AETNA BETTER HEALTH® OF TEXAS
Provider newsletter

Summer 2016

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What you can do to help improve the Behavioral Healthcare Experiences of Medicaid and CHIP members

April through June of 2015, Aetna Better Health of Texas conducted a Behavioral Health (BH) survey. We sent the survey to 1,254 members with a response rate of 22.3 %. Out of the 1,254 surveys, 599 went to members, or parents and guardians of members, age 14 and over. The balance, 657 went to the parents or guardians of children under the age of 13. We asked about their experiences with BH (mental illness and/or substance abuse) services via Aetna Better Health in the last 12 months.

The survey results revealed 90% or more of our members reported positive experiences of feeling respected and treated as a unique individual by their provider. However, responses to questions about "shared decision making, getting needed care in a timely manner, and understanding their medicines" and risks scored in the 70 to 80% range.

These tips can help you improve their behavioral health experience:

- Encourage the parent/Legally Authorized Representative (LAR)/member to participate in decision making about care
- Verify parents/LAR understand their child's care plan and/or medication and the possible side effects (adult members rated their understanding of their medication higher than the parents of children in care)
- Promote member utilization of Member Services as a prime resource
- Proactively engage in collaboration with your patients other providers to improve the integration of their physical healthcare and behavioral healthcare (use the Coordination of Care form available on our website at **www.aetnabetterhealth.com/texas**).
- Discuss the broad range goal of impact on your patients school, work and interpersonal relationships

Reminder on balance billing

Are you preparing to bill a Medicaid and/or CHIP member? If so, please remember the following:

Medicaid: 42 C.F.R. § 447.15 means Acceptance of State payment as payment in full.

This means that a provider is **not** to bill the difference between the amount paid by Aetna Better Health of Texas and the provider's customary charge to your patient, your patient's family or a power of attorney for your patient. Balance billing for Medicaid services is a violation of your provider contract.

CHIP: Health and Human Services Commission (HHSC) rule at **§370.453** prohibits balance billing to Children's Health Insurance Program (CHIP) members. You may only seek reimbursement from a CHIP managed care organization for a covered service provided to a CHIP member. You may not seek reimbursement or attempt to obtain payment directly from a CHIP member, the CHIP member's family, or the CHIP member's guardian for a covered service. Eligible providers must agree that payment received for covered services will be accepted as payment in full and must agree that they won't bill the member or the member's guardian for any remaining balance for covered services rendered.

This applies to all covered services provided to a CHIP member, including emergency services provided by an out-of-network provider.

This does not apply to:

- Authorized co-payments
- A covered service of CHIP with a capped benefit level, once the CHIP member exceeds the benefit cap
- Unauthorized out-of-network services
- Services that aren't covered services under CHIP

In addition, providers may not bill or take other recourse against the CHIP member, the CHIP member's family, or the CHIP member's guardian for claims denied as a result of error attributed to the provider or claims processing entity. This rule applies to providers that participate in Aetna Better Health of Texas' network and out-of-network providers. The number one highest volume of member complaints is balance billing issues.

Aetna Better Health of Texas' member advocates have to contact the billing provider's business office to resolve the issue and zero balance the member. Many of these issues are sent to a collection agency, which requires an additional discussion with your office. In effect, this becomes a non-issue but countless hours are spent on resolution.

We will continue to resolve balance billing issues as received. However, we want to provide this gentle reminder for your reference when preparing bills for Medicaid members.

Community outreach

You can usually find our community outreach team in the community attending health fairs and events geared towards educating existing and potential members about our health plan. In addition to representing our plan in the community, our outreach team can also be a great asset to your office. We're available to offer a number of services that enhance members' experience. Here are a few of the services we can offer you:

- **Member education** - One-on-one education session that must be conducted in a private room at your office. Community outreach will normally coordinate a date/time with you when multiple members are scheduled.
- **Texas Health Steps Drives** - This is a new initiative that we're kicking off in all of our service areas. If you're interested, our community outreach and provider relations teams will coordinate offering members a designated Saturday to come to your office to complete their Texas Health Steps exams. You set aside a designated Saturday exclusively for plan members. Just let our community outreach or provider relations team know the date/time that works for you. We'll provide outreach to a designated number of members via mail, along with outbound calls that encourage attendance at each event. Our teams support each event by offering refreshments, games and door prizes to enhance the member experience.

For more information contact Ernest Gil at **210-243-5655** or **gile@aetna.com**

Provider re-enrollment is extended from March 24, 2016 to September 25, 2016

The Centers for Medicare and Medicaid Services (CMS) recently extended the Medicaid provider re-enrollment deadline from March 24, 2016 to September 24, 2016 to allow states additional time to process applications. In an effort to ensure Texas Medicaid complies with the federal requirement, HHSC has established a plan to provide assurance to providers to meet this deadline.

To avoid potential disruption in payment, a complete re-enrollment application must be received on or before June 17, 2016 in order to be revalidated by September 24, 2016. Complete applications September 24, 2016. In the event that the re-enrollment process is not completed by September 24, 2016, and you're still working toward addressing identified deficiencies at that time, you will continue to remain enrolled in Texas Medicaid as long as you respond to the deficiency notifications within the defined time frame for response. Enrollment is contingent upon continuing to meet deficiency correction timelines and receiving final application approval. You're encouraged to submit your applications today.

For complete details, please visit: **www.hhsc.state.tx.us/medicaid/re-enrollment/index.shtml**.

Recredentialing

Recredentialing occurs every three years for provider and facilties. Aetna utilizes CAQH for practitioner credentialing. Be sure to authorize us access to view your information so we can begin credentialing and recredentialing.

It's important that practioner's keep their information up to date with CAQH to ensure completion of credentialing.

Aetna's credentialing department reaches out to you and facilities a total of three times to obtain missing information. It's imperative that you respond to these requests for information. Should the contact on file with CAQH or Aetna (for facilities) change, be sure to update your information with CAQH through their website or Aetna (for facilities). Send updated information to Aetna Provider Relations **TXProviderEnrollment@AETNA.com**. Keeping your contact information current will help us direct our correspondence and request to the appropriate person.

Pharmacy Corner

Long Acting Reversible Contraception (LARC):
On August 1, 2014, TMPH announced Long-acting Reversible Contraception products became available at pharmacies for Texas Medicaid. These sections show how to return unused unopened product should a member not show up for their insertion appointment.

Long-Acting Reversible Contraception products to be available as a pharmacy benefit of Texas Medicaid and TMHP Effective August 1, 2014

Information posted July 15, 2014

Note: This article applies to claims submitted to TMHP for processing. For claims processed by a Medicaid managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorizations, and reimbursement.

Effective for dates of service on or after August 1, 2014, long-acting reversible contraception (LARC) products will be available as a pharmacy benefit of Texas Medicaid and Texas Women's Health Program (TWHP). These LARC products will only become available through a limited number of specialty pharmacies that work with LARC manufacturers. These pharmacies will be listed on the Vendor Drug Program website at **www.txvendordrug.com/formulary/larc.shtml**.

Providers who prescribe and obtain LARC products through the specialty pharmacies listed will be able to return unused and unopened LARC products to the manufacturer's third-party processor. Prescribers should refer to the manufacturer for specific instructions. General buy-back instructions are also available at **TxVendorDrug.com**.

After August 1, 2014, LARC will remain a medical benefit and providers will continue to have the option to receive reimbursement for LARC as a clinician-administered drug.

For more information, call the TMHP Contact Center at **1-800-925-9126**.

If a member doesn't show or becomes ineligible please return to the pharmacy. Products eligible for return are:

Mirena, Skylea, Nexplanon, Paragard.

Acute otitis media

- Acute otitis media (AOM) occurs frequently in children. It's the most common diagnosis for which they receive antibiotics.
- The diagnosis of acute otitis media (AOM) requires bulging of the tympanic membrane or other signs of acute inflammation and middle ear effusion. The importance of accurate diagnosis is crucial to avoidance of unnecessary antibiotic treatment.

Antibiotic treatment versus observation

- The choice of initial treatment with antibiotics or observation depends upon the age of the child and the severity of illness.
- The 2013 American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) guideline recommends[5]:
  - **Immediate antibiotic treatment** for children <6 months, children with severe signs or symptoms (defined by moderate or severe ear pain, ear pain for ≥48 hours, or temperature ≥39°C [102.2°F]) and bilateral AOM in children <24 months of age.
  - **Either immediate antibiotic treatment or observation (with pain control)** for children between 6 and 24 months with unilateral non-severe AOM and for children ≥24 months with unilateral or bilateral non-severe AOM.

Initial antimicrobial therapy

- When the decision is made to treat acute otitis media (AOM) with antibiotics, the selection among available drugs is based upon: clinical and microbiologic efficacy; convenience of the dosing schedule; acceptability (taste, texture) of the oral preparation; cost; absence of side effects and toxicity.

There is no evidence to support a particular antibiotic-regimen versus another for treatment of acute otitis media.[2]

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Table 1: Preferred agents on the Texas Medicaid Formulary available for treatment of acute otitis media[3]

	Preferred Agents*	Non-Preferred Agents*
First line:	amoxicillin	
When amoxicillin fails:	amoxicillin/clavulanate suspension, amoxicillin/clavulanate IR tabs, cefuroxime tabs, ceftriaxone injection	amoxicillin/clavulanate XR, amoxicillin/clavulanate chewable IR tabs, Augmentin susp and tabs, Augmentin XR, Ceftin tabs and susp, cefuroxime suspension
Penicillin-allergic patients:	azithromycin, clarithromycin susp, Ery-Tab, Erythrocin, erythromycin, PCE, erythromycin+sulfisoxazole susp, sulfamethoxazole/TMP DS/SS, Bactrim DS/SS	Biaxin tabs, Biaxin XL, clarithromycin ER, EryPed, Zithromax
With tympanostomy tubes:	ofloxacin otic, Ciprodex, neomycin/polymyxinc/hydrocortisone	Cipro HC, Cetraxal, Floxin, ciprofloxacin
Second/Third line:	cephalexin, capsules and suspension, cefdinir, cefprozil, Suprax capsules and suspension, trimethoprim	Keflex, cefaclor ER, cefpodoxime, Suprax chewable and tablets

*Texas Medicaid Formulary (Last Updated Jan 28, 2016)

References:

1. American Academy of Pediatrics Subcommittee on Management of Acute Otitis Media. Diagnosis and management of acute otitis media. Pediatrics. 2004:113(5):1451-1465.
2. Takata GS, Chan LS, Shekelle P, Morton SC, Mason W, Marcy SM. Evidence assessment of management of acute otitis media: I. The role of antibiotics in treatment of uncomplicated acute otitis media. Pediatrics. 2001:108(2):239-247.
3. **Lieberthal AS, Carroll AE, Chonmaitree T, et al. The diagnosis and management of acute otitis media.Pediatrics 2013; 131:e964**.
4. Bluestone CD, Klein JO. Epidemiology. In: Otitis media in infants and children, 4th ed/ BC Decker, Hamilton, ON. 2007. P.73.
5. American Academy of Pediatrics. Tables of antibacterial drug doses. In: Red Book: 2012 Report of the Committee on Infectious Diseases, 29th ed, Pickering LK (Ed), American Academy of Pediatrics, Elk Grove Village, IL 2012. p. 808.
6. Choosing Wisely. American Academy of Pediatrics. **www.choosingwisely.org/doctor-patient-lists/american-academy-of-pediatrics/** (Accessed on March 07, 2013).

Vendor drug additions and deletions to Preferred Drug List (PDL)

Pharmacy updates for preferred and non-preferred drug list on April 29, 2016

Added to PDL	Removed from PDL to non-preferred
Stiolto Respimat	Spirivia Respimat
carbidopa/levodopa/entacapone oral	Stavelo
valacyclovir	Valtrex
Niacin Tab and Niacin ER OTC	Niacin ER
Linezolid tab	Zyvox
Invokamet	Symbicort
	Seebri Neohaler
	Utibron Neohaler

Quality improvement program

Aetna Better Health works to give our members better care and services. Each year we report how well we are providing health care services. Many of the things we report on are major public health issues.

These are our 2016 goals:

Measure	2015 rate	Goal by 12/31/2016
THStep checkups/well child (3-6 years)	**73.38%**	**76.0%**
THStep checkups (12-20)	**57.18%**	**60.0%**
Childhood immunizations	**32.87%**	**35.0%**
Timeliness prenatal care	**85.28%**	**88.0%**
Postpartum care	**63.79%**	**66.0%**

In 2015 Aetna Better Health contracted with a third party vendor to conduct the annual member satisfaction survey. A series of 50 questions were asked, each leading with "In the past six months, what was your experience...". Below reflects the member's perception of care received at their primary care provider and with Aetna overall.

CAHPS 5.0H Survey Measure - 2015	Aetna	Percentile
Rating of personal doctor	**83.71%**	**25th**
Rating of all health care	**81.39%**	**50th**
Rating of health plan	**84.88%**	**50th**
Getting needed care	**85.66%**	**50th**
Getting care quickly	**85.94%**	**25th**
How well doctors communicate	**91.84%**	**50th**
Customer service	**90.61%**	**90th**

Aetna Better Health developed an action plan internally towards improving the customer service and health plan rating. Next steps will focus on access for getting care quickly and getting needed care.

Look forward to our next newsletter on information regarding Human Papillomavirus vaccinations and cervical cancer screenings.

Or call member services:

- **1-800-306-8612** (Medicaid Tarrant)
- **1-800-248-7767** (Medicaid Bexar)

Office hours of operation parity

The State of Texas requires us to ensure that network practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non Medicaid members. Additionally, if the practitioner serves only Medicaid enrollees, hours offered to Medicaid managed care enrollees must be comparable to those for Medicaid fee for service enrollees. As a contracted Medicaid managed care organization, Aetna Better Health of Texas also adheres to these requirements.

NCQA reviews Aetna Better Health of Texas practitioner materials such as contract templates, the practitioner manual and practitioner newsletters for language that the practitioner's hours of operation are not less for Medicaid patients than for non-Medicaid patients.

Second opinions

A member, parent and/or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member. The second opinion must be obtained from a network provider (see provider referral directory) or a non-network provider, if there is not a network provider with the expertise required for the condition. PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Member satisfaction survey results

Each year, members of Aetna Better Health of Texas are randomly selected to participate in a survey. The purpose of the survey is to assess members' satisfaction with services from their health care providers as well as services from the Health Plan. Aetna uses the results to identify opportunities for improvement so members' needs may be adequately addressed.

For a copy of the most recent survey results, please visit our website at www.aetnabetterhealth.com/texas.

Visit our website to find information on:

- Quality improvement program
- Case management program
- Clinical practice guidelines
- Utilization management -- decision-making criteria -- affirmative statement -- staff availability
- Pharmacy/prescription drug management
- Member rights and responsibilities
- Credentialing rights of provider offices that don't have Internet service can reach us by phone (numbers listed below) for more information.

Aetna Better Health of Texas Integrated Care Management Program

The Aetna Better Health of Texas's Integrated Care Management (ICM) is designed to identify our most bio-psycho-socially complex and vulnerable members with whom we have an opportunity to make a significant difference. The care management program is "integrated" as it reflects our belief that care management must address the member's medical, behavioral and social needs in an integrated fashion and must address the continuum of acute, chronic and long term services and supports needs. Case managers assist members in coordinating medical and/or behavioral health services as well as those available in the community.

Our ICM department consists of non clinical and clinical employees who are trained in motivational interviewing. Our care managers would like to collaborate with you to help members improve their health and sustain improvement over time. Using available information we employ clinical algorithms and case manager judgment to recommend a level of care management that is best suited to address the member's needs.

Intensive care management
Intensive care management is intended for people with complex conditions to help them receive coordinated care, based on a customized approach to each individual's unique circumstances.

Supportive care management
Supportive care management includes problem-solving interventions that focus on improving access to, and effectiveness and safety of, standard health care for individual members.

Population health
This level of care management offers basic educational outreach and includes individualized services to members who require routine screening, monitoring, and follow-up. Low risk pregnant members and low risk members with chronic conditions are assigned to population health.

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 receive referrals from our health information line, members, caregivers, providers or practitioners to outreach members appropriate for care management and assign members to the appropriate level of ICM.

Integrated Care Management (ICM) Program is a benefit for all Medicaid, CHIP, and CHIP perinate members. 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.

A source for identification of members for case management is the monthly Consolidated Outreach Risk Evaluation (CORE) report, a predictive modeling tool. The CORE is based on three risk metrics:
1. General risk score
2. Emergency Department (ED) risk
3. Inpatient (IP) risk

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Aetna Better Health of Texas Integrated Care Management Program

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Additionally, disease conditions are identified for each member on the CORE, including asthma, chronic pain, substance abuse, congestive heart disease, cardiovascular disease, diabetes, and behavioral health diagnoses.

Other members are enrolled in case management via referrals from providers and post-discharge planners and internal referrals, as well as health risk assessments from the state enrollment broker.

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).

Medical center

Aetna Better Health's medical management department is responsible for integrating systems for managing, monitoring, evaluating, and improving the utilization of care and services members receive. The program is designed to assist members, practitioners, and providers in the appropriate utilization of care/service delivery systems, assess satisfaction with the processes, and discover opportunities to optimize members' health outcomes. Our utilization management (UM) department bases medical necessity decisions only on appropriateness of care and service and the existence of coverage. We do not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decisions makers do not encourage decisions that result in underutilization.

Utilization management

The purpose of the utilization management program is to manage the use of health-care resources so members receive the most medically appropriate and cost-effective health care that will improve their medical and behavioral health outcomes. The utilization management department consists of clinical and non-clinical staff members.

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

Aetna Better Health of Texas 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 of Texas utilization management processes. Aetna Better Health of Texas staff receives initial and ongoing training on a regular basis, but no less than annually.

Aetna Better Health's utilization management function identifies both over- and -under utilization patterns for inpatient and outpatient services. This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population. Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

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 of Texas requires utilization management staff to identify themselves by name, title, and organization name when initiating or returning calls regarding UM inquiries. 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**

Availability of utilization management criteria

Aetna Better Health of Texas employees make clinical decisions regarding members' health based on the most appropriate care and service available. Aetna Better Health of Texas makes medical necessity determinations based on established criteria. The criteria used to make determinations are available to practitioners at any time by contacting the utilization management department to obtain a mailed copy.

- National Criteria are made available on the website.

Aetna clinical policy bulletins are available via our secure website: **www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins/alphabetical-order.html**

Disease management

Caring for members with chronic conditions

A component of ICM that is offered in each service level is assistance with the management of chronic conditions. Aetna Better Health of Texas works with members to address issues related to their asthma, diabetes and depression.

Based on the member's needs case managers use condition-specific assessments and care plan interventions to assist them with chronic condition management, thereby including traditional "disease management" within the ICM process rather than it being managed separately. Members with diabetes, asthma, and depression are identified by our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk questionnaires, care management assessments, concurrent review/prior authorization referral, as well as member and provider referral.

These assessments are used to generate chronic condition management education and to evaluate whether members are receiving recommended care for their chronic conditions. If the screenings indicate a problem the case manager will arrange for member to receive an assessment and any recommended services with the appropriate provider.

Member referrals can be made by contacting our member services at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) or by email **MBUTXCMReferral@AETNA.com**

Please provide the reason for the referral and pertinent demographic information. The Active Health disease management program (DM) is delivered by Aetna nurses using technology shared with our subsidiary, ActiveHealth® Management, Inc.

Our disease management program is voluntary, and all members have the option to agree to the service or decline the service without impact to their benefits.

Aetna Better Health of Texas promotes clinical practice guidelines

Aetna has adopted clinical practice guidelines related to medical and behavioral/substance abuse and preventive service guidelines related to perinatal care for children up to 24 months old, children 2 to 19 years old, adults 20 to 64 years old, and adults 65 years and older. The recommended guidelines can be accessed from **https://www.aetnabetterhealth.com/texas/providers/info/clinical-guidelines** and copies can also be made available upon request.

On the website, you will find:

2015 medical practice guidelines

- Diabetes care
- Hypertension
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Asthma

Clinical preventive services recommendations

Birth to 10 years

- Autism screening
- Behavioral assessments
- Blood pressure screening
- Chemoprophylaxis
- Developmental screening and surveillance
- Dyslipidemia screening
- Hearing loss screening
- Hematocrit or hemoglobin screening

11 to 24 years

- Alcohol and drug use assessment
- Assess for problem drinking
- Behavioral assessments
- Blood pressure screening
- Breast (ovarian) cancer screening

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Aetna Better Health of Texas promotes clinical practice guidelines *Continued from page 9*

- Breast cancer preventive medication
- Cervical cancer/dysplasia screening (Papanicolaou (Pap) test) (women)

25 to 64 years
- Aspirin for the prevention of cardiovascular disease
- Assess for problem drinking
- Blood pressure
- Breast (ovarian) cancer screening
- Breast cancer preventive medication
- Cervical cancer/dysplasia (Papanicolaou (Pap) test) (women)

Pregnant women first visit
- Assess for problem drinking
- Assess tobacco use and tobacco-caused disease
- Blood pressure
- CBC
- Chlamydia screen
- Gonorrhea screen
- Hepatitis B surface antigen
- HIV screening
- Iron deficiency anemia screen
- Offer hemoglobinopathy screening
- Rh (D) typing, antibody screen
- Syphilis screening
- Screening for aneuploidy (extra or missing chromosome)

Re-introducing the secure online portal, with enhancements for member integration

Aetna Better Health of Texas is dedicated to providing great service to our providers and our members. That's why our HIPAA-compliant web portal is available 24 hours a day. The portal supports the functions and access to information related to:
- Prior authorization submission and status
- Claim payment status
- Member eligibility status
- eReferrals to other registered providers
- Member and provider education and outreach materials

If you're interested in using this secure online tool, you can register on our "For Providers" then My Aetna Source page at www.aetnabetterhealth.com/texas . From there, you can either complete your registration online, complete the registration form and fax your request to **1-866-510-2710**, or contact our Provider Services Department at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) to sign up over the phone. Keep in mind that Internet access with a valid email is required for registration.

Remember, provider groups must first register a principal user known as the provider representative. Once registered, the provider representative can add authorized users within each entity or practice.

Engaging members to help them get and stay healthy

Aetna members can now sign up for their own secure member portal accounts. We've customized the member portal to better meet their needs. Members will have access to:

Health and wellness appraisal. This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members' overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.

Educational resources and programs. Members are able to access self-management tools for specific topics such as smoking cessation and weight management.

Claim status. Members and their providers can follow a claim from the beginning to the end, including current stage in the process, amount approved, amount paid, member cost (if applicable) and date paid.

Pharmacy benefit services. Members can find out if they have any financial responsibility for a drug, learn how to request an exception for a non-covered drug and find an in-network pharmacy by zip code. They can also figure out drug interactions, side effects and risk for medications and get the generic substitute for a drug.

Personalized health plan services information. Members can now request a member ID card, change primary care providers and update their address through the web portal. (Address update is a feature available for members and providers.) Members can also obtain referral and information on authorization requirements. And they can find benefit and financial responsibility information for a specific service.

Innovative services information. Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.

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Re-introducing the secure online portal, with enhancements for member integration *Continued from page 10*

Health information line. The Informed Health Line is available 24 hours a day, 7 days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.

Wellness and prevention information. We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources, and automated outreach efforts with references to web-based self-management tools.

You can help your patients sign up today. We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online at **www.aetnabetterhealth.com/texas**. Or they can call Member Services at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) for assistance with registration.

Member rights and responsibilities

Aetna Better Health of Texas maintains policies and procedures that formally address a member's rights and responsibilities. The policies reflect federal and state laws as well as regulatory agency requirements.

We annually inform our members of their rights and responsibilities in the member handbook, member newsletter and community mailings, when applicable.

They are also posted to our website at **http://www.aetnabetterhealth.com/texas**. Aetna Better Health of Texas ensures that a member can exercise their rights without adversely affecting treatment by participating providers.

Members' rights and responsibilities are monitored through our quality management process for tracking grievances and appeals as well as through member surveys. issues are reviewed by our service improvement committee and reported to the quality management oversight committee.

For additional information regarding member rights and responsibilities, visit our website at **www.aetnabetterhealth.com/texas** or call your provider relations representative at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar)

Quality management program

Aetna Better Health plans work to give our members better care and services. Each year we report how well we are providing health care services. Many of the things we report on are major public health issues.

These are our 2016 goals:

- Increase the number of THStep checkups and well visits for children ages 3-6 years of age and adolescents ages 12-20.
- Ensure children have all their vaccinations before the age of two years.
- Encourage more pregnant women to obtain their first prenatal visit in the first trimester and complete a postpartum visit after delivery within 21-56 days.
- Improve our member's experience with their doctor and overall health care services.
- Seven out of ten children who are 3-6 years of age get a THStep checkup or well child exam; and only six out of ten children get a yearly teen examination.
- Seven out of 10 pregnant women seek their first prenatal exam late or in their second trimester.

Look forward to our next newsletter on information regarding Human Papillomavirus vaccinations and cervical cancer screenings.

We'll share these results with you in our member newsletter and on the website throughout the year. You can visits us at **www.aetnabetterhealth.com/texas** or call member services:

- **1-800-306-8612** (Medicaid Tarrant)
- **1-800-248-7767** (Medicaid Bexar)

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Provider Relations
P.O. Box 569150
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Who to call?

Provider Relations and Member Services lines:

Medicaid - Bexar **1-800-248-7767**
Medicaid - Tarrant **1-800-306-8612**
CHIP - Bexar **1-866-818-0959**
CHIP - Tarrant **1-800-245-5380**

Superior Vision
1-800-879-6901

LogistiCare-Medical Transportation (For Medicaid members only)
1-877-633-8747 (Aetna Bexar County)
1-855-687-3255 (Aetna Tarrant County)

Nurse Line
1-800-556-1555

Behavioral Health Provider Credentialing
1-800-999-5698

Report Fraud, Waste or Abuse
1-800-436-6184

Fax Numbers

Aetna Prior Authorization fax#
1-866-835-9589

Aetna Inpatient Authorization fax#
1-866-706-0529

Behavioral Health Prior Authorization fax #
1-855-857-9932
1-855-841-8355 (Concurrent Review)

Dental

MCNA Dental
1-855-494-6262

Denta Quest
1-800-516-0165 (Medicaid)
1-800-508-6775 (CHIP)

Vital Savings (adults only)
1-888-238-4825

CVS Caremark (Pharmacy)

CVS Caremark Help Desk
1-877-874-3317
BIN# 610591
PCN: ADV
GROUP# RX8801

Prior Auth Call In
1-855-656-0363

Prior Auth fax
1-866-255-7534