Provider newsletter

Spring 2025

Pharmacy

The Michigan Department of Health and Human Services (MDHHS) implemented a Single Pharmacy Drug List (PDL) back in 2020 and it affects all Michigan Medicaid Health Plans including Aetna Better Health. The PDL contains a listing of drugs that are covered by Michigan Medicaid as preferred and non-preferred. The link to the complete PDL can be found on our website at AetnaBetterHealth.com/Michigan/providers/pharmacy.html. Aetna Better Health of MI Members are eligible to receive a blood pressure monitor at no cost. Please write your patient a prescription for a BP Monitor and the pharmacy will be able to dispense one of the covered monitors found here.

Not all covered drugs are listed on the PDL, MDHSS still covers drugs through the Michigan Medicaid Common Formulary. A link to the common formulary may also be found on our website.

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

Electronic Visit Verification (EVV)

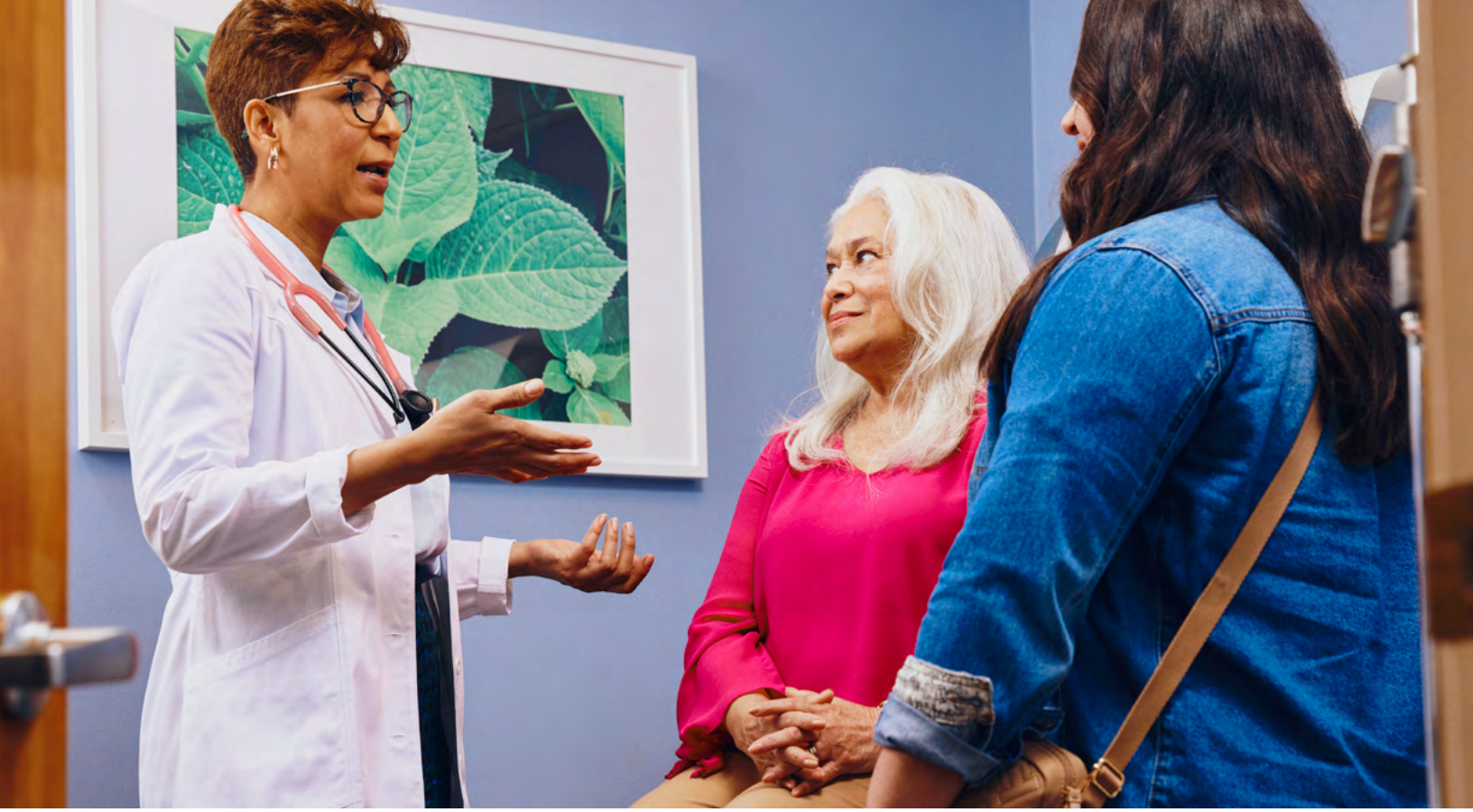
The Michigan Department of Health and Human Services (MDHHS) is partnering with HHAeXchange to implement an Electronic Visit Verification (EVV) system. This system will be used to validate in-home visits for Medicaid recipients. This will bring MDHHS into compliance with federal regulation, ensure beneficiaries are receiving services as planned and authorized, improve the accountability of caregiver services, and ensure payment accuracy for services provided. Under Section 12006(a) of the 21st Century Cures Act, states are required to implement EVV for all Medicaid personal care services and home health care services that require an in-home visit by a provider.

Next Steps

All Michigan Medicaid providers must choose one of the following EVV solution options:

- **Providers without an EVV solution** may set up and use the free EVV tools from HHAeXchange provided by MDHHS.
- **Providers with an EVV solution** may continue the use of the existing EVV system that meets state requirements and send visit data to the HHAeXchange system using electronic data interchange (EDI).

Regardless of the EVV solution selected, all impacted providers are required to complete the HHAeXchange Provider Onboarding Form. More information can be found on the MDHHS Electronic Visit Verification Page.



Member language needs

Aetna Better Health of Michigan is committed to meeting the language needs of the members we serve. One of the ways that we do this is by assessing the capacity of our provider network to meet our members' language needs. For those members who do not speak English, it is helpful to know which provider offices offer staff who speak the same language as they do and are confident in their ability to serve non-English speaking patients.

Our Quality Department asks that you ***please take a moment to answer this brief survey*** regarding the languages your practice offers. Your participation and feedback is important and very much appreciated. https://www.surveymonkey.com/r/WYVVRCZ

Aetna Better Health of Michigan cares about meeting the language needs of the members we serve. We know that language needs can vary by community and region, and that it can be helpful to educate our provider network about the specific language profiles of the service areas in which they provide care. ABHMI uses census and community-level data to determine and report on threshold languages within the state of Michigan. Threshold languages are all languages other than English spoken by 5 percent of the population or by 1,000 eligible individuals, whichever is less.

Using the most recent census data available, the breakdown of language profiles for the communities we serve are as follows:

Region 8 (Calhoun – Branch – Kalamazoo – St. Joe – Cass – Van Buren – Berrien Counties)

Region 8 Languages Spoken by Members	ABHMI 2021		ABHMI 2022		ABHMI 2023	
	#	% of Membership	#	% of Membership	#	% of Membership
English	11,212	96.13%	10,333	96.51%	9,117	97.65%
Spanish	41	0.36%	47	0.45%	51	0.55%
Vietnamese	4	0.035%	3	0.030%	3	0.032%
Unknown/Not disclosed/ Other	212	1.9%	233	2.3%	241	2.6%
Arabic	8	0.071%	9	0.087%	5	0.054%

Region 9 (Hillsdale – Jackson – Livingston – Monroe – Lenawee – Washtenaw Counties)

Region 9 Languages Spoken by Members	ABHMI 2021		ABHMI 2022		ABHMI 2023	
	#	% of Membership	#	% of Membership	#	% of Membership
English	14,511	97.62%	13,903	97.28%	13,706	98.11%
Spanish	16	1.1%	11	0.72%	13	0.91%
Vietnamese	1	0.0006%	2	0.0005%	1	0.0007%
Unknown/Not disclosed/ Other	131	0.9%	122	0.8%	139	1.01%
Arabic	2	0.006%	4	0.0007%	2	0.014%

Region 10 (Wayne – Oakland – Macomb Counties)

Region 10 Languages Spoken by Members	ABHMI 2021		ABHMI 2022		ABHMI 2023	
	#	% of Membership	#	% of Membership	#	% of Membership
English	25,915	96.84%	24,777	96.14%	22,190	95.88%
Spanish	200	0.77%	176	0.71%	205	0.92%
Vietnamese	4	0.0015%	2	0.0080%	3	0.0013%
Unknown/Not disclosed/ Other	1,083	4.17%	416	1.68%	431	1.94%
Arabic	8	0.032%	6	0.039%	5	0.024%

As always, we are committed to providing support to both our members and providers with specific language needs. To assist you, ABHMI provides interpretation services to help providers facilitate member interactions with members who have Limited English Proficiency (LEP). ABHMI will also provide, upon request, alternative formats of all member-related materials.

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

Priority measures

Dear Providers,

As we continue into 2025, we want to thank you for your continued dedication to providing high-quality care to our members.

This year, our top priority quality measures are focused on prevention, chronic condition management, and timely follow-up care. These measures not only improve patient well-being but also align with key performance metrics that impact value- based outcomes and incentives.

❤ 2025 Priority measures ❤	
Measures	**Tips to help close gaps in care**
1. GSD-Diabetes Management (A1C control (>8%), KED Monitoring, Eye Exam)	• Order screenings annually or more often needed and educate members on importance of compliance with testing and medications. • Refer member to Optometrist or Ophthalmologist for Dilated Retinal Eye Exam annually. • Educate members regarding diabetes' effect on kidneys and the importance of these tests.
2. CBP-Hypertension Control Blood Pressure (<140/90mmHG)	• Take Blood Pressure up to ***three*** times during the medical visit. • Make sure to use the correct size cuff. • Schedule follow up visits to monitor effectiveness of BP medications. • Utilize CPT II Codes. **We can take the lowest systolic pressure and lowest diastolic pressure to help a member be compliant per HEDIS Tech Specs.*
3. BPD -Blood Pressure Control for Patients with Diabetes	• Re-take blood pressure readings that are 140/90 or greater. • Schedule follow-up visits for blood pressure control after diagnosis or medication adjustment. • Utilize CPT II Codes.
4. AAP – Adult's Access to Preventative Ambulatory Health Services	• Outreach patients that have not been seen to set up an appointment. • Contact Aetna if you are interested in doing an event. We can help call, schedule members and provide rewards for the members attending the event.

5. AMR-Asthma Medication Ratio	• Perform a thorough review of medications at each visit to ensure medication is being utilized. • Provide medication compliance education.
6. Chlamydia Screening in Women	• Educate Women about STD'S, transmission and the importance of testing. • Perform routine urine test for chlamydia, document and submit claims timely.
7. LSC -Lead Screening in Children	• Make lead exposure screening and blood lead testing a priority in your practice. • Important to get the lead test or venous blood test ***on or before the child's second birthday***.
8. PPC -Prenatal	• Educate office staff to schedule the ***first*** appointment with the provider in the first trimester (asap if late to entry to care). • Visit to a PCP must include a diagnosis of pregnancy. • A prenatal visit after the first trimester is considered ***late*** in HEDIS reporting and does not count towards compliance.
9. PPC -Postpartum	• Educate staff to schedule the postpartum visit between 7-84 days after delivery. • Explain the importance of and encourage attendance for the postpartum visit. • If a visit is made outside of the time frame it is considered ***late*** in HEDIS reporting.
10. W30 - Well Child Visits in the First 30 Months of Life	• Members 0-15 months need 6 visits • Members 15-30 months need 2 visits **Never miss an opportunity!** Exam requirements can be performed during a sick visit or a well child exam.
11. CIS-Combo 3, CIS-Combo 10 -Childhood Immunization status	• Educate office staff to schedule appointments ***PRIOR*** to the 2nd birthday. • Call families to schedule appointments for those that are behind. • Emphasize the importance of the Flu vaccine. • Any vaccines after the age of 2 are considered ***late*** in HEDIS reporting.
12. IMA 2 - Immunizations in Adolescents	• Educate staff to schedule appointments ***PRIOR*** to the 13th birthday. • Give call reminders for series vaccines. • HPV requires two doses of HPV between 9th and 13th birthday with at least ***146 days between doses*** OR three doses with different dates of service between 9th and 13th birthday.

Help us stay connected, share your e-mail address!

To improve how we communicate important updates, resources, and announcements, we are asking all our valued providers to share their preferred e-mail address with us. Having your e-mail address with us will allow us to deliver timely information straight to your inbox- no delays or missed messages.

Your partnership is important to us, and we want to ensure you are always informed.....please submit your preferred e-mail address using the link below.

https://www.surveymonkey.com/r/7ZWNYRC

Thank you for helping us enhance our communication with you.

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

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

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

Support patient care with adult psychiatry eConsults

Aetna Better Health of Michigan launched a no-cost program with the leading eConsult platform RubiconMD, connecting you with adult psychiatrists via eConsult.

eConsults are asynchronous written conversations between a primary care team and a psychiatrist. They can help optimize patient care plans and improve access to specialty care. There is no charge to the patient or practice for submitting an eConsult.

It's easy to get started: First, meet with your patient and decide if an educational eConsult with a psychiatrist will help. After submitting an eConsult, a top-tier trained and board-certified psychiatrist will review the case and write a detailed response. Once you receive valuable insights to help inform your patients' care — you may choose to incorporate the recommendation into the care plan. If a referral is still needed, you may move ahead with one.

Questions?

If you have questions about improving specialty access with eConsults, email **victoria@rubiconmd.com** for more information.

Fraud, waste and abuse

Know the signs — and how to report an incident

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

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

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

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

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

Penalties

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

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

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

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

How to report fraud, waste and abuse

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

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

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

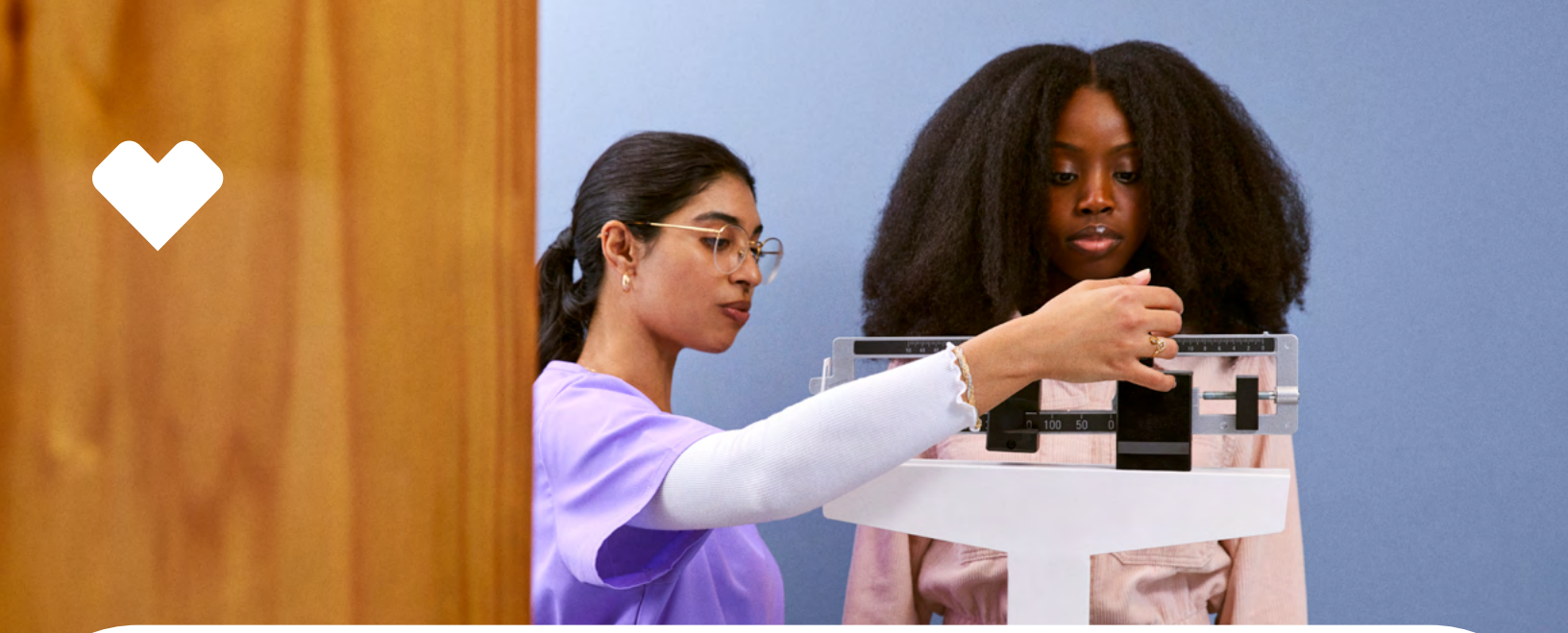
Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

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

Grievances 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. Our process includes both administrative and clinical decisions. A provider has 90 days from the Notice of Action to file an appeal and 90 days to file a grievance. Members have 60 days from the Notice of Action to file an appeal, and members can file a grievance at any time. Members and providers have a one-level internal appeal process through Aetna Better Health.

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



Provider inquiries and grievances

To ensure a high level of satisfaction, we will provide a mechanism for providers to express dissatisfaction with a decision. Providers may express questions or dissatisfactions through our provider inquiry and grievances process.

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

To submit a dissatisfaction regarding an issue with Aetna Better Health, you may contact our Provider Experience Department at **1-866- 314-3784 (TTY: 711)**. Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be registered and conveyed to the complainant within our internal system.

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.

If required, Aetna Better Health members will receive assistance from our Member Services Department to file either a grievance or an appeal.

A member may request or file a continuation of benefits during an Aetna Better Health Plan appeal review or a State Fair Hearing when the period covered by the original authorization has not expired, and the Member files for continuation of benefits, on or before the later of the following:

1. Within 10 Days of the Contractor's mailing the Adverse Benefit determination notice
2. The effective date of the proposed Adverse Benefit determination notice.

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.