AETNA BETTER HEALTH® OF MICHIGAN

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Provider Newsletter

Spring 2017

The *Mother Nurture Program* at Advantage Health Centers

At Advantage Health Centers, they know how important it is to get a great start to good health. Advantage Health Center's breastfeeding support for new and expectant moms is fully integrated into Women's Health Services through the *Mother Nurture Program*.

Expectant mothers meet with a peer counselor during their appointments to learn about the benefits of breastfeeding and how to access and utilize support to incorporate breastfeeding into any lifestyle. The *Mother Nurture Program* also includes a free, 6-week breastfeeding class called "Nourish!" which meets at the Thea Bowman Community Health Center.

Additionally, a weekly group for expectant and breastfeeding moms and their families is conducted to ensure success for the mom, baby and entire family. Every participant is also able and encouraged to meet with an International Board Certified Lactation Consultant (IBCLC) during pregnancy and after delivery. This means that all of mom's questions are answered, and concerns addressed.

Breastfeeding education is interactive and involves the whole family. It is also fun and rewarding, as moms can earn "Baby Bucks" as they learn and can use them to access much needed items including diapers, wipes and clothing.

All classes and groups are open to the community and are free of charge. Transportation is also provided at no cost to participants.

Advantage Health also offers the following services:

- On site outpatient breastfeeding support with our IBCLC
- A lactation warm line with IBCLC every Tuesday **313-282-1623**
- Peer counselors available for one-on-one education for those who cannot attend classes
- Breastfeeding education for community organizations

Please be reminded to review Bulletin # MSA 16-46 Coverage of Trauma Services for Children Under 21 Years of Age, issued Dec. 29, 2016. We will send additional explanatory information to help you interpret this bulletin. More information will be coming.

Aetna Better Health® of Michigan
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Detroit, MI 48207

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Member rights and responsibilities

We work with our members to make sure they receive the best care available. They have certain rights and responsibilities. These help them receive the best service.

Members of Aetna Better Health of Michigan have the right to:

- Get information about their health, their primary care provider (PCP), our providers, Aetna Better Health and its services, and members' rights and responsibilities
- Request information on the plan's structure, operations and services
- Be treated with respect and dignity
- Be assured their 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 PCP as their 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 (further information available through Member Services at **1-866-316-3784**)
- Request an emergency PCP transfer if their health or safety is 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 their desires about treatment options
- Be free to exercise their rights without adversely affecting the way Aetna Better Health and its providers or the state treats them
- Be free from any form of restraint or seclusion used as a means of force, discipline, 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

Members of Aetna Better Health of Michigan also have responsibilities.

These responsibilities include:

- Giving information to the plan, its practitioners and providers needed for our staff to take care of the member
- Following the instructions given to the member by doctors
- Understanding their health condition and sharing in the decisions for their health care
- Treating Aetna Better Health staff and doctors with respect and dignity
- Keeping all appointments and calling to cancel them when unable to make them
- Understanding what medicine to take
- Giving us feedback about their health rights and responsibilities
- Letting us know of any changes in member's name, address or telephone number

Quality is a group effort

Where to find evidence-based care guidelines

A group effort helps ensure quality care. Aetna Better Health of Michigan is proud to participate in the Michigan Quality Improvement Consortium (MQIC), a collaborative effort whose participants include physicians and other personnel representing the Michigan medical community.

The group includes representation from nearly all Michigan managed care organizations as well as the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Association of Health Plans, the Michigan Peer Review Organization and practicing physicians. The guidelines are developed based on current medical evidence and information from nationally recognized organizations (e.g., U.S. Preventive Services Task Force and American Cancer Society).

Annually, Aetna Better Health distributes information on how to access the guidelines to providers. Notification occurs through the provider manual, the provider newsletter and our plan's website at **www.aetnabetterhealth.com/michigan**. Additional resources are available on the MQIC website at **www.mqic.org**. Also available on our website are Aetna guidelines, which include behavioral health.

Quality counts

Aetna Better Health of Michigan monitors preventive health measures in adults and children to assist members in maintaining their health. The quality improvement (QI) program uses HEDIS specifications to track and report the care you provide to our members. We also receive feedback from our members annually through our CAHPS survey. The CAHPS survey, among other things, determines member satisfaction with:

- Communication with doctors
- Getting the care they need
- Getting care quickly

We want to work with our doctors to help improve HEDIS scores and member satisfaction rates. We're here to help if you are interested in:

- Getting information about patient-centered medical homes
- Information on HEDIS or proper coding

We share our quality reports with the Michigan Department of Health and Human Services and National Committee for Quality Assurance. Our scores are compared to other health plans statewide and nationally. To get copies of our QI program and end-of-year results or to view any of our quality reports, you can go to our website at **www.aetnabetterhealth.com/michigan** or call Provider Services at **1-855-676-5772**.

Disease Management

Aetna Better Health's (ABH) Disease Management (DM) program is integrated into the case management program. ABH uses the following sources to identify members who qualify for DM programs: claim or encounter data, pharmacy data, health appraisal results, lab results, utilization management (UM) data, health management, wellness or health coaching program data, electronic health records (EHR) data, and member and practitioner referrals.

ABH provides eligible members with the following written information about the DM program:

- Chronic conditions-specific newsletters are sent to eligible members.
- Members become eligible based on their health history and are enrolled in the program.
- How to opt in or opt out.

ABH provides practitioners with written information about the DM program that includes the following:

- The practitioner or member can call and make a program referral.
- We will provide your eligible members with integrated case and disease management, including chronic condition self-management education.

If you want to refer your patient, please call Member Services at **1-866-316-3784**. Information about disease management programs is available on the website for both members and practitioners.

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/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.

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
1333 Gratiot Ave., Suite 400
Detroit, MI 48207

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 **www.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.

We protect our members' health information

Aetna Better Health of Michigan abides by the provisions in the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule and other applicable federal, Medicaid contract or state statutes and accreditation standards regarding confidentiality.

We protect our members' health information with specific procedures, such as:

Administrative
We have policies and procedures that inform us of how to use member health information no matter what form it is in—written, oral or electronic.

Physical
Member health information is locked up and is kept in safe areas. Building entries and computers are protected from unauthorized entry and access.

Technical
Access to member health information is "role-based." We limit unnecessary or inappropriate access to and disclosure of protected health information.

All providers (covered entities) are required to abide by these standards as well as in the management, protection, use and disclosure of Aetna Better Health member personal health information (PHI).

Providers must be prepared to identify themselves via disclosure of their tax identification number when contacting the plan to use or disclose PHI.

If you have questions or concerns about the use or safety of PHI, call Member Services at **1-866-316-3784**.

Pharmacy benefits

Prescription drugs are often an important part of your patient's 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 **www.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 **1-866-316-3784** (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 prior authorization form is available on our website, or you can make a request by telephone at **1-866-316-3784** or via fax at **1-855-799-2551**.

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

Prior authorization 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 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.

An easy-to-use wellness tool for a healthier you

This information has been provided to our members to advise how they can better manage their health care. We wanted to make you aware that these tools are now available to our members.

You want to lead a healthy life. And we can help. MyActiveHealth is an easy way to take charge of your health. So you can feel better—for good. And as a member of your health plan, you'll get MyActiveHealth at no cost to you.

Getting started is easy. And it only takes a few simple steps. First, sign in to the "Member Portal" section of your health plan's website. Once you're signed in, go to "Tasks" and choose "Manage My Health." From this page, you'll be able to access the MyActiveHealth tools and sign up for a new account.

All the resources and support you need to meet your health goals

Once you have an account, you'll get secure access to all MyActiveHealth services. You'll find:

- **Health surveys and records.** Keep track of your medical history. You'll get healthy living suggestions based upon your answers. And this information can be used to improve your overall health.
- **Videos and podcasts.** Learn more about your health and other wellness topics. And get information about the resources offered by your health plan.
- **Healthy lifestyle programs.** Get the help you need to meet your goals. Programs include quitting smoking, healthy eating, managing stress and more.

You can also access MyActiveHealth with your smartphone. Visit **www.myactivehealth.com**.

If you don't have access to a computer, you can call MyActiveHealth at **1-855-231-3716** to request a printed copy of the health survey. They can also provide printed information on health conditions and wellness topics.

Questions? We're here to help. MyActiveHealth is a simple way to lead a healthy life. To learn more, call us at **1-866-316-3784**.

Get instant access to claims details
Tracking a claim is easy. You can call Member Services. Or sign in to your secure member portal. You'll find:
- Stage in process
- Amount approved
- Amount paid
- Member cost
- Date paid

Learn more about your pharmacy benefits
Get details about your pharmacy benefits and services. This information will help you make the best decisions about your care. You can call Member Services. Or sign in to your secure member portal. You'll get access to:
- Finding in-network pharmacies
- Help asking for a drug not covered by your plan
- Ordering a refill for an unexpired mail-order prescription
- Looking up drug interactions, side effects and risks
- Determining financial responsibility for a drug
- Finding out if generic substitutes are available

Health plan details—anytime, anywhere
Our goal is to make it easier for you to use your benefits. And we've built the member portal to be your go-to resource for managing your plan. You can change your doctor or get a new member ID card. You can also find out how and when to get referrals or authorizations for services. And we'll also tell you about their costs. Or to talk to us about your health plan, call Member Services.

24/7 access to a health information line
The Informed Health Line® gives you access to medical information and advice at no cost to you. And it's available 24 hours a day, 7 days a week. Call **1-866-711-6664** to speak to a nurse. Or you can connect with a nurse through the member portal. Informed Health Line services include:
- Toll-free calls to a registered nurse at any time with translation services, if needed
- Asking questions online and receiving a response within 24 hours
- Help and advice for acute and chronic conditions so you can decide if you need to be seen right away
- More information about a medical test or procedure
- Help preparing for a doctor's visit

Find support when you need it most
At Aetna Better Health of Michigan, we offer benefits and programs that help our members get and stay healthy. You can learn more at **www.aetnabetterhealth.com/michigan**. You'll find educational materials and other self-help tools. And for extra support, we can help find a wellness program that's right for you. To get started, sign in to your member portal or call Member Services.

Case management
Because we care

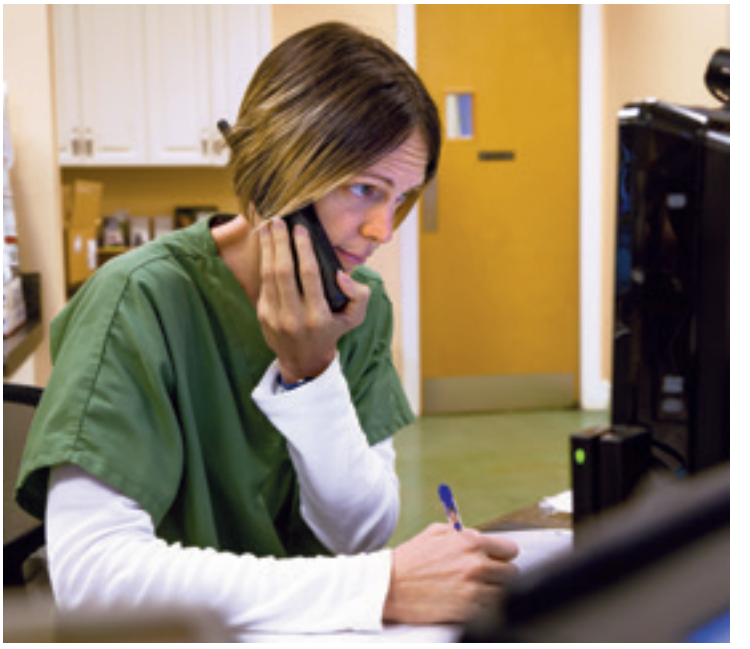
Aetna Better Health of Michigan (ABHM) offers an integrated case management program that includes disease management and complex case management. The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

A variety of programs
It 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. Complex case management is an opt-out program: All eligible members have the right to participate or decline to participate. ABHM offers a variety of programs to its members and does not limit eligibility to one complex condition.

ABHM 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 record, if available).

By referral
ABHM accepts referrals to our case/care management program from members, caregivers, the UM department, practitioners, the 24/7 health information line and discharge planners.

If you want to refer your patient for case/care management, please call Member Services at **1-866-316-3784**.



Medical records review

All participating primary care providers (PCPs), 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

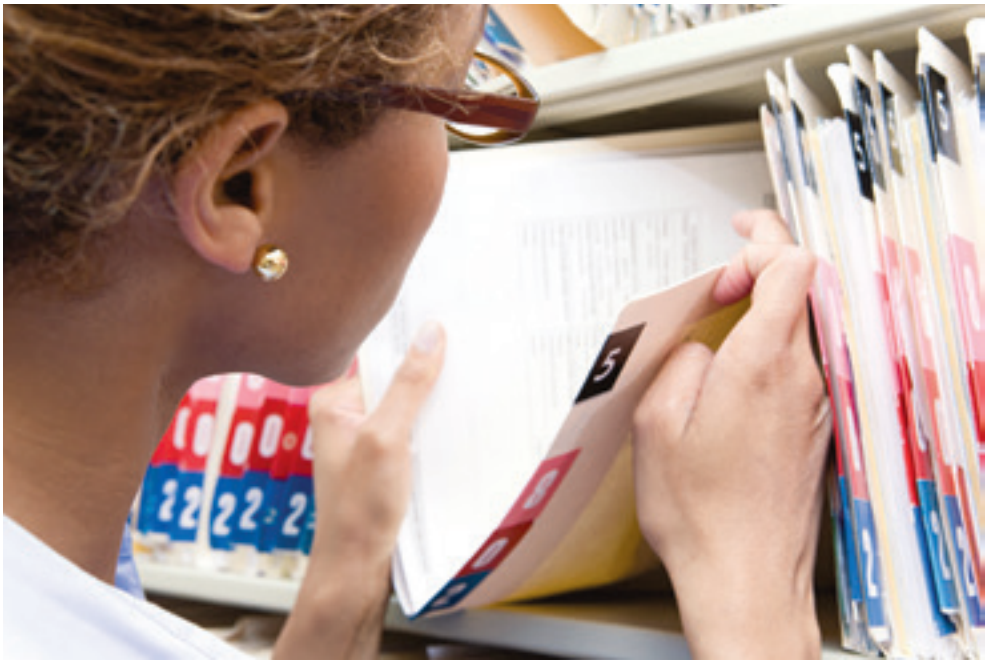
1. Past medical history is completed (for members seen three or more times) and is easily identified. It includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
2. History and Physical (H&P) documents have subjective/objective information for presenting problem.
3. For members 14 years and older, 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. Preventive screenings and services are offered according to preventive services guidelines.
6. Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for those under age 18).
7. Treatment plan is documented. Working diagnoses are consistent with findings. Evidence member is not at inappropriate risk relevant to particular treatment.
8. Blood pressure, weight, BMI percentile and height measured/recorded at least annually, if member accesses care. Lab and other studies are ordered, as appropriate.
9. 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).
10. 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 are 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 handbook, 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 seven years from the end of the contract with Aetna Better Health
- The date the State of Michigan or their designees complete an audit
- 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)

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 **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.
- 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.

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 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 enrollee 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:

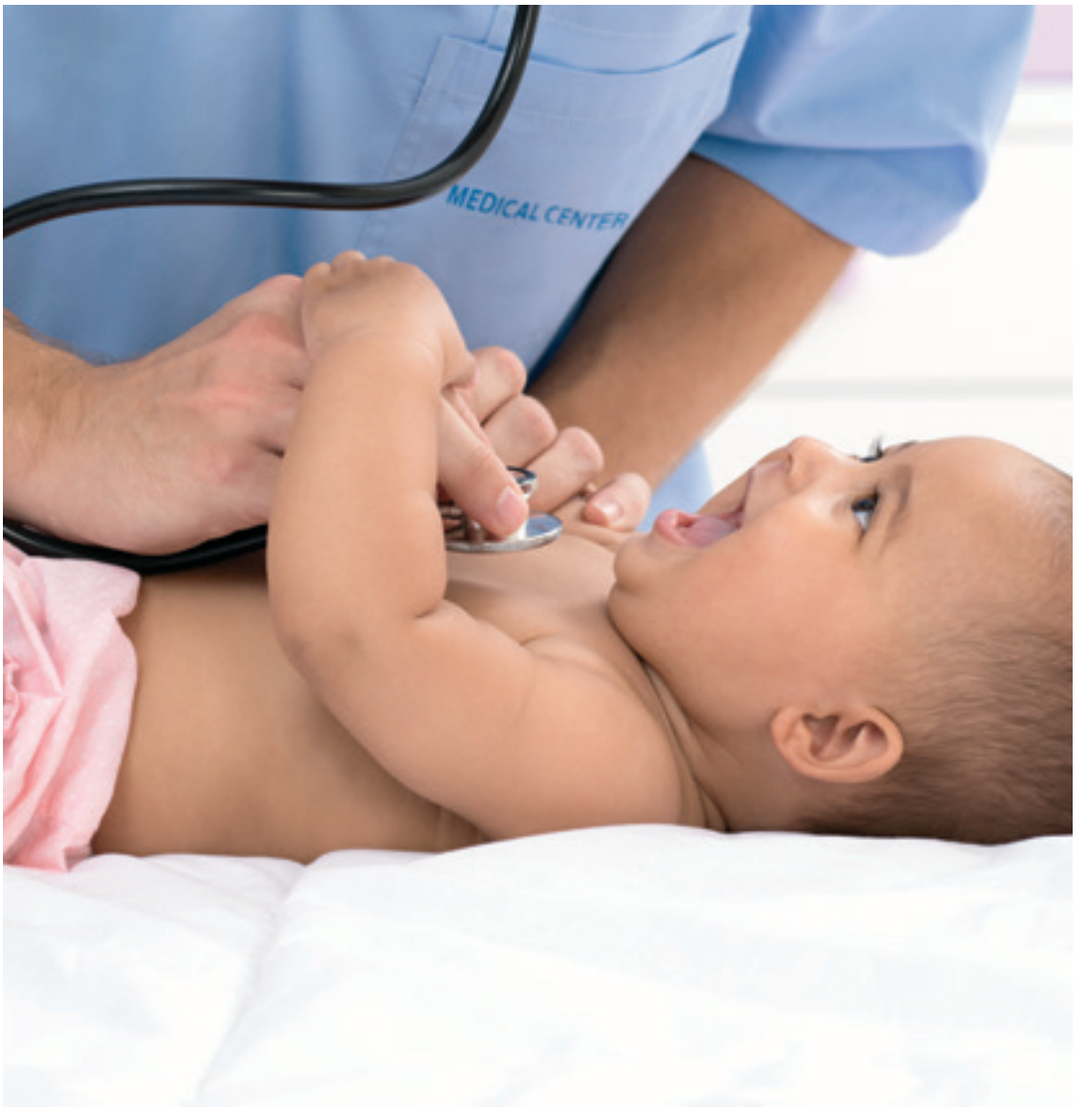
- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Request amendments/correction to records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice 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.

Assuring Better Child Health and Development

Assuring Better Child Health and Development (ABCD) screening is an ongoing initiative to screen for development disorders in young children at ages 9, 18 and 30 months. The American Academy of Pediatrics (AAP) recommends standardized screening tests, including the PEDS, PEDS: DM, Ages and Stages Questionnaire (ASQ), and Ages and Stages Questionnaire Social-Emotional (ASQSE). Aetna Better Health of Michigan reimburses providers who screen for development disorders.

Children identified with developmental delays can be referred to Early On® by phone (**1-800-327-5966**) or via the website at **www.1800earlyon.org**. You can also contact Michigan 2-1-1 for resources in the community for children who may not qualify for Early On. To receive proper reimbursement, use code 96110-developmental screening (screening tool completed by parent or nonphysician staff and reviewed by the physician), or code 96111–developmental/medical evaluation (if objective development testing is performed by the physician as an outpatient office visit). For more information, contact Provider Services.



Early and periodic screening, diagnosis and treatment

Make sure children receive appropriate preventive care. Early and periodic screening, diagnosis and treatment (EPSDT) is the key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services.

Early assessment and identification of problems by periodically checking children's health at age-appropriate intervals is essential. The screening of physical, mental, developmental, dental, hearing and vision concerns can lead to early diagnosis and treatment. When a risk is identified, referral for appropriate testing and follow-up can help correct or reduce health problems.

Medicaid members under the age of 21 are eligible for EPSDT services. Aetna Better Health of Michigan reports performance information annually to the state on EPSDT services.

More information on the periodicity schedule can be found at **https://brightfutures.aap.org**.

Is your Medicare directory information up-to-date?

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare organizations to contact you at least quarterly to confirm that the information in our directory is accurate. This includes:

- Ability to accept new patients
- Street address
- Phone number
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory.

For more information, refer to the fact sheet that you can access at this address: **www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-04-06.html**.

The Council for Affordable Quality Healthcare® (CAQH) helps meet this need

CAQH has a unique solution to ensure that directory information is accurate. They developed it with our help and that of other health plans. CAQH's directory confirmation process uses data from your CAQH ProView™ profile. You simply review, update and confirm your information in ProView. Then, CAQH does the rest. They'll share it with all participating health plans that you authorize to receive it. This eliminates the need for every plan in which you participate to contact you for the same directory information.

CAQH will send you a CAQH provider directory validation invitation by email, which has instructions on how to update your profile. CAQH will call you if you don't reply, so respond promptly.

Attention: Chlamydia

Chlamydia is one of the most commonly reported sexually transmitted infections (STIs). Conducting a sexual history and discussing STI screening is the best way to identify the transmission of chlamydia. Encourage your patients who test positive to repeat chlamydia testing after treatment.

It is also important for the partner to receive treatment. The Expedited Partner Therapy (EPT) program is another approach you can take to ensure that sexual partners are also treated. Please visit **https://www.michigan.gov/documents/mdch/EPT_for_Chlamydia_and_Gonorrhea_-_Guidance_for_Health_Care_Providers_494241_7.pdf** for tools and/or more information about the EPT program.

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.

MI-17-03-02