AETNA BETTER HEALTH®
Frequently Asked Questions

Q: Will a member be able to keep their current provider? What will happen if he/she can’t keep his or her own provider?

A: Aetna Better Health is building a network of providers to treat people enrolled in the Integrated Care Program. If a member’s provider is in our network (which means he/she has signed a contract with Aetna Better Health), the member will be able to continue to see his or her provider.

If a member’s provider is not currently in the Aetna Better Health network, the member can let us know. We will contact the provider to see if they would like to join our network.

If a member’s provider does not join Aetna Better Health’s network, the member can continue to see that provider for the first 90 days following the member’s initial enrollment in our health plan. After that time, we will help our member find a provider in our network and will work with them to help coordinate any transition of care needs.

Q: The State claims that this program will save millions of dollars. How can this happen unless your company is going to cut needed care?

A: We believe in being partners with our members. For those who want it, we use a model of care management that empowers our members to decide what their health goals are, and then we work with them, their providers and caregivers to achieve their goals. This benefit comes at no cost to the member. It pays off in increased quality of care, a reduction in duplicate services, and avoidable hospital admissions and readmissions.

By helping our members stay in their homes and/or in community-based settings and out of the hospital or nursing home, the cost of care is decreased dramatically. Meanwhile, quality of care and quality of life increases.

Q: What is integrated care?

A: Integrated care is a way to deliver health care benefits that improves people’s health by assisting them in getting the right care, at the right time, in the right setting. Members will be able to choose a medical home/primary care provider (PCP) who will get to know them and their health history and can help the member get specialty care and other services.

Other features of an integrated care health plan include integrated care teams composed of care managers who can help our members get other services they may need, such as wheelchairs, oxygen, or behavioral health care.
These teams are also dedicated to assisting our members in locating community resources for those services or needs not covered by the Integrated Care Program.

**Q: What is a medical home?**

**A:** A medical home is the place where a member’s primary care provider (PCP) is located. A medical home also includes a support team who works with the member’s PCP to coordinate the services and care needed. The goal is to help our members stay as healthy as possible.

Having a medical home is important because it is the first place a member goes to get the care needed to stay healthy.

Having a medical home means:

- Members will have a personal PCP who gets to know them well.
- A member’s PCP will work with other health care providers, such as specialists and hospitals, to coordinate their care.
- Members will receive better health care because the member’s PCP knows their health care needs.
- A member will gain an understanding of their illnesses and how to care for them.
- Members will understand how to get and take their medicine.
- Members only use the emergency room for health care emergencies.
- The PCP may use other team members to help members get better care.

**Q: Who can be a medical home/primary care provider (PCP)?**

**A:** A medical home/PCP may be one of the following:

- General practitioners
- Internists
- Family practitioner
- Women’s Health Care Providers (WHCPs)
- Federally Qualified Health Centers
- Rural Health Centers
- Nurse practitioners working with doctors

In some cases, a specialist may be a medical home/PCP.

**Q: Will pharmacy benefits be covered?**

**A:** Pharmacy benefits are covered under the Integrated Care Program. Prescription Formulary information will be available at [www.aetnabetterhealth.com/illinois](http://www.aetnabetterhealth.com/illinois) by March 1, 2011.
Q: Will members have to go into a nursing home to receive the care they need?

A: We know that most people prefer to remain at home and in their communities while still receiving the health care they need. We have had great success with assisting our members to either stay in their home or transition from a nursing home setting back into their home. Aetna Better Health has an affiliate managed health care plan in Arizona, part of whose membership is similar to members enrolled in the Integrated Care Program. The Arizona managed care health care plan began with 70 percent of its members living in a skilled nursing home. The program, which is very similar to Aetna Better Health, was able to assist the state in moving more than 40 percent of these members back into the home or community setting of their choice.

We believe that those who wish to remain in a home or community setting should be able to do so. To accomplish this, we will work with our members, their family or caregivers, and their medical home/primary care provider.

Q: What is a care manager and how can they help?

A: An Aetna Better Health care manager is a nurse, a social worker or other health care professional. They will work with our members to coordinate their care and help them get covered services and other special services they may need.

For example, if a member has a disability, care managers can help provide the member access to the equipment he or she may need, such as a wheelchair, walker or oxygen tank. Care managers can also help by coordinating special services, such as meal deliveries or home attendant care.

Q: How do members give input about the program?

A: There are many ways for us to receive input from members about the program.

These include participating in:

- Member Advisory Council
- Focus groups
- Member satisfaction survey

Or by emailing aetnabetterhealthillinois.com.

Applications for the Member Advisory Council will be available on our website: www.aetnabetterhealth.com/illinois.

Q: Does this cost the member anything?
A: When members are enrolled in the Integrated Care Program they have already met the eligibility requirements. When seeking authorized, covered services there will be no copayments or extra cost to the member.

Q: How will members transition into the new managed care health plan?

A: Members will get to choose which managed care plan they want to join. The Illinois Client Enrollment Broker (ICEB) will send materials to help members make this choice. Members can call, mail or complete the enrollment form online to tell the enrollment broker which managed care plan they have picked. ICEB will then sign the member up for their new health plan. If the member has a primary care provider (PCP) that they want to use, the member can tell ICEB when they call.

Members must choose their health plan within sixty (60) days or the enrollment broker will assign members to a managed care plan.

Whether the members pick their health plan, or the enrollment broker picks one for them, members can change their health plan within the first ninety (90) days of enrollment. Members can call ICEB at 1-877-912-8880 (TTY 1-866-565-8576) to make this change.

Q: What if a member already has services set up during this time of change?

A: Aetna Better Health is committed to providing continuity of care for new members who are currently under treatment for acute and chronic health conditions. Our goal is to make sure that our transition process is efficient, timely and seamless with no disruption in care for these new members.

During the initial transition period, we will make maximum effort to maintain the members with their current medical home/primary care provider (PCP) and continue courses of treatment with their specialty providers. Our protocols support a collaborative relationship with non-participating providers for prior authorization of the existing course of treatment and attempt to have the provider join our network. We will honor all previous service prior authorizations for up to ninety (90) days following initial enrollment.