AetnaBetterHealth.com/Michigan

Aetna Better Health® of Michigan

Aetna Better Health's new transportation provider: One Call.

To improve our Medicaid members' transportation services, we have changed our non-emergency medical transportation (NEMT) effective December 1, 2020. This change only applies to the members in our Medicaid plan. Members who are enrolled in our Medicare-Medicaid Plan, Aetna Better Health Premier Plan, still get their NEMT through MTM.

To schedule trips for Medicaid members, call Aetna Better Health Member Services at **1-866-316-3784**. **A minimum of three days (72 hours) advance notice is needed to schedule your trip.**

One Call will provide the same transportation services that members got through the previous vendor, including:

- Rides to and from the doctor
- Rides to and from the pharmacy
- Rides to and from the dentist for Healthy Michigan members and pregnant women
- Rides to and from the Member Advisory Council meetings for members on the council

Mileage Reimbursement is also available by calling One Call to complete the mileage reimbursement form. All mileage reimbursement requests should be submitted within **30 days** of the trip occurrence date.

Members who are enrolled in our Medicare-Medicaid Plan, Aetna Better Health Premier Plan, still get their NEMT through MTM.

Provider Newsletter
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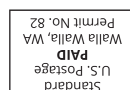

Aetna Better Health® of Michigan
28588 Northwestern Highway
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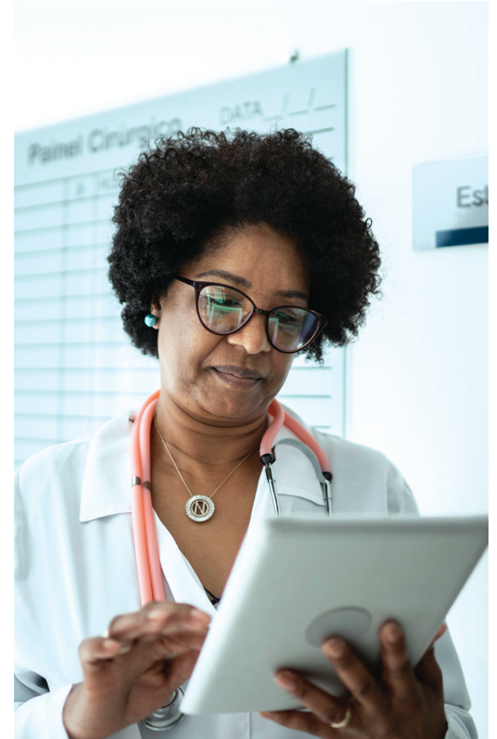
Southfield, MI 48034

Remote patient monitoring: A new way to help your patients.

Did you know Aetna Better Health of Michigan care managers can refer members for remote patient monitoring (RPM)? RPM is a tool that can improve health outcomes for your chronic condition and/or high-risk members. The tool is available for members living with diabetes and/or congestive heart failure, in addition to members experiencing a high-risk pregnancy. Participating patients submit biometric data daily and engage in regular sessions with nurse health coaches. If submitted biometric data is deemed out-of-range, their practitioner is notified by phone and appropriate interventions are implemented. Health plan care managers may be actively involved.

Members who participate receive our in-home remote monitoring technology package, which includes an iPad Mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff and glucometer. All members participating in RPM will be assigned an Aetna Better Health care manager to assist with development of a care plan and to offer education and support to each participant.



Providers, please review all Bulletins and L Letters from MDHHS. Reference Bulletins and L Letters to stay in compliance and up-to-date on COVID-19 communications. Please go to **Michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448---,00.html** for Bulletins and L Letters.

Clinical care considerations for COVID-19 vaccination.

According to the Centers for Disease Control and Prevention (CDC), The Advisory Committee on Immunization Practices (ACIP) has issued interim recommendations for the use of Pfizer-BioNTech, Moderna, and Janssen/Johnson & Johnson COVID-19 vaccines for the prevention of COVID-19 in the United States. You can find these recommendations as well as clinical considerations for managing adverse events on the CDC website: **CDC.gov/vaccines/covid-19/clinical-considerations/index.html**.

Validate your NPPES data.

Ensure that your data is accurate. Help us produce accurate provider directories for Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) suggests using the National Plan and Provider Enumeration System (NPPES) to review, update and attest to your NPPES data. We join with CMS to remind providers to keep their data up-to-date. Accurate provider directories help Medicare beneficiaries identify and locate providers and make health plan choices. Go to **CMS.gov/Files/Document/NPPES-Frequently-Asked-Questions.pdf** for CMS's frequently asked questions on using NPPES data.

Health Equity and Unconscious Bias.

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."
— The Robert Wood Johnson Foundation (RWJF)

Unconscious biases, also known as implicit biases, are the underlying attitudes and stereotypes that people unconsciously attribute to another person or group of people that affect how they understand and engage with a person or group.

The Michigan Department of Health and Human Services (MDHHS) in partnership with the Michigan Public Health Institute (MPHI) is proud to release this two-part, on-demand training, **"Unconscious Bias: One Part of a Bigger Problem."** Each session is one hour. The series discusses unconscious or implicit bias and its relationship to health equity.

Although the Unconscious Bias series may be the first step participants take in their journey toward health equity, it is also an excellent and concise refresher of key concepts and ideals related to health equity. During the series, participants will gain an understanding of health equity and unconscious bias, and their impacts on health outcomes and health disparities. Participants will also learn about root causes of health inequities and levels of oppression.

Part two of the Unconscious Bias series focuses on clinicians and health care professionals. This training will help participants explore unconscious bias and learn to apply practical tools to mitigate the impact of bias in the health care field.

This training is recommended, and can be found at **Michigan .gov/MDHHS** by selecting "Keeping Michigan Healthy," then "Maternal & Infant Health," and then "Health Equity."

Don't let your network status change — complete your FDR attestation today.

If you are a participating provider in our Medicare plans and/or our Medicare Medicaid plans (MMPs), you must meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities. You also have to confirm your compliance with these requirements through an annual attestation.

How to complete your attestation

You'll find the resources you need to ensure your compliance on the "Medicare Compliance FDR Attestation" page at **Aetna.com/health-care -professionals/medicare .html**. Once on the page, under the "Need more information on the Medicare Compliance requirements?" heading, click on "Medicare compliance FDR program guide" or "Office manual." Once you review the information and ensure that you've met the requirements, you're ready to complete your attestation. Simply click the link on the "Medicare Compliance FDR Attestation" page that corresponds to your contracting status. A single annual attestation meets all your Aetna, Coventry and/or MMP compliance obligations.

The Aetna Better Health Plan of Michigan portal is getting an upgrade!

We are pleased to announce the availability of our new and improved solution for verifying member information and submitting claims to Aetna Better Health. Within the next two months, ConnectCenter will replace Emdeon Office, giving you a more reliable, more complete way to submit claims, all at no cost to you.

You will be able to set up a new account in just seconds. Once you have received your new credentials, you may immediately begin checking eligibility. Claim submission will be available to you within one business day of setting up your account.

You will be able to use your ConnectCenter and Emdeon Office accounts at the same time until May 31, 2021. After that date, most of your Emdeon Office account will be deactivated. However, we will provide continued access to old claims by allowing you to log in directly to the Reporting & Analytics feature within Emdeon Office.

In order to ensure that you have as much time as possible to transition to ConnectCenter, we highly recommend that you start using it immediately. Please refer to bulletin 184, located on the ABH-MI website, for detailed information on how to get started.

If you are unable to obtain a new password as described above, please contact customer support for assistance at **1-877-667-1512, option 2**.

Whether you log in to Reporting & Analytics via **Access.Emdeon.com** or access it by choosing "Reporting & Analytics" from the Claims menu in the old portal, the functionality will be the same. You will be able to view details and track the status of claims submitted in Emdeon Office. Rejected claims can be corrected and resubmitted from within Reporting & Analytics. Although all claims in Reporting & Analytics remain accessible for 15 months from the date of claim submission, **you will not be able to get to these claims after May 31 unless you follow the steps above** to create a user account on **Access.Emdeon.com**.

Frequently asked questions

Q. *When will I receive my new password?*

A. Your password will be emailed to you within a few hours of the time that you sign up for ConnectCenter. You will likely receive a **separate** welcome email prior to receiving your new password. If you are eager to get started and don't want to wait for your password to be delivered, you can use the "Forgot Password?" link on the ConnectCenter login page to choose a new password. Do keep in mind, however, that you must wait one business day after your account is created before you may submit claims.

Q. *What is my vendor code?*

A. If you access the ConnectCenter sign-up screen

from the ConnectCenter login page, rather than from the link included above, you will be required to enter a vendor code before you can sign up. The vendor code that you should enter is 214563. For your convenience, this code will be automatically supplied when you access the sign-up process from here, or from the button provided on the Office login page. FYI, the vendor code 214563 will also be referred to in ConnectCenter as your biller code. This identifier indicates that your account is sponsored by Aetna Better Health Plan.

Q. *Why doesn't the "Next" button work when I try to sign up? What do I do when I get the error: "You must select a feature before continuing"?*

A. On the first page of the sign-up screen, please be sure to select the radio buttons next to "$0.00 per Transaction" in each row. Do not select the circles next to "NA," as doing so would prevent you from obtaining access to the corresponding feature.

Q. *How do I associate the providers in my office to my new account?*

A. You should add your providers by logging into ConnectCenter and then choosing "Admin" and then "Provider Management" from the ConnectCenter main menu. For more details, see Getting Started with Provider Management. Note that the first time you access Provider Management to add providers, you should click "search" on the opening page without entering ANY data in any of the fields provided. This tip and additional instructions are available in the Getting Started guide.

Q. *How do I use Provider Management if I am an atypical provider and do not have an NPI?*

A. When creating or editing a provider, atypical providers should change the ID Type field from NPI to API, and then enter the atypical provider identifier into the ID field. In some cases, the atypical ID may be your Tax ID. Whether your atypical provider ID and tax ID are the same or different, you have the option to also enter your Tax ID in a separate Tax ID field. When performing an eligibility inquiry, provider information will use an NPI if you have one, followed by a Tax ID if there is no NPI. Atypical ID will be selected only for provider records that do not contain NPI or Tax ID. When using the provider directory to help create a claim, only NPI is currently retrieved.

Q. *What is a submitter ID or a biller ID?*

A. ConnectCenter assigns an ID called a submitter ID to each provider office or provider organization. This arbitrary six-digit number will be displayed next to the name of your practice at the top of the ConnectCenter window. While you don't need to memorize the number, it will be included on most reports and also in service interactions with our customer support team. The billing ID identifies your account as sponsored by Aetna Better Health Plan and will be shared by your account and all other accounts also sponsored by Aetna Better Health.

Need help?

- Call **1-800-527-8133, option 2**, for questions about:
  - Submitting NEW claims
  - Eligibility
  - Claim status
- Call **1-877-667-1512, option 2**, for questions about:
  - The status of OLD claims
  - Access to Reporting & Analytics

Provider directory data accuracy.

We need your help! In an effort to ensure that we have the right information reflected in our online and paper provider directories, we ask that you provide routine updates of any changes at your practice. Changes that should be reported in writing to your provider relations representative include the following:

- Notice in advance if you are no longer accepting new patients
- Notice in advance if you are limiting the population you service, such as only adult patients
- Notice in advance if you are planning on closing your practice (at least 90 days notification)
- Notice in advance if you are moving to a new location or discontinuing services at a current practice location
- Notice in advance of new providers who will be added to your practice or leaving your practice
- New telephone or fax numbers, as well as email or website changes
- Any changes in office hours

For more information, please contact your provider relations representative or call Provider Relations at **1-866-314-3784**. Press *, state "more options," then state "provider services" to reach a provider services representative. Thank you for helping us improve our provider directory accuracy and member service experience!

Health Risk Assessments.

Aetna Better Health of Michigan is looking for your Health Risk Assessments (HRA). HRAs completed within 150 days of the member's enrollment date are eligible to receive the provider incentive of $50. For each completed and returned HRA, you have the opportunity to earn the incentive for up to one year of the member's enrollment anniversary date. Please fax all completed HRAs to the Healthy Michigan department at **1-866-889-7572**. Submit claims under CPT code 96160. Lab results are not mandatory. However, "Screening not recommended" or "Screening ordered" must be checked for cholesterol, diabetes and flu sections on HRAs prior to April 2020. If you have any questions, please contact the Healthy Michigan hotline at **1-866-782-8507**. Thank you for your ongoing care of our members.

How we make coverage decisions.

When making coverage decisions, Aetna Better Health of Michigan follows health care rules called MCG® Guidelines. Aetna Better Health's Health Services staff uses these rules to determine the type of treatments that will be covered for members. Aetna Better Health staff and its providers make health care decisions based only on proper care and service rules. Members also must have active coverage. There are no rewards to deny or promote care. Financial rewards for our doctors or staff cannot encourage decisions where members will not get the care they need. Call Member Services at **1-866-316-3784** if you have questions about how members' services are approved or to get a copy of the rules used.

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 for 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 at 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.

Need help? Go online to learn about these resources.

AetnaBetterHealth.com/Michigan

Medicaid and MIChild. From the member home page ("For Members"), click on the "Medicaid & MIChild" tab, and then click on the "Member Materials" tab. Then click on the "Member Handbook" link to download a copy of the Member Handbook.

Healthy Michigan. From the member home page (For Members), click on "Healthy Michigan" and then click on the "Member Handbook" tab and then on "Member Handbook" to download a copy of the Member Handbook.

- How to reach us: by phone and after hours
- How to use language assistance and interpreter services
- Benefits and services covered in your plan
- Plan restrictions or exclusions from coverage
- Co-pays and/or other charges you may be responsible for
- Benefit restrictions for services obtained outside the network or service area
- Information on participating practitioners, including contact information, specialty, qualifications and educational background
- How to get primary care services, including points of access
- How to get specialty care, second opinions, behavioral health care and hospital services through either your primary care provider or self-referral
- Direct access to women's preventive health care and family planning services
- How to get care after normal business hours
- How to get emergency care, including when to go to the emergency room or call **911**
- How to get care and coverage outside the service area
- How to file a complaint by phone or in writing
- How to file an appeal
- How new technology is evaluated
- What utilization management (UM) is, how we make decisions, how to contact our UM department and our affirmative statement about incentives
- Our Quality Management program, including goals and outcomes
- Population Health and Care Management programs, including eligibility; the referral process for member, caregiver or doctor; and opting in or out of a program
- Member rights and responsibilities
- Our privacy practices, including collection, use and disclosure of written, oral and electronic protected health information
- Information on advance directives
- Information about pharmacy procedures

Want to know how we are doing?

From the Member Home Page, click on "Quality Matters" and then on "HEDIS® And CAHPS® Performance Results."

For a printed copy of the Member Handbook on our website, call Member Services at **1-866-314-3784 (TTY: 711)**.

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.

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