

2020 Provider Manual

Aetna Better Health[®] of Michigan

aetna[®]

Important Aetna Better Health of Michigan numbers	
Prior-authorization	1-866-874-2567 (TTY:711)
Claims Inquiry Claims Research (CICR)	1-866-314-3784 (TTY:711)
Member Services	1-866-316-3784 (TTY: 711)
Provider Experience E-mail address	1-866-314-3784 (TTY:711) AetnaBetterHealth-MI-PR-Medicaid@aetna.com
Dental Network	1-844-870-3977 (TTY:711)
Transportation	1-866-316-3784 (TTY:711)
24-Hour Nurse line	1-866-711-6664 (TTY: 711)
Behavior Health Crisis Line	1-866-827-8704 (TTY:711)
Medicaid Fraud Control Unit	1-855-643-7283 (TTY:711)
Pharmacy	1-855-432-6843 (TTY:711)

	Address/information line	Phone number
Our office location	1333 Gratiot Avenue Suite 400 Detroit, Michigan 48207	1-866-316-3784
Claims information	Send claims to: P.O. Box 66215 Phoenix, AZ 85082-6215 EDI Payor ID: 128MI	1-866-316-3784
Member eligibility verification	Member eligibility verification	1-866-316-3784
	Behavioral Health	1-866-827-8704
	Dental eligibility	1-866-316-3784
	Vision	1-800-877-7195
	Interpreter services	1-866-316-3784
	Transportation benefits	1-866-316-3784
Medical Management	Pre-authorization requests	1-866-874-2567
	Case management requests	1-866-782-8507
Returned checks and Refund address	Aetna Better Health of Michigan FINANCE 4500 E. Cotton Center Blvd. Phoenix, AZ 85040	
Provider Dispute Address (Participating Providers)	Aetna Better Health of Michigan Medicaid & Premier Plans PO Box 66215 Phoenix, AZ 85082	
Website information	aetnabetterhealth.com/michigan	1-866-316-3784
Provider Web Portal	https://medicaid.aetna.com/MWP	

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CHAPTER 1 – WELCOME TO AETNA BETTER HEALTH OF MICHIGAN

We're pleased that you're part of our network of providers. At Aetna Better Health, we're committed to providing accessible, high quality service to our members in Michigan. And we greatly appreciate all our providers' efforts in helping us achieve that goal.

To ensure that we communicate effectively with providers, we've developed this Provider Manual. This document will help guide providers through our administrative processes. As changes occur, we'll continue to update providers via bulletins, letters, our website, newsletters and regular contact with the Provider Experience team.

Thank you for your participation and interest in caring for our members.

About Us

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves more than 3 million people in 16 states. Aetna Medicaid and its affiliates currently administer Medicaid managed care services in California, Arizona, Florida, Illinois, Kansas, Kentucky, Louisiana, Michigan, Maryland, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia and West Virginia.

Aetna Medicaid has more than 30 years' experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

Model of Care

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

Our combined provider and care management activities are intended to 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 reviews and proactive discharge planning activities
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care services.

Many components of our integrated care management program influence member health. These include:

- Comprehensive member health assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility

placements/stays.

- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow enrollees to reside in the least restrictive environment possible.
- Assessments and care plans that identify an enrollee's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Case Manager referral and predictive modeling software that identify enrollees at increased risk, functional decline, hospitalization, and emergency department visits.

Service Area

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

- Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Hillsdale, Jackson, Lenawee, Livingston, Macomb, Monroe, Oakland, Van Buren, Wayne and Washtenaw

About this Provider Manual

This Provider Manual serves as a resource to providers and outlines operations for Aetna Better Health of Michigan. Using the Provider Manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. Questions, problems, or concerns that the provider manual doesn't fully address can be directed to the Provider Experience department at **1-866-314-3784**. Additional information for providers and members is available online at: **aetnabetterhealth.com/michigan**.

References throughout the provider manual to "Aetna" or the "health plan" are intended to represent Aetna Better Health of Michigan.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of Aetna Better Health of Michigan's provider agreement, including requirements described in this manual, in addition to all federal and state regulations governing the provider. While this manual contains basic information about Aetna Better Health of Michigan and the Michigan Department of Health and Human Services (MDHHS), providers are required to fully understand and comply with MDHHS requirements when administering covered services. Please refer to www.michigan.gov/mdhhs/ for further information on MDHHS.

Important addresses

Department	Address
Claims	Electronic Payor ID:128MI Aetna Better Health of Michigan P.O. Box 66215 Phoenix, AZ 85082-6215
Reconsiderations (Contracted Participating Providers)	Aetna Better Health of Michigan Attn: Reconsiderations P.O. Box 66215 Phoenix, AZ 85082-6215
Appeals (Non-Contracted Providers)	Aetna Better Health of Michigan Attn: Appeals Manager 1333 Gratiot Ave. Suite 400 Detroit, MI 48207
Provider Disputes (Contracted Participating Providers)	Aetna Better Health of Michigan Aetna Better Health of Michigan Attn: Provider Disputes PO Box 66215 Phoenix, AZ 85082-6215

Websites

In addition to the telephone numbers and addresses above, providers may access the Aetna Better Health of Michigan website 24 hours a day, 7 days a week at:

<https://www.aetnabetterhealth.com/michigan/> for up-to-date information, forms and other resources.

Within the website, a secure provider web portal is maintained and accessible by participating providers. The web portal can be accessed directly at <https://www.aetnabetterhealth.com/michigan/>. The secure provider web portal provides a platform for Aetna Better Health of Michigan to communicate health care information directly to providers. The health plan's member eligibility and claims information can be accessed via the web portal. Additional information regarding the website and secure web portal is available in the Provider Experience chapter of this Manual.

State of Michigan Medicaid Program

General information regarding the Michigan Medicaid Program and Department of Health and Human Services can be found online at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---

State of Michigan Medicaid Program

Topics	For additional information
Provider Information	Information Specific to Different Providers
Provider Bulletins	Medicaid Policy Bulletins

Provider Enrollment	<p>CHAMPS (State on Michigan Single Sign-On) https://milogintp.michigan.gov</p> <p>Information for CHAMPS Provider Enrollment www.michigan.gov/medicaidproviders</p> <p>For additional CHAMPS enrollment information, contact MDHHS CHAMPS at: E-mail: ProviderSupport@michigan.gov or Phone: 1-800-292-2550</p> <p>E-mail: ProviderEnrollment@michigan.gov or Phone: 517-335-5492</p>
Michigan Medicaid Beneficiary Eligibility Verification	<p><u>Verification Options:</u> http://michigan.gov/mdhhs/0%2c1607%2c7-132-2945_42542_42543_42546-57088--%2c00.html</p> <p>CHAMPS (State on Michigan Single Sign-On) https://milogintp.michigan.gov</p>
Provider Support Services	<p>Phone: 1-800-292-2550</p>
Adult and Child Abuse & Neglect Hotline	<p>Phone: 1-855-444-3911</p>

Reporting suspected fraud, waste, and abuse

Participating providers are required to report to Aetna Better Health of Michigan and to the State of Michigan 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 to Aetna Better Health of Michigan in the following ways:

- Call our Fraud Waste and Abuse Hotline at **1-855-421-2082**
- Write us:
Aetna Better Health of Michigan
ATTN: Compliance Department
1333 Gratiot, Suite 400
Detroit, MI 48207

Penalties

Criminal Health Care Fraud

Persons who knowingly make false claims may be subject to:

- Criminal fines up to \$250,000
- Imprisonment for up to 20 years
- Suspension from Michigan Medicaid

If the violations resulted in death, the individual may be imprisoned for any term of years or for life. For more information, refer to 18 U.S.C. Section 1347.

Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly and willingly soliciting, receiving, offering, or paying remuneration (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). Fraud, waste, or abuse can also be reported to the State of Michigan:

- Michigan Department of Health and Human Services, Office of Inspector General
 - Phone number: **1-855-643-7283**
 - Website: **www.michigan.gov/fraud**
 - Mailing address: P.O. Box 30062, Lansing, MI 48909

Beneficiary Monitoring Program (BMP)

Aetna complies with the Beneficiary Monitoring Program under the Michigan Medicaid program, required to monitor for potential member fraud or abusive accessing of Medicaid services (i.e. multiple ER visits for opioid/pain scripts, etc.) Participating providers with Aetna as a component of the BMP program may be asked to serve as "lock-in" providers for members identified as potential BMP candidates. Additional information regarding BMP protocols are available by contacting Provider Experience at 1-866-314-3784.

CHAPTER 3 – PROVIDER EXPERIENCE DEPARTMENT

The Provider Experience department serves as a liaison between Aetna Better Health of Michigan and the provider community. This department also supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards. Provider Experience includes: Claims Inquiry and Claims Research (CICR) and Provider Relations.

Claims Inquiry and Claims Research

Provider Representatives are available by phone to provide telephonic or electronic support to all providers. Below are some of the areas where Claims Inquiry and Claims Research help:

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

Claims Inquiry and Claims Research can be reached at **1-866-316-3784**.

Provider Experience

Provider Experience assists providers by providing education and assistance regarding a variety of topics. Provider Experience will:

- Provide education to provider offices
- Provide support on Medicaid policies and procedures
- Clarify provider contract provisions
- Assist with demographic changes, terminations, and initiation of credentialing
- Monitor compliance with applicable State and Federal agencies
- Conduct annual Provider Satisfaction Survey
- Conduct member complaint investigation
- Maintain the provider directory
- Obtain secure web portal or member care login information
- Be a point of contact for any provider concern

The Provider Experience department is responsible for the field service, ongoing education, and training of Aetna Better Health of Michigan's provider community. We maintain a strong commitment to meeting the needs of our providers. In order to accomplish this, a provider experience representative is assigned to specific groups of participating providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of our health plan operations and is well versed in the managed care program.

A provider relations representative will visit or phone provider offices periodically to ensure providers' experiences with us are seamless. Representatives meet routinely with office staff and providers upon request and are available upon request. Provider news, electronic messages and specialized mailings are sent to providers periodically as well, including updates to the provider manual, changes in policies

or benefits, and general news and information of interest to our provider community. To contact a local provider relations representative, please call **1-866-314-3784**.

Joining the Network

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

Provider Orientation

We provide initial orientation for newly contracted providers after joining our network. In follow up to initial orientation, we provide a variety of forums for ongoing provider training and education, such as routine site visits, group or individualized training sessions on select topics (i.e. enrollee benefits, Aetna Better Health website navigation), distribution of provider newsletters and bulletins containing updates and reminders, and online resources through our website at: **aetnabetterhealth.com/michigan**.

Informed Health® Line (IHL)

Aetna Better Health of Michigan provides a free 24-hour Informed Health Line for members. The Informed Health Line uses clinical triage services consisting of a package of health care information services, call center services and 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 to route them to an appropriate level and timing of care.

Informed Health Line services are provided based on the answers to the questions in the algorithms, the nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or their doctor –or- if the member can care for him or herself or family member at home. The Informed Health Line does not provide benefit information.

The Informed Health Line 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** (TTY 711).

CHAPTER 4 – PROVIDER RESPONSIBILITIES AND IMPORTANT INFORMATION

This section outlines general provider responsibilities; additional responsibilities are included throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with the terms of the Michigan Medicaid program, provider contract, and requirements in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than the provider contract and this manual.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including providing 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 risk, benefits and consequences of non-treatment. Advice given to potential or enrolled Members should always be given in the best interest of the Member.

State of Michigan Medicaid Provider Enrollment

Providers who deliver services to Aetna Better Health of Michigan members must be enrolled as a Medicaid provider at each practice location with the State of Michigan and credentialed by Aetna Better Health of Michigan before they can provide health care to our members. To access information about how to enroll 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

The National Provider Identifier (NPI) number is a ten (10) digit number that is provider specific assigned by CMS. For additional information please visit the National Plan/Provider Enumeration System (NPPES) website at: <https://nppes.cms.hhs.gov/>. NPI numbers are required for claims submission to Aetna Better Health of Michigan. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information. On the CMS 1500 form the rendering provider's (box 31) NPI number is placed in the bottom half of the 24 J fields. The NPI for the billing provider in box 33 is placed in the 33A field.

Access and Availability Standards

Timely access

Timely access-standards for hours of operation for PCP's:

- Twenty hours per week per practice location

Physician type	Appointment type	Availability standard
Primary Care Physician (PCP)	Emergency	Within 24 hours
	Urgent Care	Two (2) calendar days
	Routine	Four (4) weeks
Behavioral Health	Non-Life Threatening Emergency	Within 6 hours
	Urgent Care	Within 24 Hours
	Initial Visit Routine care	Within 10 working days

Prenatal	First (1st) Trimester	Fourteen (14) working days
	Initial Second (2nd) Trimester	Seven (7) working days
	High Risk	Three (3) working days from date of referral

Notes:

- Primary Care Provider (PCP) is defined as Family Practice, Internal Medicine, Pediatrics, and General Practice.
- High Volume Specialists are determined by the Health Plan through annual High-Volume Specialist Reports. OB/GYN Providers are considered mandatory High-Volume Specialist providers and will be added to the annual High-Volume Specialist listing.
- When developing the network, Aetna Better Health considers the linguistic and cultural preferences of health plan Membership. Member access to more than 1 PCP that is multi-lingual and culturally diverse is required for Medicaid.
- Selection of Ancillary Provider access as determined by the State.

PCP providers must be available to members 24 hours a day, 7 days a week. When the provider is unavailable, arrangements must be made for another primary care physician to cover services.

Providers must offer hours of operation to members of Aetna’s Michigan Medicaid managed care program (“Michigan Medicaid Members”) that are no less (in number or scope) than the hours of operation offered to other non-Medicaid patients, or if a provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to members of the State of Michigan’s Medicaid Fee for Service Program. Provider agrees to provide covered services to Michigan Medicaid members on a twenty-four (24) hour per day, seven (7) day per week basis. Further, provider agrees to meet Michigan state standards for timely access to care and services, considering the urgency of need for services.

Monitoring of Standards

Monitoring of network provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members for both Primary Care Physicians (PCPs) and specialists, as appropriate. To monitor compliance with the Access and Availability Standards the health plan will:

- Review at least annually results of the Geo-mapping reports, completed by utilizing industry-standard software, to monitor compliance with the Availability standards.
- Review the annual results of 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/or provider surveys or after-hours phone audits to ensure that the physician or an associate is available 24 hours per day, 7 days per week.

Resolution of Deficiencies

- Physicians out of compliance will be required to submit a Corrective Action Plan (CAP) and will be monitored until the CAP enables them to be compliant.
- If any network deficiencies are identified through the quarterly geo-mapping review,

applications or requests for participation will be sent to non-contracted facilities or providers in the affected service area(s).

- The health plan will also monitor and trend any member complaints regarding accessibility and availability of providers by product. If trends are identified, the health plan will promptly begin the recruiting process.

Covering Providers

Aetna Better Health of Michigan must be notified of practitioners who serve as covering providers for any of our panel providers. This notification must occur in advance of the provision of any authorized services. Reimbursement to a covering provider is based on Michigan Medicaid Fee Schedule and dependent on enrollment as a provider with both Aetna Better Health of Michigan and the State of Michigan Medicaid program. Failure to notify Provider Experience of covering providers may result in claim denials.

Verifying Enrollee Eligibility

All providers, regardless of contract status, must verify an enrollee's enrollment status prior to the delivery of non-emergent, covered services. Providers are not reimbursed for services rendered to enrollees who lost eligibility.

Enrollee eligibility can be verified through one of the following ways:

- State of Michigan Champs website
- Search Member eligibility on the secure provider portal
- Contact Member Services **1-866-316-3784**

The State of Michigan Medicaid Eligibility Line **1-800-292-2550** will also have helpful information regarding the Member's assigned managed care company and program eligibility.

Secure Web Portal

The Secure Web Portal is a web-based platform that allows Aetna Better Health to communicate member healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the 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. Only claims associated with the user's account provider ID will be 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. Only authorizations associated with the user's account provider ID will be 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 enrollee has measures that they are not compliant with; a "No" means

that the Member has met the requirements.

- Secure messaging to various departments of Aetna Better Health of Michigan

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

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health of Michigan that allows Members access to Aetna Better Health of Michigan services and information. For additional information regarding the Member Care Web Portal, please access the Enrollee Care Web Portal Navigation Guide located on our website.

Aetna Better Health of Michigan is dedicated to great service for our providers and our members. That's why our HIPAA-compliant web portal is available 24 hours a day. The portal supports the functions and access to information related to:

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

If you're interested in using this secure online tool, you can register on our "For Providers" page at aetnabetterhealth.com/michigan. You can also contact our Provider Experience department to sign up over the phone. To submit your registration via fax, you can download the form from our website or request a copy from Provider Experience. Please note that internet access with a valid e-mail is required for registration.

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 better meet their needs.

- Members 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. The results will provide a summary of the members overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in 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: current stage in the process, amount approved, paid, member cost (if applicable) and the date paid.
- Pharmacy benefit services – members can find out if they have any financial responsibility for a drug, 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 risk for medications and get the generic substitute for a drug.

- Personalized health plan services information – members can now 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 referral and information on authorization requirements; and they can find benefit and financial responsibility information for a specific service.
- Innovative services information – Members will be asked to complete a personal health record and complete 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, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- Wellness and prevention information – We encourage healthy living. Our member outreach will continue to include 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 you 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 Member Services at **1-866-316-3784**.

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. Aetna Better Health shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Michigan Medicaid member who is his or her patient:

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

Further, Aetna Better Health shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each managed care member is guaranteed the right to request and receive a copy of his medical records, and to request that they be amended or corrected as specified in 45 CFR Part 164.

Primary Care Providers (PCP)

PCPs are defined as physicians who specialize in:

- Family practice
- General practice

- Internal Medicine
- Pediatrics
- Obstetrics/Gynecology
- Certified Nurse Practitioners (CNP, under 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
- Obtain prior authorization for any referrals to non-participating providers
- Provide or arranging for on-call coverage 24 hours/day, 7 days/week
- Accept new members unless Aetna Better Health of Michigan has been provided with written notice of a closed panel
- Maintain comprehensive and legible medical records
- Complete section four of the Health Risk Assessment for Healthy MI members, and fax completed form to toll- free number listed on form

Specialist Providers

- Agree to discuss treatment of members with the PCP
- 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 specified outpatient covered services
- Maintain comprehensive and legible medical records

Specialist providers acting as PCP

In limited situations, an enrollee may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Providers must be enrolled with the State of Michigan as a PCP. Please contact Provider Experience for additional assistance.

Emergency Services

Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs emergent care, or if they call after hours, the member should be referred to the closest emergency department.

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 in most cases). Please reference the online directory on the Aetna Better Health of Michigan website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in the network.

Periodically, Aetna Better Health will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Skilled Nursing Facility (SNF) providers

Skilled Nursing Facilities (SNFs) provide services to enrollees that need consistent rehabilitation care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs may provide additional services to meet the special needs of our members.

Home and Community Based Services (HCBS)

Home and Community Based Services often provide services to Aetna Better Health of Michigan members in their homes. There may be times when an interruption of service may occur due to an 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. This 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 which 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 electronic contacts and ongoing care coordination and health maintenancetracking
- 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 an enrollee and the enrollee's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development
- Facilitate the partnership between members, their personal physician, and when appropriate, the enrollee's family
- Encourage the use of specialty care services and supports

Self-Referral/Direct Access

Aetna Better Health of Michigan has an open-access network, where members may self-refer or directly access services without notice from their PCP. Aetna Better Health encourages all members to discuss specialty care with their PCP, who can coordinate needed services.

Services must be obtained from an in-network Aetna Better Health of Michigan provider. There are exceptions to this, however; 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. Enrollees may access these services from a qualified provider enrolled with the State of Michigan Medicaid program.

Second and Third Opinions

Aetna Better Health of Michigan 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. Providers should refer the member to another network provider within an applicable specialty for the second opinion.

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

Aetna Better Health of Michigan members will incur no expenses other than standard co-pays for a second and or third opinion provided by a participating provider, as applicable under the Member Certificate of Coverage. Out-of-network services must receive prior authorization and are approved only when an in-network provider cannot perform the service.

Procedure for Closing a PCP Panel

A PCP who no longer wishes to accept new Aetna Better Health of Michigan members may submit a written notification to Provider Experience to close his or her panel. In this situation, any new Member who is not an established patient of that PCP cannot select that PCP's office with an approved closed panel.

A PCP may re-open a "closed" panel by submitting a written notification to Provider Experience. This change will be made on the first of the month following submission of the request, no less than thirty days from receipt of the written request. Additional time may be necessary to update printed marketing materials.

When an Aetna Better Health of Michigan member chooses a PCP, who has a "closed" panel, Member Service will notify the subscriber of the physician's panel status. If the physician chooses to make an exception to accept the Member, they should contact Member Services for assistance in facilitating an over-ride to assign members to their practice on a case by case basis.

Non-Compliant Members/PCP Transfer (termination)

Providers are responsible for delivering appropriate services to facilitate enrollee understanding their health care needs. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. Aetna Better Health of Michigan will assist in the resolution of member specific compliance issues, by providing comprehensive Member education and case management protocols. Please contact Provider Experience for additional assistance in resolving member issues.

If Member non-compliance issues persist, additional steps can be taken to address these situations including transfer of the Member from a provider practice. The Michigan Department of Health and Human Services (MDHHS) Managed Care Program has a process in place for the PCP, as well as Aetna Better Health of Michigan (Health Plan) to request transfers of Members to another PCP. The PCP or Health Plan may request that the member be transferred to another PCP, based on the following or similar documentation to establish that the member/provider relationship is not mutually acceptable, e.g., the member is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.

- Travel distance substantially limits the member's ability to follow through the 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).

The PCP and Health Plan must not request a transfer due to an adverse change in the member's health, or adverse health status. The above reasons do not include a situation where a PCP has terminated a PCP-Member relationship prior to managed care enrollment, unless the PCP can establish that the reason(s) for termination remains an issue. The criteria for terminating a Medicaid Member from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid members.

Member transfer from provider guidelines

The PCP must follow the following guidelines in order to remove a member from his/her panel:

- 1) Provider must notify the health plan of their desire to terminate a member in writing within thirty (30) days prior to the termination, by mail, of reason for termination and to choose another PCP.
- 2) Provider is required to maintain responsibility for providing the Medicaid Managed Care benefits to the member until the transfer is completed.
- 3) Required documentation
- 4) The PCP must provide the following documentation:
- 5) Detailed accounting of the reason for the transfer/termination from practice request.
- 6) Detailed accounting of the attempt(s) made by the PCP and Health plan to resolve the issue and work with the member. Before beginning the transfer request process, the PCP and Health plan must make a serious effort to resolve the problem presented by the Member, including warning him/her that his/her continued behavior may result in transfer. The Health plan must offer to discuss the problem and any potential solution with the member, or employ the plan's internal grievance procedure, or both;
- 7) Documentation that, in spite of 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 his/her continuing participation in managed care seriously impairs the ability of the PCP and Health plan to furnish services to either the member or others;
- 8) Documentation that the Member's behavior has been 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
- 9) Documentation that the PCP and Health plan has explored appropriate alternatives with the Member, and a recommendation as to the most appropriate alternative.

Approval review requirements

The Health plan must provide documentation showing attempts were made to resolve the reason for the transfer request through contact with the member or his/her legal representative, the PCP, or other appropriate sources.

The Health plan must document that accommodating the needs of the Member would create an undue burden on the PCP and Health plan. Such documentation must include, but is not limited to, the following:

- 1) The Health plan has made reasonable efforts to locate another PCP within its network;
- 2) The Health plan does not have any PCPs in its network with special qualifications, as demonstrated by objective credentialing standards and standards for the care and management, to treat a particular condition;
- 3) The PCP has demonstrated that s/he does 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
- 4) The PCP is unable, based on objective evidence, to establish a relationship with a Member.

The Health Plan must assist its 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

The following procedure applies when a PCP requests a transfer:

- 1) The PCP must contact the Health Plan and provide documentation of the reason(s) for the transfer to another PCP. The PCP must provide a copy of the completed MS-24 Michigan Health Connection Plan/PCP Requested Transfer form. The Health Plan is responsible for investigating and documenting the reason for the request.
- 2) The Health Plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;
- 3) The Health Plan will contact the member to assist them in voluntarily changing PCPs. If the Health Plan is unsuccessful in contacting the member or the member will not voluntarily change PCPs, the request is submitted to the MDHHS. If the transfer request is for a lock-in Member, the Health Plan forwards the request to DHHS. The Health Plan attempts to contact the Member to inform them that they must call MDHHS to change their lock-in PCP and assist them in find a new PCP.
- 4) The Health Plan must submit the transfer request to MDHHS within ten days of the request;
- 5) DHHS approves or denies the transfer request within five working days and responds to the Health Plan.
- 6) The member, PCP, and Health Plan are notified by MDHHS of the approval or denial of the transfer. The Member and PCP will receive a letter and the Health Plan is notified by fax.
- 7) If the request is approved, the Health Plan will auto-assign a new PCP for the member. If the transfer request is for a lock-in member the Health Plan lists the Member's PCP as "unassigned" until notified by MDHHS that the PCP transfer is complete.

Interim PCP assignment

The Health plan will be responsible for assigning an Interim PCP in the following situations:

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

In all situations, the Health Plan is responsible for ensuring a smooth transition for the member through the assignment of an Interim PCP.

The Health Plan must immediately notify the member; by mail that the Member is being temporarily assigned to another PCP within the same Health plan and that the new PCP will be responsible for meeting the Member's health care needs.

Member notification

The notification sent to Member by the Health plan must 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: If the PCP has moved out of state, and the PCP is no longer within coverage distance to the Michigan Medicaid Member, the PCP should be treated as a terminated PCP.

Medical Records Review

All participating Primary Care Practitioners (PCP); defined as family practice, general or internal medicine, OB/GYN and pediatrics, who provide medical care in ambulatory settings must comply with the Health Plan's Medical Record Documentation standards. The following standards are required:

Medical Record Documentation	
1	Past medical history is completed and is easily identified. It includes serious accidents, operations and illnesses, travel and medication history, prenatal care, and birth as applicable and history of risk and domestic violence.,
2	History and Physical (H&P) documents have subjective/objective information for presenting problem.
3	There is appropriate notation about cigarettes, alcohol and substance use. (For Members seen three or more times, ask about substance abuse history.)
4	Note about follow-up care, calls and visits. Specific time of return is noted in weeks, months or as needed.
5	An immunization record has been initiated for children and history for adults.
6	Preventive screenings and services are offered according to preventive services guidelines.
7	Documentation about advance directives (whether executed or not) is in a prominent place in the Member's record (except for under age 18).
8	Treatment plan is documented.
9	Working diagnoses are consistent with findings.
10	Evidence Member is not at inappropriate risk relevant to particular treatment:
11	Blood pressure, weight, BMI percentile and height measured/recorded at least annually, if Member accesses care.

12	Lab and other studies are ordered, as appropriate.
13	Evidence that physician has reviewed lab, X-ray or biopsy results (signed or initialed reports and the Member has been notified of results before filing record).
14	Documentation of communications/contact with referred specialist and discharge summaries from hospitals

The Quality Management (QM) department will audit PCP clinics for compliance with the documentation standards. Written notification of aggregated review results is provided to physician offices after the Medical Record audit has been completed.

The Health Plan will provide routine education to practitioners and their respective clinics. This may include but is not limited to, articles in our Provider Newsletter on the medical record review (MRR) process, highlights of low compliance, adaptation of any universal forms by Aetna Better Health of Michigan and updates of 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 understand and agree that Members shall not be required to reimburse them for expenses related to providing copies of patient records or documents to any local, State or Federal agency (i) pursuant to a request from any local, State or Federal agency (including, without limitation, the Centers for Medicare and Medicaid Services (“CMS”)) or such agencies’ subcontractors; (ii) pursuant to administration of Quality Management, Utilization Review, and Risk Management Programs, including the collection of HEDIS data; or (iii) in order to assist Aetna in making a determination regarding whether a service is a Covered Service for which payment is due hereunder.

All records, books, and papers of providers pertaining to Members, including without limitation, records, books and papers relating to professional and ancillary care provided to Members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by Aetna, its designee and/or authorized State or Federal authorities during Provider’s normal business hours. Provider further agrees that it shall release a Member’s medical records to Aetna upon Provider’s receipt of a Member consent form or as otherwise required by law. Provider acknowledges that Member has provided consent to release such records to Aetna when Member enrolls in a Product. In addition, Provider shall allow Aetna to audit Provider’s records for payment and claims review purposes. Provider further agrees to maintain all such Members’ records for services rendered for a period of time in compliance with state and federal laws.

Medical Record Audits

Aetna Better Health of Michigan or MDHHS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a Member or provider, administrative responsibilities or quality of care issues. Providers should respond to these requests promptly. Medical records must be made available to Aetna, Michigan Department of Health and Human Services, and/or CMS for quality review upon request. Records must be stored in a secured HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant manner.

Access to Facilities and Records

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

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

Documenting Enrollee Appointments and Eligibility

When scheduling an appointment with a Member over the telephone or in person (i.e. when a Member appears at an office without an appointment), providers must verify eligibility and document the Member's information in the medical record. Please access the Aetna Better Health website to electronically verify eligibility or call the Member Services Department at **1-866-316-3784**.

Missed or Cancelled Appointments

Providers should:

- Document in the Member's medical record, and follow-up on missed or canceled appointments;
- Conduct affirmative outreach to an enrollee who misses an appointment by performing minimum reasonable efforts to contact the member.
- Notify Member Services 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 what is referred to as covered 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, as well as 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/>. In accordance with HIPAA guidelines, providers may not interview enrollees about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and enrollee information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train office staff on HIPAA;
- Consider the patient sign-in sheet – its location and handling;
- Keep patient records, papers and computer monitors out of view and in secure (locked) locations; and
- Have electric shredder or locked shred bins available.

The following enrollee information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal

regulation excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

- “Individually identifiable health information” is information, including demographic data, that relates to:
 - The individual’s past, present or future physical or mental health, or condition.
 - The provision of health care to the individual.
 - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
 - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
 - Providers’ offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.
 - Release of data to third parties requires advance written approval from the enrollee, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by enrollees or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. For additional information, please visit: <http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm>.

Member Privacy Rights

Aetna Better Health privacy policy states that Members are afforded 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 enrollee privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of Michigan personnel and providers in meeting the privacy requirements of HIPAA when enrollees or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to enrollees or their representatives about Aetna Better Health practices regarding their PHI.
- Maintaining a process for enrollees 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”) in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set

- Request amendments/correction 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

A privacy request must be submitted by the Member or Member's authorized representative. A Member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the enrollee or the deceased enrollee's estate. Except for requests for a health plan Notice of Privacy Practices, requests from Members or a Member's representative must be submitted to Aetna Better Health in writing.

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 are required to comply with federal and state law regarding advance directives for adult Members. The advance directive must be prominently displayed in the adult enrollee's medical record. Requirements include:

- Providing written information to adult Members regarding each individual's 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 the adult enrollee has been provided the information and whether an advance directive has been executed.
- Not discriminating against a Member because of his or her decision 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 the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, 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 ability to speak English. Aetna Better Health of Michigan expects providers to treat all enrollees with dignity and respect as required by federal law. 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 of Michigan has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on enrollees' diverse backgrounds, including the various cultural, racial, and linguistic challenges that enrollees encounter, and we develop and implement proven methods for responding to those challenges.

Providers may receive education about such important topics as:

- The impact that an enrollee's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, 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.
- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage enrollees from such backgrounds to seek needed treatment.

Our Provider Experience and outreach representatives may conduct cultural competency training during provider orientation meetings, which is designed to help 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

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health of Michigan is required to ensure Members with Limited English Proficient (LEP) have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons identified with LEP are often excluded from programs they are eligible for, 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 ability to speak English. Providers are required to treat all Members with dignity and respect, in accordance with federal law. 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 are required to identify the language needs of Members and to provide oral translation, oral interpretation, and sign language services to Members. To assist providers with this, Aetna Better Health of Michigan makes its telephonic language interpretation service available to providers to facilitate Member interactions. These services are free to the Member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the Health Plan, 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, Aetna Better Health of Michigan Member Services Representatives will assist the provider via a three-way call to communicate in the Member's native language.

- For outgoing calls, Member Services dials the language interpretation service and uses an interactive voice response system to conference with a Member and the interpreter.
- For face-to-face meetings, Aetna Better Health of Michigan staff (e.g., Case Managers or Member Services) can conference in an interpreter to communicate with a Member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of Michigan Member Services to link with an interpreter.

Aetna Better Health provides alternative methods of communication for enrollees who are visually impaired, including large print and/or other formats. Alternative methods of communication are also available for hearing impaired members, which include accessing the state Relay line (711). Contact our Member Services for more information on how to access alternative formats/services for visually or hearing impaired.

Aetna Better Health of Michigan requires the use of professional interpreters, rather than family or friends. Further, we provide Member materials in other formats to meet specific enrollee needs. Providers must also deliver information in a manner that is understood by the Member. If interpreter services are declined, please document this in the Members' medical record. This documentation could be important if a Member decides that the interpreter, he or she has chosen has not provided him/her with full knowledge regarding his/her medical history, treatment or health education.

During the credentialing process for Aetna Better Health of Michigan, we ask what other languages are spoken in the office so we may refer our Members with special language needs.

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Site visits will be conducted by our Provider Experience staff to ensure that 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;
- 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, our network providers must comply with all applicable CMS laws, rules and regulations for, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any enrollee based on health status.

Providers shall provide covered services to Members that are generally provided by a provider and for which the provider has been credentialed by Aetna Better Health of Michigan. Such covered services shall be delivered in a prompt manner, consistent with professional, clinical and ethical standards and in the same manner as provided to provider's other patients. Provider shall accept Members as new patients on the same basis as Provider is accepting non-Members as new patients. Provider shall not discriminate against a Member based on 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 of Michigan is unable to provide necessary medical services, covered under the contract, within the network of contracted providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network providers, for as long as the organization is unable to provide the services. Aetna Better Health of Michigan will provide any necessary information for the Member to be able to arrange the service. The Member will not incur any additional cost for seeking these services from an out-of-network provider.

Clinical Guidelines

Aetna Better Health of Michigan has clinical 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 enrollees and the general community. These guidelines are not intended to:

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

Clinical Guidelines are available on our website at aetnabetterhealth.com/michigan. The clinical guidelines are adopted from the Michigan Quality Improvement Consortium and are also available on that website www.mqic.org. For Behavioral Health clinical guidelines, Michigan adopted the American Psychiatric Association guidelines.

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 of Michigan. However, a network provider may collect deductibles, co-insurance, or co-payments from Members in accordance with the terms of the Member's Certificate of Coverage or their Member handbook. Providers must make certain 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 of Michigan for services furnished by providers that have been authorized by Aetna to service such Members, as long as the Member follows Aetna's rules for accessing services described in the approved Member Certificate of Coverage (COC) and or their Member Handbook.

- Agreeing not to bill a Member for medically necessary services covered under the plan and to always notify Members prior to rendering services.
- Agreeing to clearly advise a Member, prior to furnishing a non-covered service, of the Member's responsibility to pay the full cost of the services.
- Agreeing that when referring a Member to another provider for a non-covered service must ensure that the Member is aware of his or her 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 of Michigan will not reimburse providers for WSPPs or for any WSPP-associated medical services. In addition, Aetna Better Health of Michigan 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:

- 1) The conditions are high cost or high volume or both
- 2) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
- 3) Could reasonably have been prevented through the application of evidence-based guidelines

Effective October 1, 2008, CMS will end payment for the extra care resulting from HCACs. CMS also prohibits passing these charges on to patients. Subject to CMS policy, Aetna Better Health of Michigan will not reimburse hospitals for the extra care resulting from HACs. In addition, Aetna Better Health prohibits passing these charges on to patients.

General Reminders to all Providers

- Obtain prior authorization from Aetna Better Health of Michigan for all services requiring prior authorization.
- Referrals to non-participating providers, regardless of level-of-care must be pre-authorized, unless specifically exempted 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 prior authorization is approved by Aetna Better Health of Michigan based upon the present information that has been made available to the health plan. Payment for prior-authorized, covered services is subject to the compliance with Aetna Better Health of Michigan's Utilization 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 claim that has been processed.

- Agree to collect only applicable copayments, coinsurance and/or deductibles, if any, from Members. Except for the collection of copayments, coinsurance and/or deductibles, providers shall look only to Aetna Better Health of Michigan for compensation for medically-necessary covered services.
- Agree to meet credentialing and recredentialing requirements of Aetna Better Health of Michigan.
- Providers must safeguard the privacy of any information that identifies a Member in accordance with federal and state laws and to maintain the Member records in an accurate and timely manner.
- Providers shall 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 and confinements, as well as services specified in this manual and other provider communications as requiring prior authorization.
- 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 of Michigan's recredentialing program. Aetna must be notified of any material change in the provider's qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health of Michigan.
- Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health of Michigan through the credentialing/rec credentialing process. Providers must furnish Aetna Better Health of Michigan with evidence of coverage upon request and must provide the plan with at least fifteen (15) days' notice prior to the cancellation, loss, termination or transfer of coverage.
- Providers shall ensure the completeness, truthfulness and accuracy of all claims and encounter data submitted to Aetna Better Health of Michigan including medical records data required and ensure the information is submitted on the applicable claim form.
- If the provider or Aetna Better Health of Michigan seeks to terminate the agreement, it must be done in accordance with the contract.
- Providers must submit demographic or payment data changes at least sixty (60) days prior to the effective date of change.
- Providers shall be available to Aetna Better Health of Michigan Members as outlined in the Access and Availability Standards section of this manual. Providers will also arrange 24-hour, on-call coverage for their patients by providers that participate with Aetna Better Health of Michigan, as outlined within this manual.
- Providers must become familiar and to the extent necessary, comply with Aetna Better Health of Michigan Members' rights as outlined in the "Members Rights and Responsibilities" section of this manual.
- Participating providers agree to comply with Aetna Better Health of Michigan's Provider Manual quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures and any other policies that Aetna Better Health of Michigan may implement, including amendments made to the mentioned policies, procedures and programs from time to time.
- Providers will ensure they honor all Aetna Better Health of Michigan of Michigan Members' rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all

communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.

- Providers of all types may be held responsible for the cost of service(s) where prior-authorization is required, but not obtained, or when place of service does not match authorization. The Member shall not be billed for applicable service(s).
- Aetna Better Health of Michigan encourages providers to contact Provider Relations at anytime if they require further details on requirements for participation.

Provider Responsibilities to Aetna Better Health of Michigan

Federal Law and Statutes (as outlined in the contract) are detailed below.

Civil Rights, Equal Opportunity Employment, and Other Laws

Provider shall 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. Provider recognizes that the Michigan Fair Employment Practice Act prohibits Provider, in connection with its provision of services under this Amendment, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions or privileges of employment because of race, color, religion, sex, disability, or national origin. Provider guarantees its compliance with the Michigan Fair Employment Practice Act. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and Prohibited Relationships

Provider acknowledges that Aetna Better Health of Michigan is prohibited from contracting with parties 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. Provider warrants that it is not on this list at the time of entering into this Amendment. Should Provider's status with respect to this list change, Provider agrees to notify Aetna Better Health immediately.

Provider acknowledges that Aetna Better Health of Michigan may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Provider warrants that it is not so excluded. Should Provider's exclusion status change, Provider agrees to notify Aetna Better Health immediately. Further, Provider shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Provider acknowledges that Aetna Better Health of Michigan is prohibited from maintaining a relationship with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, and that Aetna Better Health is prohibited from having relationships with "affiliates" as the term is defined under the Federal Acquisition Regulation. Provider warrants that Aetna Better Health is not prohibited from maintaining a relationship with Provider on

these grounds, and Provider agrees to notify Aetna Better Health immediately should its status change.

Federal Sanctions

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. The Centers for Medicaid and Medicare Services (CMS) requires Aetna Better Health and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. The Controlling Interest Worksheet will be included with the credentialing application, as well as, the recredentialing application. This Form must be completed, signed and dated when returned from the provider.

Medically Necessary Services

All Services provided to Medicaid Members must be medically necessary and reflect:

- Health care services and supplies which are medically appropriate;
- Necessary to meet the basic health needs of the Member;
- Rendering in the most cost-efficient manner and type of 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 convenience of the Member his/her provider;
- 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 has a Medical Technology Committee (MTC) to review new and emerging technology. The committee uses evidenced based clinical research to make determinations regarding the efficacy of the new technologies. Providers are advised of 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

Aetna Better Health 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 his or her primary care from, or was seen on a regular basis by, the terminated provider. It is the provider's responsibility to provide timely notification as indicated in the provider contract if they are requesting a termination from the network.

Health Care Reform Update Payments Outside the United States

Effective January 1, 2011, Section 6505 of the Patient Protection and Affordable Care Act prohibits Medicaid health plans from making payments to financial institutions or entities located outside of the

United States. This includes payments to physicians, hospitals, and ancillary healthcare providers for items or services provided to Medicaid enrollees through the Aetna Better Health contract with the State of Michigan. If you or your organization are located outside of the United States, or utilize a financial institution located outside of the United States, your payments will not be sent until you locate in the United States, or in the latter instance, establish a relationship with an entity located in the United States.

Provider Satisfaction Survey

Annually, Aetna Better Health of Michigan conducts a provider satisfaction survey. If you have any questions or would like to participate please call Member Services at **1-866-316-3784**.

Provider Responsibilities to Members

This section outlines the provider responsibilities to Aetna Better Health of Michigan Members. This information is provided to providers to assist in understanding the requirements in place for the Medicaid Program.

Establishing an early primary care physician relationship is the key to ensuring that every Aetna Better Health of Michigan Member has access to necessary health care and to providing continuity and coordination of care. The Member will already have chosen a primary care physician on the date their enrollment is effective. If necessary, Aetna Better Health will assign a primary care physician if no selection is made.

PCP Qualifications and Responsibilities

To participate as a Michigan Managed Medicaid provider, the PCP must:

- 1) Be a Medicaid-enrolled provider and agree to comply with all pertinent Medicaid regulations;
- 2) Sign a contract with Aetna Better Health as a PCP which explains the PCP's responsibilities and compliance with the following Managed Medicaid requirements:
 - a. Treat Managed Medicaid Members in the same manner as other patients;
 - b. Provide the covered services to all Members who choose or are assigned to the PCP's practice according to the Enrollment Report and comply with all requirements for referral management and prior-authorization;
 - c. Provide the Managed Medicaid Member with a medical home including, when medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but 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.
 - d. As appropriate, 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.;
 - e. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the PCP or an 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;
 - f. 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 that illness or condition can be better treated by another provider type;
 - g. 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 special needs.
 - h. 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 chosen or assigned;
 - i. 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;
 - j. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;
 - k. Comply with all disease notification laws in the State;
 - l. Provide information to the Department as required;
 - m. Inform Members about all treatment options, regardless of cost or whether such services are covered by the Michigan Medical Assistance Program; and
- 3) Provide accurate information to the Health Plan in a timely manner so that PCP information can be exchanged with MDHHS and Aetna Better Health Provider Relations via the Provider Network File

Advanced Directives

Aetna Better Health of Michigan maintains written policies and procedures related to advance directives that describe the provision of health care when the Member is incapacitated. These policies ensure the Member's ability to make known his/her preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health of Michigan'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 individual's 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 of Michigan's policies provide guidance on Aetna's obligations for ensuring the documentation of any Advance Directive decisions in the provider's 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.

Aetna Better Health of Michigan will ensure that our providers are informed of their responsibilities regarding advance directives. Our Provider Relations staff educates network providers on information related to advance directives through the Provider Contract, Provider Manual, Provider newsletters and during Provider Relations' on-site office visits.

Aetna Better Health Network Management is responsible for:

- Ensuring provider contracts contain requirements that support Members' opportunity to formulate advance directives.
- Ensuring the Provider Manual contains guidance on advance directives for Aetna Better Health of Michigan Members.

Aetna Better Health of Michigan's Quality Management (QM) staff distributes Medical Record Documentation Standards annually to the providers. One of the Medical Record Documentation standards requires that if a Member has an executed advance directive, a copy must be placed in the Member's medical record. If the Member does not have an executed advance directive, the medical record would provide documentation that a discussion regarding advance Directives has occurred between the provider and the Member.

Aetna Better Health of Michigan is committed to ensuring that adult Members understand their rights to make informed decisions regarding their health care. Aetna Better Health of Michigan's Advance Directives Medicaid Policy and Procedure provides guidance on our obligations for educating Members and providers. Aetna Better Health of Michigan educates providers on advance directives processes to ensure our Members can designate advance directives.

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

- Member's rights under State law, including a description of the applicable State law.
- Aetna Better Health's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- The Member's right to file complaints regarding non-compliance with the State.

Aetna Better Health of Michigan is responsible for educating Members and providers about advance directives rights. The Chief Operating Officer and Compliance Officer are responsible for ensuring advance directives information appears, no less than annually, in our materials. Advance directives information is available in the:

- Member handbook
- Member newsletter
- Website
- Provider manual
- Provider newsletters

Our case managers educate 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 submit a request to participate within the Aetna Better Health of Michigan provider network are subject to the same process. This process is to ensure consistency amongst all providers when consideration is made for participation.

Aetna Better Health of Michigan 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; and
- 4) Who have 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 it has been determined there is not a network need, the requestor is notified by letter or email stating the panel for his/her specialty area is closed. The requestor is also informed that they may request an application to the network no sooner than 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 the review, credentialing and re-credentialing of providers and uses the CAQH Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through the Council for Affordable Quality Healthcare, or CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows practitioners to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all the 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 contacting the practitioner for the same standard information. Providers update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. 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: there are non-credentialed provider types who will not be required to complete the CAQH application; please contact Provider Relations 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 providers may **NOT** treat Members until they are fully credentialed and an effective date has been assigned. Providers may be required to be board certified.

Additions or Provider Terminations

In order to meet contractual obligations and state and federal regulations, providers who are in good standing are required to report any terminations or additions to their agreement at least ninety (90) days prior to the change for Aetna Better Health to comply with CMS and/or accreditation requirements. Providers are required to continue providing services to enrollees throughout the termination period.

Providers are responsible to notify Provider Experience on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact Provider Experience to discuss staff training, if needed.

State and accreditation guidelines require Aetna Better Health of Michigan make a good faith effort to provide written notice of a termination of a network provider at least thirty (30) days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all enrollees who are patients of that PCP must be notified when a provider termination occurs.

Continuity of Care

Providers terminating their contracts without cause are required to provide a sixty (60) day notice (or otherwise determined by their contract) before terminating with Aetna Better Health of Michigan. 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 our Case Management Department for assistance with continuity of care.

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 at least annually or as otherwise indicated.

Credentialing /Recredentialing

Aetna Better Health of Michigan utilizes credentialing and recredentialing procedures to exercise reasonable care in the selection, evaluation and retention of quality participating providers for use by the plan's Members. Our primary objectives in credentialing providers are to:

- To establish minimum standards for participation of network providers
- To provide enough participating providers by specialty/type to service the plan's Members
- To review, through appropriate application of credentialing standards, on a scheduled basis, at least every three years, network 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 participating providers must notify the plan of any changes in status relevant to the credentialing process
- To provide a means whereby issues concerning participating providers and data concerning the

level of Member satisfaction with participating providers may be brought to the attention of the plan and used during the recredentialing process

- To evaluate and recommend the approval, or denial of all new provider applications
- To evaluate the performance and credentialing information that changes over time

Application Requirements for Ancillary/Facility Providers

Requests for an ancillary/facility application should be directed to the Network Contract Negotiators. The applicant must provide a completed, signed and dated Aetna ancillary/facility application to Aetna Better Health of Michigan to properly verify the provider's qualifications. Ancillary provider sites may require a facility review if they do not hold an acceptable accreditation. In addition to the ancillary/facility application, the following items must be provided:

- Signed Participating Provider Agreements (if applicable)
- List of licensed services offered
- Copy of current Michigan or applicable 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)
- Copy of Ownership Disclosure
- 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
- Complete listing of service area, including cities and counties

Site Review

A site review will be conducted in response to member complaints, upon quality reviews, or for 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 do not have an acceptable site review may be required to provide a corrective action plan.

Aetna's Credentialing Policy

Aetna's credentialing policy has adopted the highest industry standards, which are 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. Aetna must

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/recredentialing process is considered confidential and used only for the purpose of determining the provider's eligibility to participate within the Aetna Better Health of Michigan network; and to carry out the duties and obligations of Aetna operations, except as otherwise required by law.

Provider information is shared only with those persons or organizations who have authority to receive such information or who have a need to know in order to perform credentialing related functions. All credentialing records are stored in secured/locked cabinets and access to credentialing records is limited to authorized personnel only. Individual computer workstations are locked when employees leave their workstation. Access to electronic provider information is restricted to authorized personnel via sign-on security. All employees are trained and acknowledge training in accordance with federal HIPAA regulations. Disposal of all confidential documents must be via the locked confidential shred receptacles placed throughout the work area.

Non-Discrimination

Aetna does not discriminate against any qualified applicant based on 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 Vietnam veteran status, in accordance with Federal, State, and Local laws.

All employees of Aetna Better Health of Michigan are required to attend online training within sixty (60) days of hire and annually thereafter which requires passing a comprehensive quiz at the end of each training module. This training includes our Code of Business Conduct and Ethics and Unlawful Harassment, both of which address our non-discrimination policies and practices.

Aetna maintains a compliance line 1-888-784-2693, which is available 24 hours per day, 7 days for all employees, as well as members and providers to call to report compliance matters. All Aetna Better Health of Michigan employees have been educated on the compliance line and are encouraged to call if they suspect discrimination.

Verification Activity

This section presents the policy, sources, and procedures used by Aetna Better Health of Michigan for credentialing verification activity. Aetna Better Health utilizes a source verification checklist to ensure all standards and applicable verification tasks are completed. The following verification sources and processes apply and are monitored under the checklist:

- Complete Application
- Current State Licensure (Primary Source)
- Specialty Board Certification (ABMS) OR
- Residency Program Completion (Primary Source) OR
- 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 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 position (Attestation)
- Lack of present illegal use of drugs (Attestation)
- History of loss of license and/or felony convictions (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 5 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 recredentialing status of a provider, please contact Provider Relations:

Applicant Notification and Rights

Practitioners are notified of their credentialing rights when applying for 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 and/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. CVC 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**
 - Provider Manual

CHAPTER 6 – MEMBER BENEFITS

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

Covered Services

General areas of covered services under Aetna Better Health of Michigan include:

- Ambulance and other emergency medical transportation
- Breast pumps; personal use, double-electric
- Outpatient mental health services
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic laboratory, x-ray and other imaging services
- Durable medical equipment (DME) and supplies including those that may be supplied by a pharmacy
- 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 Enrollee)
- 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
- 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
- Podiatry services
- Practitioners' services
- Preventive services required by the Patient Protection and Affordable Care Act as outline by MDHHS
- Prosthetics and orthotics
- Restorative or rehabilitative services in a place of service other than a nursing facility
- 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 development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts
- Vision services

- Well-child/EPSTD for persons under age 21 Aetna Better Health
- Dental services for pregnant women
- Continuous glucose monitoring system (for some individuals with Type 1 Diabetes)

The covered services provided to Healthy Michigan Plan enrollees under this Contract include all those listed above and the following additional services:

- Additional preventive services required under the Patient Protection and Affordable Care Act as outline by MDHHS
- Habilitative services
- Dental Services including scaling and root planning when medically necessary
- Hearing aids for persons 21 and over

ENHANCED SERVICES

In conjunction with the provision of covered services, the Aetna Better Health must do the following:

- Place strong emphasis on programs to enhance the general health and well-being of enrollees. Specifically, develop and implement programs that encourage enrollees 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 enrollees
- Promote the availability of health education classes for enrollees
- Provide education for enrollees with, or at risk for, a specific disability or illness
- Provide education to enrollees, enrollees' 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

Medicaid Members

Aetna Better Health of Michigan does not require co-pays for Medicaid Members. Aetna Better Health will pay for all their covered services. There are no co-payments, deductibles, or any other out of pocket cost for covered services.

Members should not sign or agree to pay for any services that are covered by the health plan. Members may be required to pay for services if they ask to receive services that are not covered by Aetna Better Health. If at any time Aetna Better Health of Michigan submits requests to MDHHS to allow for Member co-pays, providers and members will be notified in advance of this change.

Healthy Michigan Plan members

Healthy Michigan Plan members have co-payments (also called co-pays). Co-pays are amounts of money that members will pay to Aetna Better Health, not to the provider or doctor. Co-pays are a way for members to share in the cost of their care. Members are not required to pay any co-pays for the first six (6) months of their enrollment.

The following services will require a co-pay. The copayment requirement will be listed on the member's Aetna Better Health of Michigan ID card as well as a member liability on remittance advices and

explanation of benefits.

Covered services that require a copay*	Income up to 100%FPL	Income >100%FPL
Physician office visits (includes free-standing urgent care centers)	\$2.00	\$4.00
Outpatient Hospital Clinic visit	\$2.00	\$4.00
ER visits for Non-emergency services	\$3.00	\$8.00
Inpatient hospital stays (excluding ER admissions)	\$50.00	\$100.00
Pharmacy (Prescription drugs)	\$1.00 Generic \$3.00 Brand	\$4.00 Generic \$8.00 Brand
Chiropractic visits	\$1.00	\$3.00
Dental visits	\$3.00	\$4.00
Hearing aids	\$3.00 per aid	\$3.00 per aid
Podiatric visits	\$2.00	\$4.00
Vision visits	\$2.00	\$2.00

*Providers cannot deny services if members are eligible for services but are unable to pay the co-pay.

Members can reduce the amount of their contribution and copays by participating in healthy behavior activities. These activities include getting an annual (once a year) health risk assessment and changing unhealthy behaviors, like smoking and not exercising.

Aetna Better Health will reduce member copays or give them a gift card if members schedule a Health Risk Assessment within 60 days after being enrolled in our health plan. Providers will receive incentives upon completion of HRA. If members need help with completing the Health Risk Assessment form or need an additional another copy, they can contact Member Services at **1-866-316-3784, (TTY: 711).**

Member Communications

Aetna Better Health of Michigan has numerous ways to inform enrollees about covered health services. Communication tools are written at a sixth-grade reading level. Some are available in alternate formats and in 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 — A web portal providing 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 much more.

Aetna Better Health of Michigan's teams also communicate covered benefits and services to members on a regular basis.

- Member Services — Representatives are trained and dedicated to Michigan's Medicaid line of business. Service representatives describe benefits to members and answer questions. Interpretation services are available in several languages.
- Appeals and Grievances – The member handbook outlines the process for filing appeals and grievances. The grievance and appeals team also assist members through the process.

- *Case Management* - Aetna offers a Care Management program to help members with health needs. When needed, Aetna updates its care management program to better meet the needs of its membership. Care coordinators educate members about their health needs and how they can better manage their care.
- *Prior Authorization* – The member handbook provides an overview of what services require prior authorizations and which services do not. Members can also contact Member Services 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* — Training materials and the Provider Handbook include Michigan Medicaid covered services information.
- *Member Advisory Board* — A member, staff and stakeholder committee meeting regularly to learn about Aetna benefits and services, and provide feedback on materials, providers, and service.

Interpretation Services

Aetna Better Health provides interpreter services for members with Limited English Proficiency (LEP) or hearing and visually impaired members. MDHHS is responsible for notifying Aetna Better Health at the time of the member's enrollment about this need. 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, the provider and/or member may inquire about interpretive services in their community by contacting Member Services at **1-866-316-3784**.

Aetna Better Health offers a TTY line (TTY 711) for hearing-impaired members. Aetna Better Health Member Services Department can establish interactions with other TTY lines and/or be available to mediate a TTY line call to a health care Provider by contacting Aetna Better Health Member Services at **1-866-316-3784**.

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, this preference must be noted in the member's medical record. Also, refer to the Interpretation Services section in Provider Responsibilities and Important Information chapter.

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 a wheelchair van. Aetna Better Health covers air travel for critical medical needs. Transportation service is 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 are asked to give a three-day notice when requesting non-urgent transportation.
- Members must be eligible with Aetna Better Health on date of the scheduled appointment.

Providers or members may contact transportation vendor to arrange for transportation for medically

necessary non-emergent health services. 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, WIC appointments 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, except for 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. Fax request for authorization to Health Services **1-866-603-5535**.

Pharmacy

The Aetna Better Health pharmacy benefit follows the Michigan Department of Health and Human Services (MDHHS) Common Formulary that is required under Section 1806 of Public Act 84 of 2015. 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 includes medications that are not required to be covered by the common formulary.

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's 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's formulary by contacting the pharmacy help line at **1-855-432-6843**.

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 Member Services at **1-866-316-3784** to verify member eligibility for optical services.

Routine vision 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 Aetna Better Health's Provider Directory or Aetna Better Health's website at **aetnabetterhealth.com/michigan**.

Dental

The State of Michigan Medicaid program is currently the carrier for dental services. Please contact the State of Michigan for further information regarding dental benefits for Aetna Better Health of Michigan and Michigan Medicaid members.

Medicaid Members:

- Benefits are covered through the State - **1-800-642-3195**
- Members will use the Green MI Health Card for Services
- Members will need to contact Dental Providers in the area that accept Medicaid

Pregnant Medicaid Members:

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

Healthy Michigan Plan Members: Ages 19-64

- Benefits are covered through DentaQuest Dental
- Members call: **1-844-870-3976** and
- Providers call: **1-844-870-3977**
- Dental ID Card will be required for Dental Services
- There is a Copayment of \$3 per visit

Benefits Include:

Cleaning and Exam every 6 months

Pregnant Women Dental Benefit

Effective July 1, 2018, members who are or become pregnant can access dental services during their pregnancy and postpartum period directly through their Medicaid Health Plan. Pregnant members will be able to see dentists that are contracted as part of the Aetna Better Health network. Members may also receive transportation to and from scheduled dental appointments.

To receive dental services the member must notify Aetna Better Health of their pregnancy and due date by calling Member Services at **1-866-316-3784**. Members should also notify their caseworker of their pregnancy and due date.

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. Aetna Better Health Member Services and Medical Management 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

- a) 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;
- b) Serious impairment to bodily functions; or
- c) Serious dysfunction of any bodily organ or part.
- d) 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 person's 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 informed health line for members. Informed Health Line services are provided based on the answers to the questions in the 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

If a problem is found or suspected during a well-child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another provider or self-referral for further diagnosis and treatment.

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.

Direct Access to Care

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 practitioner, 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 Indians 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.

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. To meet that goal, Aetna Better Health has developed a maternal/child program in conjunction with the member's obstetrical provider. This program promotes prenatal screening and intervention in order to identify potential high-risk factors and monitor prenatal visit compliance.

The Maternal, Infant Health Program (MIHP) provides preventive health services that are delivered by an agency that must be certified by MDHHS. MIHP services include:

- Psychosocial and nutritional assessment
- 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)
- Coordination with medical care providers
- Childbirth classes or parenting education classes

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 an 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 mother's claim. Claims received with mother and baby charges submitted on the same claim will reject and be sent back to the provider as denied for inconsistency with member's age or sex. Providers need to resubmit claims with the mother's charges on one claim, and the baby's on another.

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 enrollee'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.

Our members are educated 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:

- 1) The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule.
- 2) 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
- Blood lead assessment using blood level determinations as part of scheduled periodic health screenings appropriate to age and must be done for children according to the following schedule:
 - Between 12 months and 24 months of age
 - Between 24 and 72 months of age if the child has not previously been screened for lead poisoning
- 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
- 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

For children who have been tested, the following questions are intended to assist physicians and nurse practitioners in determining if further 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?

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 in 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.

Hearing Services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children 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 MDHHS' 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.

Dental Services

Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. 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 up to age three (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.

https://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.

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

The fluoride varnish program is for children up to age three (0 - 35 months). Fluoride varnish can be applied to teeth up to four times a year. 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 screen is part of the well-child visit performed by the medical provider. There is no additional reimbursement for the screen

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 she states that she 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 woman, the department considers the woman 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 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**.

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 mother 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 mother or is to terminate a pregnancy that resulted from rape or incest.

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 current schedule. Go to the following website: <https://www.cdc.gov/vaccines/schedules/index.html> to retrieve forms, various patient educational materials.

For more information about the VFC Program, and how to join, please contact your local region 1 Michigan Care Improvement Registry Regional Office at **1-888-217-3900** or access the following WebPage: <https://www.cdc.gov/vaccines/programs/vfc/providers/questions/qa-join.html>

Women, Infants, and Children (WIC) Nutrition Program

The Women, Infants, and Children (WIC) Health and Nutrition Program is offered free of charge to families who qualify.

How WIC makes a difference

- The goal of the WIC Program is to keep pregnant and breastfeeding women and kids under age 5 healthy by providing nutrition facts and WIC Bridge Card to purchase healthy and nutritious food.
- All Aetna Better Health members who are pregnant or recently had a baby qualify for this program.
- All Aetna Better Health members who are babies or children under age 5 years old also qualify for this program.

How can you obtain WIC materials, forms, and information?

To learn more about WIC services and referrals call 211. You can also download many of the WIC program forms and education materials at:

- https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4910---,00.html
- <https://www.fns.usda.gov/wic/about-wic-wic-glance>
- <http://www.nal.usda.gov/wicworks/Topics/index.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 are 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 foster care and are unable to meet the above stated guidelines, please contact Member Services at **1-866-316-3784**, 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 Screening is a package of preventive services that can 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 www.mqic.com) and the American Academy of Family Physicians (AAFP at www.aafp.org).

Tobacco Cessation Treatment

1. 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 included in the services listed below.
2. Aetna Better Health provides tobacco cessation treatment that includes the following services:
 - a. Intensive tobacco cessation treatment through an MDHHS-approved telephone quit-line.
 - b. 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
 - c. Non-nicotine prescription medications
 - d. Prescription inhalers and nasal sprays
 - e. The following over-the-counter agents
 - i. Patch
 - ii. Gum
 - iii. Lozenge
 - f. Combination therapy – the use of a combination of medications, including but not limited to the following combinations
 - i. Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)
 - ii. Nicotine patch and inhaler
 - iii. Nicotine patch and bupropion SR

Members can get more information by calling the Member Outreach department at **1-855-737-0770**.

Here are other resources to help members quit:

- Go to smokefree.gov.
- Call the Michigan Tobacco Quitline at **1-800-QUITNOW** (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 comorbidities who will engage with and benefit from CHW or peer-support specialist services.

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 (PIHPs) 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 PIHPs/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 PIHPs 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) **1-888-566-0489**
- Mid-State Health Network (Covering Hillsdale and Jackson counties) **1-844-405-3095**

Services Prohibited or Excluded under Medicaid

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

CHAPTER 7 – MEMBER ELIGIBILITY AND ENROLLMENT

Member Services

Member Services 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. Member Services can be reached at **1-866-316-3784**.

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 timeperiod 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
- Member Services at **1-866-316-3784**

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 username and password to obtain access to this site, please contact your Provider Relations Representative or call Change Health Care at **1-877-469-3263**.

Identification Cards

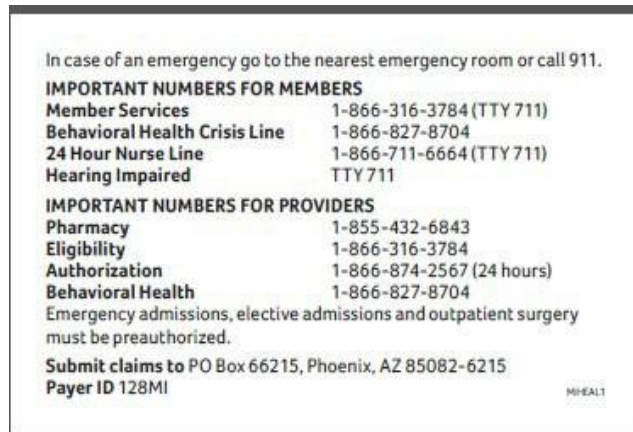
Members are provided an ID card from the State of Michigan. Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in the Aetna Better Health of Michigan plan. An ID card will be mailed to each new member when a PCP is selected or assigned.

Members are always encouraged to keep their identification card with them. If the card is lost or stolen, the member should call Member Services 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 Member Services at **1-866-314- 3784**.

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
- Member Services telephone number
- 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 are one of two member product identifiers in the lower right-hand corner of each card:

- 1) MI Medicaid - MEMIMED1
- 2) 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 act 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:

- (a) Conduct an assessment in order to identify any special conditions of the member that require ongoing case management services
- (b) 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
- (c) 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 can select a PCP at the time of enrollment and may change their PCP voluntarily at any time by contacting Member Services. 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, the member can 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 Member Services at 1-866-316-3784.

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 Member Services directly for such requests. Member Services 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 and returned 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 mother selects a different Medicaid Managed Care Plan, newborns born during the mother'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 Relations 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 mother 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 mother has not selected a PCP for her newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member.

Member Removal from PCP Panel

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

The PCP should follow the following guidelines in order to remove a member from their panel:

- Provider is to notify the member in writing within thirty (30) days by certified mail, of reason for termination and to choose another PCP.
- Provider is required to manage care for emergent services during this time period.
- Provider should fax notification with supporting documentation to Provider Experience Department.

Provider Experience Department will review the request to determine if the request needs to be addressed in Health Services for case management intervention or it may be forwarded directly to the

Compliance Department for direct action with MSA.

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's 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 MDHHS, Office of Inspector General Beneficiary Fraud Unit at **1-800-222- 8558**.
- 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

New Member Information

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 Grievance and Appeal Process

Members have the right to file a complaint (grievance) or 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 complaints and appeals, including the obligation to provide information within the timeframe reasonably requested for such purpose. For further guidance on the member grievance and appeal process, please contact Member Services.

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

Complex Case Management Process

The purpose of Complex Case Management is to identify, assess and provide intervention in cases that due to their chronicity, severity, complexity, and/or cost, require close management to affect an optimal member outcome in a cost-effective manner. Aetna Better Health of Michigan'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.

The Complex Case Manager will review medical management/utilization management data such as, but not limited to, specific high-risk diagnosis, multiple admissions or ER visits length of stay admissions greater than seven (7) days, and/or multiple disciplines/therapies such as skilled nursing facility or subacute rehab required for a treatment.

The Complex Case Manager requests information to assess the member's current medical status, treatment plan and potential medical treatment requirements and identify those social determinants of health that may impact the member's medical outcome. The Complex Case Manager will collaborate with specialty consultants, attending physician, PCP, member, member's "family", Behavioral Health Providers and other members of the health care team in order to facilitate the highest quality of service, at the most cost-effective level, that support the member centered goals established to achieve the member's best long-term outcome.

The Complex Case Manager will attempt to identify and direct the use of alternative resources within the community that serve to support achieving established goals in the event a benefit is not available. The Complex Case Manager program is also inclusive of Community Health Worker (CHW) services and community-based support.

The Complex Case Manager serves as a liaison for providers, members, family, and/or alternate payers to insure compliance to the treatment plan, facilitate the appropriate use of cost-effective alternative services, as well as assess effectiveness of the treatment plan based on goals achieved.

Cases will be considered closed upon the termination of the member, refusal of the member or family to participate with the case management process; and/or if the physician and/or member agree that the reassessment, current treatment plan and/or progress of the member is such that case management intervention is no longer required to maintain the member at his/her optimum level of wellness.

Providers may contact Aetna Better Health of Michigan at **1-866-316-3784** to request an evaluation for complex case management support. Provider referrals to Complex Case Management can be sent via secured fax to **1-866-889-7572**.

Disease Management and Outreach Programs

Aetna Better Health of Michigan implements a population-based approach to specific chronic diseases or conditions. All Aetna Better Health members with identified conditions are auto enrolled in the program based on claims date. Members that do not wish to participate can call member services and

notify the Plan of their desire not to participate and they will be dis-enrolled from the program.

All enrollees are sent educational material to promote better member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care and testing which are supported by evidence-based practices and tools. Disease Management Program is incorporated within the Care Management Program and the same staff will provide member outreach, engagement and education.

Additionally, auto alerts flag to the case managers desk top identifying members with significant "gaps" in their care and/or disease/condition education. Case managers reach out to those members to educate and assist the members in obtaining needed services, including, lifestyle modifications and health resource access.

Aetna Better Health of Michigan 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). These programs are designed to guide members and support their physician/clinical providers in accordance with the Clinical Practice Guidelines adopted by Aetna Better Health.

Our goal is to assist our members/your patients, to better understand 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 are designed to reinforce your treatment plans. Providers can contact the Plan at **1-866-316- 3784** and follow the prompts to refer a member to our Case/Disease Management program.

Members of Aetna Better Health of Michigan do not have to enroll; they are automatically enrolled when we identify them for one or more of the chronic conditions covered by our disease management programs. If you would like to refer any of your patients who are Aetna Better Health members into any of the programs, please let us know.

The following services are offered by the program:

- 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 effectively plan for visits to see practitioners 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 at any time members can request withdrawal from the program. Members need only call the health plan's Member Services department.

CHAPTER 9 – PHARMACY

Aetna Better Health of Michigan covers prescription medications and certain over-the-counter medicines when you write a prescription for Members enrolled in the Michigan Family Cares program. 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

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, a Pharmacy Prior Authorization Request form must be completed before the 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** 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 most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. 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 oversees 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** 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 a.m. and 8 p.m., 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:
https://www.caremark.com/wps/portal!/ut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP1An_z0zDz9gnRHRQDSauup/ 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.
- 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 of covered benefits as indicated.

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 (8am to 5 pm.) call Customer Service at **1-866-316-3784** and ask to be connected to a nurse; Providers may call **1-866-874-2567** for prior authorization.
- Call **1-866-782-8507** 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**. 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**.

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 Enrollee	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 Enrollee	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
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider and Enrollee	Electronic/Written

If Aetna Better Health approves a request for expedited determination, a notification will be sent to the member and the physician involved, as appropriate, of its determination as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receiving the request.

If Aetna Better Health denies a request for an expedited determination, the request will automatically be transferred to the standard time frame. Aetna Better Health will promptly provide the member oral notice of the denial of an expedited review and of their rights. Aetna Better Health will send to the member within seventy-two (72) hours, a written letter of the members' rights.

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 denial 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**

CHAPTER 12 – QUALITY MANAGEMENT

Overview

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 designed 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 the health status of enrollees or maintain current health status when the enrollee'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 Enrollee Advisory Committee. This structure allows enrollees 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.

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 and make recommendations to the Board of Directors about our quality management and performance improvement activities and to work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers. Major functions of the QMOC Committee include:

- Confirm that quality activities are designed to improve the quality of care and services provided to enrollees
- 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, Provider Experience, and quality and utilization management

Additional committees such as Service Improvement, Credentialing and Performance, Appeals/Grievance, and Quality Management/ Utilization Management further 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. Based on the work plan, we conduct an annual QM Program evaluation, which assesses the impact and effectiveness of QM activities.

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 enrollees. 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 enrollees.

Aetna Better Health of Michigan's 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 enrollees. Providers are obligated to support and meet Aetna Better Health of Michigan's QAPI by the cooperate 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 enrollees and families, providers, and state and community agencies.
- **Findings from External Program Monitoring and Formal Reviews**: Externally initiated review activities, such as an 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 Enrollee or Provider Issues**: In addition to receiving grievances and appeals from enrollees, providers, and other external sources, Aetna Better Health of Michigan proactively identifies potential quality of service issues for review through daily operations (i.e. enrollee services, 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 enrollees.
- **Findings from Internal Program Assessments**: Aetna Better Health of Michigan conducts several formal assessments/reviews of program operations and providers that are used to identify opportunities for

improvement. This 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 an array of 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 enrollees' care plans -Availability of 24/7 telephonic assistance to enrollees 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 for the identification of opportunities for improvement in many levels of care.
- **Other Service Performance Monitoring Strategies:** Aetna Better Health of Michigan uses a myriad of monitoring processes to confirm effective delivery of services to all our enrollees, such as provider and enrollee 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 enrollees receive.
 - Effectiveness of the assessment and service planning process, including its effectiveness in assessing an enrollee's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization.
 - Delivery of services enhancing enrollee 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.

2020 PAY-FOR-QUALITY (P4Q) PROGRAM

ANNUAL P4Q PROGRAM MODEL

Standardized, market-based programs where performance can be accurately tracked on a monthly basis.

Provider Eligibility	No less than 150+ Aetna members per practice (average over the performance period) Must have “open” panel
Performance Measurement	Selected measures – Up to 5 of 12 HEDIS measures; bonus will be based upon the 5 measures most relevant to provider’s member panel determined by denominator size Applicable measure must have at least ten (10) members in the denominator to be eligible for payment Two targets are set based on the 2019 National Medicaid HEDIS 50th, 75th, or 90th percentile.
Payment Model	Annual payment if quality targets 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 Aetna Medicaid Web Portal. Reports include gaps in care The first performance report will be available in April, 2020
Management Process	Quarterly review of performance with providers 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.	78.63	82.36
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.	86.32	88.84
Adolescent Well Care (AWC)	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner in the measurement year.	54.26	62.77
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.	58.67	63.98
Children’s Access (CAP) Members: 12-24 Months of Age	The percentage of members 12 months-24 months of age who had a visit with a PCP in the measurement year.	95.62	97.04
Children’s Access (CAP) Members: 25 Months - 6 Years of Age	The percentage of members 25 months-6 years of age who had a visit with a PCP in the measurement year.	87.87	90.32

Measure	Description	T1	T2
Children's Access (CAP) Members: 7-11 Years of Age	The percentage of members 7-11 years of age who had a visit with a PCP in the measurement year or year prior to the measurement year.	91.08	93.41
Cervical Cancer Screening (CCS)	The percentage of women 21-64 years of age who were screened for cervical cancer.	60.65	66.49
Comprehensive Diabetes Care (CDC): HbA1c Adequate Control (<8)	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test in the measurement year and the HbA1c< 8%.	50.97	55.96
Comprehensive Diabetes Care (CDC): HBA1C Testing	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test in the measurement year.	88.55	90.51
Well Child Visits First 15 Months of Life (W15): 6 Visits	The percentage of members who turned 15 months old in the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	65.83	69.83
Chlamydia Screening in Women (CHL): Total	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in the measurement year.	66.24	71.58

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 2021.

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.

QUARTERLY P4Q QUALITY MEASURES

Service	Measure	Incentive Basis	Rate
Cervical Cancer Screening – Q0091	Women ages 21-64 who received 1 or more pap tests to screen for cervical cancer during the measurement year.	Provider will be paid for each HEDIS eligible Member that receives one (1) Cervical Cancer Screening per measurement year.	\$25.00
Antepartum Care	Women who receive a prenatal care visit within 90 days of their last menstrual cycle.	OB/GYN's, Midwives and Family Practitioners can earn an incentive for Antepartum care examinations performed in accordance with HEDIS guidelines.	\$100.00
Post-Partum Care	Women who had post-partum care on or between 21 & 56 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
Childhood Immunizations Combo 3	Children that received the following immunizations by their 2 nd birthday: (4) DtaP/DT; (3) IPV; (1) MMR; (3) Hib; (3) Hep B; (1) VZV; and (4) Pneumococcal conjugate.	Provider will be paid for each HEDIS eligible member who completes a series or receives all Combo 3 immunizations by their 2 nd birthday.	\$25 per completion of each series, plus \$100 bonus for completion of Combo 3

Service	Measure	Incentive Basis	Rate
Adolescent Immunizations Combo 2	Adolescents turning 13 during the measurement year that receive the following immunization prior to their 13 th birthday: 1 Meningococcal & 1 Tetanus, or (Tdap). HPV	Provider will be paid for each HEDIS eligible Member that receives both Combo 2 immunizations between their 11 th and 13 th birthday.	\$50.00
Mammogram	Women ages 50-74 years who had a mammogram to screen for breast cancer during the measurement year.	Provider will be paid for each HEDIS eligible member that has received at least one (1) mammogram during the measurement year.	\$50.00
Blood Lead Testing	Children that received 1 or more capillary or venous lead blood lead tests for lead poisoning by their 2 nd birthday.	Provider will be paid for each HEDIS eligible Member that receives one (1) blood lead screening prior to their 2 nd birthday.	\$25.00
Comprehensive Diabetes Care Dilated Eye Exams	Members 18-75 years of age with diabetes (type 1 or type 2) that have had a retinal or dilated eye exam by an eye care professional during 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
Comprehensive Diabetes Care HbA1C Testing	Members 18-75 years of age with diabetes (type 1 or type 2) that have had an HbA1c test during the measurement year.	Provider will be paid for each HEDIS eligible diabetic member that receives HbA1c test per measurement year. Payment is limited to one (1) per year.	\$25.00
Well Child Visits – First 15 months of life	Members 0-15 months that have received well-child visits with a PCP during their first 15 months of life.	Provider will be paid for each eligible member having a comprehensive well-child visit, up to six (6) per HEDIS eligible member per measurement year, performed within their first 15 months of life.	\$25 per service up to 5 with bonus of \$125 at service 6
Well Child Visits – Third, Fourth, Fifth and Sixth years of life	Member 3-6 years of age that have received one or more well-child visits with a PCP during the measurement year.	Provider will be paid for each eligible member having one (1) comprehensive well-child visit per HEDIS eligible member per year.	\$50.00
Well Child Visits – Adolescent	Members 12-21 years of age that have received at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Provider will be paid for each eligible member having one (1) comprehensive well-care visit per HEDIS eligible member per year.	\$50.00
Care Management/Care Coordination Services	Code	Description	Provider will be paid for each eligible Care Management/Care Coordination Service appropriately rendered and billed during the measurement period, in accordance with State guidelines.
	G9001	Comprehensive Assessment	
	G9002	In-person CM/CC Encounters	
	G9007	Care Team Conferences	
	G9008	Provider Oversight	
	98966, 98967, 98968	Telephone CM/CC Services	
	98961, 98962	Education/Training for Patient Self-Management	
	99495, 99496	Care Transitions	
S0257	End of Life Counseling		

Michigan 4 x 4 Plan Health Screening – Provider shall be eligible for additional incentive reimbursement for the Eligible Services, described in the chart directly below, that comply with the Michigan 4 x 4 Plan. Payment will be made on a quarterly basis for Eligible Services rendered.

Health Screen/Required Billing Codes	Payable Codes	Incentive Basis
Body Mass Index (BMI) Diagnosis Codes	Diagnoses Codes V85.0-V85.5x	Provider will be paid \$5.00 one (1) time per eligible member per year
Blood Pressure Screening	CPT Codes 93770	Provider will be paid \$5.00 one (1) time per eligible member per year
Cholesterol Level (LDL-C)	CPT Codes 80061, 83700, 83701, 83704, 83721	Provider will be paid \$5.00 one (1) time per eligible member per year
Blood Glucose Level	CPT Codes 82947-82962	Provider will be paid \$5.00 one (1) time per eligible member per year

All P4Q Quarterly and Michigan 4 x 4 Plan Health Screening 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, 2020	July, 2020
April 1 to June 30, 2020	October, 2020
July 1 to September 30, 2020	January, 2021
October 1 to December 31, 2020	June, 2021

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

Potential Quality of Care (PQoC) Concerns

Aetna Better Health of Michigan has a process for identifying PQoC concerns 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 enrollees' 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, prevalence of disease and potential consequences (risks) of the disease

Our QM Department prepares PIP proposals that are reviewed and approved by our Chief Medical Officer (CMO), Quality Management/Utilization Management Committee, and the Quality Management Oversight Committee (QMOC) prior to submission to the MDHHS for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health of Michigan, as well as from network providers who are enrollees of our 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, 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 plans 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

We collect and report clinical and administrative performance measure data to the MDHHS. The data enables Aetna Better Health of Michigan, the MDHHS to evaluate our adherence to practice guidelines, as applicable, and/or improvement in enrollee outcomes.

Satisfaction Surveys

We conduct enrollee and provider satisfaction surveys to gain feedback regarding enrollee and providers' experiences with quality of care, access to care, and service/operations. We use enrollee and provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

Enrollee 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 enrollees and summarizes satisfaction with the health care experience.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.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 enrollees. 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 network's 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 enrollees in their practices, as well as the minimum threshold of enrollees 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. Our 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 enrollees 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 Health rewards qualifying members who take care of their health. There are several services for which qualifying members receive incentive gift cards. All members are rewarded for having an annual physical and for receiving the recommended diabetic services. Adults are rewarded for tobacco cessation and weight management. Women are rewarded for having breast cancer screening and cervical cancer screening. Pregnant women receive incentives for prenatal and postpartum physician visits. Pediatric visits that qualify for an incentive include: immunizations, lead screening and well-child visits.

Provider Incentives

Every month practitioners may access their HEDIS scorecard along with a list of members with gaps in care via the provider portal. Providers may receive quarterly incentive checks for services provided to members that meet the specifications for a list of nineteen HEDIS measures. Annually, practitioners receive an incentive check based upon twenty-three HEDIS measures and how their performance computes within the incentive formula.

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of enrollees, 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. The link is available on our website. 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 MDHHS for Medicaid 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?

We recognize that it is in the best interest of both the provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to provider electronic medical records (EMRs) and setting up electronic data exchange from the provider EMP to the plan. Please contact a Provider Experience Representative or the QM department 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 for more information.

CHAPTER 13 – ENCOUNTERS, BILLING AND CLAIMS

Aetna Better Health processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in 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. To facilitate electronic claims submissions, Aetna Better Health has developed a business relationship with Change Healthcare. 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 of Michigan members must be reported to Aetna Better Health, including prepaid services.

Timely filing

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- New Claim Submissions – Claims must be filed on a valid claim form within 365 days from the date services were performed (unless there is a contractual exception). For hospital inpatient claims, date of service means the date of discharge of the member.
- Providers have 180 days from the date of the remittance advice to submit a Coordination of Benefits (COB) Claim.
- Claim Resubmission – Claim resubmissions must be filed within 180 days from the date of payment or denial. Please submit any additional documentation that may effectuate a different outcome or decision.)
- Providers have 180 days from the original denial for appeals and reconsiderations. Failure to submit accurate and complete claims within the prescribed time period may result in payment delay and/or denial.

How to file a claim

- 1) Select the appropriate claim form:
 - a. Medical and professional services use 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 Provider Experience 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 - Providers who are contracted with us can use electronic billing software. 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. Additionally, a Level Two report is provided to vendors, which is the only accepted proof of timely filing for electronic claims.
- 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 66215
Phoenix, AZ 85082-6215

Claim filing tips

- Corrected claims must be clearly 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 insures 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 recoument 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 pre-fixes 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-1500Form).
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500Form).
- 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-1500form)
- All providers, including FQHCs and RHCs, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.

NDC requirements

Federal regulations require States and Managed Care Organizations (MCOs) to collect NDC numbers from providers on claims for the purposes of billing manufacturers for drug rebates. As a result, providers will not be reimbursed for drugs unless a valid 11-digit NDC number, Unit of Measure and quantity administered are reported 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 of Michigan 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
 - Enter the 2-digit qualifier of "ZZ" followed by the taxonomy code
 - Do not enter a space, hyphen, or other separator 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 contact Provider

Experience.

Multiple procedures

Multiple procedures performed on the same day and/or at the same session are processed at 100% of the contracted rate for the primary procedure, 50% of the contracted amount for the secondary procedure and 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 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 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 each 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 a service 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 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 reimbursement and coverage.
- Evaluation and Management Service Billing - Review the billing for services in conjunction with procedures performed.

When reviewing a remittance advice, 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 that providers submit an Itemized Billing Statement along with their original claims. Claims billed in excess of \$50,000 will always require an Itemized Billing Statement. If an Itemized Billing Statement is required, the claim will be denied for an Itemized Billing Statement if one is not supplied.

Balance billing

Aetna Better Health participating providers are prohibited, by contract, 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 when a service is not a covered benefit and 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 an Aetna Better Health Provider Experience Representative to research the complaint. Aetna Better Health is obligated to notify MDHHS when a provider continues the inappropriate practice of balance billing a member.

Coordination of benefits (COB)

By law, Medicaid is the payor of last resort. Aetna Better Health, as an agency of the State of Michigan 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.

COB claims must be received by Aetna Better Health within one hundred eighty (180) 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/or limitations under Aetna Better Health's contract with the State of Michigan.

Participating and/or non-participating providers are required to follow Aetna Better Health's policies on authorization requirements even when Aetna is not the primary payor.

Other general claims instructions

Aetna Better Health of Michigan claims are paid in accordance with the terms outlined in the provider contract for this product.

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use 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.

Home Health Care

Providers submitting claims for Home Health should use CMS UB-04 Form. Providers must bill in accordance with their contract and/or State of Michigan Medicaid guidelines.

Durable Medical Equipment (DME)

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

Hospice

Aetna Better Health of Michigan members currently receiving hospice services are routinely transitioned back to State of Michigan Fee-For-Service Medicaid coverage. Please contact a Case Manager or Provider Experience 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 to prior remits to ensure proper tracking and posting of adjustments. We recommend that providers keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call Provider Experience for more information about electronic remittance advices.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), a provider must currently submit claims through EDI and receive payment for claim by EFT. Providers must also be able 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
 - 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:
 - Answer questions about claims
 - Assist in resolving problems or issues with a claim
 - Provide an explanation of the claim adjudication process
 - Help track the disposition of a claim
 - Correct errors in claims processing

Corrected Claims and Resubmissions

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 does not necessarily constitute reconsideration or claim dispute. Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Please submit the Reconsideration/Reconsideration Form located on our website along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriately on initial submission.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction. Please remember 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 appropriate claims address.

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

Claim Reconsiderations

Providers have 180 days from the date of claim processing to correct and resubmit claims.

- Resubmission: A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information.
- Reconsideration: A request for the review of a claim that a provider believes was paid

incorrectly or denied because of processing errors.

A resubmission or reconsideration should be submitted with the Provider Claims Resubmission/Reconsideration Form (available on the Aetna Better Health of Michigan website) to the following address:

Aetna Better Health of Michigan
Attn: Reconsiderations
P.O. Box 66215
Phoenix, AZ 85082

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

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 Advices

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 a 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 this remit. TIN refers to the tax identification number.
- Claim Header area of the remit lists information pertinent to the entire claim. This includes:

– Member Name	– Provider Name
– Member ID number	– Claim Status
– Date of Birth	– Claim Number
– Account Number	– Refund Amount, if applicable
– Authorization ID, if obtained	

- 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.
- Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

Sample remittance advice and check:

PS824028007

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

WHITE STOCK
301508240180
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

3 0.7130 SP 0.465
SINGLE PIECE
HORIZON TREATMENT CENTER,
24681 NORTHWESTERN HWY STE 306
SOUTHFIELD, MI 48075-2322

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:	Patient Acct #: CW0055	Claim Status: PAID
Member ID:	Authorization ID:	Claim#: 15217C000006
Date of Birth:	Provider: SMITH, MONIQUE A	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
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aetna Aetna Better Health of Missouri LLC
10 South Broadway, Suite 1200
St. Louis, MO 63102

91478
R21

CHECK NO.: 00000000
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

⑆ 000000000000 ⑆ ⑆ 22 23037841 ⑆ 111111111111 ⑆

CHAPTER 14 – INQUIRY, GRIEVANCE AND APPEALS

Aetna Better Health has an Inquiry, Grievance, and Appeals process for members and providers to dispute a claim authorization or an Aetna Better Health decision. This includes both administrative and clinical decisions of Aetna Better Health. A provider has 90 days from the Notice of Action to file an Appeal and 90 days 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. Appeal filing must be in writing. 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. Members and providers have the right to submit written comments with all levels of the process.

Provider Inquiries and Grievances

In order to ensure a high level of satisfaction, Aetna shall provide a mechanism for providers to express dissatisfaction with Plan decisions. Providers may express questions or dissatisfactions through our Provider Inquiry and Grievances Process.

If a provider has questions regarding member benefits/eligibility, claim status/payment, remittance advices, authorization inquiries, etc. please access the provider portal or contact with Claims Inquiry and Claims Research (CICR). Inquiries are handled daily and are normally resolved on the initial contact.

To submit a dissatisfaction regarding an issue in the Health Plan, you may contact Provider Experience at **1-866-314-3784**. Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be documented within our internal system and conveyed to the complainant.

After following these steps, if you are still dissatisfied you may have the right to file an appeal. Please refer to the Appeals section for instructions on filing an appeal.

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. Aetna Better Health members will receive assistance, if required, to file either a Grievance or an Appeal. Aetna Better Health also provides a toll-free number for members at **1-866-316-3784, (TTY: 711)**. Interpretive services are also available to members by calling the telephone numbers above.

The member may request continuation of benefits during the Health Plan Appeal review or a State Fair Hearing. The request must be filed within ten (10) days of the mail date of the Notice of Action. 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 Reconsideration vs. Claim Appeal

Aetna Better Health of Michigan has two separate and distinct processes designed to assist providers with issue resolution. The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal. If the provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing an appeal. However, before filing an

appeal, the provider should verify the claim does not qualify to be submitted as a claim resubmission or reconsideration.

	Reconsideration	Non-Par Provider Appeal Dispute	Par Provider Approval
Form (available online)	Resubmission/Reconsideration Form	Non-Par Provider Appeal Form	Par Provider Appeal Form
Address	Aetna Better Health of Michigan Attn: Reconsiderations PO Box 66215 Phoenix, AZ 85082-6215	Aetna Better Health of Michigan Medicaid & Premier Plans Attn: Grievance & Appeals PO Box 818070 Cleveland, OH 44181	Aetna Better Health of Michigan Attn: Reconsiderations PO Box 66215 Phoenix, AZ 85082-6215
Appropriate Categories	<ol style="list-style-type: none"> 1) Claim resubmissions 2) Corrected claims (including missing/ incomplete/ invalid diagnosis, procedure or modifier denials) 3) Timely Filing 4) COB (missing/ illegible primary explanation of benefits) 	<ol style="list-style-type: none"> 1) Denied days for IP (inpatient) stays 2) Authorization denials for late notification 3) Claim denial for no authorization/ pre-certification/ medical necessity not met 4) Services denied per finding of a review organization 	<ol style="list-style-type: none"> 1) Denied days for IP (in-patient) stays 2) Authorization denials for late notification 3) Claim denial for no authorization/pre-certification/medical necessity not met 4) Services denied per finding of a review organization
Timeframe	180 days from the date of processing/denial	<p>Claim denial appeals must be submitted within 60 days of the date of service.</p> <p>Authorization denial appeals must be submitted within 90 days after the date of the adverse action (denial letter).</p>	<p>Claim denial appeals must be submitted within 90 days of the date of service.</p> <p>Authorization denial appeals must be submitted within 60 days after the date of the adverse action (denial letter).</p>

Provider Dispute of Appeal Claim Action

Providers may dispute any adverse claim action. Prior to disputing a claim action, providers may contact Claims Inquiry/Claims Research (CICR) 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, in order to minimize claims issues:

- Contact CICR at **1-866-314-3784** as the first step is to clarify any denials or other actions relevant to the claim. A representative will be able to assist a provider with a possible resubmission of a claim with modifications.
- If an issue is not resolved after speaking with Aetna representatives or by submitting a claims resubmission participating network providers may challenge actions of a claim denial or adjudication by filing a claim dispute.
 - The dispute must be filed using the Aetna Claim Dispute form found on the Aetna Better Health of Michigan website at: <https://www.aetnabetterhealth.com/michigan/providers/forms>.

Examples of appeals:

- Denied as not medically necessary

Tips to writing an effective appeal

If a provider does not agree with Aetna Health Care of Michigan's decision regarding requested services or benefit coverage, we have provided tips to writing an effective grievance or appeal letter:

- Include the name, address, and a phone number where the appellant 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
- Address issues raised in our denial letter
- Address the medical necessity of the requested service
- Include information about the patient's medical history:
 - Prior treatments
 - Surgery Date
 - Complications
 - 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 and/or functional improvement
- An explanation of the referral to an Out-of-Network provider

When submitting an appeal, be sure to 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 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. A verbal request indicating the need for an expedited review should be made directly to Prior Authorization at **1-866-874- 2567**. Those requests for an expedited review 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 timeframes

Process	Definition	Determination
Inquiry	Any question from an Enrollee or provider regarding issues received by a Customer Service Representative in the Customer Service Operation. These questions may regard issues like benefit information, claim status and eligibility. Inquiries are handled daily and are normally resolved on the initial contact. To avoid delay in processing inquiries, 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, which is considered an Appeal expressed by an Enrollee or provider. The issue may be resolved by the Customer Service Representative in the CSO. This dissatisfaction refers to any reason other than dissatisfaction due to an adverse benefit determination or action made by the Health Plan. 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 90 days
Appeal	An Appeal is a written or oral request by the Enrollee or provider to review an Adverse Determination or payment/reimbursement denial related to a health service request or benefit that the Enrollee or provider believes he or she is entitled to receive. A denial or a 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.

Written inquires and grievances can be mailed Written appeals can be mailed to:

Aetna Better Health of Michigan Attn: Inquiries 1333 Gratiot Suite 400 Detroit, MI 48207	Aetna Better Health of Michigan Attn: Grievance & Appeals 1333 Gratiot Suite 400 Detroit, MI 48207
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State Fair Hearing

Aetna Better Health members have 120 days from the date of Aetna Better Health's notice of Action or Appeal decision letter to initiate a State Fair Hearing. The member must first complete the Health Plan Appeal process before initiating 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 48909
1-877-833-0870

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

Fraud, Waste and Abuse

Aetna Better Health of Michigan will not tolerate health care fraud, waste, or abuse in any of its relationships with either internal or external stakeholders. Aetna Better Health will identify, report, monitor and, when appropriate, refer for prosecution situations in which suspected fraud, waste or abuse occurs:

Medicaid managed care fraud: The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself and some other person. It includes any act that constitutes fraud under applicable Federal and State law.

Medicaid managed care waste: Involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to inappropriate act or omission by players with control over or access to government resources. Waste goes beyond fraud and abuse and most waste does not involve a violation of law; it relates primarily to mismanagement, inappropriate action and inadequate oversight.

Medicaid managed care abuse: provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs 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 enrollee practices that result in unnecessary costs to the Plan, Federal or State programs.

To report fraud and abuse, please contact Aetna Better Health Provider Inquiry Line at **1-866-314-3784** (select Menu Options for Fraud/Waste/Abuse Reporting).

Aetna Better Health follows a mandatory corporate compliance plan that incorporates annual employee training, system controls, data mining tools, internal auditing and a designated Special Investigations Unit (SIU) to monitor, detect, investigate and report potential fraud. All Aetna staff complete required training in identifying potential fraud, waste or abuse and the tools for reporting questionable situations upon hire and annually thereafter. Training includes how to detect and prevent member, provider and

employee fraud.

Additionally, the Member Services staff receives thorough training for fraud, waste, and abuse. At Aetna, our goal is to operate at the highest level of ethical standards.

The Special Investigations Unit (SIU) detects and investigates cases of potential health care fraud, waste, and abuse. Examples of fraud, waste, and abuse include but are not limited to the following:

- Submitting a Claim for services not furnished either by using genuine patient information to fabricate entire Claims or by padding Claims with charges for procedures or services that did not take place;
- Submitting a Claim with inaccurate diagnosis or procedure codes with the intent of maximizing payments or obtaining Coverage that the member is not entitled to;
- Submitting a Claim knowing reimbursement has previously been remitted;
- Misrepresenting dates of services, description of service, or identity of member or provider in order to obtain reimbursement to which the provider or member is not entitled;
- Submitting a Claim for Non-Covered Services in a manner that categorizes them as Covered Services;
- Submitting a Claim for a more costly service than the one actually performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code);
- Submitting unbundled Claim(s) for the purpose of avoiding these Claim policies and procedures;

The SIU utilizes state-of-the-art data analysis tools to detect irregularities which could be indicators of possible fraud. Clinical Investigators and experienced fraud, waste, and abuse investigators work collaboratively to conduct investigations identified through various sources.

The SIU reviews medical claims on a prospective and retrospective basis using sophisticated data mining technology tools to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU also may request supporting documentation or schedule an on-site audit to investigate previously paid claims. The investigation does not mean that a provider is practicing fraud. In many cases, the SIU finds the provider billing practice was in error. In all cases, the SIU will work with the appropriate Provider Experience Representative to communicate what is believed an inappropriate billing practice.

The Compliance (Fraud Waste and Abuse) Committee reviews all suspected fraud and abuse cases and, if warranted, findings will be reported to the appropriate regulatory agencies and legal authorities.

If a member is suspected of fraud, waste, or abuse, they are referred to our Compliance Committee for review. If it is determined that additional investigation is warranted, those cases are reported to appropriate external entities, including the MDHHS Office of Inspector General. Reports include the name and ID number of the party involved, the source of the complaint, the provider type, nature of the complaint, approximate dollar amount involved and the legal and administrative status of the case.

Our credentialing process for contracted providers includes a verification that the provider is eligible to

participate. We specifically check the Excluded Provider Database on the HHS OIG Web site to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid or CHIP. This information is also requested on the credentialing and re-credentialing application.

Aetna Better Health of Michigan's contract provisions with participating providers specifically state, that they shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. The provider hereby certifies that no such excluded person currently is employed by or under contract with them or with any "downstream" entity with which they contract relating to the furnishing of these services to Medicare Advantage members.

Our Credentialing Verification Center conducts ongoing monitoring of the HHS OIG and State Professional Registration boards internet sites and any information found pertaining to participating Aetna Better Health of Michigan providers are referred for review by the credentialing committee to ensure compliance.

Our delegated credentialing entities are required to verify that the providers with whom they contract are eligible to participate, including checking the HHS OIG Web site to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid or CHIP. Part of our ongoing evaluation of the delegated entities is confirmation of ongoing monitoring of state and federal web sites to identify current sanctions or complaints.

As required by the Deficit Reduction Act of 2005, it is Aetna Better Health's policy to provide detailed information to Aetna Better Health employees, vendors or other subcontractors, and other persons acting on behalf of Aetna Better Health, about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, "False Claims Acts"). The False Claims Acts assist the Federal and State Government in preventing and detecting fraud, waste and abuse in Federal health care programs, such as Medicare and Medicaid.