



Spring 2016

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.

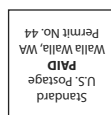
Children identified with developmental delays can be referred to Early On® by phone (**1-800-327-5966**) or via the website at **www.1800earlyon.org**. You can also contact Michigan 2-1-1 for resources in the community for children who may not qualify for Early On. To receive proper reimbursement, use 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>**.



Aetna Better Health® of Michigan
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 Suite 400
 Detroit, MI 48207

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 just 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. Just 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, just call us at **1-866-316-3784**.

Get instant access to claims details

Tracking a claim is easy. You can call Member Services.

Or just 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 just 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, just 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. Just 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, just 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**.



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 (STI). 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.

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