Provider newsletter

Fall 2025

Table of Contents

aetna®

AetnaBetterHealth.com/Michigan

6400752-01-01

Aetna Better Health® of Michigan

As we move into Quarter 4, we want to thank our provider partners for your continued collaboration and commitment to improving member health outcomes. This quarter, we will be focusing on several key measures to ensure we are closing care gaps and preparing for the upcoming HEDIS season.

Key Measures for Q4 Focus

Measure	Quick Reference Tools to Close Gaps
Adult's Access to Preventative Ambulatory Health Services (**AAP**) *20 years and older*	Offer expanded hours, keep open appts slots, implement a patient reminder system to send appt reminders, address transportation barriers. Aetna covers transportation if they call 3 days ahead of their appt.
Asthma Medication Ratio (**AMR**) *5-64 years of age*	Ensure members with persistent asthma are prescribed for 90-day supply with up to one year of refills. Inform members that Aetna can send their prescriptions via mail they can call **1-855-271-6603** for additional information.
Blood Pressure for Patients with Diabetes (**BPD**) *18-75 years of age*	Encourage home BP monitoring; schedule follow-ups every 3–6 months; document readings in the chart. Retake BP if slightly elevated up to three times.
Controlling High Blood Pressure (**CBP**) *18-85 years of age*	Encourage home BP monitoring; schedule follow-ups every 3–6 months; document readings in the chart. Retake BP if slightly elevated up to three times.
Eye Exam for Patients with Diabetes (**EED**) *18-75 years of age*	Review diabetes services at each visit, utilize standing order for eye exams, help patients schedule appts with an appropriate ophthalmologist or optometrist.
Glycemic Status Assessment for Patients with Diabetes (**GSD**) *18-75 years of age*	Implement point of care testing, use standing orders, track missed appointments. Glycemic Status <8.0% Glycemic Status >9.0%
Lead Screening (**LSC**) *12-24 months of age*	Order capillary or venous lead test at 12 and 24 months; document results clearly.
Childhood Immunization Combo-10 (**CIS-COMBO 10**) *2 years of age*	Review vaccine registry; offer same day immunizations at sick and well visits. Educate members on the importance of vaccines to help reduce hesitancy.

Continued on next page.

Continued from previous page.

Measure	Quick Reference Tools to Close Gaps
Immunizations for Adolescents Combo 2 (**IMA-2**) *13 Years of age*	Review vaccine registry; offer same day immunizations at sick and well visits. Educate members on the importance of vaccines to help reduce hesitancy. Schedule second doses of HPV vaccine before the patient leaves the office after the first dose.
Kidney health evaluation for Diabetes Patients (**KED**) *18-85 years of age*	Ensure both labs are ordered and documented within the year.
Timeliness of prenatal care (**PPC-TOPC**)	Schedule initial visit in the first trimester on or before the enrollment starts date or within 42 days of enrollment in the organization to meet HEDIS standards.
Postpartum Care (**PPC**)	Schedule postpartum visit before hospital discharge within 7-84 days after delivery to meet HEDIS standards.
Well child Visits in the first 30 Months of life (**W30**) *0-15 months of life*	Schedule next well child visits at checkout; use reminder calls/texts.
Chlamydia Screening (**CHL**) *16-24 years of age*	Incorporate annual screening into well-woman and family planning visits.
Cervical Cancer Screening (**CCS**) *21-64 years of age*	Offer testing options, educate patients effectively, and offer same-day screenings.

Medical Record Retrieval Project

Aetna is currently conducting a medical record retrieval project to prepare for the upcoming HEDIS season MY2025. We will be requesting records for select measures that are no longer hybrid, including:

- W30 (Well-Child Visits, 0–15 months)
- EED (Eye Exam for Patients with Diabetes)

Your partnership in timely submission of these records helps ensure accurate reporting and reduces future outreach.

Why Medical Record Collection Matters Off-HEDIS Season

Collecting and reviewing medical records outside of HEDIS season is critical because it:

- Improves accuracy early – Gaps can be identified and closed before the official reporting period.
- Reduces provider burden – Spreads record collection throughout the year instead of concentrating requests in a short timeframe.
- Drives better outcomes – Ensures members receive care in a timely manner, improving health and satisfaction.
- Supports compliance – Helps meet state and national quality benchmarks.

Action Requested: Please respond promptly to medical record requests to help us maintain compliance and ensure our members receive the best possible care. If you need assistance with medical records collection or would like to offer EMR access to Aetna's quality team, please reach out to Sandra Rodriguez, SR Health Care Quality Manager at rodriguezs4@aetna.com.

The Community Resource Directory (CRD) is now available to contracted providers through the Availity Provider Portal.

Integrating the CRD into the Availity Provider portal will now allow providers to create referrals for members to address a full spectrum of Social Determinants of Health needs. This creates a wholistic approach of touch points by the care team for members as the CRD interfaces with other platforms, such as Aetna's Care Management documentation and reporting systems, as well as the Aetna Member Medicaid Web Portal. Data from the CRD relays the top categories requested by member need as well as community organizations to whom have been issued the most referrals overtime.

For more information on the Availity Provider Portal as well as user Guide to access the CRD please contact us at **1-866-316-3784**.

The organization allows women direct access to women's health specialists for routine and preventive health care services. "Direct access" means that the organization cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network.

Women's health specialists include, but are not limited to:

- Obstetricians.
- Gynecologists.
- Certified nurse midwives.

Routine and preventive health care services include, but are not limited to:

- Prenatal care.
- Breast exams.
- Mammograms.
- Pap tests.

Direct access does not prevent the organization from requesting or requiring notification from the practitioner for data collection purposes.

Aetna Better Health of Michigan allows members with special health care needs to have direct access to specialists, as appropriate for their condition and identified needs. The health plan assesses members to identify those with special health care needs.

Direct access means that the organization cannot require members to obtain a referral or prior authorization as a condition to receiving services from specialists in the provider network. Direct access does not prevent the health plan from requesting or requiring notification from specialists for data collection purposes.

Medicaid law requires that members have the right to a second opinion from a qualified health care professional. If an appropriate professional is not available in network, the health plan arranges for a member to obtain the second opinion out of network at no more cost to the member than if the service was obtained in network.

If the Aetna Better Health of Michigan Provider network is unable to provide necessary services covered under its member contract, they will provide adequate and timely coverage of these services out of network. The health plan does not need to arrange or schedule out-of-network services, but it should provide necessary information for members to be able to arrange them.

Aetna Better Health of Michigan coordinates payment for care or services provided by an out-of-network practitioner and ensures that the cost to members is no greater than it would be if the service was provided in-network.

Aetna Better Health of Michigan makes services included in its Medicaid contract available 24 hours a day, 7 days a week, when medically necessary. The organization's policies and procedures outline which medically necessary services warrant this type of availability.

Aetna Better Health of Michigan uses **clinical practice guidelines** to help practitioners make decisions about appropriate health care for specific clinical circumstances and behavioral healthcare services. The health plan adopts at least four evidence-based clinical practice guidelines, approved by its Quality Improvement committee, that:

1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field.
2. Consider the needs of their members.
3. Are adopted in consultation with contracted health care professionals.
4. Are reviewed and updated at least every two years, as applicable

Aetna Better Health of Michigan distributes the evidence-based guidelines it adopted to the appropriate practitioners and to members and potential members, upon request.

Distribution of PHI communication:
The organization distributes information to members by mail, fax or email, or on its website, if it informs members that the information is available online. The organization mails the information to members who do not have fax, email or internet access

Upon member enrollment and annually thereafter, the organization distributes a notice of privacy practices to members that includes:

1. The organization's routine use and disclosure of PHI.
2. Use of authorizations.
3. Access to PHI.
4. Internal protection of oral, written and electronic PHI across the organization

Aetna Better Health of Michigan makes decisions for member education that are consistent with its practice guidelines.

Aetna Better Health of Michigan care coordination process includes provisions for all members, including:

1. Having a person or entity formally assigned to coordinate health care services accessed by members.
2. Providing the contact information of the individuals coordinating healthcare services to members.
3. Ensuring coordination between settings of care.
4. Coordinating services members receive from any other organizations.
5. Coordinating services members receive in fee-for-service Medicaid.
6. Coordinating services members receive from community and social support providers.

The organization annually makes information about its QI program available to members.

Communication of QI program information. The annual QI program information includes information about QI program processes, goals and outcomes as they relate to member care and services, in language that is easy to understand. The organization may provide detailed information (such as a full program description), or information may be limited to an executive summary or outline of the QI program and its achievements.

The organization distributes information by regular mail, email or, fax, through messages to members' mobile devices or on its website. The organization mails the information to members who do not have internet access. If the organization posts the information on its website, it notifies the target audience of the availability of the information on the web through another method listed.

***Note**: Information may be made available by request if the organization notifies members that the information is available by request.*

Aetna Better Health of Michigan's affirmative statement declares that the health plan does not use incentives to encourage barriers to care and service.

The health plan distributes a statement to all members and to all practitioners, providers and employees who make Utilization Management (UM) decisions, affirming the following:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. The health plan does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

MDLIVE

cares for hundreds of mental health needs, including:

- Addictions
- Anxiety
- Depression
- Grief & Loss
- Life Changes
- Obsessive Compulsive
- Disorder (OCD)
- Panic Disorders
- Phobias
- Relationship Issues
- Stress Management
- And more

Your health plan includes talk therapy and psychiatry from the privacy of home.[1] Get reliable care for needs like anxiety, stress, life changes, grief, and depression.

fast and easy.

Have your first therapy session in a week or less. Choose a time that works for you, including nights and weekends.

affordable.

Our large network makes it easy to find a therapist or psychiatrist that is the right fit. Choose the same one for each appointment. Or, you can switch at any time.[2] **No surprise costs. No hassle.**

Meet Sophie, your personal assistant.

Text **AETNAMI** to **635483** to create an account.

Get the app

mdlive.com/aetnami | **888.807.4840**

Your copay is $0 per appointment.

[1]Your eligible dependents ages 10-17 have access to expert mental health support with an MDLIVE licensed therapist or board-certified psychiatrist.

[2]Patients may switch providers up to two times following their first appointment but may not exceed three providers total.

Check your plan documents for eligibility and details. Not all plans include coverage for behavioral health services.

Fraud, Waste and Abuse

Know the signs — and how to report an incident

Health care fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.

Abuse means provider practices are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Healthcare program is doing something that results in needless costs.

Waste goes beyond fraud and abuse. Most waste does not involve a violation of law. It relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Some examples are:

- Inefficient claims processing and health care administration
- Preventable hospital readmissions
- Medical errors
- Unnecessary emergency room visits
- Hospital-acquired infections or conditions

Everyone has a duty to report suspected fraud, waste and abuse.

Penalties

Criminal health care fraud. Persons who knowingly make false claims may be subject to:

1. Criminal fines up to $250,000
2. Prison for up to 20 years
3. Being suspended from Michigan Medicaid

If the violations resulted in death, the individual may go to prison for years or for life. For more information, refer to 18 U.S.C. Section 1347.

Anti-Kickback Statute. The Anti-Kickback Statute bans knowingly and willingly asking for, getting, offering or making payments (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicare program). For more information, refer to 42 U.S.C. Section 1320a-7b(b).

How to report fraud, waste and abuse

If you suspect a colleague, member or other individual of fraud, waste or abuse, report it. You can report anonymously on the Aetna Better Health of Michigan Fraud, Waste and Abuse Hotline at **1-855-421-2082**. You may also write to:

Aetna Better Health of Michigan
28588 Northwestern Highway, Suite 380B
Southfield, MI 48034

You may also anonymously report fraud, waste and abuse to the Michigan Department of Health and Human Services' Office of the Inspector General by calling **1-855-643-7283**, going online at Michigan.gov/Fraud or writing to:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

You do not have to leave your name when you report fraud, waste or abuse.