Aetna Better Health® of Michigan
Provider Orientation 2024

Provider Relations

Aetna Better Health of Michigan's Mission

Aetna Better Health of Michigan (ABHMI) is looking forward to serving Michiganders and partnering with health systems, providers, FQHCs and community resources to bring quality healthcare to the state through our experience and dedication in serving Medicaid/Medicare populations.

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

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

Orientation Agenda

- Our Members, Your Patients
- Value Based Services
- Credentialing
- Prior Authorizations
- Concurrent Review
- Pharmacy
- EPSDT
- Health Risk Screening
- Access to Care Guidelines
- Telephone Accessibility Standards
- Abuse, Neglect and Exploitation
- Fraud, Waste and Abuse
- Claims & Availity
- Provider Preventable Conditions (PPC)
- Grievance & Appeals
- Contacting Aetna Better Health of Michigan
- Resources
- ABHMI Team

How we connect with our Members

What is health equity?

Our health equity definition:

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

Fair and just

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

Healthy

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

Recognition of Racism and Discrimination

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

Health Equity & Social Determinants of Health

Health Equity is the Goal

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

Social Determinants of Health are Contributing Factors

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

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


Aetna Better Health seeks to provide simplified structures and services to achieve better health outcomes and cost savings through their SDoH programs.
Better *Together*:
Social Impact Solutions

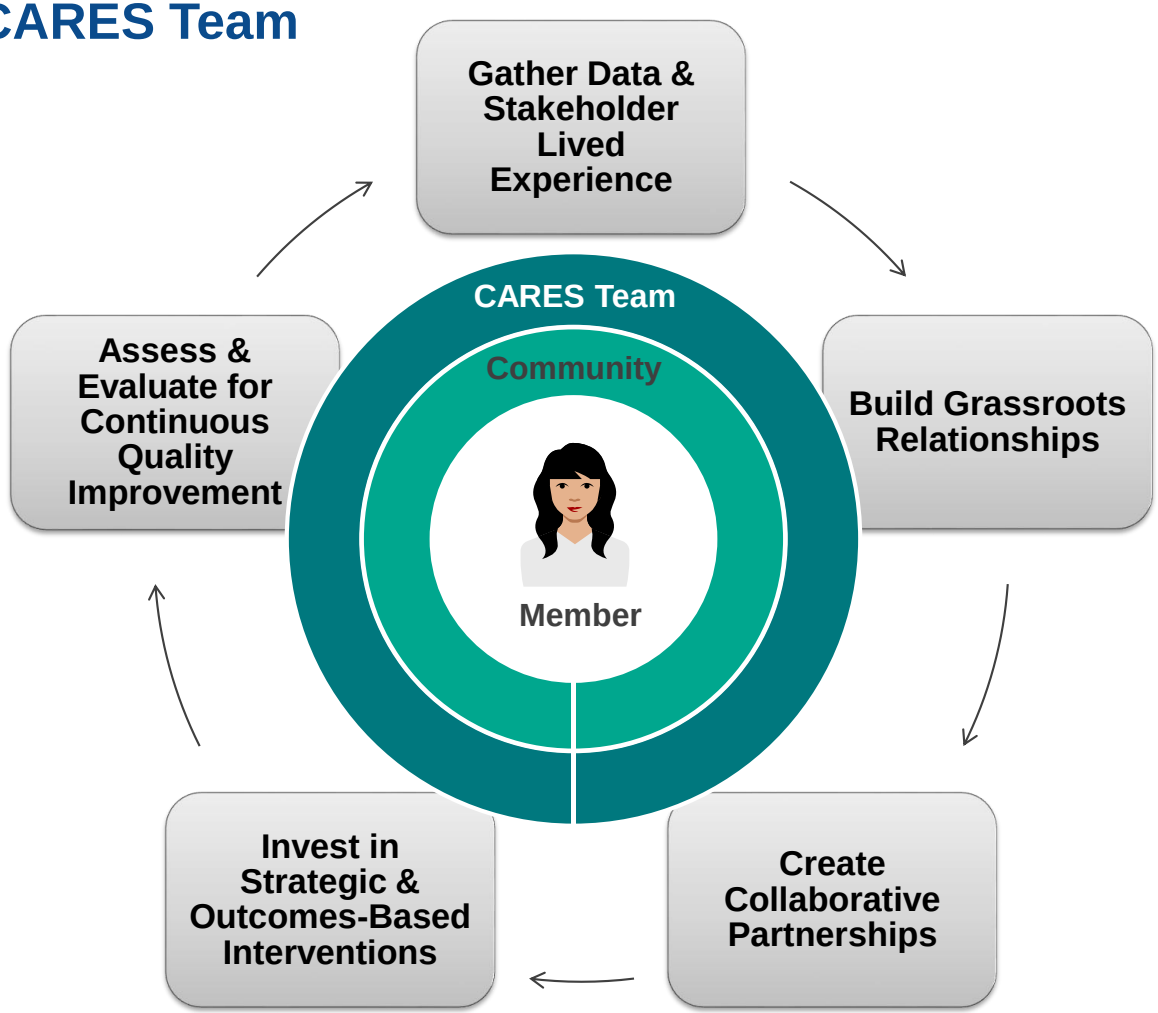
Better Together: Community CARES Team

External facing

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

We know in order for any one person, family, or community to focus on being the healthiest they can be they must ensure they have all basic needs met.

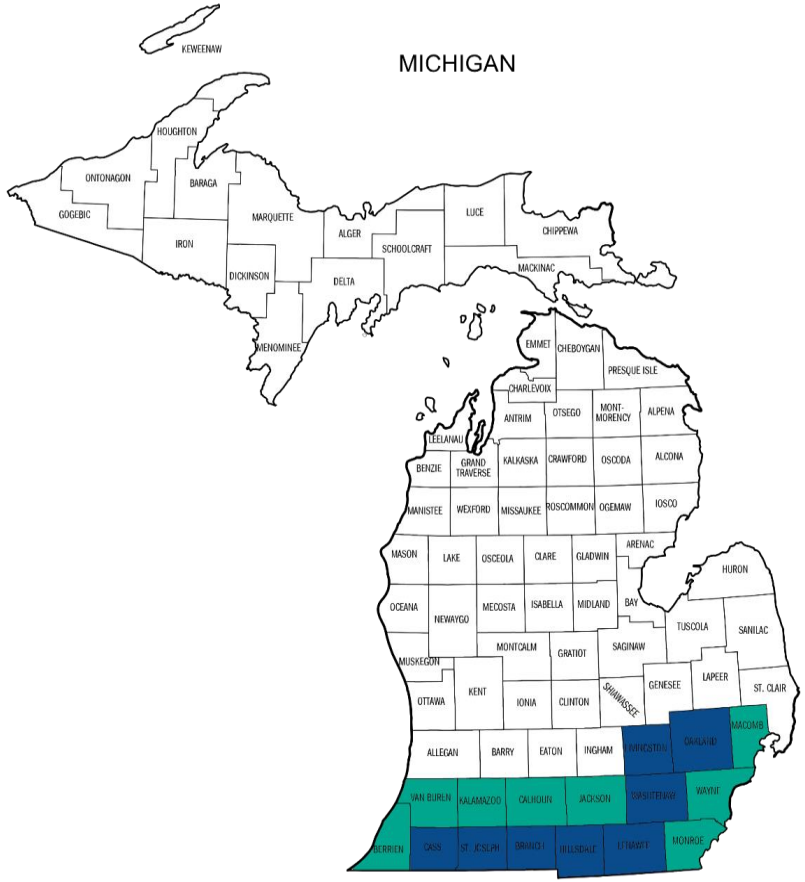
Here's how our CARES team works:



Our **Better Together: Community CARES** team aims to create healthier members and communities, with a focus on the social determinants of health. To learn more, reach out to the Aetna Better Health partner in your area:

Laura Dyszlewski, Manager
DyszlewsiL@aetna.com

Ki-Jana Malone, Community Strategist
MaloneK3@aetna.com



Anti-Discrimination Policy and Americans with Disabilities Act (ADA)

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

Race
National Origin
Creed
Color
Age
Gender/Gender Identity
Sexual Preference
Religion
Health Status
  Physical/Mental Disability
Other Basis Prohibited by Law

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

If we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be taken.

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

- Race
- National Origin
- Creed
- Sexual Preference
- Religion
- Age
- Physical/Mental Disability
- Color
- Gender/Gender Identity

The ADA guarantees equal opportunity for individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

Value Added Benefits for Members

Get healthy. Earn rewards.

Reward your healthy choices

As a member of Aetna Better Health® of Michigan, you are automatically enrolled in Aetna Better Care® Rewards. You can earn reward points for making certain healthy choices. For example, members age 20+ can earn **500 points** ($50 value) for completing an annual wellness checkup with a primary care provider.

Enjoy the rewards of better health

The Aetna Better Care Rewards program is more than just rewards. Completing healthy activities can help you improve your health and well-being. Visit **AetnaBetterCareRewards.com/MI** for healthy tips, tools, and resources.

Earn reward points and go shopping

Check out pages 2-3 of this booklet to learn about all the ways you can earn reward points. Use your points to shop for fun, healthy items in the Aetna Better Care Rewards catalog.

Sample reward categories and items

Athletics	Education & Creativity	Kitchen & Nutrition
		
Wilson® NCAA® Basketball WBB_200	**Deluxe Art Set** DAS_600	**Magic Bullet® Blender** MBB_300

Shop online
AetnaBetterCareRewards.com/MI
All items ship free!

Shop by phone
1-877-473-5147 (TTY: 1-844-200-2094)
8 AM to 5 PM ET, Mon.–Fri.

***Finity Member Rewards Program**

Member Healthy Rewards Program

Reward Activities

Prevention and Screening Rewards

Adult PCP Checkup (age 20+)
Complete a checkup with your primary care provider (PCP)
500 points ($50 value)

Breast Cancer Screening (women, ages 50-74)
Complete a mammogram
500 points ($50 value)

Cervical Cancer Screening (ages 21-64)
- Ages 21-64, complete a Pap test
- Ages 30-64 and high-risk, complete a human papillomavirus (HPV) test
- Ages 30-64 and high-risk, complete Pap+HPV cotest

500 points ($50 value)

Diabetes Testing (ages 18-75)
Diagnosis of type 1 or 2 diabetes
Complete an HbA1c test and a diabetic eye exam
250 points ($25 value)

Maternal Care Rewards

Prenatal Checkup (age 18+)
Complete a prenatal care visit in the first trimester or within 42 days of plan enrollment
500 points ($50 value)

Postpartum Checkup (age 18+)
Complete a postpartum care visit 7-84 days after delivery
500 points ($50 value)

Step-Up Challenge

Step-Up Challenge (age 10+)
Complete the three-week walking challenge
250 points ($25 value)

Well-Child and Well-Adolescent Reward Activities

Well-Baby Checkups (ages 0-15 months)
- Complete 3 well-baby visits in the first 6 months
- Complete 3 well-baby visits between 6 and 15 months

500 points ($50 value)

Well-Child/Adolescent Checkups* (ages 3-21)
Complete an annual well-care visit with a PCP or an OB/GYN
500 points ($50 value)

Childhood Immunization Series (ages 0-2)
Complete full childhood vaccination series against DTap, HiB, polio, HepB, chicken pox, PCV, MMR, HepA, rotavirus, and influenza (flu)
250 points ($25 value)

Adolescent Immunizations (age 13 and under)
Complete all three required adolescent immunizations by your child's 13th birthday
250 points ($25 value)

Lead Screening (ages 0-2)
Complete a blood test for lead poisoning by your child's second birthday
250 points ($25 value)

*Members ages 20-21 can earn either the Adult PCP Checkup or the Well-Child/Adolescent Checkup reward, but not both.

Healthy Michigan Plan Members (Medicaid Expansion) Reward

Health Risk Assessment (ages 19-64)
HMP members can earn an additional reward by completing the Healthy Michigan Plan Health Risk Assessment
500 points ($50 value)

Member Advisory Committee

Member Advisory Committee
This group is made up of ABHMI staff, members, individuals and providers with knowledge of and experience with serving the older population and individuals with disabilities, representatives from community agencies and community advocates.
This committee discusses how to improve ABHMI policies and is responsible for:

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

We encourage you to become a part of this group. Or if you have a member that would be interested, call Member Services at 1-855-676-5772 (TTY: 711), 24 hours a day, 7 days a week, for more information.

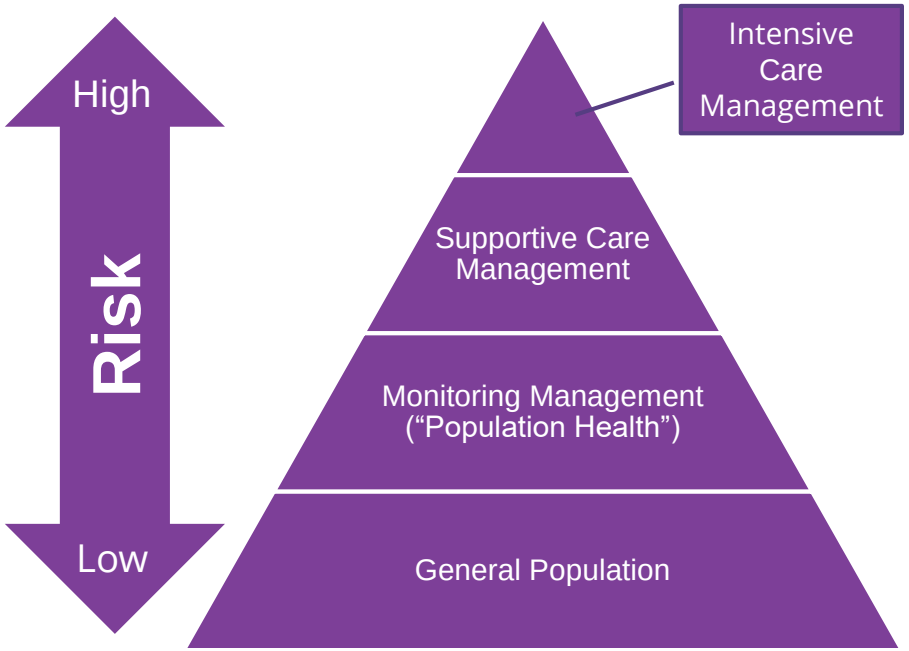
Medical Management: Care Management

Integrated Care Management Program (ICM)

A member-centered approach that addresses physical and behavioral health, psychosocial needs and collaboration with the members' system of care and relationships.

Specialized Care markets for:

- COPD
- Asthma
- Depression
- Heart Failure
- Diabetes
- Hypertension



How to Refer to Care Management:

Phone: 1-855-676-5772

How to Refer to Care Management

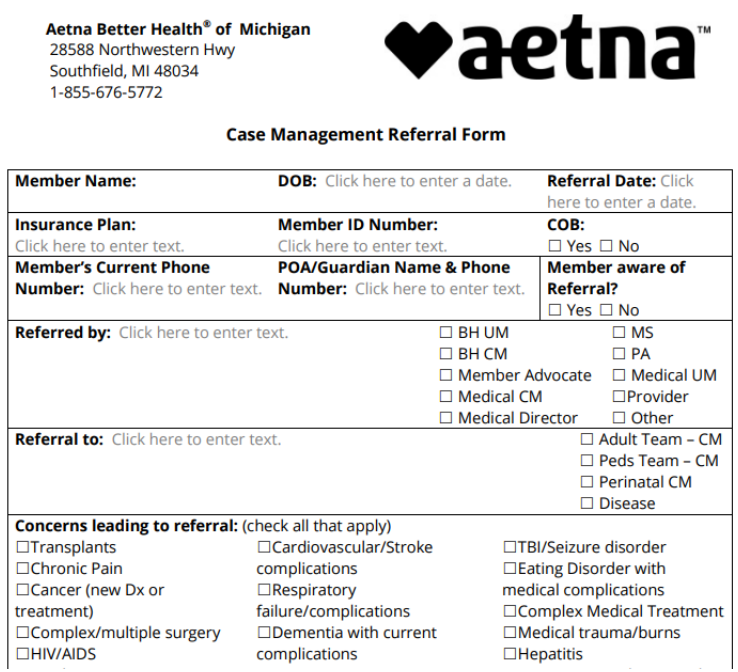
Referral Process:

To make referrals for care management consideration, please call:

Phone: 1-855-676-5772

Fax referral form to secured CM Fax line:

Fax: 866-889-7572



Aetna Better Health® of Michigan
28588 Northwestern Hwy
Southfield, MI 48034
1-855-676-5772

aetna™

Case Management Referral Form

Member Name:	**DOB:** Click here to enter a date.	**Referral Date:** Click here to enter a date.
Insurance Plan: Click here to enter text.	**Member ID Number:** Click here to enter text.	**COB:** ☐ Yes ☐ No
Member's Current Phone Number: Click here to enter text.	**POA/Guardian Name & Phone Number:** Click here to enter text.	**Member aware of Referral?** ☐ Yes ☐ No

Referred by: Click here to enter text.

☐ BH UM ☐ MS
☐ BH CM ☐ PA
☐ Member Advocate ☐ Medical UM
☐ Medical CM ☐Provider
☐ Medical Director ☐ Other

Referral to: Click here to enter text.

☐ Adult Team – CM
☐ Peds Team – CM
☐ Perinatal CM
☐ Disease

Concerns leading to referral: (check all that apply)

☐Transplants	☐Cardiovascular/Stroke complications	☐TBI/Seizure disorder
☐Chronic Pain	☐Respiratory failure/complications	☐Eating Disorder with medical complications
☐Cancer (new Dx or treatment)	☐Dementia with current complications	☐Complex Medical Treatment
☐Complex/multiple surgery		☐Medical trauma/burns
☐HIV/AIDS		☐Hepatitis

Forms can be found here:
CM ICM Referral. Jan 2019docx (aetnabetterhealth.com)

Behavioral Health

Basic Behavior Health Services

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

Primary Care Provider Referral

ABHMI promotes early intervention and health screening for identification of behavioral health problems and patient education. To that end, ABHMI providers are expected to:

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

Behavioral Health - continued

Multiple Access Points for Behavioral Health Services

Mild to Moderate Impairment
Moderate to Severe Impairment
Substance Use Disorder

Responsibility of Aetna Better Health of Michigan, includes Mild to Moderate Impairment:

- PCP
- Psychiatric Testing
- OP Counseling
- Psychiatric Evaluation & Medication Management
- ABA Services
- Intensive Outpatient Program (IOP)

- Participating Providers are required to provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within twenty-four (24) Hours of assessment.

- Participating Providers providing inpatient psychiatric services to Enrollees are required to schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven (7) Calendar Days from the date of discharge.

- Providers must notify ABHMI of all discharge medications PRIOR to member's planned discharge from inpatient (IP) stay:
  - 1) IP Mental Health
  - 2) IP Detox
  - 3) Residential

Behavioral Health Resources

Screening, Brief Interventions, & Referral to Treatment (SBIRT)

Screening: assess patient for risky substance use behaviors using standardized screening tools

Brief Intervention: healthcare professional engages patient in a short conversation, providing feed back and advice

Referral to Treatment: healthcare professional provides referral to brief therapy or additional treatment for patients who screening demonstrates the need for additional services

Additional Resources:

SBIRT

Home | Aetna Better Health® of Michigan

Resources and Materials:

CMS Health insurance reform for consumers (MH Parity Act of 2008)

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

- MCG BHG is nationally recognized, evidence-based clinical guidelines used for determining medical necessity, appropriate levels of care: www.mcg.com/content/behavioral-health-care

Depression Screening

Unhealthy drug use screening

Early and Periodic Screening, Diagnostic and Treatment info

Cognitive Health Assessment for Members 65 years of age or older

Overview of Health Plan

Aetna Better Health of Michigan (Medicaid)

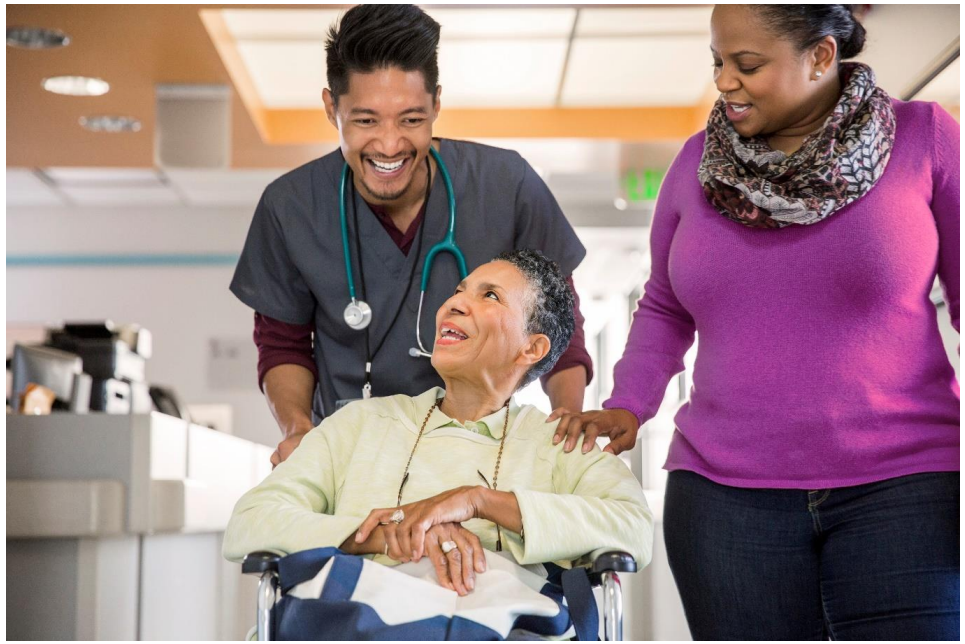
Providers benefits to families meeting the eligibility requirements for Medicaid benefits under the following programs

- Temporary Aid to Needy Families (TANF)
- Aged, Blind and Disabled (ABD)
- Children's Special Health Care Services (CSHCS)
- Healthy Michigan (HMP) - is a health care program through MDHHS covering individuals meeting the income guidelines who are between ages 19 to 64, and not currently eligible for Medicaid (based on income)

Aetna Better Health of Michigan (Medicaid)

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

Aetna Better Health® Premier Plan (Duals MMP Program)

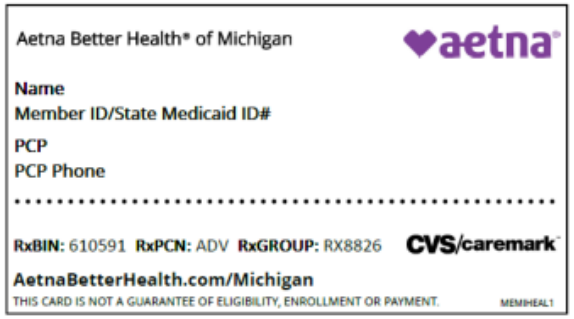


Provides benefits to people 21 and over who qualify for both Medicare and Medicaid under the Michigan Department of Health and Human Services (MDHHS) MI Health Link Program

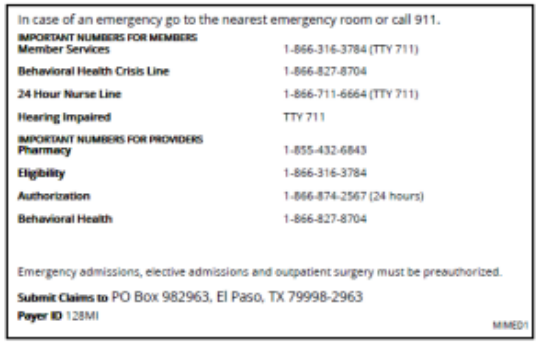
Service Area	Counties
Region 4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph or Van Buren County
Region 7	Wayne
Region 9	Macomb

Member Information

Front of ID Card



Back Of ID Card



Member Rights and Responsibilities:

- To be provided with information about the State and its services, including Covered Services.
- To be able to choose a Primary Care Provider within Aetna's network.
- To participate in decision making regarding their own health care, including the right to refuse treatment.
- Give their health care provider all the information they need.
- Ask for more information if they do not understand their care or health condition.
- Tell their provider about any other insurance they have.
- Physical Accessibility. Participating Providers are to provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3)

Verifying Member's Eligibility

You can verify member eligibility, PCP assignment, benefits, co-pays/deductibles by:

- Using the State CHAMPS system accessed at **www.michigan.gov/medicaidproviders**
- Provider portal **AetnaBetterHealth-Michigan.Aetna.com**
- Contact your Provider Relations Team at **AetnaBetterHealth-MI-ProviderServices@Aetna.com**
- **CHAMPS PROVIDER ENROLLMENT**
  - All Providers must be enrolled in CHAMPS effective January 1, 2019, to receive Medicaid Funds from all Health Plans.
  - ABH-MI will require all contracted providers to have a CHAMPS identification number, which is provided once providers are enrolled into the system.
  - Information for CHAMPS enrollment can be found at
  - For additional CHAMPS enrollment information, contact MDHHS CHAMPS at **ProviderSupport@michigan.gov** or **1-800-292-2550.**

Language Services

Language Services can be accessed via Member Services at 1-866-316-3784 Interpretation (Over the Phone)

- **Interpreter services and translated materials are free of charge. Call Member Services at 1-866-316-3784 (TTY: 711) for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Aetna Better Health complies with all applicable federal and state laws with this matter.**

Additional Resources:

Interpreter Quality Standards Guidance
https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf

Office for Civil Rights
https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Sub-Contractors

Aetna Better Health of Michigan partners with the following vendors to coordinate services for members :

CVS Health
Pharmacy Benefits Manger
1-800-552-8159

DentaQuest
Dental Benefits Manager
1-866-316-3784

VSP
Vision Benefits Manager
1-800-877-7195

Access 2 Care
A Global Medical Response Solution
Transportation
1-866-316-3784
option 6

eviCore healthcare
Radiology Benefits Manager
1-888-693-3211

How we connect with Providers

Provider Roles & Responsibilities

Aetna Better Health of Michigan participating providers are contractually obligated to comply with all Federal and State laws and guidelines outlined in their Michigan Medicaid Contract and their Provider manual.

The quality of our network and the ability to provide excellent service is dependent on having accurate provider data.

Providers should be easily accessible to our members by having appointments and after-hour coverage available.

Access and Availability Standards

Providers must comply with the following appointment and accessibility requirements.

Physician Type	Service Type	ABH Response Standard
Primary Care Physicians (PCP)	Emergency Urgent Care Routine	Within 24 hours Two (2) calendar days Fourteen (14) working days
Behavioral Health	Non-Life Threatening Emergency Urgent Care Initial Visit	Within six (6) hours Within 48 hours Within 10 working days
Prenatal	First (1st) Trimester Initial Second (2nd) Trimester High Risk	Fourteen (14) working days Seven (7) working days Three (3) working days from referral

Provider Resources

- Aetna Better Health of Michigan Website
- Provider Portal
- Provider Trainings
  - Fraud Waste and Abuse
  - Cultural Competency
  - FDR
- Provider Newsletter
- Joining Our Network
- Credentialing and Re-Credentialing
- Important Contacts

Overview of Value-Based Services (VBS)

Our Offer — Various Incentive Arrangements

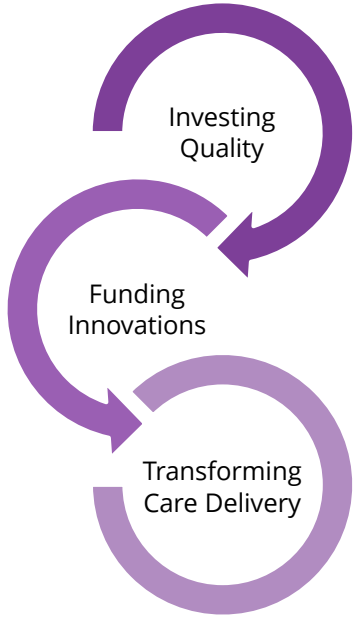
- Pay for Quality with designated incentive pool
- Shared Savings Models
- Shared Risk Models
- Full Risk Models/Capitation Models

We look for — Participating providers in

- Primary Care
- Pediatric Care
- Obstetrics and Gynecology

Interested? — Please Contact:

- Kate Zavala, MHA, LPC, CCM – Senior Manager, Value-Based Services
- Email: Zavalak@aetna.com



Credentialing

Adding a New Provider to Existing Practice

(Physicians/Mid-Levels)

- Each new provider must be credentialed before s/he can render care to an ABHMI Member.
- Providers must be registered with CHAMPS.
- Mid-levels must have a supervising physician.
- Providers are re-credentialed every three (3) years and must complete the required
- reappointment application.
- Utilize CAQH for credentialing
- CAQH ProView
  - Complete Attestation & Documentation
  - Authorize ABHMI to view CAQH Profile

*Aetna Better Health's Credentialing Policy Our credentialing policy has adopted 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.

Medical Prior Authorizations (PA)

You may submit PA Requests by:

Phone	Secure	Fax
1-855-676-5772	Availity	1-844-241-2495

Service Authorization Decision Timeframes	Turnaround Times
Urgent pre-service approval	72 Hours from receipt of request
Post-service approval	Thirty (30) Calendar days from receipt of the request
Standard non-urgent pre-service approval	Fourteen (14) Calendar from receipt of the request
Urgent concurrent approval	24 hours from receipt of request
Retrospective review approval	14 calendar days from receipt of the request

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

Documentation requirements for authorization request:

- Member Information
- Diagnosis Code(s)
- Treatment or Procedure Code(s)
- Anticipated Start and End Dates of Service(s)
- Presentation of supporting objective clinical information, such as clinical notes, clinical notes, comorbidities, complications, progress of treatment, psychosocial situation, home environment, laboratory and imaging studies, and treatment dates, as applicable for the request.

- Include:
  - Office/Department Contact Name
  - Telephone
  - Fax Number

Additional information can be found here:
Prior Authorization | Aetna Better Health of Michigan

Aetna Authorization Tools (PROPAT and EviCore)

PROPAT

Available to providers to determine if PA is required; allows for entry of up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes or a CPT group and select SEARCH. Search result definitions:

- YES - Prior authorization request is required for this service.
- NO - Health plan does not require a prior authorization request for this service **(PAR Providers Only)**.
- NON-COV - CPT or HCPCS code entered is not a covered benefit by health plan.
- INVALID - CPT or HCPCS code entered was invalid, not found.
- EXPIRED - CPT or HCPCS code entered is no longer valid for use by health plan providers.
- **MedicaidPortal.Aetna.com/propat/Default.aspx**

EviCore

Healthcare performs utilization management services on behalf of Aetna for Musculoskeletal (pain management) and Radiology Management (includes advanced imaging such as CT, MRI, MRA, PET scans, and diagnostic OB ultrasounds).

- For radiology services, submit your PA request directly to EviCore at **www.eviCore.com** or call **1-888-693-3211** or fax **1-844-822-3862**.

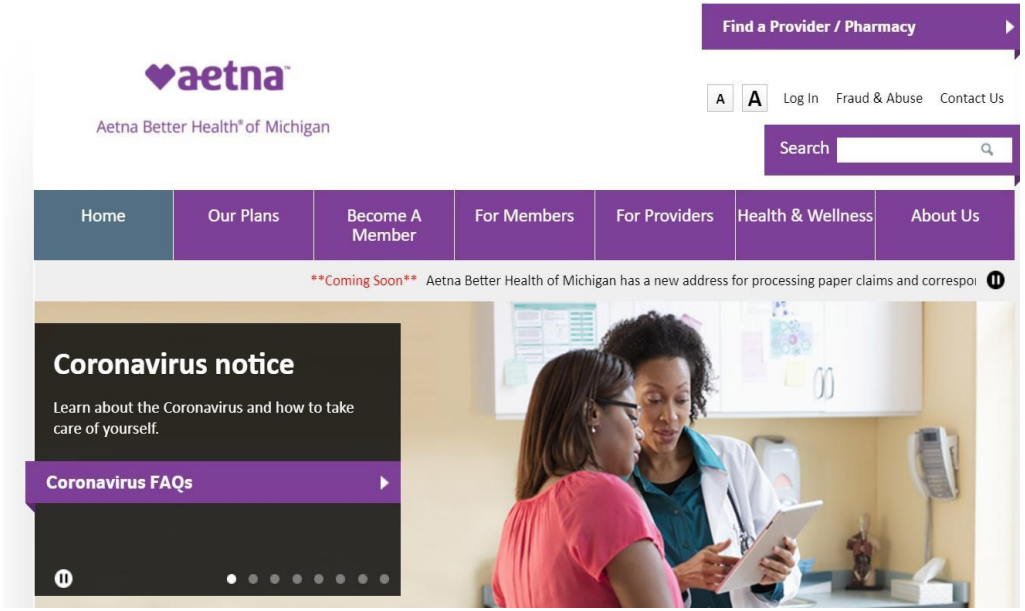
Additional timeframes and authorization information, is in the Provider Manual

Aetna Better Health of Michigan Website

Providers can access the Aetna Better Health of Michigan website at **AetnaBetterHealth.com/Michigan**

There you'll find tools and resources to make doing business with Aetna quick and simple. We've listed a few of the tools and resources found on the "For Providers" tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Authorizations
- Document Library
- Pharmacy
- Practice Guidelines/Screening Tools
- Provider Education
- Secure Provider Portal
- HEDIS



Concurrent Review Process

Overview

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

What does that mean?

- Admission certification 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.
- Review of the member's medical record to assess medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines.
- 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.**

Pharmacy

Aetna Better Health of Michigan covers prescription medications and certain over-the-counter medicines when you write a prescription for a member.

We use CVS/Caremark for pharmacy benefit management services.

Online formulary search tool includes formulary status and indicates whether a drug requires step therapy (ST), has a quantity limit (QLL) or requires Prior Authorization (PA)

CVS Caremark Mail Order Pharmacy

Pharmacy Billing Information:
BIN: 610591
PCN: ADV
Group: RX8826

Pharmacy PA:

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

Use Surescripts or Covermymeds® to:

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

Visit our provider page for more information :

Pharmacy | Aetna Better Health of Michigan

Quality Management Program

Overview

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

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

Medical Records Standards

ABHMI's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).

All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the ABHMI Provider Manual

Quality Management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

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

What is Our Ultimate Goal

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

Please see HEDIS Tips for PCPs located on our website at:

Home | Aetna Better Health® of Michigan

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

What is EPSDT?

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

Provider Responsibilities:

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - continued

EPSDT Services

Screening services must include, at a minimum,

- comprehensive health and developmental history (including assessment of both physical and mental health development);
- comprehensive unclothed physical exam;
- appropriate immunizations;
- laboratory tests (including blood lead level assessment appropriate for age and risk factors);
- health education (including anticipatory guidance).

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

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

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

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

Vaccines for Children (VFC) Program

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 are the advantages to you 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.
- You no longer must refer patients to public health to get their vaccines.
- Enhances all services you provide relative to EPSDT and access to care.

For more information regarding VFC follow link:

https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/immunization/providerinfo/vacforchildren/vfc-resource-guide

Health Risk Screening

As an Aetna Better Health provider, it is expected that you perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has an OCS eligible medical condition. We rely on you, our network providers, to complete the Initial Health Risk Screening within thirty (30) days of the members enrollment to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care.

The Health Risk Questionnaire for will assist us in identifying enrollees with special health care needs. If identified, we will follow-up with a Comprehensive Assessment (CA) as a part of the Risk Stratification Level Framework. This information must be included in the patient's medical records and supplied to Aetna Better Health of Michigan or its regulators upon request.

Three (3) documented outreach attempts:

Enrollee to complete the questionnaire in-person, by phone, electronically via ABHMI member portal, or by mail.

Health Risk Screening Questionnaire & Triggers

Questionnaire include but is not limited to:

a. Demographic information for verification purposes;

b. Current and past physical health and behavioral health conditions;

c. Identifying Enrollees with Special Health Care Needs and specialized treatment or equipment;

d. Services or treatment the Enrollee is currently receiving, including from out-of-State Providers;

e. Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another plan;

f. Most recent ER visit, Hospitalization, physical exam, and medical appointments;

g. Current medications; and

h. Questions to address Social Determinants of Health, including food, shelter, transportation, utilities, and personal safety.

ABHMI Comprehensive Assessment

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

How we remain compliant

Access to Care Guidelines

Appointment Availability Standards

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

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

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

Access to Care Guidelines - continued

Physician Type	Service Type	ABH Response Standard
Primary Care Physicians (PCP)	Emergency Urgent Care Routine	Within 24 hours Two (2) calendar days Fourteen (14) working days
Behavioral Health	Non-Life Threatening Emergency Urgent Care Initial Visit	Within six (6) hours Within 48 hours Within 10 working days
Prenatal	First (1st) Trimester Initial Second (2nd) Trimester High Risk	Fourteen (14) working days Seven (7) working days Three (3) working days from referral

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

Telephone Accessibility Standards

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:

• Our medical and provider management teams will 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.

• Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all the following situations:

• 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 special member needs while scheduling an appointment

• Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

Abuse, Neglect and Exploitation

As mandated by state of Michigan, all providers who work or have any contact with an Aetna Better Health of Michigan members, are required as “mandated reporters” to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency.

Children

Providers must report suspected or known child abuse, and neglect to the Michigan Department of Human Services (MDHHS) **Statewide 24-hour Child Abuse and Neglect Hotline at 1-855-444-3911** or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable Adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following State agencies:

•Michigan reporting Hotline : **855-444-3911**

•Reporting Agencies

• Please follow link below for more information on abuse, neglect, and exploitation :Abuse & Neglect (michigan.gov)

Claims and Claims Submission

Clearinghouse & Clean Claims
We accept both paper and electronic claims via Change Healthcare (formerly Emdeon) and is the preferred clearing house for electronic claims

- **Payer ID: 128MI**

EDI claims received directly from Change Healthcare & processed through pre-import edits to:

- Evaluate Data Validity
- Ensure HIPAA Compliance
- Validate Member Enrollment
- Facilitate Daily Upload to ABHOK System

Claims Submissions
ABHMI requires clean claims submissions for processing. To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure code

New Claim Submissions

- Submitted within 365 calendar days from the date the service unless there is a contractual exception.
- For hospitals inpatient claims (date of service means the entire length of stay for the member).
- For FQHC and RHC providers, please list the rendering provider on your claims.

Claim Resubmission
Corrected claims must be submitted within 180 days from the original date of payment or denial and must be clearly marked as a resubmission.

- Providers may resubmit a claim that was originally denied because of:
  - Missing documentation
  - Incorrect Coding
  - Incorrectly Paid or Denied because of Processing Errors

How to Submit a Claim:

Mail
Aetna Better Health of Michigan.
PO Box 982963
El Paso, TX 79998-2963

Online
www.changehealthcare.com/

Fraud, Waste, and Abuse

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to 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

Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result 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.

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

•By phone to the confidential Aetna Better Health of Michigan

•By phone to our confidential Special Investigation Unit (SIU) at **1-855-421-2082**

Aetna Better Health of Michigan

You can also report provider fraud to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at 1-855-643-7283).

Claim Submission Resources

Claim Submission Assistance/Links

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

  - How to fill out a CMS 1500 Form:
    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

  - Sample CMS 1500 Form:
    http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf

  - How to fill out a CMS UB-04/1450 Form:
    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

Claim Reconsideration vs. Provider Appeal

Aetna Better Health has two separate and distinct processes designed to assist providers with issue resolution. The chart below illustrates filing a claims reconsideration/resubmission versus a provider appeal. If the provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing a request to appeal. However, before filing an appeal, the provider should verify the claim does not qualify as a claim resubmission or reconsideration.

Information	Reconsideration	Non-Par Provider Appeal Dispute	Par Provider Approval
Form (online)	Resubmission/Reconsideration Form	Non-Par Provider Appeal Form	Par Provider Appeal Form
Address	Aetna Better Health of Michigan Attn: Reconsiderations PO Box 982963 El Paso, TX 79998-2963	Aetna Better Health of Michigan Medicaid Attn: Grievance & Appeals PO Box 81040 5801 Postal Road Cleveland, OH 44181	Aetna Better Health of Michigan Attn: Reconsiderations PO Box 982963 El Paso, TX 79998-2963
Appropriate Categories	Claim resubmissions Corrected claims (including missing/incomplete/invalid diagnosis, procedure, or modifier denials)	Denied days for IP (inpatient) stays Authorization denials for late notification	Denied days for IP (inpatient) stays Authorization denials
Appropriate Categories	Timely Filing COB (missing/ illegible primary explanation of benefits)	Claim denial for no authorization/ precertification / medical necessity not met Services denied per the finding of a review organization Disclaimer: All Tenet Appeal is 365 Days from Denial Date.	Claim denial for no authorization/ precertification/medical necessity not met Services denied per the finding of a review organization
Timeframe	180 days from the date of processing/denial	Claim denial appeals must be submitted within 90 days of the date of service	Claim denial appeals must be submitted within 90 days of the date of service
		Authorization denial appeals must be submitted within 90 days after the date of the adverse action (denial letter). Disclaimer: All Tenet Appeal is 365 Days from Denial Date	Authorization denial appeals must be submitted within 90 days after the date of the adverse action (denial letter)

Grievance & Appeals

How to submit a Provider Grievance?

Call: **1-866-316-3784** and press * option and follow prompt.

Fax: **1-866-889-7517**

Mail: Aetna Better Health of Michigan

Attn: Provider Grievance

PO Box 818070 5801 Postal Road

Cleveland, OH 44181-0040

Email: **MIAppealsandGrievances@Aetna.com**

Secure Web Portal:
AetnaBetterHealth.com/Michigan/providers/portal

How to submit a Member Grievance?

By Calling Member Services: **1-866-316-3784**

Fax: **1-866-889-7517**

Mail: Aetna Better Health of Michigan
Attn: Appeals Coordinator
PO Box 818070
5801 Postal Rd
Cleveland, OH 44181-0040

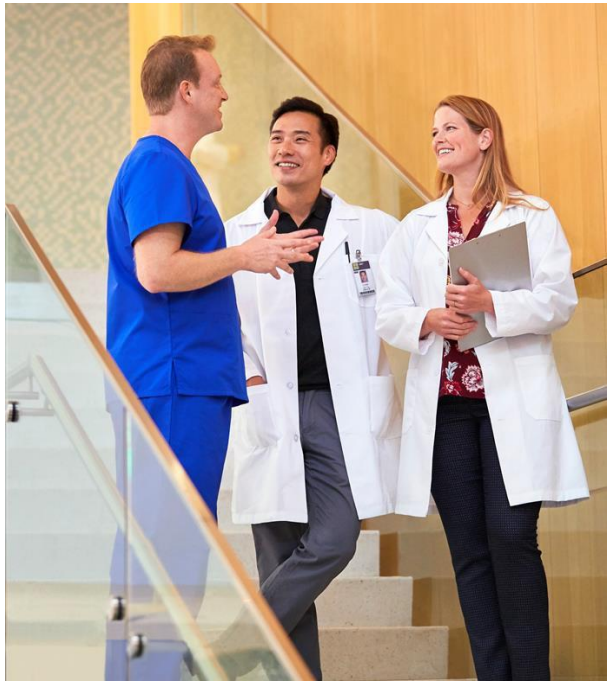
In person : Aetna Better Health of Michigan
Attn: Member Grievance
28588 Northwestern Hwy Suite# 380B
Southfield, MI 48034

Email: **MIAppealsandGrievances@Aetna.com**

Grievance & Appeal (Expedited)

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
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.

How to submit a Provider Appeal?



Call: **1-866-316-3784** and press * option and follow prompt.

Fax: **1-866-889-7517**

Mail: Aetna Better Health of Michigan
Attn: Provider Grievance
PO Box 818070 5801 Postal Road
Cleveland, OH 44181-0040

Email: **MIAppealsandGrievances@Aetna.com**

Provider Portal : **AetnaBetterHealth.com/Michigan/providers/portal**

What is the Appeal Decision Response Time?

- Pre-service Appeals: within 30 calendar days
- Post service Appeals: within 45 calendar days
- Appeals are reviewed by a physician not involved in original decision and not subordinate to original decision marker
- The Appeal decision is the final decision

Grievance & Appeal (Expedited) Address

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.

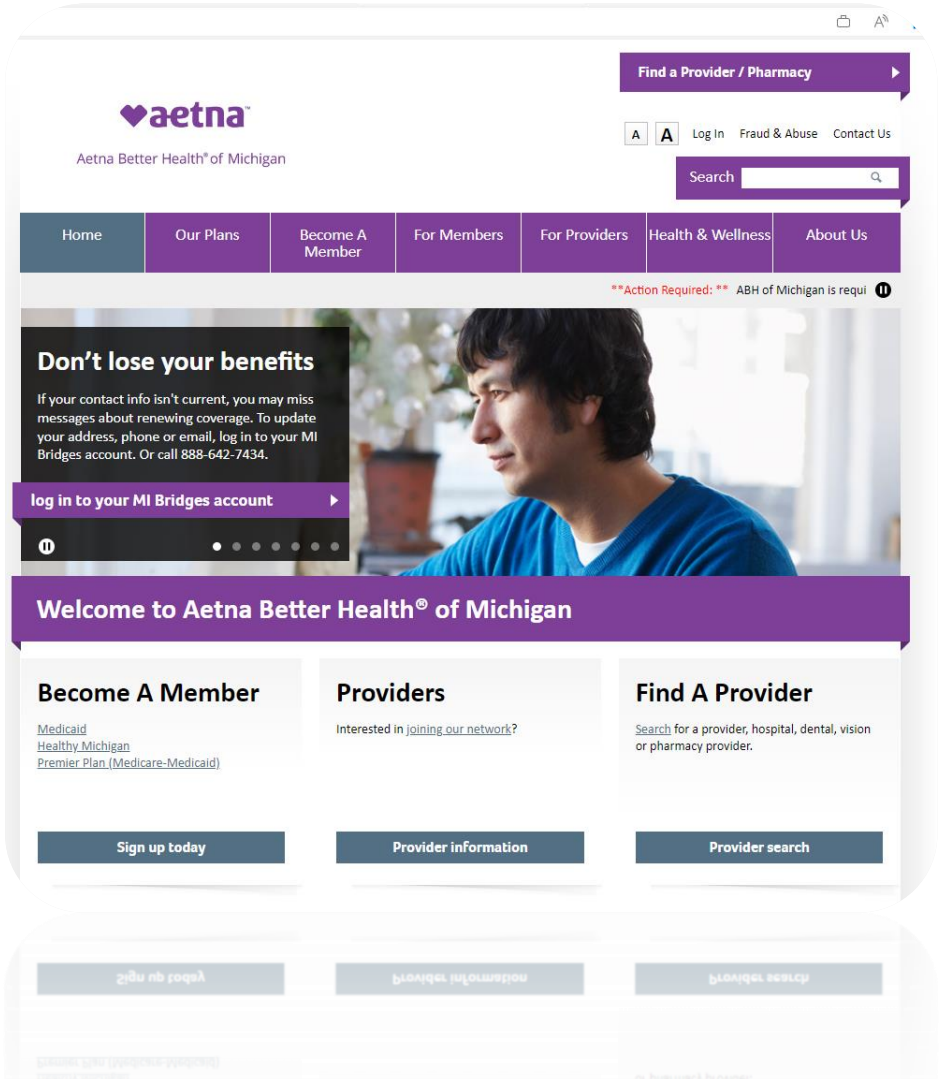
To request an expedited review, send a fax to **1-866-889-7517**

Address for written inquiries and grievances	Address for written appeals
Aetna Better Health of Michigan Attn: Inquiries PO Box 81040 5801 Postal Road Cleveland, OH 44181	Aetna Better Health of Michigan Attn: Grievance & Appeals PO Box 81040 5801 Postal Road Cleveland, OH 44181

Additional Information & Resources

Available Resources

- Claims Inquiry & Research (CICR) team
- Provider Enrollment team
- Online provider manual
- Secure web portal
- Dedicated Network Relations Manager
- Quick Reference Guide



Our Website

Tools

List of Participating Providers

Pharmacy Search Tool

Provider Manual

24/7 Secure Provider Portal

Clinical Guidelines Forms

Provider Education

BH Screeners

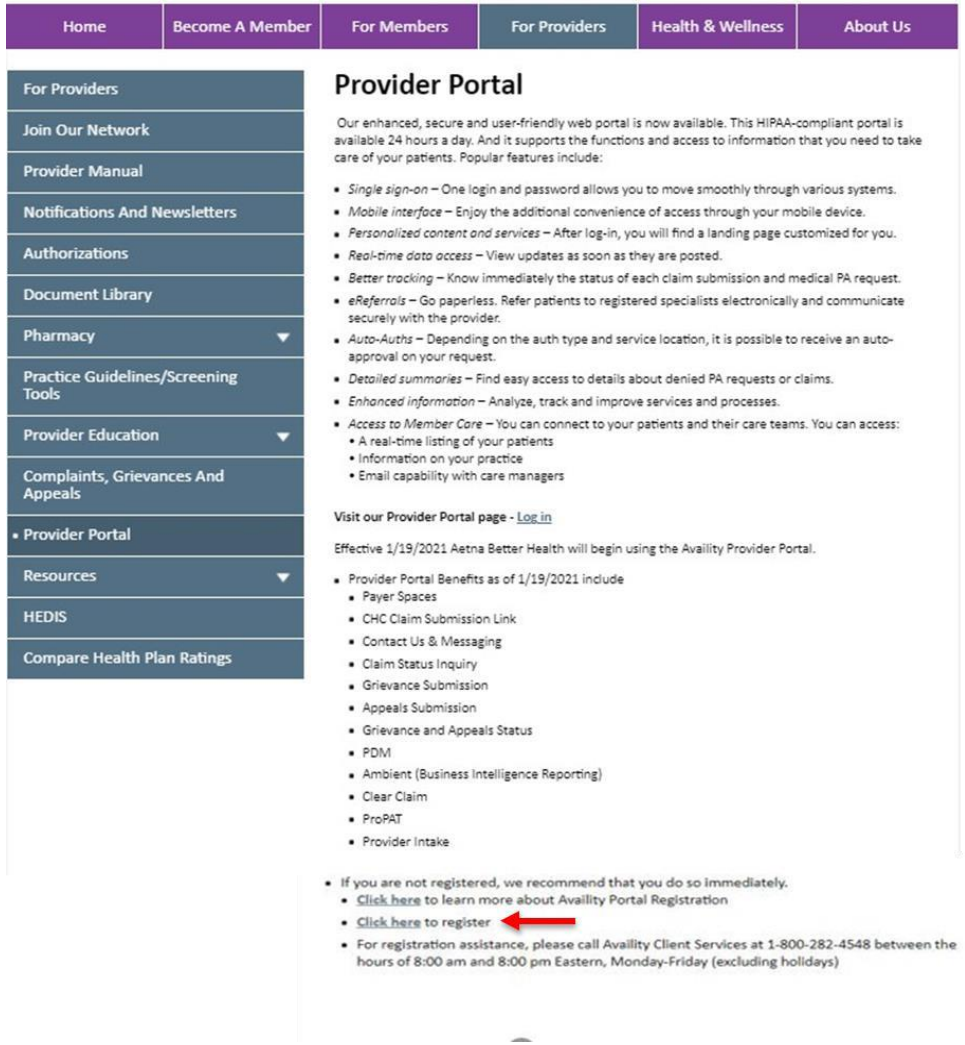
Website:

Home | Aetna Better Health® of Michigan

Secure Provider Portal Registration

To register for access to the secure provider portal on Availity, simply follow these four easy steps:

1. Select the For Providers tab on the navigation bar at the top of our website.
2. Select Portal from the menu on the left side of your screen.
3. Scroll to the bottom of the page and select Click here to register and follow the on screen prompts to complete your registration.
4. Once logged into the Availity homepage, go to Payer Spaces on the navigation bar. Select Aetna Better Health from your payer list to access all available transactions and features.

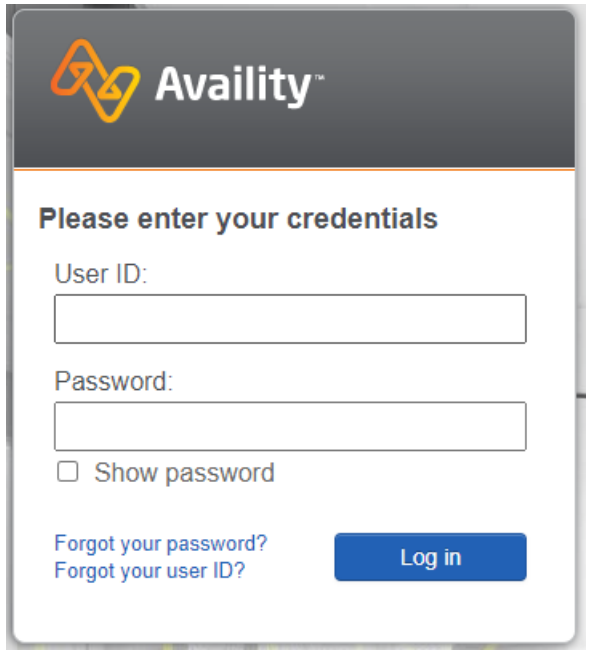


Availity (Provider Secure Web Portal)

We are thrilled to announce that Aetna Better Health Michigan will be using Availity for our provider portal. We are excited to support you as you provide services to our members. Our communications will be via email. Keeping our providers informed is our priority.

Some highlights of increased functionality include:

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



Availity

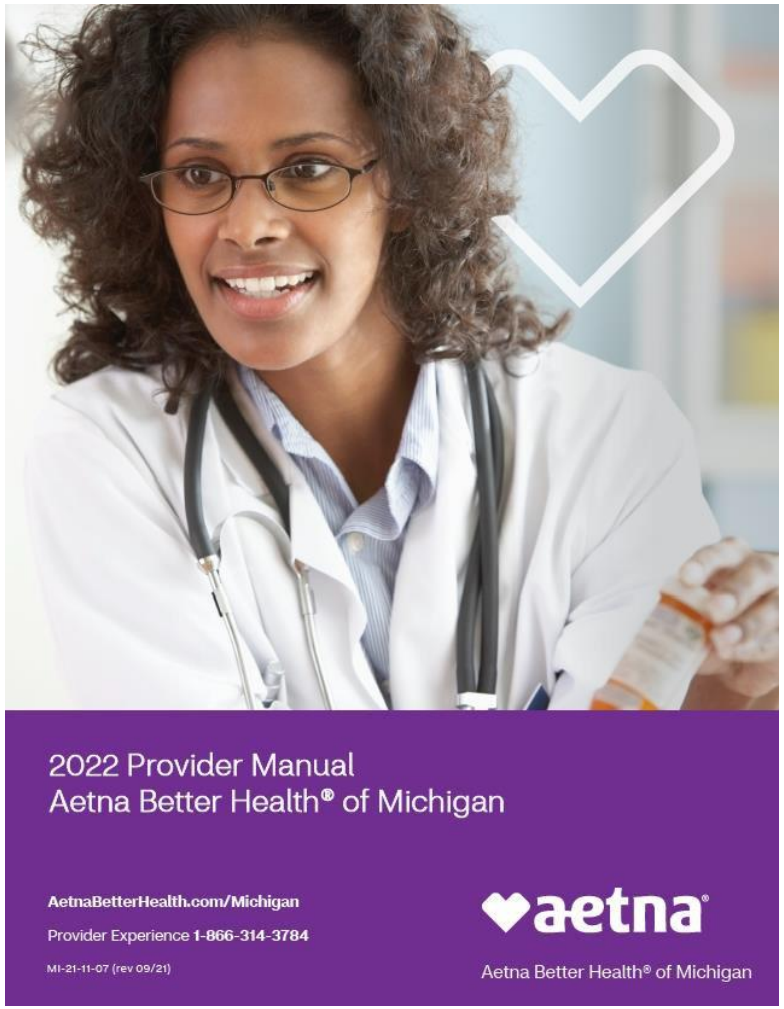
Provider Manual

The provider manual contains plan policies, procedures and benefits. You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available on **AetnaBetterHealth.com/Michigan**.

To request a copy of the provider manual by email or mail, or for general questions, simply contact our Provider Relations Department:

Email: **AetnaBetterHealth-MI-ProviderServices@Aetna.com**



Secure Provider Portal Tools and Resources

Availity Provider Portal benefits include:

- Payer Spaces
- Claim Submission and Status transactions
- Contact Us & Messaging
- Grievance and Appeals transactions
- PDM
- Eligibility and benefits inquiries
- Enhanced Grievance & Appeals transactions
- Panel roster
- Ambient (Business Intelligence Reporting)
- Clear Claim
- Prior Authorizations tools
- Provider Intake
- Dynamo (Case Management)
- View EOB
- Remittance viewer

For registration assistance, call Availity Client Services at 1-800-282-4548 between the hours of 8 AM and 8 PM Eastern, Monday-Friday (excluding holidays)

For access to the following features, please continue to use the Aetna Better Health of Michigan provider portal until they transition to the secure providerportal on Availity:

- Eligibility & Benefits
- Panel Roster
- Remit PDF
- Provider Portal Registration Form
- Provider Portal Instructions

Provider Relations

Our provider Relations staff is available to you Monday - Friday 8 AM - 5 PM to assist you on any facets of your relationship with Aetna Better Health of Michigan. You can reach Provider Relations via:

Aetna Better Health Premier Plan **1-855-676-5772**

Aetna Medicaid Plan **1-866-314-3784 (Option 4 then Option 6)**

AetnaBetterHealth-MI-ProviderServices@Aetna.com

Each Participating Provider Practice is also assigned a Provider Relations Liaison to assist with questionsor concerns.

Remittance advice

- Remittance advices are located within the Aetna Better Health of Michigan new provider portal **AetnaBetterHealth.com/Michigan**
- Electronic Remittance Advice (ERA) are available via your electronic vendor/clearinghouse, if applicable
- Claims and remit information will remain available on our provider portal for up to three (3) years

Enrollment Options for EFT/ERA

- Online via our Secure Web Portal **AetnaBetterHealth.com/Michigan**
- Call Provider Relations at **1-866-314-3784**

Provider Trainings

Providers must complete Annual Compliance Trainings, which includes the following:

- Cultural Competency Training
- HIPAA/Confidentiality Training
- Compliance/Fraud/Waste/Abuse Training
- First Tier, Downstream and Related (FDR) Medicare Compliance Training
- Americans with Disability Act (ADA) Trainings

Once complete, provider offices must complete the required attestation indicating all required staff have been trained.

Newsletters

Aetna Better Health of Michigan regularly communicates important plan information through its Newsletter to providers.

Your Aetna Better Health of Michigan Team

Provider Experience (PE) Team Contact List

Email:
Phone:
Fax:

Your Provider Experience Manager:
Primary Point of Contact

Provider Experience Specialist:

Manager, Provider Experience:
Lawrence Hayes

Director, Provider Experience:
Shelonda Dobson

Thank you for you time and partnership!

Questions?


aetna®
Thank you for you time and partnership!