attending physician

CHAPTER 11 – PRIOR AUTHORIZATION

The requesting practitioner or provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Access to our Utilization Medical Team

For members who may need access to one of our nurses, they can contact our staff as follows:

- During business hours (8 AM to 5 PM.) call Customer Service at **1-866-316-3784 (TTY: 711)** and ask to be connected to a nurse; Providers may call **1-866-874-2567 (TTY: 711)** for prior authorization
- Call **1-866-782-8507 (TTY: 711)** and ask to speak to a nurse for case and disease management. You will be transferred to one of our nurses. If the nurse is not available, you should leave a message. The nurse will call you back by the next business day
- After business hours, call **1-866-711-6664 (TTY: 711).** You will be connected to the 24-hour nurse line
- For members with special communication needs:
  - Member with hearing impairment can call the TDD line at **1-866-711-6664 (TTY: 711)**
  - Language translation services can be provided free of charge by calling **1-866-316-3784 (TTY: 711)**

A prior authorization request must include the following:

- Current, applicable codes (may include):
  - Current Procedural Terminology (CPT),
  - International Classification of Diseases, 10th Edition (ICD-10),
  - Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the Member
- Name, address, phone, and fax number of the treating practitioner

- Problem/diagnosis, including the ICD-10 code
- Presentation of supporting objective clinical information, such as:
  - Clinical notes
  - Laboratory and imaging studies
  - Prior treatments

All clinical information should be submitted with the original request.

Timeliness of decisions and notifications to practitioners, providers and/or members

Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable members in a timely manner. Unless otherwise required by MDHHS, Aetna Better Health adheres to the following decision/notification time standards.

Decision	Decision Timeframe	Notification to	Notification Method
Urgent pre-service approval	Seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Seventy-two (72) hours from receipt of request	Practitioner/Provider and member	Oral and Electronic/Written
Non-urgent pre-service approval	Fourteen (14) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	(14) Calendar Days from receipt of the request	Practitioner/Provider and member	Oral and Electronic/Written
Urgent concurrent approval	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent concurrent denial	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written

Decision	Decision Timeframe	Notification to	Notification Method
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider and member	Electronic/Written

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the decision. Aetna Better Health sends documentation of the approval or to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case- by-case basis in consultation with Aetna Better Health's Medical Director(s).

Prior Authorization List

Treating practitioner/providers must request authorization for certain medically necessary services. A complete and current list of services which require prior authorization can be found online at **www.aetnabetterhealth.com/Michigan**. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is required. If the service is not covered by the primary payer, the provider must follow Aetna Better Health of Michigan's prior authorization rules.

How to Request Prior Authorizations

A prior authorization request may be submitted by:

- 24/7 Secure Provider Web Portal located on the Aetna Better Health's website
- Fax the request form to 1-866-603-5535 (forms are available on the health plan website)
  - Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing
  - Call Prior Authorization directly at **1-866-874-2567 (TTY: 711)**

CHAPTER 12 – QUALITY MANAGEMENT

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

We perform QM through a Quality Assessment and Performance (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of our QM Program is to improve members' health status or maintain the current health status when the member's condition is not amenable to improvement.

Our 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, 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 our quality improvement process.

Our 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 Committee. This structure allows members and providers to offer input into our quality improvement activities. Our Chief Medical Officer (CMO) oversees the QM program. The CMO is supported in this effort by our QM Department and the Quality Management Oversight Committee (QMOC), and subcommittees.

Program Purpose

The QMOC's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee is designated to provide executive oversight of the QAPI program. The

committee will also recommend the Board of Directors about our quality management and performance improvement activities and work to ensure the QAPI is integrated throughout the organization and among departments, delegated organizations, and network providers. Primary functions of the QMOC Committee include:

- Confirm that quality activities are designed to improve the quality of care and services provided to members
- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators, and satisfaction surveys
- Advise and make recommendations to improve the health plan
- Review and evaluate company-wide performance monitoring activities, including care management, customer service, credentialing, claims, grievance and appeals, prevention and wellness, the provider experience, and quality and utilization management

Additional committees such as Service Improvement, Credentialing and Performance, Appeals/Grievance, and Quality Management/ Utilization Management support our QAPI Program. We encourage provider participation on key medical committees. Providers may contact the Chief Medical Officer (CMO) or inform their Provider Experience representative if they wish to participate.

Our QM staff develops and implements an annual work plan, which specifies projected QM activities, timelines for completion and adherence to required NCQA standards. Based on the work plan, we conduct a yearly QM Program evaluation, which assesses the impact and effectiveness of QM activities. Recommendations for Performance Improvement Plans are also part of the annual QM Program evaluation.

Per NCQA Quality Standards and MDHHS contractual guidance, per Section XI, Quality Improvement Program Development and Annual Effectiveness Review, information on the effectiveness of the QAPI program must be provided annually to Network Providers. The QAPI documents are accessible via the Quality Assurance section of the Aetna Better Health of Michigan Website at: Quality Assurance | Aetna Better Health of Michigan. Links to the Quality Improvement Program Documents will also be included in the Provider Newsletters annually. Providers may also request a complete copy of our Quality Improvement Program Description and Annual Evaluation Report, by contacting the Quality Department at 1-855-737-0770 (TTY 711). Monday – Friday from 8a.m. – 5p.m.

Our QM Department is an integral part of the health plan. 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 care and service to our members. Our QM and Medical Management (MM) departments maintain

ongoing coordination and collaboration regarding quality initiatives, care management, and disease management activities involving the care of our members.

Aetna Better Health QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, Aetna Better Health of Michigan, in collaboration with providers, can monitor and reassess the quality of services provided to our members. Providers are obligated to support and meet Aetna Better Health's QAPI by cooperating activities to improve the quality of care and services and member experience and Utilization Management program standards.

Note: Providers must also participate in the Michigan Department of Health and Human Services (MDHHS) quality improvement initiatives. Any information provided must be reliable and complete.

Identifying Opportunities for Improvement

We identify and evaluate opportunities for quality improvement and determine 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 of Michigan monitors to identify opportunities for quality improvements include:

- Formal Feedback from External Stakeholder Groups: Aetna Better Health of Michigan 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 annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process, assists Aetna Better Health of Michigan 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 the potential quality of service issues for review through daily operations (i.e., member service issues, 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 of Michigan can identify specific opportunities for improving care delivered to individual members
- Findings from Internal Program Assessments: We conduct several formal

assessments/reviews of program operations to identify opportunities for improvement. The assessment includes but is not limited to 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 of Michigan uses various 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 of Michigan can identify opportunities for improvement in clinical and operational functions. These measures include:
- Adherence to nationally recognized best practice guidelines and protocols
- Prior 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 of Michigan makes extensive use of data trending and pattern analysis to identify opportunities for improvement in many levels of care
- Other Service Performance Monitoring Strategies: Aetna Better Health of Michigan uses many monitoring processes to confirm the effective delivery of services to all our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health of Michigan 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 effectiveness in 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

2024 PAY-FOR-QUALITY (P4Q) PROGRAM	
Standardized, market-based programs where performance can be accurately tracked on a monthly basis.	
Provider Eligibility	No fewer than 150+ Aetna Medicaid members per practice (average over the performance period)
	Must have “open” panel
Performance Measurement	Selected measures – Up to 5 of 14 HEDIS® measures based upon the 5 measures most relevant to Provider's member panel and 2 separate dental measures outside of the 5 HEDIS® measures
	Applicable measure must have at least 10 members in the denominator to be eligible for payment
	Two targets are set based on the 2023 National Medicaid HEDIS® 50th and 75th percentiles or Plan custom targets where 2023 National Medicaid HEDIS® benchmarks were not available
Payment Model	Annual payment if quality targets identified achieved
	$5 PMPM is the maximum payout. Each selected measure has a maximum payout $1 PMPM
	A PCP Practice is either rewarded $0.50 PMPM for their entire assigned Aetna Better Health Medicaid membership panel for each eligible measure for which they meet or exceed target 1 (T1) or a $1.00 PMPM incentive for each eligible measure that meets or exceeds target 2 (T2)
Data & Reporting	Standardized, centralized, actionable monthly group report available to providers through Availity (www.availity.com)
	Reports include gaps in care
	The first performance report will be available in March 2024
Management Process	Provider performance reviews as needed
	Annual determination of provider readiness to move to more advanced APM

ANNUAL P4Q QUALITY MEASURES

Measure	Description	T1	T2
Adults Access to Preventive/Ambulatory Health Services (AAP): Members Age 20-44	The percentage of members 20-44 years of age who had an ambulatory or preventive care visit.	69.69	74.69
Adults Access to Preventive/Ambulatory Health Services (AAP): Members Age 45-64	The percentage of members 45-64 years of age who had an ambulatory or preventive care visit.	80.18	84.08
Breast Cancer	The percentage of		

ANNUAL P4Q QUALITY MEASURES			
Screening (BCS)	women 50-74 years of age in the measurement year who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement year through December 31 of the measurement year.	52.20	58.35
Blood Pressure Control for Patients with Diabetes (BPD)	The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	63.99	70.07
Controlling High Blood Pressure (CBP)	The percentage of members 18-85 of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	61.31	67.27
Cervical Cancer Screening (CCS)	The percentage of women 21-64 years of age who were screened for cervical cancer.	57.11	61.80
Lead Screening in Children (LSC)	The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	62.79	70.07
Childhood Immunization Status (CIS): Combo 3	The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP), 3 polio (IPV), 1 measles, mumps and rubella (MRR), 3	63.99	68.86

ANNUAL P4Q QUALITY MEASURES			
	haemophilus influenza type B (HiB), 3 hepatitis B (Hep B), 1 chicken pox (VZV), 4 pneumococcal conjugate (PCV) by their second birthday.		
Eye Exam for Patients with Diabetes: (EED)	The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam in the measurement year.	52.31	59.37
Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: <8.0%	52.31	57.18
Kidney Health Evaluation for Patients with Diabetes (KED): Total	The percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) *and* a urine albumin creatinine ration (uACR), during the measurement year.	33.52	41.49
Weight Assessment, Counseling for Nutrition, Physical Activity for Children/Adolescents (WCC)	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had BMI percentile documentation, counseling for nutrition, and counseling for physical activity during	67.76	77.37

ANNUAL P4Q QUALITY MEASURES			
	the measurement year.		
Child & Adolescent Well-Care Visits (WCV): Total	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	48.07	55.08
Well Child Visits in the First 30 Months of Life (W30): First 15 months, 6+ visits	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	58.38	63.34
Diagnostic Dental Service	The percentage of members between the ages of 19-64 who had at least one Diagnostic Dental Service (D0100-D0999) during the measurement year.	30.0	36.0
Preventive Dental Service	The percentage of members between the ages of 19-64 who had at least one Preventive Dental Service (D1000-D1999) during the measurement year.	17.0	24.0

Annual Pay-for-Quality incentive payments will be paid based upon administrative data with 90 days run-out to ensure data completion. Expected payout will be June 2025.

Pay-for-Quality Annual Report Access

Providers can obtain P4Q Performance reports by accessing our provider portal Availity (www.Availity.com). Reports are updated monthly, and data is provided with a 90-day claim lag. Providers can get access to Availity by contracting Aetna Better health of MI

Provider Services at (866) 314-3784 or Availity at 1-800-282-45-48. We encourage providers to log in frequently to review data and identify opportunities for achieving quality of care.

Quarterly P4Q Quality Measures

In addition to the reimbursement described above, Provider shall be eligible for additional incentive reimbursement for the services as described in the chart directly below ("Eligible Services") that meet the corresponding measure for a member. Payment will be made on a quarterly basis for Eligible Services rendered.

Service	Measure	Incentive Basis	Rate
Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age in the measurement year who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement year through December 31 of the measurement year.	Provider will be paid for each HEDIS® eligible member that has received at least one (1) mammogram during the measurement year. Payment is limited to one (1) per year.	$50.00
Immunization for Adolescents (IMA): Combo 2	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Provider will be paid for each HEDIS® eligible member that received both Combo 2 immunizations between their 11th and 13th birthday.	$50.00
Eye Exam for Patients with Diabetes: (EED)	The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam in the measurement year.	Provider will be paid for each HEDIS® eligible diabetic member that has received a dilated eye exam during the measurement year. Payment is limited to one (1) per year.	$25.00

Service	Measure	Incentive Basis	Rate
Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: <8.0%	Provider will be paid for each HEDIS eligible diabetic member who completes an HbA1c test or GMI test with a value less than 8.0% per measurement year. Payment is limited to one per year.	$25.00
Lead Screening in Children (LSC)	The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	Provider will be paid for each HEDIS® eligible Member that receives one (1) blood lead screening prior to their 2nd birthday.	$25.00
Prenatal and Postpartum Care (PPC): Postpartum Care	The percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 to 84 days after delivery.	OB/GYN's, Midwives and Family Practitioners can earn an incentive for Postpartum care examinations performed in accordance with HEDIS® guidelines.	$100.00
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	The percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	OB/GYN's, Midwives and Family Practitioners can earn an incentive for Antepartum care examinations performed in accordance with HEDIS® guidelines.	$100.00

<table>
<tr><th>Service</th><th colspan="2">Measure</th><th>Incentive Basis</th><th>Rate</th></tr>
<tr><td>Diagnostic and Preventive Dental Services</td><td colspan="2">Members that received either a Diagnostic (D0100-D0999) or Preventive (D01000-D01999) Dental Service.</td><td>Provider will be paid per member receiving a diagnostic or preventive dental service during the measurement year. Payment is limited to one (1) diagnostic and preventive service per year.</td><td>$10.00</td></tr>
<tr><td rowspan="14">Care Management/ Care Coordination Services</td><td><u>Code</u></td><td><u>Description</u></td><td rowspan="14">Provider will be paid for each eligible Care Management/Care Coordination Service appropriately rendered and billed during the measurement period.</td><td rowspan="14">$25.00</td></tr>
<tr><td>G9001</td><td>Comprehensive Assessment</td></tr>
<tr><td>G9002</td><td>In-Person CM/CC Encounter</td></tr>
<tr><td>G9007</td><td>Care Team Conferences</td></tr>
<tr><td>G9008</td><td>Provider Oversight</td></tr>
<tr><td>98966
98967
98968</td><td>Telephone CM/CC Services</td></tr>
<tr><td>98961
98962</td><td>Education/Training for Patient Self-Management</td></tr>
<tr><td>99495
99496</td><td>Care Transitions</td></tr>
<tr><td>S0257</td><td>End of Life Counseling</td></tr>
<tr><td>G0511</td><td>Chronic Care Management for FQHCs</td></tr>
<tr><td>G0512</td><td>Psychiatric Collaborative Care Model for FQHCs</td></tr>
<tr><td>99497
99498</td><td>Advanced Care Planning</td></tr>
<tr><td>99487</td><td>Complex Chronic Care Management</td></tr>
<tr><td>99490</td><td>Chronic Care Management Services</td></tr>
</table>

All P4Q Quarterly incentives earned for Eligible Services will be calculated and paid quarterly. Incentives will be paid in accordance with the following schedule:

Claim Service Date	Incentive Payment Date
January 1 to March 31, 2024	July, 2024
April 1 to June 30, 2024	October, 2024

Claim Service Date	Incentive Payment Date
July 1 to September 30, 2024	January, 2025
October 1 to December 31, 2024	June, 2025

After Hours – Provider shall be eligible for additional incentive reimbursement for the Eligible Services, described in the chart directly below. Services will be paid at the rate below, based on billed claims.

Service	Measure	Incentive Basis	Rate
After Hours (99050, 99051)	Services provided in the office at times other than regularly scheduled office hours must be billed with appropriate E & M Code to be paid.	Provider will be paid for services provided in the office Monday through Friday after 5:00 p.m. and on weekends.	$25.00

SDoH Z-Code Incentive

Provider shall be eligible for additional incentive reimbursement for eligible z-codes, described in the chart directly below. Services will be paid at the rate below, based on billed claims.

Code	Description	Incentive Basis	Rate
Z55	Problems related to education and literacy	Provider will be paid per member identified as having an applicable Z-code diagnosis during the measurement year. Payment is limited to (1) payment per member per PCP during the measurement period.	$10.00
Z56	Problems related to employment and unemployment		
Z59	Problems related to housing and economic circumstances		
Z60	Problems related to social environment		
Z62	Problems related to upbringing		

Vaccines for Children (VFC) Incentive

Service	Measure	Incentive Basis	Rate
VFC Enrollment	Successful provider enrollment into the VFC program complying with all CDC and Michigan state requirements.	Providers that service pediatric members will be paid per member per month for assigned pediatric membership if VFC enrolled at time of annual verification.	$1.50 PMPM

Potential Quality of Care (PQoC) Concerns

Aetna Better Health of Michigan has a process for identifying PQoC concerns including those received as member grievances related to our provider network, including 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 of Michigan 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 of Michigan 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 MDHHS protocols. Aetna Better Health of Michigan 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 of Michigan enrollment in terms of demographic characteristics, the prevalence of disease, and potential consequences (risks) of the disease

Our QM Department prepares PIP proposals reviewed and approved by our Chief Medical Officer (CMO), Quality Management/Utilization Management Committee, and the Quality Management Oversight Committee (QMOC) before submission to the MDHHS for review and approval. The committee review process allows us to solicit advice and recommendations from other functional units within Aetna Better Health and providers of the Provider Advisory Committee.

The QM Department conducts 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, we immediately conduct 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 we achieve real and sustained improvement.

Peer Review

Peer review activities are evaluated by the Credentialing and Performance Committee. This committee may take action if a quality issue is identified. Such actions may include, but are not limited to, the development of a corrective action plan with time frames for improvement, evidence of education, counseling, development of policies and procedures, monitoring and trending of data, limitations, or discontinuation of the provider's contract with the plan. The peer-review process focuses on the issue identified but, if necessary, could extend to a review of utilization, medical necessity, cost, and/or

health provider credentials, as well as other quality issues.

Although peer review activities are coordinated by the Quality Management Department, they may require the participation of Utilization and Care Management, Provider Experience, or other departments. Aetna Better Health of Michigan may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plan's peer review process adheres to Aetna Better Health of Michigan policies, is conducted under applicable state and federal laws, and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in the Aetna Better Health of Michigan network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension, or termination of a contract under specific circumstances.

Performance Measures

MDHHS monitors the performance of Medicaid Health Plans (MHPs) through 34 key performance measures aimed at improving the quality and efficiency of health care services provided to Michigan residents enrolled in a Medicaid program. These measures include Healthy Michigan Plan (HMP) Measures, MDHHS Dental Measures, CMS Core Set Measures, HEDIS Measures, and Managed Care Quality Measures, Maternal Health Measures, and Chronic Conditions Measures. Aetna monitors outcomes of these performance measures monthly and work to achieve standards for these measures. For more information on Performance Monitoring Measure reporting, please contact a Quality Representative at 855-737-0770 ext. 711.

Satisfaction Surveys

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

Member Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems® (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are subsets of Healthcare Effectiveness Data and Information Set® (HEDIS) reporting. Aetna Better Health of Michigan contracts with a National Committee for Quality Assurance (NCQA) certified vendor to administer the survey according to HEDIS® survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the healthcare experience.

External Quality Review (EQR)

External Quality Review (EQR)is a requirement under Title XIX of the Social Security Act, Section1932(c), (2) [42U.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. External Quality Review (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 of Michigan cooperates fully with external clinical record reviews assessing our networks quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by the MDHHS. Aetna Better Health of Michigan assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. We also provide complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Better Health of Michigan'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.

Provider Profiles

In an effort to promote the provision of quality care, we profile providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for specific profiling measures. Individual providers and practices are profiled for multiple measures and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

The Provider Profiling Program is designed to share standardized utilization data with physicians to improve clinical outcomes. The profiling program is intended to support clinical decision-making and patient engagement as providers often have little access to information about how they are managing their members or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider-patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

Aetna Better Health of Michigan includes several measures in the provider profile, which include, but are not limited to:

- Frequency of individual patient visits to the PCP
- HEDIS-type screening tests and evidence-based therapies (i.e. appropriate asthma

management linked with correct use of inhaled steroids)
- Use of medications
- ER utilization and inpatient service utilization
- Referrals to specialists and out-of-network providers

We distribute profile reports to providers so they can evaluate:
- Potential gaps in care and opportunities for improvement
- Information indicating performance for individual cases or specific disease conditions for their patient population.
- A snapshot of their overall practice performance relative to evidence-based quality metrics

Our Chief Medical Officer (CMO) regularly visits individual network providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our Chief Medical Officer (CMO) investigates potential utilization or quality of care issues that may be identified through profiles. Aetna Better Health of Michigan's medical leadership is committed to collaborating with providers to find ways to improve patient care.

Member Incentives: Aetna Better Care Rewards Program

Aetna Medicaid enrollees may be eligible for a variety of rewards for completing annual preventive health services like their annual checkup, 3-week walking challenge and diabetic screening tests. All Aetna members are automatically enrolled in the rewards program and can register to spend points earned for completing preventive health care services throughout the year. To register, members can visit **AetnaBetterCareRewards.com/MI or call 1-877-473-5147 (TTY:1-844-200-2094)**.

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of members, opportunities for improvement identified through our QM Program, and feedback from participating providers. Guidelines are updated as appropriate, but at least every two years. Aetna Better Health participates with the Michigan Quality Improvement Consortium (MQIC) to develop, adopt, and distribute clinical practice guidelines. Aetna Better Health also adopts behavioral health guidelines from the American Psychiatric Association.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. Aetna Better Health of Michigan collects this data routinely.

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by the Center for Medicare and Medicaid Services (CMS) for Medicare Advantage Members. Accrediting bodies such as

the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS data, The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes, and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?
HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of Members along with claims and encounter data)
- Survey

Why does the plan need to review medical records when it has claims data for each encounter?
Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of test that may not be available in claims/encounter data. Typically, a plan employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to fax or mail the specific information. How accurate is the HEDIS data reported by the plans?
HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan may ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the plan?
The HIPAA Privacy Rule permits a provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506 (c) (4). Thus, a provider may disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the provider bill the plan for providing copies of records for HEDIS?
According to the terms of their contract, providers may not bill either the plan or the Member for copies of medical records related to HEDIS.

How can provider reduce the burden of the HEDIS data collection process?
Options for reducing administrative burden in record retrieval efforts, you can grant

Aetna Remote Access to your Electronic Medical Records. Providers may also use CPTII Codes to supplement billing to support improved HEDIS outcomes. Please contact a Provider Experience representative or the QM Department at 855-737-0770 ext. 711 for more information.

How can providers obtain the results of medical record reviews?
The plan's QM Department can share the results of the medical record reviews performed at provider offices and show how results compare to that of the plan overall. Please contact a Provider Experience representative or the QM Department at 855-737-0770 ext. 711 for more information.

Where can I securely send medical records to reach my HEDIS Goals?

All medical records can be sent to the Aetna Quality Department in the following ways:
Fax: 855-789-5314
Email: AetnaBetterHealthofMI-HEDISMailbox@aetna.com
Secure Upload: www.submitrecords.com password: aetmedoff57
Grant Remote EMR Access: email AetnaBetterHealthofMI-HEDISMailbox@aetna.com or call a Quality Representative at 855-737-0770 ext. 711 to grant EMR access for Aetna to collect records

CHAPTER 13 – ENCOUNTERS, BILLING AND CLAIMS

Aetna Better Health processes claims in compliance with state and federal laws, rules, and regulations. Aetna Better Health will not pay claims submitted by a provider excluded from the Michigan Medicaid program.

Aetna Better Health uses the Cognizant QNXT® system to process and adjudicate claims. Both electronic and paper claims submissions are accepted. To assist Aetna Better Health in processing and paying claims efficiently, accurately, and timely, the health plan highly encourages providers to submit claims electronically, when possible. Aetna Better Health has developed a business relationship with Change Healthcare to facilitate electronic claims submissions. Aetna Better Health receives EDI claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, and 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 trading partners to validate successful transactions and identify errors for correction and resubmission.

When to Bill a Member

All providers are prohibited from billing any member beyond the member's cost-sharing liability, if applicable, as defined on the Aetna Better Health of Michigan remittance advice.

When to File a Claim

All claims and encounters with Aetna Better Health members must be reported to us, including prepaid services.

Timely Filing

Our timely filing limitations are as follows:

- New Claim Submissions – Providers have 365 days from the date service to submit a new claim unless there is a contractual exception. For hospital inpatient claims, the date of service means the date of discharge of the member
- COB Submissions – Providers have 365 days from the date of the primary remittance advice to submit a Coordination of Benefits (COB) Claim
- Claim Resubmission – Claim for reconsideration or for correction must be filed within 180 days from the original date of payment or denial and must be clearly marked as a resubmission. (Please submit any additional documentation that may effectuate a different outcome or decision). Failure to submit accurate and complete claims may result in payment delay and or denial
- Non-PAR Claim Appeals- Providers have 90 days from the remittance advice or notice of action to submit an appeal with all required documentation. Failure to submit accurate and complete appeals may result in payment delay and denial

How to File a Claim

1. Select the appropriate claim form:
   a) Medical and professional services use the current version of the CMS 1500 Health Insurance Claim Form
   b) Hospital inpatient, outpatient, skilled nursing, and emergency room services use UB-04
   c) Rural Health Clinics and Federally Qualified Health Centers use UB-04 or CMS 1500 as appropriate for the services rendered. Please contact our Provider Experience Department with additional questions
2. Complete the claim form
   a) Claims must be legible and suitable for imaging for record retention. Complete ALL required fields and include additional documentation when necessary
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted, or required documentation is missing. This could result in the claim being denied for untimely filing
3. Submit claims electronically or original copies through the mail (faxed claims are not routinely accepted)
   a) Payer ID: 128MI
   b) Electronic Clearing House -. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors
4. Change Healthcare (formerly Emdeon) is the EDI vendor we use
5. Contact the software vendor directly for further questions about electronic billing
6. Contact our Provider Experience Department for more information about electronic billing
7. Through the mail
   a) To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health at the correct address:

      Aetna Better Health of Michigan
      P.O. Box 982963
      El Paso, TX 79998-2963

Claim Filing Tips

- Corrected claims must be identified as a resubmission by stamping/writing "corrected claim" or "resubmission" on the paper claim form
- Altered claims must be clearly initialed at the correction site. Initialing corrections ensures the integrity of a corrected claim
- Corrected claims must include all original claim lines, including those previously paid correctly. Resubmitted claims without all original claim lines may result in the recoupment of correct payments

- Dates of service on the claim should fall within the prior authorized service date range. Including dates of services outside the authorized range may result in denials
- Claims for services requiring an authorization should include the authorization number in block 23 on the CMS- 1500 form and block 63 on UB-04 forms or in the appropriate field on EDI claims
- The authorization number should not contain any prefixes or suffixes such as “R12345,” “#7890,” or “3456 by Laura”
- Claims must have current, valid, and appropriate ICD diagnosis codes
- The diagnosis codes must be coded to the highest degree of specificity (fifth digit) to be considered valid
- Claims must be submitted with valid CPT, HCPCS, and or revenue codes
- Claims submitted with nonstandard CPT, HCPCS, revenue codes, or modifiers will NOT be processed and will be returned to the provider. These claims should be reworked and submitted timely to the initial claims address
- Each CPT or HCPCS code line must have a valid place of service (POS) (block 24B) code when billing on a CMS- 1500 form
- Accident details should be provided when applicable (Block 10B of CMS-1500 Form)
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500 Form)
- Providers must submit the appropriate NPI numbers in Block 33A of the CMS-1500 and Block 56 of the UB-04
- Billing provider taxonomy information should be submitted (Block 33B of the CMS-1500 form)
- All providers, including FQHCs and RHCs, must include their usual and customary charges as the billed amounts on the appropriate claim form

NDC Requirements

When billing manufacturers for drug rebates, Aetna Better Health must collect NDC numbers from providers. As a result, providers will not be reimbursed for drugs unless a valid 11-digit NDC number, unit of measure, and the quantity administered is available on the UB 04 or CMS 1500 claims.

A complete NDC data set consists of:

- An 11 Digit National Drug Code (NDC) Number
- NDC Quantity (not procedure code units)
- Unit of Measure code
- F2-International Unit
- GR-Gram
- ML-Milliliter

- UN-Unit
- If the NDC data set is missing, incomplete, or invalid, Aetna Better Health will deny the affected claim line

Encounter Data

Aetna Better Health requires the submission of certain data for encounter data collection by the State of Michigan. Please be sure to include the current, valid information below that corresponds to each provider's enrolled location with the State of Michigan Medicaid program. Failure to submit this information correctly will result in a denial of the claim.

Paper Billing

CMS 1500 Paper Claims (professional):

- Box 33 - Billing Provider Physical Address
- Box 33A - Billing Provider NPI
- Box 33B - Billing provider taxonomy
  a) Enter the 2-digit qualifier of "ZZ" followed by the taxonomy code
  b) Do not enter a space, hyphen, or other separators between the qualifier and number (e.g., ZZ207Q00000X)
- Box 24J - Rendering NPI - (bottom of box, non-shaded area)

UB-04 Paper Claims (institutional):

- Billing Provider NPI submitted in field 56, top row
- Billing provider taxonomy submitted in field 81

Enter the 2-digit qualifier of "B3" in the first column and then the taxonomy code immediately following. If there are questions regarding this information, please get in touch with our Provider Experience Department. Multiple Procedures
Multiple procedures performed on the same day and, or at the same session are processed at the following rates:

- 100% of the contracted rate for the primary procedure
- 50% of the contracted amount for the secondary procedure
- 50% of the contracted amount for any subsequent procedures
- Or as defined by a provider's current contract with Aetna Better Health or Medicaid guideline changes

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Certain modifiers may affect payment amounts as defined by the State of Michigan Medicaid Fee Schedule or contract with Aetna Better Health of Michigan. Common modifier issue clarification is below:

- Modifier 59 – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect the appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201- 99499) or radiation therapy codes (77261 -77499).
- Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect the appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, a provider may bill the component code with modifier 50. Services should be billed on one line reporting one unit with a 50 modifier.
- Modifier 57 – Decision for Surgery – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period.

Please refer to the Current Procedural Terminology (CPT) manual for further detail on proper modifier usage.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure
- Are necessary to accomplish the comprehensive procedure
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect Coding

Examples of incorrect coding include:

- “Unbundling” - Fragmenting one service into components and coding each as if it were a separate service or billing separate codes for related services when one code includes all related services
- Breaking out bilateral procedures when one code is appropriate
- Down coding services in order to use an additional code when one higher level, more comprehensive code is appropriate

Correct Coding Initiative

Aetna Better Health of Michigan utilizes claims editing systems designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Our edit guidelines are based on, but not limited to NCCI, CPT-4, HCPCS and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy, and literature research input from academic affiliations.

The major areas of reviews are:

- Procedure Unbundling - Billing two or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure
- Incidental Procedures - A procedure that is performed at the same time as a more complex procedure; however, the procedure requires little additional physician resources and or is clinically integral to the performance of the primary procedure
- Mutually Exclusive Procedures - Two or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service
- Multiple Surgical Procedures - Surgical procedures are ranked according to the clinical intensity and paid following percentage guidelines
- Duplicate Procedures - Procedures that are billed more than once on a date of service
- Assistant Surgeon Utilization - Determination of appropriate reimbursement rate and coverage
- Evaluation and Management Service Billing - Review the billing for services in conjunction with procedures performed

When reviewing remittance advices, any CPT code that has been changed or denied by the editing system will be noted by the appropriate disposition code.

Submission of Itemized Billing Statements

Aetna Better Health may require an itemized billing statement along with the original claims, especially if the claim is more than $50,000. If an itemized billing statement is required, the claim will be denied until submitted.

Balance Billing

Providers are prohibited from billing members for any balance of payment other than co-pays for covered services or as otherwise permitted under applicable law. Providers accept reimbursement from Aetna Better Health in full.

A provider may seek reimbursement from a member only when a service is not a covered benefit, and if the member has given informed written consent before treatment, that they agree to be held responsible for all charges associated with the service.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by a Provider Experience representative to research the complaint. Aetna Better Health is obligated to notify MDHHS when a provider continues the inappropriate balance billing a member.

Coordination of Benefits (COB)

By law, Medicaid is the payor of last resort. As an agency of the State of Michigan, Aetna Better Health is considered the payor of last resort when other coverage for a member is identified. Aetna Better Health shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

Aetna Better Health must receive COB claims within three hundred and sixty-five (365) days from the member's primary carrier remittance advice date. A copy of the primary carrier RA and disposition detail must accompany the claim.

Aetna Better Health pursues third-party liability (TPL) claims based on requirements and limitations under Aetna Better Health's contract with the State of Michigan. All providers are required to follow Aetna Better Health's policies on authorization requirements even when Aetna is not the primary payor.

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use the CMS UB-04 Form. Providers should bill Aetna Better Health using Level of Care HCPCS coding (e.g., level of care 101 is billed under HCPCS code LC101). Please bill with the corresponding HCPCS code for services rendered. Please contact Claims Inquiry/Claims Research with additional questions or concerns.

Federally Qualified Heath Centers, Rural Health Clinics and Tribal Health Centers (FQHC/RHC/THC)

Services must be billed according to instructions published in the Billing & Reimbursement for Institutional Providers Chapter of the Michigan Medicaid Provider manual. Providers submitting claims electronically must use the ASC X12N 837 5010 institutional format. The National Uniform Billing Committee (NUBC) UB-04 claim form must be used when submitting paper claims. The Type 2 (Organization) NPI number must be used as the billing provider on all electronic and paper claims. Place of service codes are not applicable to institutional billing.

However, if the FQHC/RHC/THC performs a service that must be billed on the professional claim form, the appropriate place of service code is 50.

Home Health Care
Providers submitting claims for home health services should use the CMS UB-04 Form. Providers must bill following their contract and State of Michigan Medicaid guidelines.

Durable Medical Equipment (DME)
Providers submitting claims for DME rental should use the CMS 1500 Form. DME rental claims are only paid up to the purchase price of the durable medical equipment.

Hospice
Aetna Better Health members currently receiving hospice services are routinely transitioned back to State of Michigan Fee-For-Service Medicaid coverage. Please contact the member's Case Manager or our Provider Experience Department to discuss these services in greater detail.

Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare it to prior remits to ensure proper tracking and posting of adjustments. We recommend that providers keep all remittance advice and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Contact our Provider Experience Department for more information about electronic remittance advices.

In order to qualify for Electronic Remittance Advice (ERA), a provider must currently submit claims through EDI and receive payment for a claim by EFT. Providers must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for providers to receive payment and reconcile outstanding accounts. Please contact our Provider Experience Department for assistance with this process.

Checking Status of Claims
Providers may check the status of a claim by accessing our secure provider portal website or by calling Claims Inquiry and Claims Research.

- Online Status through Aetna Better Health's Secure Provider Portal Website
  a) Aetna Better Health encourages providers to take advantage of using online status, as it is quick, convenient, and can be used to determine status for multiple claims
- Claims Inquiry and Claims Research can:
  a) Answer questions about claims
  b) Assist in resolving problems or issues with a claim
  c) Explain the claim adjudication process

d) Help track the disposition of a particular claim
e) Correct errors in claims processing

Resubmissions: Corrected Claims and Reconsiderations

Claims Corrections

Providers have 180 days from the date of payment or denial to resubmit a corrected version of a processed claim. The review and reprocessing of a corrected claim do not necessarily constitute reconsideration or claim dispute. Providers may resubmit a claim if:

- The original claim was denied because of missing documentation, incorrect coding, etc.
- The claim was incorrectly paid or denied because of processing errors

Please submit:

- An updated copy of the claim. Please note that all lines must be rebilled, even lines that were paid appropriately on initial submission
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation as required
- A brief note describing the requested correction. Please remember that corrections must be made on the claim form
- Clearly label as “Resubmission” or “Corrected Claim” at the top of the claim in black ink and mail to the appropriate claims address

Failure to mail and accurately label the resubmission to the correct address may cause the claim to deny as a duplicate.

All corrections must be submitted to the following address:

Aetna Better Health of Michigan
Attn: Corrected Claim
P.O. Box 982963
El Paso, TX 79998-2963

Claim Reconsiderations

Providers have 180 days from the date of claim processing to correct and resubmit claims. Please submit the PAR Provider Dispute Form located on our website along with:

- Factual or legal basis for dispute statement (separate page)
- A copy of the original claim

- Copy of remittance notice showing the claim denial
- Any additional supporting documentation
- Resubmission: A claim initially denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information
- Reconsideration: A request to review a claim that a provider believes was paid incorrectly or denied because of processing errors

All reconsideration must be submitted with the PAR Provider Resubmission Form (available on the Aetna Better Health of Michigan website) to the following address:

Aetna Better Health of Michigan
Attn: Reconsiderations
P.O. Box 982963
El Paso, TX 79998-2963

Examples of reconsideration requests:
- Contract interpretation issues
- Timely Filing (please submit acceptance report if billed electronic)
- Entire claim denied for no authorization due to the Member providing the incorrect insurance information
- Rejected as cosmetic and submitting medical records/documentation
- No authorization when it is required
- Coding edit reconsideration
- You may also submit your Dispute thru Availity. Instructions can be found on our website at
- https://apps.availity.com/availity/web/public.elegant.login

Timely Filing Denials

It is the responsibility of the provider to maintain their account receivables records, and Aetna Better Health of Michigan recommends that providers perform reviews and follow-up of their account receivables on at least a monthly basis to determine outstanding Aetna Better Health claims. Aetna Better Health of Michigan will not be responsible for claims that were received outside timely filing limits.

Recognizing that providers may encounter timely filing claims denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by providers. If a claim is denied for timely filing, complete the Provider Claim Resubmission/ Reconsideration Form available on the Aetna Better Health of Michigan's website and attach proof of timely filing.

Electronic Submission

Electronic claim submission (EDI) reports are available from each provider's claims clearinghouse after each EDI submission. These reports detail the claims that were sent to and received by Aetna Better Health of Michigan. Providers must submit a copy of the acceptance report from the provider's respective clearinghouse that indicates the claim was accepted by Aetna Better Health of Michigan within timely filing limits to override timely filing denial and pay the claim.

Please confirm that the claim did not appear on a rejection report. If Aetna determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the provider.

Paper Submission

Providers must submit a screen print from the provider's respective billing system or database with documentation that shows the claim was generated and submitted to Aetna Better Health of Michigan within the timely filing limits. Documentation should include:

1. The system printout that indicates:
   a) Claim was submitted to Aetna Better Health of Michigan
   b) Name and ID number of the Member
   c) Date of service
   d) Date the claim was filed to Aetna Better Health of Michigan
2. A copy of the original CMS-1500 or UB-04 claim form that shows the original date of submission

Remittance Advice

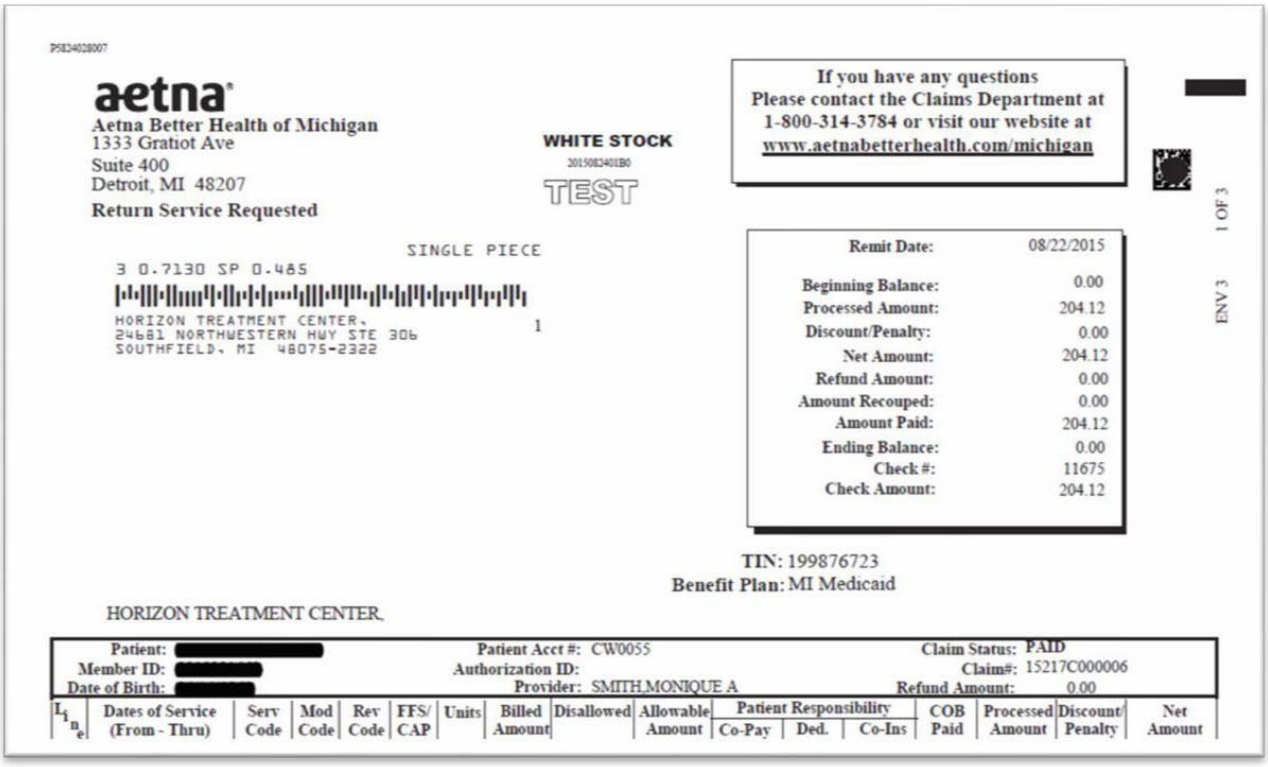
Aetna Better Health generates checks weekly. The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates. Claims processed during a payment cycle will appear on the remittance advice as paid, denied, or reversed. Information provided on the remit includes:

- Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle
- Remit Date represents the end of the payment cycle
- Beginning Balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced
- Processed Amount is the total of the amount processed for each claim represented on the remit
- Discount Penalty is the amount deducted from or added to the processed amount due to late or early payment depending on the terms of the provider contract
- Net Amount is the sum of the Processed Amount and the Discount/Penalty
- Refund Amount represents funds that the provider has returned to Aetna Better

Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of **REVERSED** in the claim detail header with a non-zero Refund Amount listed

- Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped
- Ending Balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative Amount Paid
- Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically, then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates
- Benefit Plan refers to the line of business applicable for the remit. TIN refers to the tax identification number
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
  - Member Name
  - Member ID number
  - Date of Birth
  - Account Number
  - Authorization ID, if obtained
  - Provider Name
  - Claim Status
  - Claim Number
  - Refund Amount, if applicable
- Claim Totals are totals of the amounts listed for each line item of that claim.
- Code/Description area lists the processing messages for the claim
- Remit Totals are the total amounts of all claims processed during this payment cycle
- The message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information

Sample remittance advice and check:



PSI24028007

aetna

Aetna Better Health of Michigan
1333 Gratiot Ave
Suite 400
Detroit, MI 48207
Return Service Requested

WHITE STOCK
201508240180
TEST

If you have any questions
Please contact the Claims Department at
1-800-314-3784 or visit our website at
www.aetnabetterhealth.com/michigan

[redacted]

1 OF 3

ENV 3

SINGLE PIECE
3 0.7130 SP 0.485

HORIZON TREATMENT CENTER,
24681 NORTHWESTERN HWY STE 306
SOUTHFIELD, MI 48075-2322
1

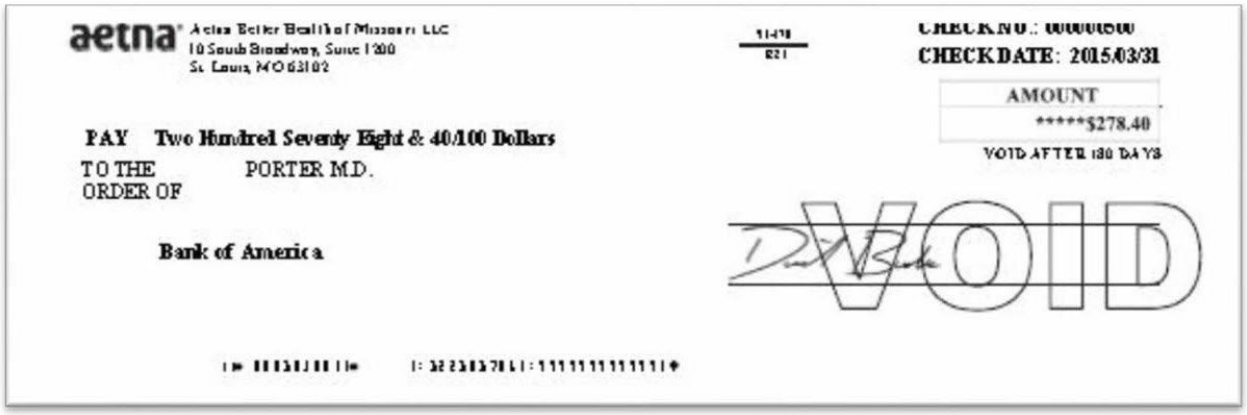
Remit Date:	08/22/2015
Beginning Balance:	0.00
Processed Amount:	204.12
Discount/Penalty:	0.00
Net Amount:	204.12
Refund Amount:	0.00
Amount Recouped:	0.00
Amount Paid:	204.12
Ending Balance:	0.00
Check #:	11675
Check Amount:	204.12

TIN: 199876723
Benefit Plan: MI Medicaid

HORIZON TREATMENT CENTER

Patient: [redacted]
Member ID: [redacted]
Date of Birth: [redacted]
Patient Acct #: CW0055
Authorization ID:
Provider: SMITH,MONIQUE A
Claim Status: PAID
Claim#: 15217C000006
Refund Amount: 0.00

Line	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Patient Responsibility Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Penalty	Net Amount



aetna Aetna Better Health of Missouri LLC
10 South Broadway, Suite 1200
St. Louis, MO 63102

11471
821

CHECK NO.: 0000000
CHECK DATE: 2015/03/31

AMOUNT
*****$278.40
VOID AFTER 180 DAYS

PAY Two Hundred Seventy Eight & 40/100 Dollars
TO THE ORDER OF PORTER M.D.

Bank of America

VOID

CHAPTER 14 – APPEAL AND GRIEVANCE

Aetna Better Health has an Inquiry, Appeal and Grievance process for members and providers to dispute a claim authorization or an Aetna Better Health decision. Our process includes both administrative and clinical decisions. A provider has 90 days from the Notice of Action to file an Appeal and 90 days from when they became aware of the issue to file a Grievance. Members have 60 days from the Notice of Action to file an Appeal, and members can file a Grievance at any time. Members and providers have a one-level internal appeal process through Aetna Better Health.

There are no punitive actions to members or providers for filing a complaint (appeal or grievance). Members and providers have the right to submit written comments at all levels of the process.

Provider Inquiries and Grievances

To ensure a high level of satisfaction, we will provide a mechanism for providers to express dissatisfaction with Aetna Better Health policies, procedures or any aspect of Aetna Better Health's administrative functions including grievances about any matter other than an appeal, Providers may express questions or dissatisfactions through our Provider Inquiry and Grievance Processes.

If a provider has questions regarding member benefits/eligibility, claim status/payment, remittance advice, authorization inquiries, etc., please access the provider portal or contact our Claims Inquiry and Claims Research (CICR). Provider inquiries are typically handled and resolved during the initial contact.

To submit dissatisfaction regarding an issue with Aetna Better Health, you may contact our Provider Experience Department at **1-866-314-3784 (TTY: 711).** Grievances received will be documented and forwarded to appropriate personnel in the Appeal and Grievance department for resolution. The resolution will be registered and communicated to all parties to the grievance.

Members and providers also have the right to request and receive a written copy of Aetna Better Health utilization management criteria in cases where the Appeals are related to a clinical decision/denial.

If required, Aetna Better Health members will receive assistance to file either an Appeal or a Grievance with the help of our Member Services Department.

A member may request/file a continuation of benefits during an Aetna Better Health Plan Appeal review or a State Fair Hearing if those services are part of ongoing course of treatment that were previously approved during the appeals process when requested timely and under the following circumstances

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The enrollee or their designed representative request continuation of benefits
- The services were ordered by an authorized provider; and
- The original period covered by the original authorization has not expired.

Timely is within ten (10) days of the Notice of Action or Appeal Decision mail date. If the Health Plan's action is upheld in a hearing, the member may be liable for the cost of any disputed services furnished while the Appeal was pending determination.

Claim Resubmission: Correction or Resubmission vs. Provider Appeal

Aetna Better Health has two separate and distinct processes designed to assist providers with issue resolution. If a non-par provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing a request to appeal. Providers should submit a Resubmission/Reconsideration form to the address below:

Aetna Better Health of Michigan
Attn: Reconsiderations
PO Box 982963
El Paso, TX 79998-2963

Claim resubmissions must be submitted within 180 days from the date of processing/denial and include: Corrected claims (including missing/incomplete/invalid diagnosis, procedure, or modifier denials); Timely Filing; and COB (missing/illegible primary explanation of benefits).

To appeal, non-par providers can follow the appeal process by submitting the Provider Appeal Form to:

Aetna Better Health of Michigan
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

63

Appeals must be submitted within 90 days of the date of service for claim denials, or in the

case of authorization denials, within 90 days after the date of adverse action (denial letter), unless otherwise specified in your provider contract, and include: Claim denial for no authorization/ precertification/medical necessity not met; Services denied per the finding of a review organization.

Provider Dispute of Claim Reconsideration Action Providers may dispute any adverse claim action. Before disputing a claim action, providers may contact our Claims Inquiry/Claims Research (CICR) Department for claim information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections, as well as the steps below, to minimize claims issues:

Contact our CICR Department at **1-866-314-3784 (TTY: 711)** as the first step is to clarify any denials or other actions relevant to the claim. A representative will assist a provider with a possible resubmission of a claim with additional modifications.

Provider Appeals

Non-par providers may submit an appeal regarding the denial or payment amount of a claim. Both par and non-par providers may submit pre-service appeals on behalf of a member with written consent. Preservice member appeals will be processed following the member appeal processes and timeframes.

Tips to writing an effective appeal

If a provider disagrees with Aetna Better Health of Michigan's decision regarding pre-service denial or post service claim decision, we have provided tips to writing an effective appeal letter:

- Include the name, address, and a phone number where the appealer can be reached in case there are any questions
- Include the patient's name, date of birth, and insurance I.D. number
- Describe the service or item being requested
- Prior Authorizations Number
- Address issues raised in our denial letter
- Address the medical necessity of the requested service
- Include information about the patient's medical history:
  a) Prior treatments
  b) Surgery Date
  c) Complications
  d) Medical condition and diagnosis

If applicable to an appeal situation, please also provide:

- Any unique patient factors that may influence our decision

- Why alternate methods or treatments are not effective or available
- The expected outcome or functional improvement
- An explanation of the referral to an Out-of-Network provider

When submitting an appeal, provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

Expedited Appeal Requests

Expedited requests are available for circumstances when the application of the standard appeal time frames would seriously jeopardize the life or health of the member or the member's ability to attain, maintain or regain maximum function. Only member pre-service appeals are eligible for expedited processing. Claim related appeals are not eligible for expedited processing. To request an expedited review, send a fax to 1-866-889-7517. Expedited review requests that meet the above criteria will have determinations made within seventy-two (72) hours or earlier as the member's physical or mental health requires.

Process definitions and determination time frames

Process	Definition	Determination
Inquiry	Inquiries are handled daily and are generally resolved during the initial contact. Questions received from a member or provider regarding issues from an Aetna Better Health Member Service Representative, such as benefits information, claim status, or eligibility, are classified as an inquiry To avoid delay in processing an inquiry, do not label an Inquiry as a Grievance or Appeal. Written Inquiries should be mailed to the address listed below	Fifteen (15) working days from receipt of the Inquiry
Grievance	Any written or oral expression of dissatisfaction with any aspect of care other than the Appeal of actions is considered an Appeal expressed by a member or provider. This dissatisfaction refers to any reason other than dissatisfaction due to the Health Plan's adverse benefit determination or action. A complaint is a Grievance. Most Grievances are categorized as Quality of Care, Quality of Service, or Service Center Specific.	Member 90 days and Provider 45 days

Process	Definition	Determination
Appeal	An Appeal is a written or oral request by the member or provider to review an Adverse Determination or payment/reimbursement denial related to a health service request or benefit that the member or provider believes he or she is entitled to receive. Denial or limited authorization of a requested service, including the type or level of service that the service is determined to be experimental, investigational, cosmetic, not medically necessary, or inappropriate. A failure to provide services in a timely manner as defined by the State and failure of the Health Plan to act within specified timeframes. The Appeal must be received by Health Plan within ninety (90) calendar days after the date of the Health Plan's Notice of Action for it to be considered an Appeal	Seventy-two (72) hours from receipt of the Expedited Appeal request for each level of internal Appeal 30 calendar days for members and 45 days for providers from receipt of the Standard Appeal request for each level of internal Appeal

WHERE TO SEND INQUIRIES, GRIEVANCES & APPEALS		
By	**Type**	**Address**
Mail	Provider Claim Appeals & Grievances	Aetna Better Health of Michigan PO Box 81040 5801 Postal Road Cleveland, OH 44181
Mail	Member Pre-Service Appeals	Aetna Better Health of Michigan PO Box 81139 5801 Postal Road Cleveland, OH 44181
Email	Appeals & Grievances	MIAppealsAndGrievances@AETNA.com

WHERE TO SEND INQUIRIES, GRIEVANCES & APPEALS		
By	**Type**	**Address**
FAX	Appeals & Grievances	Fax: 866-889-7517
Provider Portal: Availity	Appeals & Grievances	https://apps.availity.com/availity/web/public.elegant.login

State Fair Hearing

Aetna Better Health of Michigan members have 120 days from the date of Aetna Better Health's Appeal decision letter to initiate a State Fair Hearing. The member must complete the Health Plan Appeal process before starting the State Fair Hearing. If the member is dissatisfied with the state agency determination denying a member's request to transfer plans or disenroll, they may also access the State Fair Hearing process. To arrange for a State Fair Hearing, members should call or write to:

Michigan Department of Health and Human Services
Legal Services-Hearing Section
P.O. Box 30763
Lansing, MI 489091
877-833-0870

A member's provider may request a State Fair Hearing if the provider is acting as the member's authorized representative. In addition, the provider can request a State Fair Hearing without representing the member for claims issue resolution, as allowable per state law.

External Review

Members can also request an external review under Michigan's Patient Right Independent Review Act (PRIRA). Aetna Better Health of Michigan members have 127 days from the date of Aetna Better Health's Appeal decision letter to initiate an external review. The member must complete the Health Plan Appeal process before starting the external review. Member can request external review at the same time as or instead of State Fair Hearing. In the event a member request both an external review and a State

Fair Hearing at the same time, the decision that is the most favorable to the member is the one that counts.

To arrange for an External Review, members should call or write to:

Appeals Section
Office of Financial and Insurance Services (OFIS)
Health Plan Division, Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Fax: 1-517-241-4168

A member’s provider may request a external review if the provider is acting as the member's authorized representative.

CHAPTER 15 – FRAUD, WASTE AND ABUSE

Fraud, waste, and abuse

Aetna Better Health of Michigan has an aggressive, proactive fraud, waste, and abuse (FWA) program that complies with state and federal regulations. Our program targets areas of health care related fraud and abuse including internal fraud, electronic data processing fraud, and external fraud. Aetna Better Health of Michigan's Special Investigations Unit (SIU) is a key element of the program. The SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste or abuse to appropriate state and federal agencies as mandated by MDHHS-OIG. During the investigation process, we maintain the confidentiality of the member, or people referring the potential fraud and abuse case. We use a variety of mechanisms to detect potential FWA. All key functional areas (Claims, Provider Services, Member Services, Medical Management, etc.) as well as providers and members, share the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation and data analysis.

Special Investigations Unit

Aetna's Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and is responsible for investigating cases of alleged fraud, waste, and abuse. With a total staff of approximately 170 individuals, the SIU is comprised of experienced, full-time investigators, analysts, a full-time dedicated information technology organization and supporting management and administrative staff.

To achieve its program integrity objectives, Aetna's SIU employs state-of-the-art technology and systems capable of monitoring the huge volume of Aetna claims data across health product lines. One component of Aetna's technology advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers.
If suspected fraud is identified, the SIU's IT and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate to conduct in-depth analyses of case-related data.

Reporting suspected fraud and abuse

Participating providers are required to report to Aetna all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program. Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to Aetna's confidential Compliance/SIU Fraud, Waste Abuse Reporting Hotline at 1-855-421-2082 (TTY: 711)
- You can also report provider fraud to the following: MDHHS's Online Report Fraud and

Abuse Form or calling MDHHS-OIG toll free at 1-855-MI-FRAUD (1-855-643-7283
- Federal Office of Inspector General in the U.S. Department of Health and Human Services/Medicaid Fraud Control Units (MFCU) at 1-800-HHS-TIPS (1-800-447-8477) or online at US DHHS OIG - Submit a Hotline Compliant

The MFCU is a division of the Office of Attorney General created by statute to preserve the integrity of the Medicaid 108 program by conducting and coordinating fraud, waste, and abuse control activities for services funded by Medicaid.

Best practices for providers to prevent and detect FWA

- Develop a compliance program
- Monitor claims for accuracy – verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Take action if you identify a problem
- Remember, you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Fraud, waste, and abuse defined

- Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- Waste: Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- Abuse: Provider practices inconsistent with sound fiscal, business, or medical practices resulting in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program

Examples of fraud, waste and abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna due to improper payments to providers or overpayments

- Physical or sexual abuse of members
- Fraud, waste, and abuse can incur risk to providers:
- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members cash payments to encourage enrollment in a specific plan
- Selecting or denying members based on their illness profiles or other discriminating factors
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider)
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment) 109
- Billing for services not rendered or supplies not provided includes billing for appointments the members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for 20 nursing home visits without furnishing any specific service to the members.
- Double billing (billing both Aetna and another health plan)
- Misrepresenting the date services were rendered or the identity of the member who received the services
- Misrepresenting who rendered the service or billing for a covered service other than the non-covered service that was rendered
- Fraud, waste, and abuse can incur risk to members as well:
- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the member's medical history
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addiction
- In addition, member fraud is also reportable, and examples include:
- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit

- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another member's ID)
- Forging and altering prescriptions
- Doctor shopping (i.e., when a member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

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