AETNA BETTER HEALTH® OF TEXAS
Provider newsletter

Summer 2015

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TX-15-07-14

Quality Improvement

Aetna Better Health of Texas has an ongoing Quality Assessment and Performance (QAPI) Program that is comprehensive in scope, including both the quality of clinical care and service for all aspects of our health care delivery system. It is tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status. We comply with all state and federal requirements for Quality Improvement (QI). The QAPI Program is overseen by the governing board and committees whose membership broadly represents the 77 networks of participating providers and members. There is a designated senior executive who is responsible for program implementation. Additionally, the Aetna Better Health Medical Director has substantial involvement in QI activities. The QAPI Program is directed by a multidisciplinary committee whose members bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program. The QI Committee and other QI sub-committees include input from members, clinical practitioners and others who are involved in the provision of care and service to Aetna Better Health Medicaid and CHIP members.

All aspects of member care and satisfaction are important to us. The monitoring and evaluation of clinical care encompass all components of the delivery system and the full range of services. The delivery system includes both individual practitioners and institutional providers. The monitoring and evaluation of services includes availability, accessibility, and acceptability services delivered in the appropriate manner.

A variety of techniques are used to gather suggestions from members in order to identify and meet their needs. These may include, but are not limited to:

- Satisfaction surveys
- Focus groups

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- Member advisory councils
- Member representation on QI Committees and selected QI work teams
- Member suggestion forms

We annually assess the demographics and health risks of the enrolled population and choose meaningful clinical issues that reflect the health needs of significant groups within that population. High risk, high volume, problem prone diagnoses, preventive health and acute and chronic conditions are monitored and evaluated.

Continuity and coordination of care is evaluated across health care settings and practitioners. Methods may include medical record review for presence of advance directives, discharge plans and signing of abnormal test results; evaluation of the referral process, case management interventions and systems for tracking and notifying practitioners of abnormal lab/radiology results.

Mechanisms are also in place to identify patterns of under- and over-utilization. Methods may include physician profiles, review of practitioner performance against practice guidelines, trending of complaint data, sentinel events and adverse outcomes and number of member encounters per primary care provider.

Access and availability of care are monitored through appointment availability for preventive care, routine primary care and urgent care, 24 hour access, number and geographic distribution of primary care providers and high volume specialists and telephone service standards. For more detailed access requirements, please see the primary care provider responsibilities section of this manual.

Medicaid and CHIP Provider participation in Aetna Better Health and HHSC sponsored training programs, as well as the aforementioned issues are carefully scrutinized. We work in conjunction with its physician and facility partners to maintain a program of the highest quality. All Aetna Better Health Medicaid and CHIP network providers are required to comply with our QAPI program requirements.

We strive to keep all network providers informed about the QI plan and the quality activities performed. We monitor the quality of care across all services and all treatment modalities, according to the written quality assessment and performance improvement plan. Information about the QI Program is available upon request.

If you have any questions please contact the Quality Director at **214-200-8214**.

Member Rights and Responsibilities

Just a reminder, Aetna Better Health plan member Rights and Responsibilities can be found in the Provider Manual. The Provider Manual is located at **www.aetnabetterhealth.com/texas/providers/manual**. Member Rights and Responsibilities are distributed to new members upon enrollment and annual in the member newsletter.

Billing Medicaid Members

Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment, such as co-pay, from members for Medicaid covered services. Providers may not bill, or take recourse against members for missing appointments or denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program.

We can help if you have a member who is constantly missing appointments. Please call Aetna Better Health at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) and we will contact the member to review her/his rights and responsibilities including missing appointments. For more information, please refer to Texas Medicaid Provider Procedures Manual (TMPPM) found at **www.tmhp.com**.

Integrated Care Management

Did you know we have care mangers that can help?
Integrated Care Management Program is a benefit for all Medicaid, CHIP, and CHIP Perinate members. Our Care Management department consists of non-clinical and clinical employees who are trained in motivational interviewing. We use a biopsychosocial model to identify vulnerable members. Staff can assist you with locating resources in the member's area for education, food, housing, financial help, and support groups. Our care managers would like to collaborate with you to help members improve their health and sustain the improvement over time. We offer intensive care management services built upon a collaborative relationship with a single clinical care manager and their caregivers. This relationship continues throughout the care management engagement. We also offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support. A care manager can assist you in locating in network specialists to meet member needs as well as arrange transportation to get them to appointments. To request care management services please call our member services department and ask to talk to a care manager.

You can refer your Aetna Better Health patients for care management service by calling member service at: **1-800-306-8612** (Tarrant Medicaid), **1-800-248-7767** (Bexar Medicaid), **1-800-245-5380** (Tarrant CHIP), **1-866-818-0959** (Bexar CHIP).

There are multiple ways we consider members for care management services. Information sources include but are not limited to:

- Enrollment data from the state
- Predictive modeling tools
- Claim/encounter information including pharmacy data if available
- Data collection through the utilizations management processes
- Hospital or facility admissions and discharges
- Health risk appraisal tools.

We may also use referrals from our health information or special needs line, members, caregivers, providers or practitioners to identify members appropriate for care management and stratification level for care managed members.

Utilization Management

The Utilization Management department is responsible to monitor the use of designated services before the services are delivered in order to confirm that they are:

- Provided at an appropriate level of care and place of service
- Included in the defined benefits, and are appropriate, timely, and cost-effective
- Accurately documented in order to facilitate accurate and timely reimbursement

The department consists of clinical and non-clinical staff members in the concurrent review, prior authorization and retrospective review departments.

Aetna Better Health's Utilization Management staff has expertise in physical, behavioral health care services. Staff receives training to combine clinical skills with service techniques to support the Aetna Better Health's utilization management processes. Aetna Better Health staff receives initial and ongoing training on a regular basis, but no less than annually.

The Utilization Management department has a toll-free voicemail phone line available 24 hours a day, 7 days a week. The Utilization Management department conducts outgoing communications with practitioners and providers regarding authorizations during the hours of 8 AM and 5 PM CST. This telephone help line will have staff to respond to practitioner and provider questions about authorization. This voice mail can be access by calling member services at: **1-800-306-8612** (Tarrant Medicaid), **1-800-248-7767** (Bexar Medicaid), **1-800-245-5380** (Tarrant CHIP), **1-866-818-0959** (Bexar CHIP).

Member Services can also provide callers with TDD/TTY and language assistance services for providers and members who need them.

Aetna Better Health requires Utilization Management staff to identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues. And upon request, verbally facility personnel; the attending physician and other ordering practitioners/providers of specific utilization management requirements and procedures.

Important fax numbers for you to know!
Prior authorizations: fax requests to **1-866-835-9589**
Concurrent review: fax requests to **1-866-706-0529**

The Aetna Better Health of Texas Utilization Management department makes decisions based on appropriateness of care and services. A physician reviews all cases in which the care does not appear to meet guidelines. Decisions regarding coverage are based on the appropriateness of care and service and existence of coverage. The decisions are in no way influenced by financial or incentives of any kind. When a service authorization request or authorization of service amount is questioned regarding duration or scope, the health care provider will be given the opportunity to have a peer-to-peer discussion regarding the patient's treatment plan prior to the issuance of a determination. Reasonable attempts at consultation between the Medical Director and the treating physician will be made prior to an adverse determination. If a request for coverage is denied, the member (or a physician acting on behalf of the member) may appeal this decision through the complaint and appeal process. For more information regarding the prior authorization process, please refer to the Provider Manual. Please call member service for status updates on service authorizations at **1-800-306-8612** (Tarrant Medicaid), **1-800-248-7767** (Bexar Medicaid), **1-800-245-5380** (Tarrant CHIP), **1-866-818-0959** (Bexar CHIP).

Pharmacy Formulary Terminology

Generic Substitution

Aetna Better Health Plan of Texas covers both brand and generic drugs. Generic drugs usually cost less and are approved by the Food and Drug Administration (FDA). Generic drugs are listed in lower-case (e.g., amoxicillin). Brand name drugs are capitalized (e.g., AMOXIL) on the Texas Medicaid Formulary/Preferred Drug List (PDL). The PDL is located at **www.txvendordrug.com/pdl/**. In some cases preferred drugs may be brand name drugs, even though a non-preferred generic may be available. . In this case a trial and failure of a PDL brand name drug is required before a Non-Preferred Drug (NPD) drug is covered. Preferred brand name drugs are not MAC'd on the Texas Medicaid formulary and do not require a "Brand Necessary" or Brand Medically Necessary" override.

For all other generic equivalent generic drugs that do not have a preferred brand, Texas State Board of Pharmacy regulations on generic substitution apply.

A pharmacist may dispense a generically equivalent drug product if:

- The generic product costs the patient less than the prescribed drug product
- The patient does not refuse the substitution
- The practitioner does not certify on the prescription form that a specific prescribed brand is medically necessary

In the event of multiple prescription orders appearing on one prescription form, the practitioner shall clearly identify to which prescription(s) the dispensing directive(s) apply. If the practitioner does not clearly indicate to which prescription(s) the dispensing directive(s) apply, the pharmacist may substitute on all prescriptions on the form.

When a prescription is issued for a brand name product that has no generic equivalent product, the pharmacist must dispense the brand name product. If a generic equivalent product becomes available, a pharmacist may substitute the generically equivalent product unless the practitioner has specified on the initial prescription that the brand name product is medically necessary.

If the practitioner has prohibited substitution through a dispensing directive in compliance, a pharmacist shall not substitute a generically equivalent drug product unless the pharmacist obtains verbal or written authorization from the practitioner, notes such authorization on the original prescription drug order, and notifies the patient.

The dispensing directive, "Brand Medically Necessary" or "Brand Necessary", must be in the prescribers own handwriting. It may not be preprinted, rubber stamped, or otherwise reproduced on the prescription form.

Narrow Therapeutic Index Drugs

The Board of Pharmacy and the Texas Medical Board shall hold a joint committee to recommend to the board a list of narrow therapeutic index drugs and the rules. The

Drug Generic Substitution Law Summary

Type of Law	States and Territories
Orange Book	*Generic substitution requires use of Orange Book:* AZ, AR, DE, DC, HI, ID, IL IN, KS, KY, LA ME, MD, MA MS, NE NV, NH, NJ, NM, NY, OH, PA SD, TN, TX, UT, VA WV, WI, WY *No reference to Orange Book in generic-substition laws:* AL AK, CA CO, CT, FL, GA MI, MN, MO, MT, NC ND, OK, OR, RI, SC, VT, WA
Mandatory/permissive substitution: States generally either permit or mandate that the pharmacist substitute a generic version of a prescribed drug if all prescription requirements are met	*Mandatory:* FL, KY, MA MN, MS, NJ, NY, PA, PR, RI, WA, WV *Permissive:* AL AK, AZ, AR, CA CO, CT, DE, DC, GA GU, HI, ID, IL IN, IA KS, LA, ME, MD, MI, MO, MT, NE, NV, NH, NM, NC, ND, OH OR, SC, SO, TN, TX, UT, VT, VA, WL, WY
State drug formulary: Some states provide a positive (drugs are equivalent and interchangeable) or a negative (drugs are not equivalent and not interchangeable) formulary to guide appropriate substitution.	*Positive:* DE, DC FL HI, IL, MA, NE, NV, NH, NJ, NY, TN, UT, VA, WI *Negative:* AR, KY, MN, MO, NC
Patient consent/notification requirement: Most states require patient consent for, or notification of, substitution.	*Required:* AK, AZ, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA KS, KY, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NY, ND, OH, PA PR, SC, SD, TX, UT, VT, VA WV, WI, WY. *Not required:* AL AR, GU, LA MA, NJ, NM, NC, OR, RI, TN, WA
Cost savings requirement: Most states require that the drug dispensed be less or no more expensive than the drug prescribed and that some of the cost savings be passed on to the purchaser.	*Less or no more expensive;* AK, AR, CA DC, GA GU, HI, ID, IL KS, KY, ME, MD, MA, MS, MO, NV, NH, NJ, NY, NC, ND, OH, OR, PA PR, RI, TN, TX, VT, VA WI, WY. *Savings passed on:* CO, CT, DE FL IN, IA, ME, MD, MI, MN, MT, NE, NM, RI, TN, WA, WV. Requirement not mentioned: AL, AZ, LA ME PR, SC, SD, UT
NTI drugs recognized as special category	*Recognizes NTI:* KY, NC, PA, SC, TN
NTI: narrow therapeutic index	

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Pharmacy Formulary Terminology *Contined from page 5*

board, on the recommendation of the joint committee, has determined that no drugs shall be included on a list of narrow therapeutic index drugs.

A pharmacist shall use a reputable source for determining generic equivalency.

Approved drug products with therapeutic equivalence evaluations and current supplements (Orange Book) published by the Federal Food and Drug Administration, within the limitations stipulated in that publication. For drugs listed in the publications, pharmacists may only substitute products that are rated therapeutically equivalent in the Approved Drug Products with Therapeutic Equivalence Evaluations and current supplements. There are limitations to the Orange Book as pre-1938 drugs and DESI drugs are not included.

Step Therapy
Step Therapy is one of the two forms of (PAs) applied to the Texas Vendor Drug Program (VDP) formulary. The other type of PAs are Clinical Edit PAs.

Step Therapy is a type of automated PA whereby one or more prerequisite medications, which may or may not be in the same drug class, must be tried first before a Step Therapy medication will be approved. All Non-Preferred Drugs (NPD) require Step Therapy. You can go to **www.txvendordrug.com/formulary/formulary-search.asp** to search for Preferred and Non-Preferred Drugs on the Texas VDP Formulary.

To obtain a prior approval for an NPD drug one of the following criteria must be met:

- Treatment failure with preferred drugs within any subclass
- Contraindication to preferred drugs
- Allergic reaction to preferred drugs

Prescription Benefits

Aetna Better Health covers prescription medications. Our members can get their prescriptions at no cost (Medicaid) or with copays (CHIP) when:

- They get their prescriptions filled at a network pharmacy
- Their prescriptions are on the formulary or preferred drug list (PDL).

Note: PDL applies only to Medicaid members.

It is important that you as the provider know about other prescriptions your patient is already taking. Also, ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of the drug.

Medicaid Preferred Drug List (PDL)
Texas Medicaid maintains a Preferred Drug List comprised of various therapeutic classes. You can find out if a medication is on the preferred drug list. Many preferred drugs are available without PA. Check the list of covered drugs at **www.txvendordrug.com**.

The Texas Medicaid Preferred Drug List is now available on the Epocrates drug information system **(online.epocrates.com/home)**. The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm, Pocket PC handheld device, or smartphone.

Formulary Drug List
The Texas Drug Code Formulary at **www.txvendordrug.com** covers more than 32,000 line items of drugs including single source and multi-source (generic) products. You can check to see if a medication is on the state's formulary list. Remember before prescribing these medications to your patient that it may require prior authorization. If you want to request a drug to be added to the formulary, please contact an Aetna Provider Relations representative for assistance.

Over-the-Counter Drugs
Aetna Better Health also covers certain over-the-counter drugs if they are on the list. Like other drugs, over-the-counter drugs must have a prescription written by the member's physician. Check the list of covered drugs at **www.txvendordrug.com**. All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Mail Order Form for Aetna Better Health Members
While mail order is an option, the use of pharmacy mail order delivery is not required. You can assist your member in completing the Mail Order Delivery (MOD) form at **www.aetnabetterhealth.com/texas** if you are prescribing a maintenance medication. Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. Signatures on prescriptions must be legible in order for the prescription to be dispensed. For the most current and up-to-date version of the PDL, go to the website at **www.txvendordrug.com.**

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Prescription Benefits *Contined from page 6*

Procedure for Obtaining Pharmacy Prior Authorization

Prescriptions written for non-PDL drugs will be available with prior authorization. This will involve the prescriber or one of his/her designated agents calling the prior authorization line at **1-855-656-0363** or via fax at **1-866-255-7534** to obtain approval before the drug can be dispensed. For fax requests, please use the appropriate authorization form designed specifically for pharmacy requests available on the website at **www.aetnabetterhealth.com/texas**. Incomplete forms will result in a denial.

Please also include any supporting medical records that will assist with the review of the prior authorization request. Allow 24 hours to complete a request. In certain circumstances, upon demonstration of medical necessity, members may obtain approval to receive medication not on the PDL through the pharmacy prior authorization process.

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and PA is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- '8' in "Prior Authorization Type Code' (field 461-EU)
- '801' in "Prior Authorization Number Submitted" (Field 462-EV)
- '3' in "Days Supply" in the claim segment of the billing transaction (Field 405-D5)

The quantity submitted in "Quantity dispensed" (Field 442-E7) should not exceed the quantity necessary for a three day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three day supply, e.g., an inhaler, unbreakable package, the pharmacy may still indicate an emergency prescription and enter the full quantity dispensed.

Call the Pharmacy Help Desk **1-877-874-3317** for more information about the 72-hour emergency prescription supply policy.

Excluded Drugs

There are some prescriptions that are not covered by Aetna Better Health. These include:

- Erectile Dysfunction drugs
- Drug Efficacy Study Implementation (DESI) Drugs
- Diet pills/anorexics drugs
- Contraceptives not covered for CHIP unless medical necessity

For the most current and up-to-date information on the excluded prescriptions, go to the website at **www.txvendordrug.com**.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Aetna Better Health reimburses for covered Durable Medical Equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), Aetna Better Health also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must become an enrolled provider with Aetna Better Health and submit claims as follows.

If you are interested in enrolling in our network, please call our Provider Relations department at **1-800-306-8612** or download and complete prospective provider form located on our website at **www.aetnabetterhealth.com/texas**.

For claims submission:

Electronic Claims:
Emdeon - Use Payer ID 38692

If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054. If using this payer ID, we recommend that you use "MC" prior to the member number to make sure the claims are processed correctly.

If your electronic billing vendor can convert to 38692, but doesn't submit directly to Emdeon, we recommend that

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Prescription Benefits *Contined from page 7*

you use "MC" prior to the member number to make sure the claims are processed correctly.

Paper Claims:
Aetna Medicaid and CHIP Services
Attention: Claims Department
P.O. Box 60938
Phoenix, AZ 85026

Call us at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

Practice Guidelines

Clinical Practice Guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and expert consensus information from nationally recognized sources and organizations such as the National Institute of Health, the American Academy of Pediatrics, the Center for Disease Control and Prevention, the National Heart, Lung and Blood Institute, the American College of Obstetrics and Gynecology, national disease associations and peer-reviewed, published literature.

Practice guidelines are developed nationally and adopted locally through Provider Advisory Committees that include practicing physicians who participate in the plan. This group also suggests topics for guideline development, based on relevance to enrolled membership, with selection of high volume, high risk, problem prone conditions as the first priority.

The Aetna Better Health Medicaid and CHIP programs have adopted the following guidelines, which can be located at **www.aetnabetterhealth.com/texas/providers/manual/clinical-guidelines**.

- ADD/ADHD: American Academy of Pediatrics ADHD: Clinical Practice Guideline for the Diagnosis,
- Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. **http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654**
- Addiction: American Society of Addiction Medicine Behavioral Health Checklist for ASAM Adult Patient Placement Criteria-Second Edition Revised. **www.asam.org/**
- Alcoholism: National Institute on Alcohol Abuse and Alcoholism (NIAAA), Helping Patients Who Drink Too Much, A Clinician's Guide, 2005 Edition. **https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines**
- The: National Heart Lung and Blood Institute. Guidelines for the Diagnosis and Management of Asthma **www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/**
- Coronary Artery Disease: American Heart Association/American College of Cardiology Foundation Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease. **http://circ.ahajournals.org/content/124/22/2458**
- Diabetes: 2014 American Diabetes Association (ADA) Standards of Medical Care for Patients with Diabetes Mellitus. You can find the full text of this guideline online at **care.diabetesjournals.org/content/37/Supplement_1**
- Major Depressive Disorder: American Psychiatric Association's Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition. **psychiatryonline.org/guidelines.aspx**

The intent of the guidelines is to promote a consistent application of evidence-based treatment methodologies to reduce unnecessary practice variation. We also use the guidelines to measure the impact of the health management programs on outcomes. The guidelines are provided for informational purposes and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of physicians or health care professionals, and these guidelines do not dictate or control the clinical judgment of the health care professionals caring for a member.

Preventive Services Guidelines
It is widely known that providing primary prevention services, such as adult and childhood immunizations, can result in the reduction of the incidence of illness, disease and accidents. Secondary prevention services, such as early detection of potentially serious illnesses, may reduce the impact of the illness on the patient, thereby decreasing the cost of care. Each primary care office visit should be viewed as the only opportunity for a comprehensive assessment of the member's health status. The preventive service guidelines can be found at **www.aetnabetterhealth.com/texas/providers/info/preventive-guidelines**.

NCQA: Helping you get quality care

Our plan is committed to providing you with the highest-quality health care available. And the NCQA seal reflects that commitment.

NCQA stands for National Committee for Quality Assurance, a nonprofit organization that evaluates health care plans.

This seal signifies that we have passed a stringent, voluntary, comprehensive review by the most rigorous and highly regarded accreditation program in the health care industry.

How we're measured

During the accreditation process, a team of doctors and other experts carries out detailed surveys of our program, reviewing it against more than 60 standards, which fall into five broad categories:

- Access and service.
- Provider qualifications.
- Keeping members healthy.
- Helping members who are ill get better.
- Helping members manage chronic diseases.

Our participation in this review helps us improve care, better manage diseases, enhance services and reduce costs.

Comparing apples to apples: HEDIS

NCQA accreditation is based in part on the Healthcare Effectiveness Data and Information Set (HEDIS).

HEDIS measures a plan's performance on a broad range of specific health issues, such as comprehensive diabetes care or controlling high blood pressure.

A group representing employers, consumers, health plans and others decides which measures are included. More than 90 percent of America's health plans use HEDIS measures--helping you to compare health plans and choose the best one for you.

The NCQA seal signifies that we have passed a stringent, voluntary, comprehensive review by the most highly regarded accreditation program in the health care industry.

How we rank

Based on their compliance with NCQA requirements, organizations can earn the following accreditations, ranked from highest to lowest: Excellent, Commendable, Accredited and Provisional. Programs that do not meet NCQA requirements are considered Denied.

Our Excellent accreditation from the NCQA is a testament to how seriously we take health.

To learn more about NCQA accreditation go to the NCQA Health Care Quality Report Cards website at **reportcard.ncqa.org**.

Small steps can help kids avoid type 2 diabetes

Once upon a time, it was mostly adults who got type 2 diabetes. But times have changed. Now some kids and teens are getting it. That's because millions of kids are either overweight or obese. And that extra weight puts them at risk for type 2 diabetes. So does not getting enough exercise.

But there are a lot of things kids can do to avoid getting diabetes. For example, they can:

- Hop off the couch and hop onto a skateboard, bike or soccer field. Getting at least 60 minutes of exercise a day can help kids stay at a healthy weight.
- Carry a bottle of water and limit sugar-sweetened sodas.
- Snack on baked chips instead of french fries.

Parents can help too. Here's how:

- Shorten TV time and head outside for a brisk family walk.
- Keep healthy snacks on hand. Set a bowl of grapes or plain popcorn on the kitchen counter.
- Try some friendly competition. Have each family member count the steps he or she takes each week with a step counter. Then see whose total is tops.

Sources: American Diabetes Association; National Diabetes Education Program

Health tip: Sports drinks and coffee drinks are high in sugar. Vegetable juices and water are healthier choices.

Call to action: Get more ideas for active family fun at www.letsmove.gov/active-families.

Is it allergies, or just a cold?

As a parent, you know this is true: Colds are common. Kids get them all the time. But when a cold seems to linger on, it may actually be allergies.

Allergies and colds share many symptoms. But they are not the same. Colds are caused by viruses (germs). Allergies are when the body overreacts to harmless things.

BB: How to tell them apart

Many kids with allergies have problems about the same time each year, such as spring or fall. These are called seasonal allergies. One example is hay fever, a reaction to plant pollens in the air.

A child with seasonal allergies might have regular bouts of cold-like symptoms that last longer than a week or two and include:

- A runny or stuffy nose
- Sneezing
- Itchy, watery eyes
- Itchy or tingling feelings in the mouth or throat--which are not common with a cold
- Frequent throat clearing
- Nose rubbing and sniffling and snorting

Allergies can run in families. So if you have allergies, it's more likely your child will have them too.

If you think your child has allergies, tell your provider.

You can buy allergy medicines at the drugstore. But it's a good idea to ask the doctor what's best for your child.

Sources: American Academy of Pediatrics; U.S. Food and Drug Administration

Health tip: Allergy troubles can often be avoided if you know the cause. Did the doctor say pollen is the problem? You may want to give your child fun things to do indoors when pollen counts are high.

aetna®

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TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

CHIP We've got your kids covered.