

Provider newsletter

Fall 2026



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Community Outreach

Our Community Outreach department can normally be found in the community attending health fairs and community events geared towards educating existing and potential members about our plan. In addition to providing an overview of our plan, Community Outreach educates our communities on CHIP/Medicaid, Texas Health Steps, and Accelerated Services for Farmworker Children. Our Outreach team can also be a great asset to any provider office offering a number of services geared for members to enhance not only their experience with our plan but with the provider as well. Here are a few of the services we can offer:

- **Member education** – 1 on 1 education session with a member that must be conducted in a private room at the provider's office. Community Outreach will normally coordinate a date/time with a provider when multiple members are scheduled.

Re-enrollment assistance –

Members can call **2-1-1 Texas** or visit YourTexasBenefits.com/Learn/Home to renew their Medicaid benefits.

- **Provider education** – Education sessions for provider offices to assist in the identification of children of migrant farmworkers in order to help them receive the health care services their child/children may need.

- **Farmworker children** - Farmworker children have parents or guardians who meet the state definition of a migratory agricultural worker, generally defined as an individual:

1. Principal employment is in agriculture on a seasonal basis;
 2. Has been so employed within the last twenty-four months.
 3. Performs any activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence.
 4. Establishes for the purposes of such employment a temporary abode.
- Source: Texas Health and Human Services Commission, Uniform Managed Care Contract Terms & Conditions, Version 1.17, p. 11*

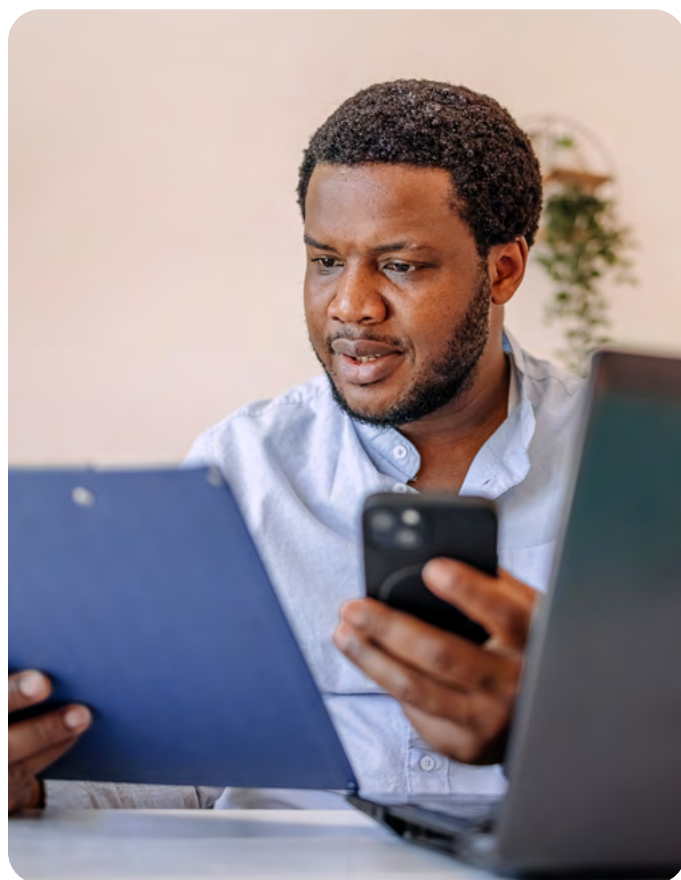
- **Farmworker children referral process** - Providers who identify farmworker children members can contact our member services team at **1-888-672-2277** so we can provide additional outreach and assistance if needed.

For more information on our value-added services and programs please call **1-877-751-9951**.

Member Advocates

Our Member Advocate team can normally be found working with members to ensure that they have the best healthcare experience possible. In addition to providing an overview of our plan, Member Advocates educate our members on benefits available for STAR/CHIP/STAR Kids coverage, Texas Health Steps, renewal, and Accelerated Services for Farmworker Children. Here are a few additional services our outreach team offers:

- **Questions about coverage** – Our Member Advocate team can assist members in obtaining answers to questions about their coverage.
- **Re-enrollment assistance** – Call **2-1-1** Texas or visit YourTexasBenefits.com/Learn/Home
- **Member Advisory Group Meetings** – Our Member Advocate team schedules quarterly STAR Member Advisory Group Meetings and welcomes all STAR members to attend.
- **Member Baby Shower Program** - Come and learn about our Maternity Care Program. You'll get lots of great information to help with your pregnancy. Schedule can be found by visiting our website at: AetnaBetterHealth.com/texas/wellness/women/pregnancy
- **CVS Health HUB events** - Our Member Advocate team schedules weekly health education events at local CVS Health HUB's in order to provide member education on STAR/CHIP/STAR Kids coverage, Texas Health Steps, renewal, Accelerated Services for Farmworker Children and the latest on COVID-19 and vaccination incentives.



To get connected with a Member Advocate please call the number on the back of your member ID card or leave a message in our Member Advocate Mailbox and we will return your call within 1-2 business days:
1-800-327-0016.

For members who are deaf or hard of hearing please call: **1-800-735-2989**

For information on our value-added services please visit:

[What Does Medicaid Cover? | Aetna Medicaid Texas \(aetnabetterhealth.com\)](https://AetnaBetterHealth.com/MedicaidTexas)

[What Does STAR Kids Cover? | Aetna Medicaid Texas \(aetnabetterhealth.com\)](https://AetnaBetterHealth.com/MedicaidTexas)

[What Does CHIP Cover? | Aetna Medicaid Texas \(aetnabetterhealth.com\)](https://AetnaBetterHealth.com/MedicaidTexas)

Medicaid balance billing prohibited for STAR and STAR Kids providers

Aetna Better Health of Texas (ABH TX) is committed to ensuring that STAR and STAR Kids members have access to covered healthcare services without inappropriate financial burden. This notification serves as a reminder of provider responsibilities regarding balance billing, member hold harmless requirements, and member financial liability under Texas Medicaid managed care programs.

Federal and state Medicaid regulations prohibit providers from billing Medicaid members for covered services beyond the amount paid by the Medicaid program. As participating providers, you are required to comply with all applicable Texas Medicaid, HHSC, TMHP, and Aetna Better Health of Texas billing requirements.

What is balance billing?

Balance billing occurs when a provider bills, charges, seeks payment from, or otherwise holds a Medicaid member financially responsible for any amount associated with a covered service beyond the reimbursement paid by Aetna Better Health of Texas or Texas Medicaid.

Examples of prohibited balance billing include:

- Billing a member for the difference between the provider's billed charge and the Medicaid allowed amount.
- Billing a member for a denied or reduced claim involving a covered service.
- Billing a member because a prior authorization was not obtained.
- Billing a member because a claim was submitted after the filing deadline.
- Billing a member due to coding, billing, or documentation errors.
- Billing a member due to reimbursement disputes or provider administrative errors.
- Collecting deposits for covered services.
- Referring members to collections for balances related to covered services.

Any billing dispute related to a covered service must be resolved between the provider and Aetna Better Health of Texas and may not be transferred to the member.



STAR and STAR Kids member protections

Members enrolled in the STAR and STAR Kids programs are protected from liability for covered Medicaid services. Providers must accept payment from Aetna Better Health of Texas as payment in full for covered services.

Providers may not:

- Bill members for covered Medicaid services.
- Bill members for services denied due to provider error.
- Bill members for untimely filing.
- Bill members for claim submission errors.
- Bill members for failure to obtain required authorization.
- Require deposits for covered services.
- Initiate legal action against members for covered services.
- Report member balances related to covered services to collection agencies or credit reporting entities.

STAR and STAR Kids members must be held harmless from liability for payment of covered services.

Non-covered services and member financial responsibility

A STAR or STAR Kids member may only be financially responsible for services that are not covered benefits when all of the following conditions have been met:

1. The service is not a covered Medicaid benefit.
2. The member is informed in advance that the service is not covered.
3. The member is informed that he or she will be financially responsible for payment.
4. The member voluntarily agrees to receive the service.
5. The member signs the applicable Private Pay Agreement and Member Acknowledgement Form before services are rendered.

Providers must maintain signed documentation in the member's medical record and make it available upon request. Without proper advance notice and completed documentation, members may not be billed for services that would otherwise be subject to Medicaid coverage requirements.

Claims filing requirements

Providers are responsible for submitting claims in accordance with Aetna Better Health of Texas and Texas Medicaid requirements.

If a claim is not received by Aetna Better Health of Texas within ninety-five (95) days, the claim may be denied unless an applicable filing exception exists.

Providers may not bill members for services denied due to:

- Untimely filing
- Administrative errors
- Missing documentation
- Claims submission errors
- Failure to obtain required authorization
- Other provider-related noncompliance

For additional information regarding filing requirements and exceptions, refer to the Texas Medicaid Provider Procedures Manual, Section 6.1.4, "Claims Filing Deadlines." TMPPM.book

Scenario	Can the member be billed?	
	Yes	No
Claim denied for no prior authorization		✗
Claim denied for timely filing		✗
Provider disagrees with reimbursement		✗
Non-covered service with signed consent	✓	
Doctor Communication	✓	
CHIP copayment (authorized amounts only)	✓	



Provider compliance responsibilities

Providers are responsible for ensuring that office staff, billing personnel, and third party billing vendors understand and comply with Medicaid balance billing requirements.

Failure to comply with balance billing and member hold harmless requirements may result in:

- Recovery of improperly collected member payments
- Corrective Action Plans (CAPs)
- Additional provider education and monitoring
- Increased compliance oversight
- Additional contractual remedies, as applicable

Aetna Better Health of Texas actively monitors provider compliance with Medicaid billing requirements to protect members and ensure adherence to program standards.



Questions or support

- Reference the ABH TX **Provider Manual** for Health Care Providers - Aetna Medicaid Texas
- Use the Availity Provider Portal for claims and billing support **[Availity Essentials - Sign In](#)**
- **Medicaid (STAR)**
1-800-248-7767 (Bexar)
1-800-306-8612 (Tarrant)
- **STAR Kids**
1-844-787-5437
- **TTY 1-800-735-2939**





Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is a telephone and computer-based system used to verify service visits for STAR Kids members. Similar to an electronic timesheet, EVV helps agencies document and confirm services provided by personal attendants and private-duty nurses. EVV is required for certain Medicaid services delivered through the Texas Health and Human Services Commission (HHSC) and Medicaid managed care organizations.

Aetna Better Health of Texas offers a variety of EVV resources to support providers, including:

- EVV resources and reference materials
- Training information
- Policies and procedures

For more information, visit our EVV webpage: <https://www.aetnabetterhealth.com/texas/providers/electronic-visit-verification.html>

Need to submit a Visit Maintenance Unlock Request? Please send your request to the Aetna Better Health of Texas EVV Mailbox: EVVMailbox@AETNA.com

For additional EVV information and state guidance, visit the HHSC EVV website: <https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv>

If you have any EVV-related questions, please contact the Aetna Better Health of Texas EVV team at: EVVMailbox@AETNA.com.

ABHTX Appeal Member Consent Form

Member Appeal Reminder – A provider may appeal on behalf of the member only if the member provides signed consent. Member consent is required to appeal on behalf of the member, if it is not received the appeal request will be dismissed. Please use the member's consent form or the member may provide signed consent to us directly as an attachment. It can be emailed to txmemberadvocate@aetna.com The member's signature must be on the consent with any pre-service appeal submission on behalf of the member.



MEMBER CONSENT FORM
To Allow a PROVIDER to Appeal
On behalf of MEMBER

Member Name: _____
Member Identification Number: _____
Member Date of Birth: _____

I give consent for my provider _____ to appeal, on my behalf, the denial made
by Aetna Better Health dated _____ about _____

Member Signature (Parent or Legal Guardian, if applicable)

Date

Print Name of Parent or Legal Guardian (if applicable)

Please sign or have your legally authorized representative sign in order for your provider to
appeal on your behalf. Once this has been signed, please have your provider fax or mail this form
with an appeal letter to

Aetna Better Health of Texas
Attn: Member Advocate Dept.
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181
Fax#1-877-223-4580

TX-19-11-11

Any changes to your demographic information?

Aetna Better Health of Texas strives to ensure provider directory information is as accurate and current as possible for our members. If you are a provider or provider group and need to update demographic information, please contact us at the emails below.

Contact	Type of Update
ABHTXCredentialing@Aetna.com	Adding providers, change of physical address, contracting, credentialing, copies of contract or checking credentialing/contracting status. If you have a new provider joining your practice, you must submit a: • Prospective Provider Form • W9 The application can be found on our website at AetnaBetterHealth.com/Texas
TXproviderenrollment@Aetna.com	If you have an EFT/ERA update or delegated roster update.



Help us ensure your Aetna patients have timely and appropriate access to care

We want to remind Aetna Better Health providers of the required availability and accessibility standards. Please review the standards listed below.

Level of care	Timeframe
Emergency services	Upon member presentation at the service delivery site
Urgent care appointments	Within 24 hours of request for primary and specialty care
Routine primary care	Within 15 business days for non-urgent, symptomatic condition
Routine specialty care	Within 21 days of request for non-urgent, symptomatic condition
Adult preventive health physicals/wellness visits for members over the age of 21	Within 15 business days of request
Preventive health services	Members less than 6 months of age – within 14 calendar days. Members 6 months through age 20 – within 60 calendar days.
Prenatal care/first visit	Within 15 business days of request. For high-risk pregnancies or new members in the third trimester, appointments should be offered immediately within 5 business days.
Behavioral Health visit	Initial outpatient behavioral health visit (child and adult within 10 business days.



Appointment availability requirements

After-hours access requirements: The following are acceptable and unacceptable phone arrangements for contacting PCPs after normal business hours.

Acceptable	Unacceptable
• Office phone is answered after hours by an answering service, in English, Spanish or other languages of the major population groups served, that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes. • Office phone is answered after normal business hours by a recording in English, Spanish or other languages of the major population groups served, directing the patient to call another number to reach the PCP or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable. • Office phone is transferred after office hours to another location, where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.	• Office phone is only answered during office hours. • Office phone is answered after hours by a recording, which tells the patients to leave a message. • Office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed. • Returning after-hour calls outside of 30 minutes.

Provider email contact update

Aetna Better Health of Texas has updated several provider-facing email mailboxes. Providers should begin utilizing the email addresses referenced throughout this newsletter and update any internal contact records accordingly. Questions regarding provider enrollment, contracting, credentialing, and provider support should be directed to the appropriate mailbox listed in this issue.



Provider Engagement update:

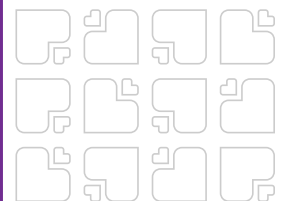
Please use ABHTXProviderEngagement@Aetna.com to contact our ABH TX Provider Engagement team.

Where to find important pharmacy information

You can access important pharmacy information on AetnaBetterHealth.com/Texas.

Once you access AetnaBetterHealth.com/Texas, select “*Provider Site*”, click on “*Programs and services*”, and then click on “*Pharmacy*”:

- Preferred Drug list
- Medications that require prior authorization, and applicable coverage criteria
- A list and explanation of medications that have limits or quotas.
- Copayment and coinsurance requirements, and the medications or classes to which they apply (CHIP members only).
- Procedures for obtaining clinical PA or PDL PA prior authorization, generic substitution, preferred brand interchange
- Information on the use of pharmaceutical management procedures
- Criteria used to evaluate new medications for inclusion on the formulary
- A description of the process for requesting a medication coverage exception
- Medication Preferred Drug List QR Code:



Changes to the Texas Medicaid Preferred Drug List

Texas Medicaid will publish the semi-annual update of the Medicaid Preferred Drug List in January and July. The updates will be based on the changes presented and recommended at the quarterly Texas Drug Utilization Review Board meetings. The table below summarizes noteworthy changes for the April and July 2026 update.

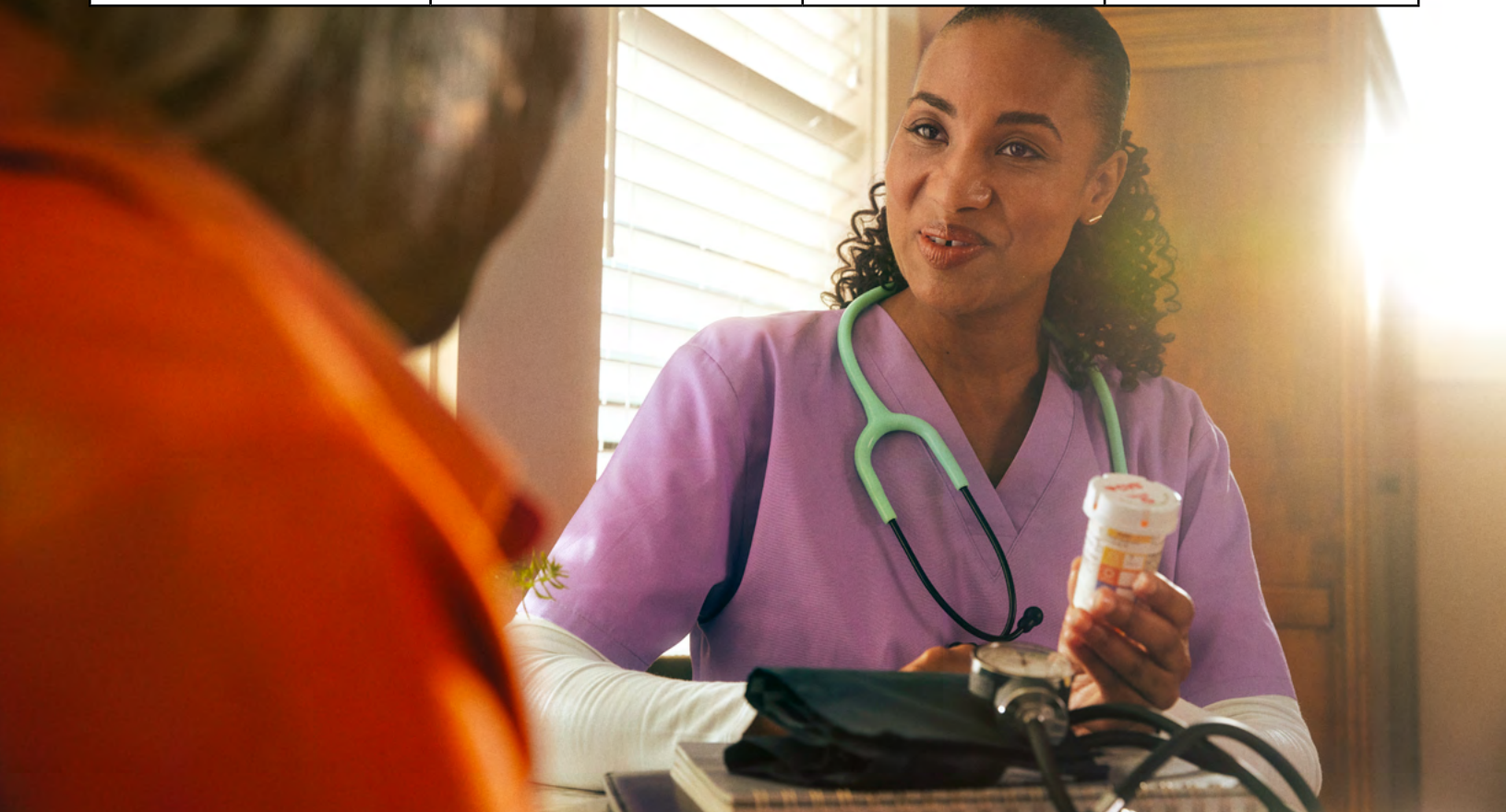
Drugs on the Texas Medicaid formulary are designated as preferred, non-preferred, or have neither designation. The preferred drug list includes only drugs identified as either preferred or non-preferred. Drugs on the preferred drug list listed as “preferred” are available to members without prior authorization; however, some could require a clinical prior authorization. Drugs on the preferred drug list that are identified as “non-preferred” will require prior authorization. There are certain clinical prior authorizations that all Medicaid managed care organizations (MCO) are required to perform. MCOs have the same non-preferred prior authorization criteria requirements from following the Texas formulary and PDL.

Notable April 2026 Preferred Drug List updates

Preferred Drug List category	Brand name (route)	Current preferred Status	Recommendations
Anticonvulsants	Subvenite (oral) susp	Not Reviewed	Preferred
Antihypertensives, Sympatholytics	Javadin (oral) solution	Not Reviewed	Non-Preferred
Colony Stimulating Factors	Nypozi (injection) syringe	Not Reviewed	Non-Preferred
Non-Narcotic Analgesics	Vyscoxa (oral) susp	Not Reviewed	Non-Preferred
Non-Narcotic Analgesics	Coxanto (oral) capsule	Not Reviewed	Non-Preferred
Oncology, Oral - Hematologic	Komzifti (oral) capsule	Not Reviewed	Preferred
Oncology, Oral - Hematologic	Xpovio (oral) tablet	Not Reviewed	Preferred

Notable April 2026 Preferred Drug List updates (continued)

Preferred Drug List category	Brand name (route)	Current preferred Status	Recommendations
Oncology, Oral - Lung	Ensacove (oral) capsule	Not Reviewed	Preferred
Oncology, Oral - Lung	Hyrnuo (oral) tablet	Not Reviewed	Preferred
Pulmonary Hypertension (PAH) Agents, Oral and Inhaled	Tyvaso DPI (inhalation) cart inhal 32-64 mcg	Not Reviewed	Non-Preferred
PAH Agents, Oral and Inhaled	Tyvaso DPI (inhalation) cart inhal 48-64 mcg	Not Reviewed	Non-Preferred
Penicillins	Pivya (oral) tablet	Not Reviewed	Non-Preferred
Skeletal Muscle Relaxants and Related	Tonmya (sublingual) tab subl	Not Reviewed	Non-Preferred



Provider notice: Texas Medicaid provider revalidation & extension criteria

Dear Aetna Better Health Providers,

This notice serves to inform contracted providers that Texas Medicaid provider revalidation is required in accordance with requirements established by the Texas Health and Human Services Commission (HHSC) and administered by the Texas Medicaid & Healthcare Partnership (TMHP).

Provider revalidation requirements

Providers must complete the revalidation process through the Provider Enrollment and Management System (PEMS) upon receiving notification from the Texas Medicaid & Healthcare Partnership (TMHP). Completing revalidation is a mandatory requirement for maintaining active enrollment in Texas Medicaid. **Providers who need to request an extension must follow the instructions outlined on the next page.**

Failure to complete revalidation by the applicable TMHP deadline **may result in administrative action**, including but not limited to claims payment delays, claim denials, or disenrollment from Texas Medicaid. Disenrollment from Texas Medicaid may affect participation in the Aetna Better Health of Texas provider network.

Provider responsibilities

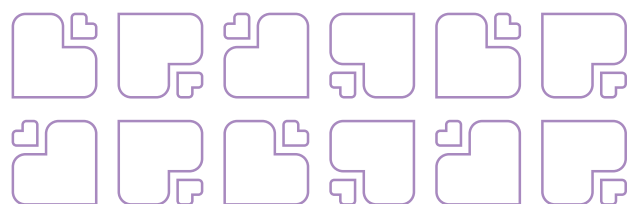
Providers who receive a TMHP revalidation notice are responsible for:

- Accessing **TMHP My Account** at [\[tmhp.com\]](https://www.tmhp.com)
- Completing and submitting the required **PEMS Revalidation Application**
- Ensuring enrollment information, disclosures, licensure, ownership, and practice location data are accurate and current
- Monitoring application status until it reflects **Closed – Enrolled**

Revalidation is not considered complete until TMHP has finalized the application and the status reflects **Closed – Enrolled** in PEMS.

Questions

- TMHP Contact Center: **800-925-9126**
- TMHP Provider Enrollment Help: <https://www.tmhp.com/topics/provider-enrollment/provider-enrollment-help>



HHSC provider revalidation extension criteria: effective June 16, 2026

Aetna Better Health of Texas (ABH-TX) is providing this notice to inform network providers and partners about recent updates from the Texas Health and Human Services Commission (HHSC) regarding eligibility for second and third revalidation due date extensions in the Provider Enrollment and Management System (PEMS). Beginning June 16, 2026, a provider's revalidation due date will be extended by 60 calendar days if they meet the following extension criteria:

The provider's current revalidation due date is on or after June 16, 2026.

The provider's revalidation application was submitted before their revalidation due date, and it is now an in-flight application.

Note: "*In-flight*" applications refer to applications that providers have submitted through the Provider Enrollment and Management System (PEMS) but that have not yet been approved. This does not include applications that are in "*Draft*" status.

Reminder: Providers should begin the revalidation process as early as 180 days before their revalidation due date and should respond to deficiencies in a timely manner to allow sufficient time to complete the process and maintain their enrollment status.

The Texas Medicaid & Healthcare Partnership (TMHP) is expecting a high volume of applications and encourages providers to begin the revalidation process as soon as possible. TMHP acknowledges that providers are receiving several revalidation notices. To avoid further notices, providers should complete their applications as soon as possible.

Important: Providers that do not have a completed revalidation application or an in-flight application by the day before their revalidation due date will be disenrolled from all Texas state health care programs and claims and prior authorization requests will be denied. Providers that have been disenrolled will need to submit a reenrollment application through PEMS.

Resources:

Educational Videos (TMHP YouTube Playlist): Playlist link: https://www.youtube.com/playlist?list=PLVyay6IWAC_7RImGSrEs—XcP8gbMsnGS

- Revalidating an Individual
- Revalidating a Performing Provider
- Revalidating a Clinic/Group Practice or Facility

For plan level support please contact your designated Provider Experience Representative or email our team at ABHTXProviderEngagement@AETNA.com.

Sincerely,

Aetna Better Health of Texas Provider Experience.

Providers: Refer Aetna Better Health members for personalized support through their health plan

How to refer patients to our team

STAR Kids: Call **1-855-243-3226**

STAR or CHIP: Call **1-800-306-8612**

Select options **Provider > More Options > Care Manager**

You can also invite patients to call our Member Services team and request Service Coordination (STAR Kids) or Care Management (STAR and CHIP).



We help patients engage in care

Service Coordination (STAR Kids) and Care Management (STAR and CHIP) is a benefit available at no cost. Our teams work one-on-one with members and their families to connect with care, coordinate services, and meet personal health goals.

Examples of how we can help:

- Understanding and using benefits
- Coordinating services across programs and Providers
- Getting care for medical and behavioral health needs
- Disease management and self-management supports
- Getting and taking medications as prescribed
- Non-medical needs including transportation
- Support during and after pregnancy
- Transitional care assistance
- Ongoing assessments and service planning
- Interpreter services, accessible communication

Member Services

1-800-248-7767 (TTY:711)

Visit us at [**Aetna Better Health of Texas**](#)

Medical facilities

MTM Health partners with medical facilities throughout Texas to ensure seamless, successful transportation delivery to Texas Medicaid and Medicare members. Let us know how we can help you best arrange NEMT services for your patients.

Click here to access the MTM Link Facility Portal. Reach out to CO-TX@mtm-inc.net for training and account setup information. This self-service tool allows you to view contact information, scheduling requirements, reimbursement rates, and download resources and documents tailored to each Texas health plan we work with.

[Click here to access the MTM Link Facility Portal](#)

Our Community Outreach team welcomes the opportunity to visit your facility to facilitate presentations on MTM Health's services and provide training for online trip scheduling through the MTM Link Facility Portal. Reach out to us to learn more:

- Texas Community Outreach Team: CO-TX@mtm-inc.net
- General Community Outreach: CO@mtm-inc.net

Availity Provider Portal for Aetna Better Health of Texas

Availity is the Provider Portal for Aetna Better Health of Texas. Providers can register for access directly on the Availity site: <https://apps.availity.com/availability/web/public.elegant.login>.

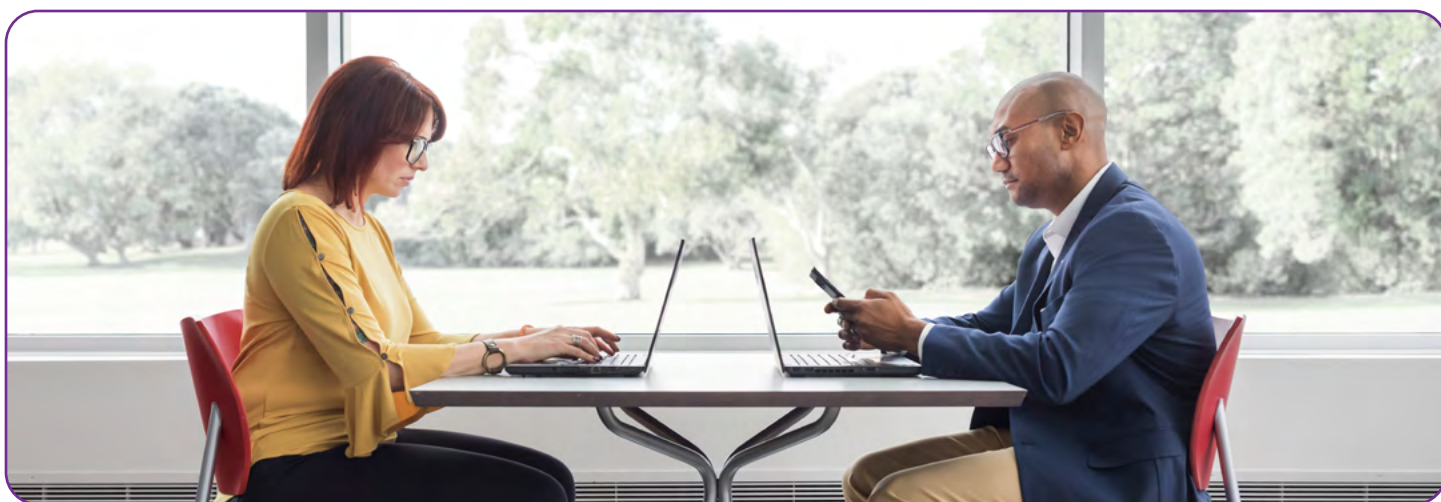
Current functionality of the Medicaid Web Portal has parallel functionality on Availity, including:

Portal Functionality

Payer Spaces	ProPAT
Change Healthcare Claim Submission Link	Provider Intake
Contact Us & Messaging	Dynamo (Case Management)
Claim Status Inquiry	Prior Authorization submission and status lookup
Grievance Submission	Eligibility & Benefits

Portal Functionality

Appeals Submission	Enhanced G&A tool
Grievance and Appeals Status	Panel Roster
Provider Deliverable Manager	Remit PDF
Ambient (Business Intelligence Reporting)	Enhanced (electronic) Remit Viewer
Clear Claim	Utilization management decision-making criteria



Login, registration, and assistance links

If already registered in Availity, providers can log in and select Aetna Better Health from their list of payers to access the portal and features listed above.

If not registered, we recommend you register immediately. Registration resources:

Acceptable	Unacceptable
Learn more about Availity Portal Registration	Availity Essentials - Sign up
Register for Availity	www.availity.com/provider-portal-registration
Availity Client Services	1-800-282-4548 , 8 AM to 8 PM ET, Monday-Friday, excluding holidays

Care Management/Service Coordination

Sometimes, managing a chronic condition or multiple conditions can become overwhelming. To offer support, a doctor, hospital discharge planner or other provider may refer an Aetna Better Health of Texas member to Care Management/Service Coordination. Additionally, a nurse on our health information line may refer members. However, they don't need to wait for a referral if they need help.

Members can self-refer by calling and asking for Care Management/Service Coordination:

- Medicaid (STAR): **1-800-248-7767** (Bexar)
- Medicaid (STAR): **1-800-306-8612** (Tarrant)
- STAR Kids: **1-844-787-5437**
- CHIP: **1-800-248-7767** (Bexar)
- CHIP: **1-800-306-8612** (Tarrant)
- TTY: **1-800-735-2939**

After a member joins Care Management/Service Coordination, they'll get a welcome letter that will explain how our services can help. They'll also get a call from a Case Manager/Service Coordinator.



Our Case Managers/Service Coordinators can:

- Help members understand their covered benefits
- Show them how to get specialty, behavioral health, or hospital services
- Talk with their doctors and other agencies to ensure they get needed services
- Teach them more about their disease or condition
- Help them locate community resources to meet their needs

ABHTX Population Health Programs

Aetna Better Health of Texas recognizes the need to align the right resources with the right member, at the right time. Not everyone requires the same level of support to manage their physical and/or behavioral health conditions. Some members prefer to use self-management tools at their convenience, while others may need reminders or assistance in scheduling preventive care services.

As a Provider, you can also help us identify members who may benefit from our **Population Health Programs**. These include programs listed below, or on our Member Website: AetnaBetterHealth.com/texas/population-health-programs.html.

- **Maternity Matters** - to promote healthy pregnancies & healthy babies
- **Care Management** - offers one-on-one support for members with specific health care needs
- **Chronic Condition Management** - for Asthma or COPD, Diabetes, Cardiovascular Diseases, Mental or Behavioral Health concerns
- **Appropriate Use of Acute Care settings** - PCP vs. ED vs Urgent Care

Members may request to opt-in or opt-out of these programs. The tools and services described here are educational support for our members. We may change them as necessary to meet the needs of our members.

Information below for Provider referrals to connect with a Care Manager or Service Coordinator:

*STAR or CHIP member referrals, providers may call **(800) 306-8612** or email to

TXSTARCHIPLeaders@Aetna.com

*STAR Kids member referrals, providers may call **(855) 243-3226; (TTY: 711)** or email to

TXSKSupervisors@Aetna.com

Or use the QR code below for your service area:

Scan for
STAR Kids



Scan for
STAR and CHIP





2026 CAHPS member satisfaction

Each year, Aetna Better Health of Texas (ABHTX) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to evaluate member satisfaction with their health care experience. Survey results help identify strengths and opportunities to improve access to care, provider communication, care coordination, and overall member satisfaction.

Key 2026 results compared to 2025

Measure	Adult 2025	Adult 2026	Adult YOY	Child 2025	Child 2026	Child YOY
Getting Needed Care	80.14%	76.86%	-3.27 pts	82.13%	85.98%	+3.85 pts
Getting Care Quickly	72.68%	75.32%	+2.64 pts	86.94%	88.72%	+1.79 pts
Rating of Health Plan	56.22%	63.18%	+6.96 pts	74.02%	70.40%	-3.62 pts
Rating of Health Care	56.30%	64.96%	+8.66 pts	77.21%	69.35%	-7.86 pts
Care Coordination	74.19%	69.44%	-4.75 pts	80.99%	82.14%	+1.15 pts
How Doctors Communicate	91.00%	86.51%	-4.49 pts	91.81%	94.95%	+3.14 pts

Adult members reported notable improvements in *Rating of Health Plan*, *Rating of Health Care*, and *Getting Care Quickly*. Child survey results demonstrated continued strength and improvement in *Getting Needed Care*, *Getting Care Quickly*, *Care Coordination*, and *How Doctors Communicate*.

Provider best practices

To help improve member satisfaction and CAHPS performance:

- Offer timely appointments for routine and urgent care.
- Minimize office wait times and communicate delays.
- Help members navigate referrals and specialty care.
- Clearly explain diagnoses, treatment plans, medications, and next steps.
- Confirm member understanding and use interpreter services when needed.
- Coordinate care with specialists and other providers to ensure continuity of care.
- Follow up on tests, referrals, and treatment recommendations.



ABHTX appreciates the partnership of our provider network in delivering high-quality, member-centered care and remains committed to improving the health care experience for all members.

Aetna Better Health members who obtain in-network care should never be balance billed.

Collaborative Care Management

To support collaborative care management with provider partners and reduce care fragmentation, the health plan and participating providers will share responsibility for delivering coordinated, patient-centered care. Each party will work collaboratively to ensure timely communication, clear accountability, and seamless transitions across care settings in support of patient outcomes and experience. Roles and responsibilities are outlined below and will be reviewed at least annually or when processes change. This collaborative approach is intended to help reduce patient frustration, improve accountability, and support improved health outcomes.



Population Health Management Programs

Population health programs are available to help support members in their health care journey. We have programs available for members who are managing conditions or just trying to stay healthy. Our programs are designed to complement the care you provide and support members by addressing preventive care, chronic conditions, maternal health and complex clinical needs. Providers can support population health program outreach by validating member status, encouraging engagement and coordinating with the member's care team as needed.



Learn more: Health Programs OR contact us at one of the following numbers:

- **1-800-248-7767 (TTY: 711)** for STAR members in the Bexar service area
- **1-800-306-8612 (TTY: 711)** for STAR members in the Tarrant service area
- **1-844-STRKIDS (1-844-787-5437) (TTY: 711)** for STAR Kids members in Tarrant or Dallas service areas
- **1-866-818-0959 (TTY: 711)** for CHIP members in the Bexar service area
- **1-800-245-5380 (TTY: 711)** for CHIP members in the Tarrant service area

Clinical practice resources

Aetna Better Health of Texas adopts nationally accepted, evidence-based clinical practice, preventive care and behavioral healthcare guidelines based on information from the U.S. Preventive Services Task Force (USPSTF), the Centers for Disease Control & Prevention (CDC), and other specialty societies and national clinical organizations.

Guidelines are adopted to facilitate improved health care and appropriateness in the delivery of healthcare. They are not intended to direct coverage or benefits determinations, or treatment decisions.

ABHTX reviews these at least every two years, or more frequently if national guidelines change within the two-year period. The guidelines are also reviewed and adopted

by our Provider Advisory Committee (PAC) and Clinical & Administrative Advisory Committee (CAAC).

Find our current Preventive, Clinical and Behavioral Health Care guidelines at:

[Clinical Guidelines & Policy Bulletins](#)

[| Aetna Medicaid Texas](#). This site also includes medical clinical policy bulletins, care resources from MCG Health, and Bright Futures recommendations for preventive pediatric care.

Providers may request hard copies of our clinical practice resource documents by contacting their Provider Relations Representative.

Role / Function	Health plan responsibilities	Provider partner responsibilities
Designated Point of Contact	Assign care management contact(s) and provide contact information.	Assign practice contact(s) and ensure availability for coordination activities and timely response.
Identification & Outreach	Identifying populations and stratifying members based on risk, clinical needs, and social drivers of health.	Support outreach by validating member status, encouraging engagement, and coordinating with the member's care team as needed.
Referrals to Care Management	Maintain a defined referral intake process and confirm receipt, triage, and assignment. Communicate enrollment status and next steps to the provider partner.	Refer eligible members using the defined process and provide relevant clinical context.
Care Plan Development & Updates	Develop an individualized care plan with the member / caregiver and share relevant care plan components and goals with the provider partner.	Engaging patients in recommended care plans and reinforcing care management interventions.
Documentation & Sharing Information	Maintain documentation of care management activities and communicate relevant updates to provider partners consistent with privacy, consent, and data-sharing requirements.	Accurately document care coordination and follow up activities in the medical record and provide requested clinical information to support coordinated, patient-centered care.
Non-Medical Drivers of Health (NMDoH) / Social Determinants of Health (SDOH) Coordination	Provide NMDoH/SDOH resource navigation and community referrals.	Screen for social risks when appropriate; coordinate referrals and document outcomes.
Gaps in Care Coordination	Communicating care gaps and care management engagement status to provider partners.	Review care gap reports shared by the health plan and take appropriate clinical action within the scope of practice.
Transitions of Care	Coordinate post-discharge outreach, medication reconciliation support, and share discharge-related information with provider partners when available.	Schedule timely follow-up visits, review discharge instructions and reconcile medications as clinically appropriate.

Shared Decision-Making Aids

At Aetna Better Health of Texas, we are committed to supporting both providers and members in making informed healthcare decisions. One of the ways we do this is through evidence-based Shared Decision-Making Aids on topics such as asthma, depression, and diabetes, as well as Medication Decision Aids for statins, antidepressants and more.

These Aids are communication tools that help providers, and their patients make informed healthcare decisions based on what is important to the patient. They are not intended to replace professional medical advice. Instead, they serve as a valuable resource to enhance patient and provider communication, and support informed decision-making on treatment options, lifestyle changes, and outcome goals to ensure that patients' values and preferences are considered in their care plans. View our Shared Decision-Making Aids at: <https://www.aetnabetterhealth.com/texas/providers/forms.html>

Colorectal Cancer Screening and Exact Sciences Cologuard

Aetna Better Health of Texas is excited to partner with Exact Sciences to foster a healthier lifestyle for your patients. According to the American Cancer Society, colorectal cancer is the third leading cause of cancer deaths in the United States, estimated to take the lives of about 53,000 Americans in 2021.

Exact Sciences is making colorectal cancer screening options available to our members at no cost through their preventive health benefits. They are committed to promoting shared decision-making in helping all our Aetna Better Health of Texas eligible members get screened.

Exact Sciences offers a non-invasive option for average risk adults 45 and older using Cologuard®, a stool-based test that detects blood and DNA associated with colon cancer and pre-cancer. The collection kit is shipped to and from your patient's home via UPS®, and Exact Sciences Laboratories provides results to you, the healthcare provider within a few weeks.

Cologuard is covered for use every 3 years with no patient copay or prior authorization required for Aetna Better Health of Texas members.

To learn more about Cologuard, visit <https://www.cologuardhcp.com/>.

Need support or have Quality Measure questions?

Reach out to the ABHTX Quality Management team at AetnaBetterHealthTXQM@aetna.com

Telehealth guidelines for Aetna medical providers

Telehealth is a cost-effective, evidence-informed option for delivering health care services, particularly for behavioral health, chronic-condition management and follow-up care. For 2026, NCQA continues to recognize telehealth, telephone, e-visit and virtual check-in encounters for applicable measures.

Billing and coding for telehealth services

- Use standard CPT and HCPCS codes for professional services.
- Include a telehealth modifier and/or a telehealth Place of Service (POS) code.
- CPT or HCPCS telehealth codes meet criteria regardless of modifier or POS code presence.

Types of telehealth visits

- 1. Synchronous telehealth:** Real-time interactive audio-video communication between provider and patient; for 2026, CPT 98000–98007 are examples for eligible E/M audio-video visits when otherwise appropriate.
- 2. Telephone visits:** Audio-only interactions that may qualify when the measure and payer rules allow; CPT 98008–98015 and CPT 98966–98968 are examples depending on provider type and service.
- 3. Asynchronous telehealth:** Also known as e-visits, digital assessments or virtual check-ins. These are not conducted in real time but require documented, two-way interaction; examples include patient portal messaging, secure messaging and review of transmitted images or recorded information. CPT 98970–98972, CPT 98016, HCPCS G0071, HCPCS G2251 and HCPCS G2252 are examples, when applicable.



Support and contact information

For assistance with appropriate coding for telehealth measures, please contact:

aetnabetterhealthtxqm@aetna.com

Measures eligible for telehealth or telephone visits include:

Abbreviation	Measure Name
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication
AXR	Antibiotic Utilization for Respiratory Conditions
CBP	Controlling High Blood Pressure
CWP	Appropriate Testing for Pharyngitis
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
FUA	Follow-Up After Emergency Department Visit for Substance Use
FUH	Follow-Up After Hospitalization for Mental Illness
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder
FUM	Follow-Up After Emergency Department Visit for Mental Illness
IET	Initiation and Engagement of Substance Use Disorder Treatment
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia
SPC-E	Statin Therapy for Patients with Cardiovascular Disease (electronic)
SPD-E	Statin Therapy for Patients with Diabetes (electronic)
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
TRC	Transitions of Care
URI	Appropriate Treatment for Upper Respiratory Infection



Close the gap today

One conversation can change a patient's outcome

Every missed screening is a missed opportunity to prevent disease, detect cancer earlier, treat infection sooner, and protect long-term health. Providers can help close gaps by making preventive screenings visible, routine, and easy to complete.

Provider reminder: Adult annual wellness visits, breast, cervical, colorectal, and chlamydia screenings are key HEDIS-aligned priorities that support early detection, timely treatment, and better outcomes.^{1,2,3} For many patients, one clear recommendation from a trusted provider is the push they need to act.

A few key screenings to check for at each visit

Identify overdue screenings, recommend next steps, and help patients' close gaps in care.

- **Adult Annual Visit:** Encourage eligible adult members aged 20 and older to complete their annual wellness visit to review health history, address preventive care needs, and identify open care gaps.¹
- **Breast cancer screening:** Encourage mammography for women ages 40-64 who are due to support earlier detection and treatment.²
- **Cervical cancer screening:** Promote Pap and/or HPV testing for patients ages 21-64 to identify precancerous changes early.²
- **Colorectal cancer screening:** Remind adults ages 50-64 who are due that screening can find cancer early and may detect precancerous polyps.²
- **Chlamydia screening:** Normalize annual screening for sexually active patients ages 16-24 and those at increased risk; untreated infection can cause serious reproductive health complications.³
- **Gonorrhea and other STI screening:** Assess risk for sexually active adolescents and adults, offer testing when appropriate, and reduce stigma by making sexual health part of routine preventive care.³

Close the gap before the patient leaves

- Check care gaps before or during every visit.
- Call out overdue screenings directly, including during sick, telehealth, and follow-up visits.
- Use clear language: “You are due for this screening. Completing it can help protect your health.”
- Make sensitive screenings, including chlamydia and STI testing, feel routine and stigma-free.³
- Address barriers in the moment, including scheduling, transportation, cost concerns, privacy, and health literacy.
- Document screenings, results, exclusions, referrals, and follow-up plans clearly.
- Use timely follow-up to help patients complete overdue or missed screenings.

Why this matters now

A screening gap is not just a quality metric. It is a patient waiting for a clear next step.

Act now: make preventive screening part of every visit where a member is due.

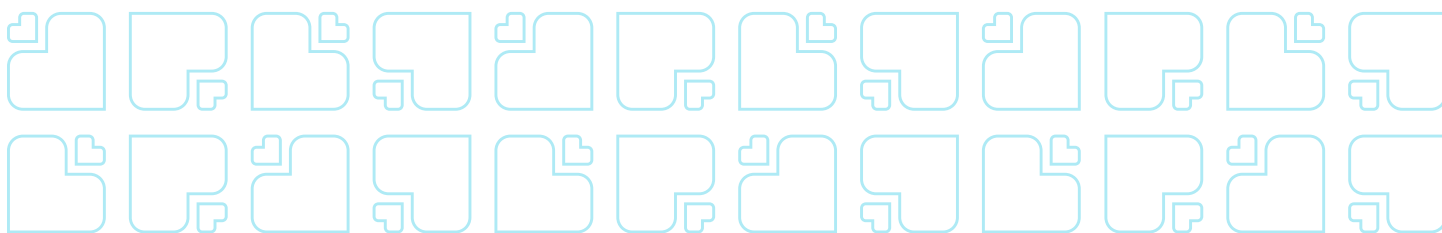
Your voice matters. Your recommendation matters. Your follow-up matters.

Need support or have Quality Measure questions?

Reach out to the ABHTX Quality Management team at AetnaBetterHealthTXQM@aetna.com.

References

1. National Committee for Quality Assurance. HEDIS Measures and Technical Resources.
2. Centers for Disease Control and Prevention. Cancer Screening Tests.
3. Centers for Disease Control and Prevention. STI Screening Recommendations.



Flu Season 2026-2027

Prevention is the key in controlling flu outbreaks each year. Now is the time to discuss, encourage, and monitor preventive measures with your staff, as well as with patients and their families. The best preventive measure is getting an annual flu vaccine, beginning at 6 months of age, unless contraindicated.

The CDC website ([2026-2027 Flu Season | Influenza \(Flu\) | CDC](#)) recommends the “S.H.A.R.E.” approach when talking to patients:

Share reasons for the importance of flu vaccines.

Highlight positive experiences of getting a flu shot.

Address patient questions.

Remind patients that flu vaccination can help protect them, their family, and friends.

Explain the potential costs of getting sick from the flu.

Other preventive flu measures:

- Encourage all medical staff to get their flu vaccine, then share their personal reasons for getting vaccinated with patients, friends, etc.
- Send flu shot reminder to patients via text, or post on Patient Portal.
- Mention flu vaccine availability, and how to schedule for flu shot on your office voicemail message.
- Use every patient encounter as an opportunity to discuss flu precautions.
- Offer flu vaccines as you register patients, or as they’re being roomed.
- Post flyers or information in your office waiting room and exam rooms.
- Getting a flu vaccine during pregnancy can also protect the baby after birth for several months, when they are too young to get vaccinated for flu.

Find useful codes for administering flu vaccines using THSteps Quick Reference Guide:

[Texas Health Steps Quick Reference Guide.](#)

And, to keep track of flu outbreaks across the U.S. check the “FluView” CDC site for weekly reports:

<https://www.cdc.gov/fluview/index.html>.

Prescription medications

Please visit our website at [AetnaBetterHealth.com/texas/providers/pharmacy.html](https://www.AetnaBetterHealth.com/texas/providers/pharmacy.html) for information about our pharmaceutical management procedures.

Here you can find:

- A list of pharmaceuticals, including restrictions and preferences
- How to use the pharmaceutical management procedures
- An explanation of limits or quotas
- How you must provide information to support an exception request
- Our process for generic substitution, therapeutic interchange and step-therapy protocols



One visit, two kidney tests

Complete diabetes kidney screening

Bundle tests. Collect urine. Close the gap.

One missed urine sample can keep a diabetes kidney screening gap open all year. As your health plan partner, we want to support timely KED gap closure for members ages 18-85 with type 1 or type 2 diabetes. KED is complete only when members receive both during the measurement year: estimated glomerular filtration rate (eGFR) and urine albumin-creatinine ratio (uACR). uACR can be either a Urine Albumin Creatinine Ratio (uACR) or a quantitative urine albumin test and a urine creatinine test within 4 days¹.

Provider Action: Before checkout, ask one question: “Did we collect the urine?” When members are due, bundle A1C, eGFR, and uACR, give the cup during rooming, collect urine the same day, and document result dates^{1,2}.

Why this matters: We know providers manage many care gaps at each visit. For KED, a CMP may help report eGFR, but it does not replace uACR. Without the uACR and result date, the KED gap can stay open¹.

That is why we encourage care teams to close KED while the member is already in the office, whenever possible.

Make bundling part of the visit flow

When	Bundle	How
Pre-visit planning	Identify the open gap early.	Check registry/labs; pend A1C, eGFR, and uACR when due. ^{1,2}
Annual wellness visit	Complete it while the member is there.	Order bloodwork and collect uACR urine before checkout. ^{1,2}
Follow-up or lab-only visit	Use the visit to close what is still open.	Use standing orders when allowed; confirm codes and result dates are captured. ¹

Even strong workflows can leave one part of KED incomplete. Use these reminders to help prevent common misses before the member leaves the office.

Common Misses to Avoid

- Instead of relying on CMP only, add uACR. CMP does not close KED alone.¹
- Instead of using urine dipstick only, order uACR.¹
- Instead of ordering bloodwork now and urine later, collect urine before checkout.
- Instead of waiting for symptoms, test annually. Kidney damage can be silent.^{2,3}

Let's make it the standard: Help ensure the visit does not end without completing or clearly ordering both parts of KED when due: eGFR and uACR. Collect urine before checkout whenever possible and document the result dates.^{1,2}

References:

1. NCQA. HEDIS Measure Library: Kidney Health Evaluation for Patients with Diabetes (KED), ages 18-85, eGFR and uACR during the measurement period.
2. American Diabetes Association. Standards of Care in Diabetes Chronic Kidney Disease and Risk Management.
3. Centers for Disease Control and Prevention. Chronic Kidney Disease Testing and Diagnosis.

Members' cultural and language needs

Aetna Better Health of Texas' membership is diverse and is constantly growing. While most of our members speak English as their preferred language, we'd like to provide you an overview of the languages spoken by our members. As indicated by the chart below:

Language	2024 Count	2024 %	2025 Count	2025 %	2026 Count	2026 %
Spanish	8,238	6.41%	8,231	6.39%	9,099	6.80%
Vietnamese	137	0.11%	140	0.11%	121	0.09%
French	64	0.05%	64	0.05%	75	0.06%
Swahili	60	0.05%	60	0.02%	64	0.05%
Pashto	51	0.04%	43	0.03%	41	0.03%

Resources for translation or interpretation services for Aetna Better Health of Texas members include:

- Providers may call **(800) 385-4101 (TTY: 711)** at least 2 business days in advance of member's appointment for translation services.
- Providers/staff may call ABHTX Member Services number below during the visit for the Language Line assistance as a third-party conversation.
- For hearing impaired services, call TTY line at **(800) 735-2989** and ask them to connect with our Member Services.
- Interpreters are also available to accompany a member to their medical visit. Please call the Member Services number below at least 72 hours in advance to arrange.

Member Services:

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

CHIP: **1-866-818-0959** (Bexar)
1-800-245-5380 (Tarrant)

STAR Kids: **1-844-787-5437**
(Dallas and Tarrant)

To learn more about Aetna Better Health of Texas' Health Equity and Cultural Competency Program Description, Goals and Resources please visit our Provider Website at [AetnaBetterHealth.com/texas/providers/health-equity.html](https://www.aetna.com/provider/health-equity.html)

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. We make medical necessity determinations based on established criteria. The criteria used to make determinations are available to practitioners at any time by contacting the member services and/or provider relation department to obtain a mailed copy.

The national criteria are made available on our website at [AetnaBetterHealth.com/texas/providers/clinical-guidelines-policy-bulletins.html](https://www.aetna.com/providers/clinical-guidelines-policy-bulletins.html)

Aetna clinical policy bulletins are available on the main Aetna website at [Aetna.com/health-care-professionals/clinical-policy-bulletins.html](https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html)



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 [AetnaBetterHealth.com/Texas](https://www.aetna.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 or reach out to your assigned provider relations representative.