Support

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AetnaBetterHealth.com/Michigan

Aetna Better Health® of Michigan

Healthy Home Visit program

As part of the Aetna Better Health of Michigan Healthy Home Visit program, we will be reaching out to some of your patients to schedule in-home assessments with Signify Health. These assessments may offer additional insight into the social and environmental factors identified in the home.

Recognizing that these elements may affect your patient's health, we will be mailing you and the patient a summary of the visit. We encourage our members (your patients) to share the findings with you, their primary care physician (PCP), during their next visit. This program is not intended to replace the member's relationship with you as their PCP.

A licensed clinician (MD, NP or PA) will conduct the Healthy Home Visit in the comfort of the member's home (or via a video conference). The assessment may help identify clinical programs or services available through Aetna Better Health of Michigan that could benefit your patient. There will also be instances where they may be referred to community resources, if necessary. A letter describing the program will be sent to your patients, which may result in additional questions.

To support you in answering questions your patients may

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Provider Newsletter
Fall 2022
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Aetna Better Health® of Michigan
28588 Northwestern Highway
Suite 380B
Southfield, MI 48034

Healthy Home Visit program

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have, we have provided the following information:

- The purpose of the home visit is to gather additional health and quality data from your patient and to understand social and environmental factors obtained from the patient's home that may be affecting their health.
- In addition to aiding the health plan in better understanding the member's/patient's needs for community and clinical programs, this same information may be helpful for the PCP or other health care providers' care plans.
- This visit will not affect the eligibility of patients with Aetna Better Health of Michigan coverage, change their benefits or cause the cost of coverage to change. This is a voluntary program for the patient and is offered at no cost.
- Signify Health health care providers will review and document medical history, current medications, and social determinants of health needs. The assessment also may address existing health conditions and services received that you may not be aware of, as they may have been diagnosed and provided by other physicians, such as specialists.
- A noninvasive physical exam (vitals), as well as a comprehensive assessment, including depression screenings, functional status, fall risks and home safety, and family support will be performed. The entire health assessment may last up to an hour.

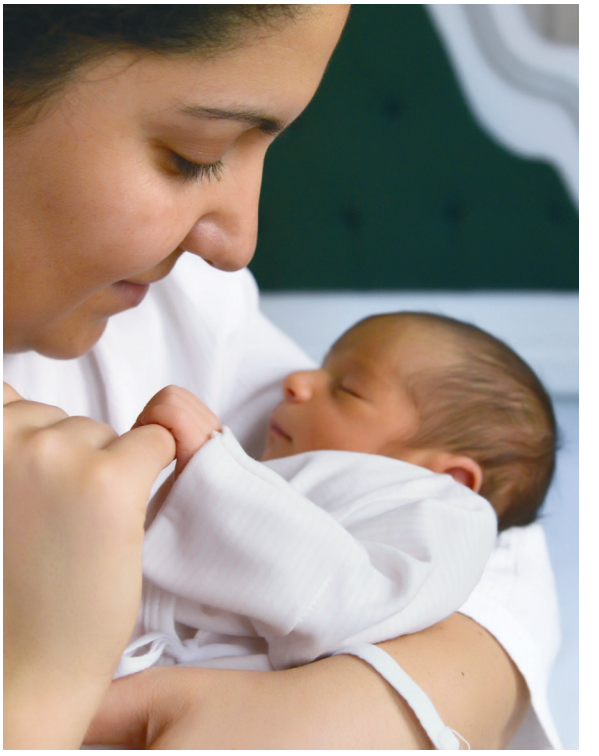
If you have general questions, please call Aetna Customer Service at **1-866-316-3784 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m. Eastern time. If you have specific questions about this program or letter, please contact Signify Health at **1-855-225-3183**, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

OB-GYNs: LARC reimbursement

Effective since October 1, 2018, separate reimbursement is available for long-acting reversible contraception (LARC) devices when the device is provided immediately postpartum in an inpatient hospital setting prior to discharge. Individual practitioners will continue to receive payment for their professional services related to the immediate postpartum LARC insertion procedure if billed separately from the professional global obstetric procedure codes and the hospital facility.

Payment for the LARC will be made in accordance with the Medicaid practitioner fee schedule in effect on the date of service for the procedure code billed.

- IUD procedures: 58300–58301
- IUD device: S4989, J7300
- LARC procedures: S4981, 11976, 11980, S4989
- LARC device: J7296–J7298, J7306, J7307



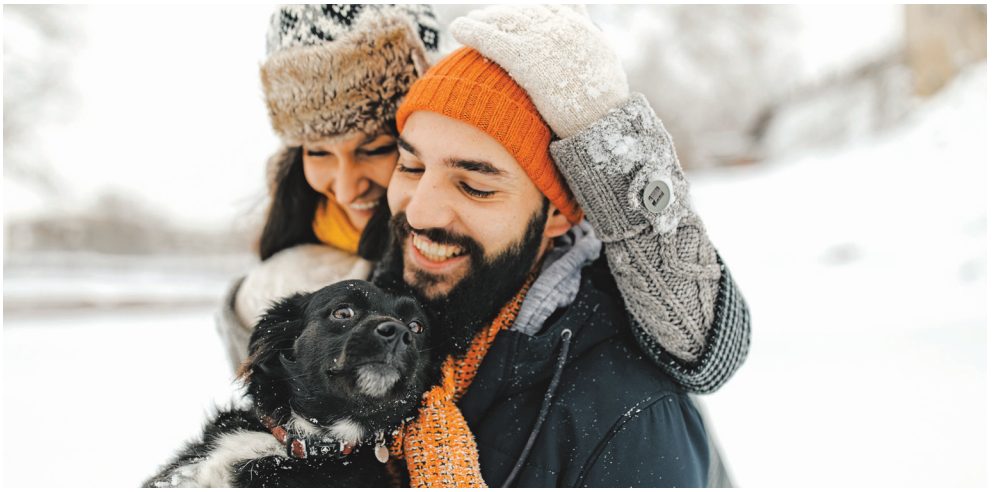
Family planning

Our members have direct access to family planning services without a referral and may also seek family planning services at the practitioner or provider of their choice.

It is the policy of Aetna Better Health of Michigan that family planning services include medical history and physical examinations (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care, and genetic counseling. These specific services include:

- Comprehensive family planning examination
- Contraceptive medical visits
- Family planning education and counseling by a practitioner or provider
- Contraceptive medications, including LARCs
- Birth control methods ordered at a family planning visit
- Supplies and associated medical and laboratory examinations, including oral and barrier method contraceptives
- Treatment of complications resulting from contraceptive use, including emergency department treatment

The following are important components of a comprehensive family planning exam:



- Assessing a member's risk for unintended pregnancy, poor pregnancy outcome or need for family support services
- Age-appropriateness of information provided to members and the need for confidentiality of information
- Pregnancy diagnosis and counseling, including:
  - Referral to a participating obstetrical practitioner or provider for early entry into prenatal care, for members diagnosed as pregnant who wish to continue the pregnancy
  - Information on all legal options available for members diagnosed with unintended pregnancies and, if they desire, referral for appropriate obstetrical and gynecological services
  - Information about the availability of contraceptive methods for nonpregnant members
- Education, including:
  - Reasons why family planning is important to maintain individual and family health
  - Basic information regarding reproductive anatomy
  - Risk factors and complications of various contraceptive methods
  - Information on the transmission, diagnosis and treatment of sexually transmitted diseases
  - Education about acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV)
  - Procedures of breast self-examination

For members 15 to 44 years of age, the medical record should include documentation of a discussion regarding family planning, which may include assessments of sexual activity, contraception, STD screening and counseling — or documentation that the member saw a family planning practitioner.

Aetna Better Health of Michigan encourages providers and practitioners to notify the health plan of newly diagnosed pregnancies within seven days.

Use 988 for mental health support

In support of providers delivering care that improves health care equity and fosters immediate access to critical behavioral health services, information on the nationwide **988** Suicide & Crisis Lifeline is being shared as a resource for immediate use.

On July 16, 2022, dialing **988** replaced the National Suicide Prevention Lifeline (**1-800-273-8255**) to meet the demand nationwide for access to urgent and emergent mental health care. **988** elevates early intervention and suicide prevention to the same level that emergency medical services has in addressing life-threatening illness or physical injury.

How 988 works

- It's similar to the National **911** Program for emergency services.
- Calls are routed to a local crisis center based on the caller's location.
- Special routing is available for both veterans and Spanish-speaking individuals.

What you need to know

- The **988** Suicide & Crisis Lifeline is available in three formats:
  - Dialing **988** on any phone, sending a text to **988** or visiting **988lifeline.org** to chat
- If you have referred in the past to the National Suicide Prevention Lifeline or have it listed in resource directories, make sure to update it to the **988** Suicide & Crisis Lifeline as of July 16, 2022, or as soon as possible thereafter.
- The National Suicide Prevention Lifeline temporarily remains in effect to ease the transition; all calls will be routed to **988**.
- **988** aligns with CVS Health's commitment to make mental well-being services more accessible and less complicated.

988 is a major step toward a transformed crisis care system in America. Visit the Substance Abuse and Mental Health Services Administration website, **SAMHSA.gov/Find-Help/988**, for detailed information about the **988** Suicide & Crisis Lifeline.

Correct prior authorization fax number for Michigan members

If you are submitting a prior authorization request, please note that there are separate fax lines for Aetna Better Health of Michigan members and Michigan Medicare-Medicaid Plan members.

For an Aetna Better Health of Michigan member, which includes HealthyMI and MI Medicaid, please submit your request to **1-866-603-5535**.

If you are submitting a prior authorization request for a Michigan Medicare-Medicaid Plan (MMP) member, which includes MI Health Link Medicare and MI Health Link Medicaid, please submit your request to **1-844-241-2495**.

If you have questions, please contact our Prior Authorization department at **1-866-874-2567**.

Pharmacy benefits

Prescription drugs are often an important part of your patients' health care.

Aetna Better Health of Michigan's members have the right to certain prescription drug benefits. Aetna Better Health of Michigan covers prescription drugs and certain over-the-counter drugs when presented with a prescription at a pharmacy.

To find out if a drug is covered, you can check our formulary. A formulary is a list of drugs that Aetna Better Health covers. The formulary is available on our website at **AetnaBetterHealth.com/Michigan**. You can use the prescription drug search tool to find out if a drug is covered. You may also request a printed copy of this formulary by calling Provider Services. If you have any questions about a drug that is not listed, please call the Pharmacy Helpdesk toll-free at **1-866-314-3784 (TTY: 711)**, 24 hours a day, 7 days a week.

If a drug is not listed on the formulary, a pharmacy prior authorization (PA) request form must be completed. You or your staff can complete this form. You must demonstrate why a formulary drug will not work for your patient. Please include any medical records needed for the request.

The pharmacy PA form is available on our website, or you can make a request by telephone at **1-866-314-3784** or via fax at **1-855-799-2551**.

Aetna Better Health of Michigan members must have their prescriptions filled at a network pharmacy.

Pharmacy PA process

Aetna Better Health of Michigan's pharmacy PA process is designed to approve drugs that are medically needed. We require doctors to obtain a PA before prescribing or giving out the following:

- Injectable drugs provided by a pharmacy
- Nonformulary drugs that are not excluded under a state's Medicaid program
- Prescriptions that do not follow our guidelines (like quantity limits, age limits or step therapy)
- Brand-name drugs, when a generic is available

Aetna Better Health of Michigan's medical director decides if a drug is denied or approved by using our guidelines. The medical director may need additional information before making a decision. This information may include the following:

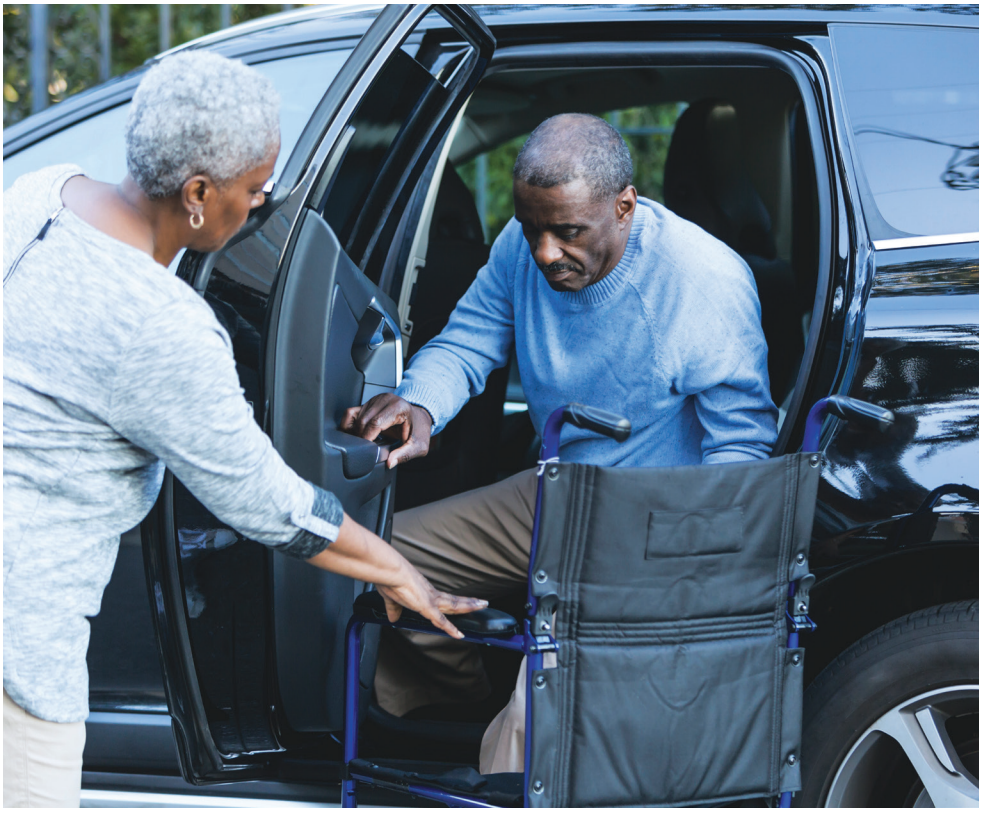
- Drugs on the formulary have been tried and do not work (step therapy).
- No other drugs on the formulary would work as well as the drug requested.
- The request is acceptable by the U.S. Food and Drug Administration (FDA) or is accepted by nationally noted experts.
- For brand-name drug requests, a completed FDA MedWatch form documenting failure or issues with the generic equal is required.

What resources are available to help reach quality goals?

The year 2023 is quickly approaching! Be sure to submit your claims for preventive services to close out your patients' gaps in care before December 31, 2022. 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 its fourth-quarter push soon 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 at **getzm@aetna.com** or by phone at **248-296-4463**, with comments and ideas.



Advance directives

We maintain written policies and procedures related to advance directives that describe the provision of health care when a member is incapacitated. These policies ensure the member's ability to make known their 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.

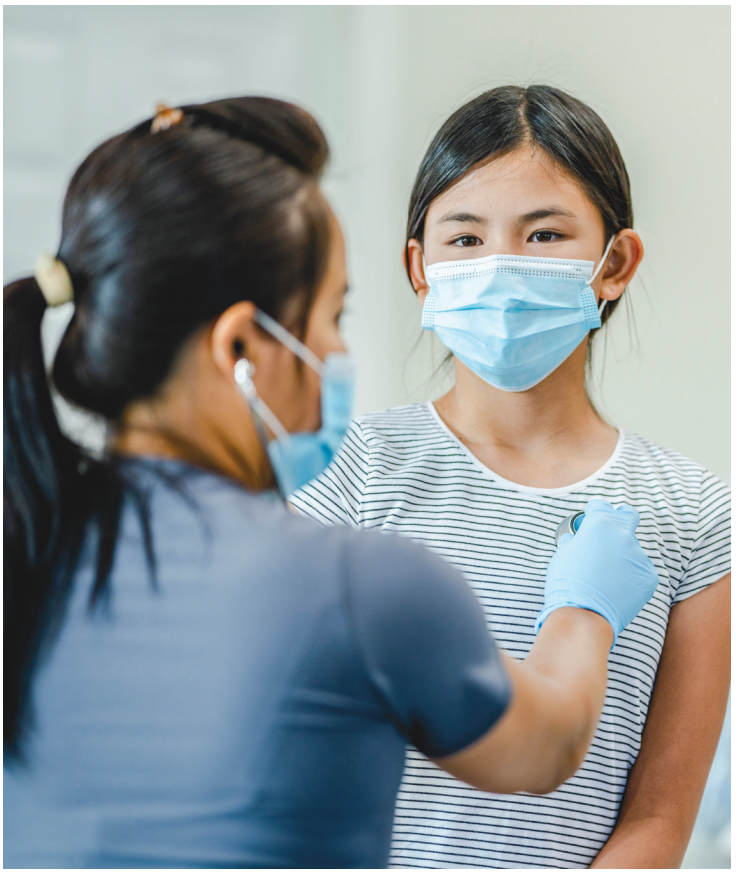
The primary care physician is responsible for documenting in the member's medical record whether or not a member has executed an advance directive and communicating the member's request to accept or refuse treatment to attending staff in hospitals or other facilities. See the provider manual for more information on advance directives.

Continuity and coordination of care

Continuity and coordination of care research indicates that health outcomes are far better when primary care practitioners (PCPs), specialists and behavioral health practitioners work in partnership to meet an individual's health care needs. We expect this collaboration will positively affect the overall health and well-being of our members.

Aetna Better Health has identified that continuity and coordination of care for our members is an area where we have room for improvement. Therefore, we encourage our behavioral health practitioners and specialists to keep PCPs informed about member treatment, including hospitalizations, assessments or recommended treatment plans.

Our members may self-refer or directly access services without referral from their PCP. Therefore, we encourage PCPs to discuss specialty and behavioral care with their patients to help coordinate needed services.



Electronic remittance advice (ERA)

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. In order to qualify for an ERA, a provider must currently submit claims through EDI and receive payment for claims by EFT. Providers must also be able to receive ERAs through an 835 file. For assistance with this process, please contact our CICR at:

- Medicaid: **1-866-316-3784** or **1-866-314-3784**

Cultural competency training

A culturally competent practitioner effectively communicates with patients and understands their individual concerns. It's incumbent on practitioners to make sure patients understand their care regimen. Each segment of our population requires special sensitivities and strategies to embrace cultural differences.

Aetna Better Health offers a variety of training resources for practitioners, including cultural competency and LGBTQ trainings. See the "Cultural Competency" tab of the "For Providers" section on our website for details on these trainings and other resources.

Aetna Better Health of Michigan's staff and its providers must make health care decisions based on the proper care and service rules, including member eligibility. There are no rewards or financial incentives for providers or staff for the denial or reduction of services.

Population Health Management and Integrated Care Management programs

The Aetna Better Health Population Health Management (PHM) strategy is a personalized approach that emphasizes empowering members to achieve health goals by recognizing and elevating the individual's expertise and central role in their own health. Our PHM programs meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals. Members are stratified to high risk, medium or rising risk, or low risk, as indicated by their known risk factors.

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 chronic condition program based on claims data. The chronic conditions managed include diabetes, COPD, asthma, CAD, depression and heart failure. Our goal is to assist our members and their caregivers to better understand their conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Members who do not wish to participate can call Member Services to disenroll from the program.

Members with complex health care needs often need extra help understanding their choices and benefits. They may need support to navigate the community resources and services available. Aetna Better Health of Michigan offers an Integrated Care Management program that includes disease management and complex case management. The goal of complex case management is to help members regain optimal health or improved functional capability in the right setting and in a cost-effective manner.

A variety of programs

Complex case management involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. It is an opt-out program: All eligible members have the right to participate or decline to participate. Aetna Better Health of Michigan offers a variety of programs to its members and does not limit eligibility to one complex condition.

Aetna Better Health of Michigan uses the following sources to identify members for complex case management: claims data, hospital discharge data, pharmacy data, utilization management (UM) data and data supplied by the state. We also use data supplied by our members or their caregivers (such as health appraisals) and data supplied by practitioners (such as electronic health records, if available).

By referral

Aetna Better Health of Michigan accepts referrals to our case/care management program from members, caregivers, the UM department, practitioners, the 24/7 health information line and discharge planners.

MDHHS is partnering with Aetna Better Health in the We Treat Hep C initiative

Hep C treatment no longer requires a prior authorization (PA) if using the state-preferred PDL agent Mavyret®. Hep C treatment is carved out to MDHHS fee-for-service (MagellanRx), and as of April 1, 2021, the system is set up to approve Mavyret® for up to a 12-week supply. Network pharmacies have also been made aware of the changes to the PA status of Mavyret® and should be prepared to dispense accordingly.

Please see the below FAQ for further information for prescribers of Mavyret ® as part of the We Treat Hep C initiative:

Q. Which type of provider may prescribe Mavyret®?

A. All MDHHS-registered prescribers, including nonspecialists, may prescribe Mavyret® as of April 1, 2021.

Q. What has to be submitted with a Mavyret® claim now that no PA is required?

A. The claim will be paid if submitted in accordance with our Pharmacy Claims Processing Manual: **michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_D0_claims_processing_manual.pdf**. Diagnosis codes are not required on these claims.

Q. Will Mavyret® be covered without a PA in the rare case a patient requires 12 weeks of therapy?

A. Yes.

Q. For patients currently taking another direct-acting antiviral (DAA) therapy (Zepatier, Epclusa, etc.), will they be able to complete their course of therapy (i.e., refills)?

A. Yes.

Q. Will there be specific PA criteria listed in the PDL for the nonpreferred DAAs?

A. Nonpreferred DAAs will require a PA explaining why Mavyret® is not clinically appropriate: **MIRx_PAfaxform_General.pdf** (**magellanrx.com**).

Q. Are prisoners covered by Medicaid upon release and therefore able to get Mavyret® without a PA?

A. We are working on a targeted case management benefit that provides support and resources for individuals recently released from a correctional facility, including some degree of in-reach, but this has not yet been implemented.

Q. Can patients fill their Mavyret® prescription at any specialty or retail pharmacy?

A. Yes.

Q. What is the co-pay for Mavyret® under this agreement? What is the co-pay for a nonpreferred DAA?

A. For Medicaid, the co-pay for Mavyret® is $1, and the co-pay for nonpreferred DAAs is $3. There are no co-pays for viral hepatitis treatments under the Healthy Michigan Plan.

Q. Can more than four weeks of therapy be prescribed at a single time (e.g., eight weeks of therapy or, less frequently, 12 weeks of therapy, as opposed to four weeks with refill[s])?

A. Pharmacies are authorized to dispense up to 102 days of therapy at a single time. However, many pharmacies may default to dispensing in four-week increments, unless the script specifies an eight- or 12-week supply.

Q. Is Mavyret® covered for patients on Emergency Services Only (ESO) Medicaid?

A. Yes. Mavyret® is covered for beneficiaries on ESO Medicaid. The pharmacy should indicate level of service 3 (emergency) on the claim.

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 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.

Members' 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**.

Evidence-based guidelines

Aetna Better Health of Michigan uses evidence-based clinical practice guidelines and preventive health guidelines. The guidelines consider the needs of enrollees, opportunities for improvement identified through our Quality Management program, and feedback from participating practitioners and providers. Guidelines are updated as appropriate, but at least every two years.

The clinical practice guidelines and preventive health guidelines are located on our website. Click on "For Providers" and then "Practice Guidelines." You can also obtain the criteria by calling Provider Services at **1-866-314-3784 (option 4)**. Specific criteria will be made available upon request.

Get the updated Medicaid provider manual

Aetna Better Health is pleased to announce the new updated version of the Medicaid provider manual, which has been developed for your use.

Key features:
- Contact information
- Provider responsibilities and important information
- Covered services
- Eligibility and enrollment
- Encounters, billing and claims

The 2022 provider manual is available at **AetnaBetterHealth.com/Michigan**. The provider manual is intended to provide Aetna Better Health contracted providers with guidance in understanding our programs, processes and policies.

Manuals may be revised as Aetna Better Health's policies, programs or regulatory requirements change. All changes and revisions will be updated and posted to the Aetna Better Health website located at **AetnaBetterHealth.com/Michigan**.

Please share this reminder with members

Has your personal information changed?

Any changes in phone number, email or address should be reported to the Michigan Department of Health and Human Services. You can do this by going to the MIBridges website at **Michigan.gov/MIBridges**. If you do not have an account, you will need to create an account by selecting "Register." Once in your account, when reporting changes, please make sure you do so in both the Profile section and the Report Changes area. The Report Changes area is what the local office will use to update the address for your case.

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.