aetna®

AetnaBetterHealth.com/Michigan

Aetna Better Health® of Michigan

Check out the Availity Provider Portal

Now open to all Aetna Medicaid providers

You told us you wanted one efficient workflow to communicate with payers, so we teamed up with Availity® to streamline the process. We are excited to announce that Aetna Medicaid is now on the Availity Provider Portal, the same platform used by Aetna Commercial and Medicare. That means you only need access to one website to interact with all Aetna products.

On the Availity portal for Aetna Medicaid providers, you can use:

- Payer spaces
- Claims submission link (Change Healthcare)
- Messaging system
- Claims status inquiry
- Grievance and appeal submission and status
- Panel roster/panel lookup
- Reports
  - Provider deliverables manager (PDM)/ProReports
  - Ambient (business intelligence reporting)
- Prior authorization submission and status lookup
- Eligibility and benefits lookup

Get registered

If you are already registered, simply select Aetna Better Health from your list of payers to start using the available tools and features. If you have not registered, go to **Availity.com/Provider-Portal** for free tips and training on how to register with Availity. You may also call Availity Client Services at **1-800-282-4548** between the hours of 8 AM and 8 PM Eastern time, Monday through Friday (excluding holidays).

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

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2021 value-based programs

At Aetna Better Health of Michigan, we understand that a key component of achieving superior health care and satisfaction for members is the doctor-patient relationship. Members who have a positive relationship with their health care provider are more likely to seek appropriate care. Our primary care programs seek to enhance this relationship and support our members in achieving the highest quality health care, as measured by national benchmarks.

Our value-based programs are quality focused. These programs reward providers for meeting or exceeding specific quality goals. As a result of delivering the highest-quality health care to our members, providers are eligible to earn incentive payments. Our value-based programs support your patients and our quality care initiatives by promoting:

- Care that improves quality and outcomes, thus resulting in a healthier population
- Health care delivery consistency and adherence to evidence-based standards of care
- Continuous quality improvement orientation
- Care coordination between providers and the health plan and alignment of goals for our members' health

We have value-based programs for every primary care setting. Some programs apply to smaller practices and others to larger practices. We also offer incentive opportunities specific to providers serving only adult or pediatric populations.

Quality performance outcomes included in Aetna Better Health's value-based programs are determined using HEDIS quality measures administrative data only.

For more information on each of the programs offered, please visit our website at: **aetnabetterhealth.com/michigan/assets/pdf/Provider/2021_provider_value_based_programs.pdf**

Provider quarterly Pay for Quality (P4Q) program

In addition to the value-based programs described above, providers shall be eligible for additional incentive reimbursement for the services as described in the chart on pages 3 and 4 ("eligible services") that meet the corresponding measure for a member. Payment will be made on a quarterly basis for eligible services rendered.

What resources are available to help reach quality goals?

2022 is quickly approaching! Be sure to submit your claims for preventive services to close out your patients' gaps in care ***before*** **December 31, 2021**. Aetna is happy to help schedule appointments and arrange transportation for patients in your gaps in care listings.

As our Aetna Better Health partner, we want to know how we can help you meet your HEDIS goals! Our Quality Team is starting our fourth-quarter push to get members in for preventive care visits. We are performing targeted live outreach calls, text message campaigns, IVR outreach and health education mailings for services such as lead screenings, well visits, diabetes care, prenatal and postpartum care, dental examinations, immunizations, and breast and cervical cancer screenings. *What other activities can we perform to support you and your staff to get your patients in for health care?* Feel free to contact our Quality Manager, Megan Getz, via email, **getzm@aetna.com**, or phone, **248-296-4463**, with comments and ideas.

Quarterly P4Q quality measures

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

Service	Measure	Incentive basis	Rate
Breast Cancer Screening (BCS)	The percentage of women 50 to 74 years of age in the measurement year who had a mammogram to screen for breast cancer from Oct. 1 two years prior to the measurement year through Dec. 31 of the measurement year.	Provider will be paid for each HEDIS-eligible member who has received at least one (1) mammogram during the measurement year. Payment is limited to one (1) per year.	$50
Cervical Cancer Screening (CCS)	Women ages 21 to 64 who received one or more Pap tests to screen for cervical cancer during the measurement year.	Provider will be paid for each HEDIS-eligible member who receives one (1) cervical cancer screening per measurement year. Payment is limited to one (1) per year.	$25
Childhood Immunization Status (CIS): Combo 3	The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps and rubella (MMR); 3 *haemophilus influenzae* type B (Hib); 3 hepatitis B (Hep B); 1 chickenpox (VZV); and 4 pneumococcal conjugate (PCV) by their second birthday.	Provider will be paid for each HEDIS-eligible member who completes a series or receives all Combo 3 immunizations by their second birthday.	$25 per completion of each series in Combo 3 plus $100 bonus for completion of Combo 3
Chlamydia Screening in Women (CHL): Total	The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia in the measurement year.	Provider will be paid for each HEDIS-eligible member who has received at least one (1) test for chlamydia during the measurement year. Payment is limited to one (1) per year.	$25
Comprehensive Diabetes Care (CDC): Eye Exam	Members 18 to 75 years of age with diabetes (type 1 and type 2) who had a dilated retinal eye exam in the measurement year or a dilated retinal eye exam that was negative in the year prior to the measurement year.	Provider will be paid for each HEDIS-eligible diabetic member who has received a dilated eye exam during the measurement year. Payment is limited to one (1) per year.	$25
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.	Provider will be paid for each HEDIS-eligible diabetic member who receives an HbA1c test per measurement year. Payment is limited to one (1) per year.	$25

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Service	Measure	Incentive basis	Rate
Immunizations for Adolescents (IMA): Combination 2	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Provider will be paid for each HEDIS-eligible member who receives both Combo 2 immunizations between their 11th and 13th birthday.	$50
Lead Screening in Children (LSC)	The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	Provider will be paid for each HEDIS-eligible member who receives one (1) blood lead screening prior to their second birthday.	$25
Prenatal and Postpartum Care (PPC): Postpartum Care	The percentage of deliveries of live births between Nov. 6 of the year prior to the measurement year and Nov. 5 of the measurement year that were followed by a postpartum visit on or between 21 to 56 days after delivery.	OB/GYNs, midwives and family practitioners can earn an incentive for antepartum care examinations performed in accordance with HEDIS guidelines.	$100
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	The percentage of deliveries of live births between Nov. 6 of the year prior to the measurement year and Nov. 5 of the measurement year that included a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	OB/GYNs, midwives and family practitioners can earn an incentive for antepartum care examinations performed in accordance with HEDIS guidelines.	$100
Care Management (CM)/Care Coordination (CC) Services	**Code** / **Description** 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	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.	$25

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

Claim service date	Incentive payment date
Jan. 1 to March 31, 2021	July 2021
April 1 to June 30, 2021	October 2021
July 1 to Sept. 30, 2021	January 2022
Oct. 1 to Dec. 31, 2021	June 2022

Sickle cell disease: Bust these common myths

Here are five myths your patients might have heard about sickle cell disease — with the facts they should know:

Myth: People with sickle cell trait will get sickle cell disease.

Fact: You get sickle cell disease when you inherit two sickle cell genes — one from each of your parents. If you inherit just one gene, that's called sickle cell trait. It means you can pass the gene on to your kids, but you won't get sickle cell disease yourself.

Myth: SCD only affects Black people.

Fact: SCD is more common in Black people. But it affects others too. These include people with ancestors from Central or South America, Saudi Arabia, India, Turkey, Greece, and Italy.

Myth: People with SCD overstate their pain to get drugs.

Fact: The pain of a sickle cell crisis is real and can be severe. People in a pain crisis may need strong medicines to find relief.

Myth: Babies born with SCD won't live to be adults.

Fact: In the U.S., more than 95% of newborns with SCD live to be adults. A good treatment plan can help people live longer and better.

Myth: There is no cure.

Fact: A bone marrow transplant can cure SCD. But not everyone is a good candidate. It can be hard to find a close match — and there are serious risks. So it's only done in the most severe cases.

Sources: Centers for Disease Control and Prevention; Sickle Cell Disease Association of America

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Member rights and responsibilities

Aetna Better Health of Michigan maintains policies and procedures that formally address a member's rights and responsibilities. The policies reflect federal and state laws as well as regulatory agency requirements. We annually inform our members of their rights and responsibilities in the member handbook, member newsletter and other mailings. They are also posted within the "For Members" section on our website at **AetnaBetterHealth.com/michigan/members/medicaid/rights**. We ensure that members can exercise their rights without adversely affecting treatment by participating providers. Members' rights and responsibilities are monitored through our quality management process for tracking grievances and appeals as well as through member surveys. Issues are reviewed by our Service Improvement Committee and reported to the Quality Management Oversight Committee. For additional information regarding member rights and responsibilities, visit our website or call your Provider Relations Representative at **1-855-676-5772**.

Fraud, waste and abuse

Know the signs — and how to report an incident

Health care fraud means getting benefits or services that are not approved. Fraud can be committed by a provider, member or employee.

Abuse is doing something that results in needless costs.

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

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

Everyone has a right and duty to report suspected fraud, waste and abuse. An example of provider fraud is billing for services, procedures and/or supplies that were not provided. Abuse is treatment or services that do not agree with the diagnosis. Hostile or abusive behavior in a doctor's office or hospital is also abuse. Suspected use of altered or stolen prescription pads is an example of member fraud. An example of abuse would be a member asking the transportation driver to take him or her to an unapproved location.

Penalties

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

- Criminal fines up to $250,000
- Prison for up to 20 years
- Being suspended from Michigan Medicaid

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

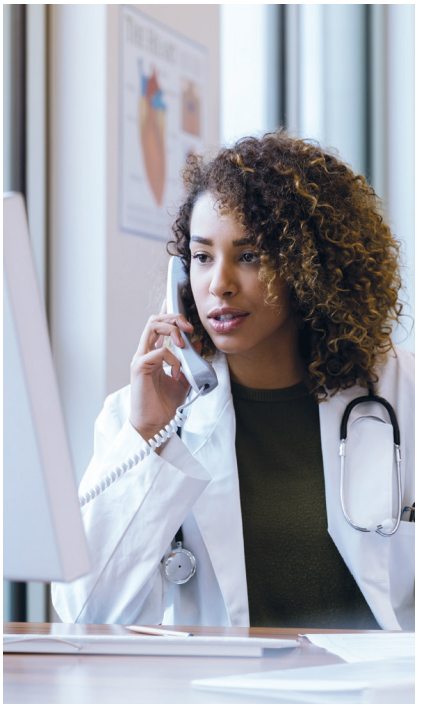
Anti-Kickback Statute. The Anti-Kickback Statute bans knowingly and willingly asking for, getting, offering or making payments (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicare program).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

How to report fraud, waste and abuse

If you suspect a colleague, member or other individual of fraud, waste or abuse, report it. You can report anonymously on the Aetna Better Health of Michigan Fraud, Waste and Abuse Hotline at **1-855-421-2082**. You may also write to: Aetna Better Health of Michigan, 28588 Northwestern Highway, Suite 380B, Southfield, MI 48034.

You may also anonymously report fraud, waste and abuse to the Michigan Department of Health and Human Services' Office of the Inspector General by calling **1-855-643-7283**, going online at **Michigan.gov/Fraud** or writing to: Office of the Inspector General, P.O. Box 30062, Lansing, MI 48909.

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



Coming soon: New address for paper claims

Aetna Better Health of Michigan has a new address for processing paper claims and correspondence, effective November 15, 2021.

New address:
Aetna Better Health
of Michigan
P.O. Box 982963
EL Paso, TX 79998-2963

Are you currently being paid with paper checks or virtual credit cards? We encourage you to sign up for electronic funds transfer (EFT) and electronic remittance advice (ERA):

EFT: **AetnaBetterHealth.com/michigan/assets/pdf/Provider/EFT-MI.pdf**

ERA: **AetnaBetterHealth.com/michigan/assets/pdf/Provider/ERA-MI.pdf**

Coventry payer ID number 25133 is no longer valid

For some time now, we have allowed providers to use the outdated Coventry HealthCare payer ID number 25133 when submitting claims for Aetna Better Health of Michigan members. As a courtesy to our providers, those claims have been redirected to the correct Aetna Better Health of Michigan payer ID number 128MI.

Please note that the courtesy redirects ended on August 1, 2021. Claims sent to the invalid payer ID number will be rejected.

Avoiding claim rejections and payment delays

Please check your systems and processes to ensure that you are only submitting claims for Aetna Better Health of Michigan members using the Aetna Better Health of Michigan payer ID number 128MI.

Grievances and appeals

Our provider/member grievances and appeals mailing address has changed. We kindly ask that you update your records accordingly and address all future grievances and appeals to our new mailing addresses as follows:

Nonparticipating provider grievances and appeals NEW address
Aetna Better Health of Michigan
P.O. Box 81139, 5801 Postal Road
Cleveland, OH 44181

Member grievances and appeals NEW address
Aetna Better Health of Michigan
P.O. Box 81040, 5801 Postal Road
Cleveland, OH 44181

Do you have immediate claims questions?

Please contact our CICR team:

- Medicaid TANF: **1-866-316-3784** or **1-866-314-3784**
- Duals: **1-855-676-5772**

The toll-free numbers let you use our Interactive Voice Response system to check claim status, eligibility and benefits, frequently asked questions, and more.

The importance of dental care

Aetna Better Health's Healthy Michigan members are offered dental coverage through our partner DentaQuest. It's important for everyone to obtain regular dental services each year. We are happy to help schedule appointments and arrange transportation for any of your Aetna Healthy Michigan members that require accommodation!

We encourage our providers to remind their patients about the importance of completing routine preventive dental services. Michigan's Dental Association® offers great insight on current dental practice protocols of sanitation for patients that are worried about contracting COVID-19 at the dentist.

Dental infection controls prevent the spread of infection and disease

All dental staff who treat patients are trained in infection prevention methods. The dentist and their staff uphold strict infection control guidelines set by the Centers for Disease Control and Prevention and follow recommendations from the American Dental Association, the Michigan Dental Association and other governing bodies.

Some of these infection prevention and control practices include:

- Dental exam room disinfection protocol
- Proper handwashing and hand hygiene techniques
- The wearing of personal protective equipment (PPE)
- The use of sterilized dental instruments
- Employing safe medical waste disposal methods
- Following additional, up-to-date coronavirus-specific prevention protocols set by the CDC, ADA, MDA, and other agencies

How dentists reduce the risk of infection and illness at every visit

What gets disinfected before you sit in the dentist's chair? In between every patient — yes, every patient — the dental care team takes steps to prevent the spread of infection and illness. Before a patient enters the treatment room, dental staff clean and disinfect all surfaces and change any protective covers on the equipment.

This means the following are always clean, disinfected or changed before a patient enters the treatment room:

- Dental treatment chair
- Dental light
- Instrument tray and all dental instruments
- Drawers and countertop surfaces
- All protective coverings

This newsletter is published as a community service for the providers of Aetna Better Health® of Michigan. Models may be used in photos and illustrations.