aetna™

Aetna Better Health® of California

Always learning

Winter 2019

Ways to get involved as a provider

At Aetna Better Health of California (ABHCA), we strive to integrate quality and performance improvement into all of our health plan processes. Our quality program includes a structure of oversight committees with representation from ABHCA staff as well as from our provider network and member population. We welcome and encourage our contracted network providers to participate on our committees.

During these meetings, network providers can review and provide feedback on items such as proposed medical and preventive health guidelines, disease management programs, quality and HEDIS results, quality improvement study designs, policy setting, and development of action plans and interventions to improve levels of care and service. Attendance can be in-person or remote.

Call us at **1-855-772-9076** or email us at **CaliforniaProviderRelations Department@Aetna.com** to join any of the following committees:

- **Quality Management/Utilization Management Committee (QM/UM):** Advise and make recommendations on matters pertaining to the quality of care and service provided to members.

— Continued on next page

Provider manual

Aetna Better Health of California has completed its annual provider manual update, which can be located on our website at **AetnaBetterHealth.com/California/Providers/Resources**.

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Ways to get involved as a provider

— *Continued from front page*

- **Membership Advisory Committee (MAC):** Formulate strategies for improving member care and services, including health education and other member materials.
- **Public Policy Committee (PPC):** Provide a forum for the consideration and formulation of ABHCA policy on issues affecting members.
- **Pharmacy and Therapeutics Committee (P&T):** Formulate and review policies that promote the safe and effective use of approved medications.

A stipend is available for participation.

Transportation

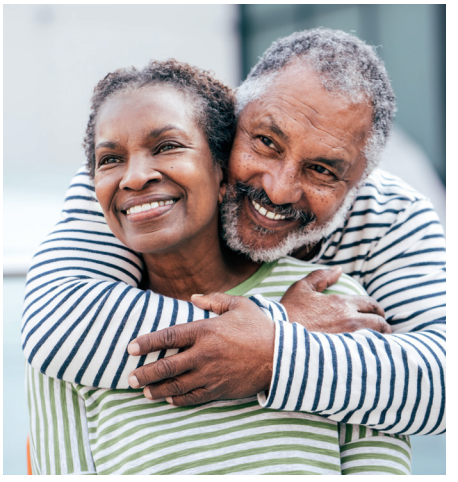
Aetna Better Health of California, in coordination with Access2Care, provides transportation to members in need of non-emergency medical transportation (NEMT) or non-medical transportation (NMT).

Members may use NEMT when:

- They are physically or medically unable to use a car, bus, train or taxi to get to a medical appointment.
- They need assistance from the driver to and from their residence, vehicle or place of treatment due to physical or mental disability.
- Their provider is requesting transportation by means of an ambulance, litter van, wheelchair van or transport.
- They have been approved by Aetna Better Health of California in advance by an authorization with provider request.

Members may use NMT when:

- They are traveling to and from an appointment for Medi-Cal services authorized by a provider.
- They do NOT require assistance from a driver or have need of an ambulance, litter van or wheelchair van.
- The service is a Medi-Cal covered benefit.



All effective members of Aetna Better Health of California are eligible to receive the transportation benefit. Members or providers may call Aetna Better Health of California at **1-855-772-9076** to schedule transportation or call Access2Care at **1-888-334-8352** at least 48 hours before the medical appointment or as soon as possible for urgent medical needs.

Member identification and validation must be provided upon scheduling transportation, including member address, member DOB and phone number, as well as the trip reason, service location, and time and day of the medical appointment.

Balance billing

What should you know about balance billing a Medi-Cal member?

Balance billing is illegal under both federal and state law. Provider must take immediate action to fix this issue once they know that their member has active Medi-Cal eligibility.

Language assistance

Language interpretation services, including sign language and special services for the hearing impaired, are available. For more information on how to schedule these services in advance of an appointment, please call Member Services at **1-855-772-9076**, 24 hours a day, 7 days a week.

Cultural conversation

Aetna Better Health of California has an ongoing commitment to increase provider cultural and linguistic competency through expanded learning opportunities. On Sept. 25, 2019, in a cultural conversation, we:

- Defined some key terms and concepts related to people who identify as LGBTQ
- Presented major LGBTQ health care disparities and social determinants of health that drive disparities
- Briefly described expectations of care and access that LGBTQ people have under Medi-Cal
- Shared and discussed resources and strategies for creating welcoming and affirming health care experiences for LGBTQ members

We look forward to having you join us for future cultural conversations. You can find additional information on our website, **AetnaBetterHealth.com/California/Providers/Training**.

EPSDT benefit — focus on dental services

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive health program for individuals under the age of 21.

Dental services are an important part of the EPSDT benefit. In 2017, just **45% of children and adolescents** ages 1 to 20 who were enrolled in Medicaid in California had **at least one preventive dental service** during the measurement year.

The following dental services are outlined under the EPSDT benefit:

- A dental screening/oral health assessment must be performed as part of every periodic assessment for members under the age of 21.
- Annual dental referrals must be made no later than 12 months of age or when referral is indicated based on assessment.
- Fluoride varnish and oral fluoride supplementation assessment and provision must be consistent with the American Academy of Pediatrics/Bright Futures periodicity schedule and anticipatory guidance. The updated schedule can be found on the AAP/Bright Futures website at **AAP.org/En-US/Documents/Periodicity_Schedule.pdf**.

Members under the age of 21 may receive dental services that are not provided by dentists or dental anesthetists but may require prior authorization for medical services required in support of dental procedures.

At Aetna Better Health of California, we inform members about the availability and importance of the EPSDT benefit, including information about dental services. We want to help ensure that children and adolescents receive the dental services they are eligible for under EPSDT to help them on their path to better health.

Working together, we can increase the number of children who receive dental services as part of their EPSDT benefit.

Sources: Medicaid.gov; California Department of Health Care Services

Health Risk Questionnaire

Aetna Better Health of California assesses members through the Health Risk Questionnaire (HRQ). Aetna Better Health of California staff members go over the HRQ with the member or caregiver during a telephone call made to each member to welcome them to the health plan. The HRQ gathers:

- Member contact information
- Primary care provider (PCP) or medical home information
- Member's health history and self-rated assessment of health
- Frequency of ER use
- Medication usage

Be safe: Get your flu shot every year

Adults: Lead the way, and get your shot today

Because flu viruses change all the time, you need to get a shot every year. If you have a serious health condition, it's even more important. Plan to get your shot every fall.

Protect your children: It's very important they get shots too

Every child 6 months of age and older should get a flu shot. Your child may need two doses the first time. Ask your doctor what's best for your child.

Source: Centers for Disease Control and Prevention

Referral options

Referrals from primary care providers (PCPs) will be provided to a specialist, if needed. The PCP's office can help set up a time to see the specialist. Other services that may require a referral include in-office procedures, x-rays, lab work, and mental health and substance use services. PCPs may provide a form for patients to take to the specialist. A specialist may treat for as long as he or she thinks the patient needs treatment. A health problem that needs special medical care for a long time may need a standing referral.

Referrals are not needed for:

- PCP visits
- OB-GYN visits
- Urgent or emergency care visits
- Family planning (to learn more, call California Family Planning Information and Referral Service at **1-800-942-1054**)
- HIV testing and counseling (only for minors 12 years or older)
- Treatment for sexually transmitted infections (only for minors 12 years or older)
- Acupuncture
- Chiropractic services
- Podiatry services
- Certain mental health and substance use services

Minors also do not need a referral for:

- Outpatient mental health services for:
  - Sexual or physical abuse
  - When they may hurt themselves or others
- Pregnancy: Family planning (except sterilization)
  - Sexual assault: HIV/AIDS testing (only for minors 12 years or older)
  - Sexually transmitted infections (only for minors 12 years or older)
  - Drug and alcohol abuse

Winter bread salad

Makes 4 servings.

Ingredients

Salad

3 cups whole-wheat Italian bread (4 ounces), in 1-inch cubes

1 garlic clove, halved lengthwise

3 very ripe plum tomatoes

1 celery rib, thinly sliced

½ cup diced sweet onion

3 cups romaine lettuce, cut crosswise into ¾-inch strips

3 tablespoons chopped flat-leaf parsley, optional

Dressing

3 tablespoons white or red wine vinegar

¼ teaspoon sea salt

½ teaspoon natural cane sugar

1 teaspoon dried oregano

Freshly ground pepper

2 tablespoons extra-virgin olive oil

Directions

- Spread cubed bread in single layer on baking sheet, and let sit until surface feels dry on most sides, or cubes are firm but not stale-hard, 2 to 6 hours.
- Rub salad bowl, preferably wood or bamboo, liberally with cut side of half a garlic clove. Reserve the other garlic half for another use.
- Cut tomatoes lengthwise into quarter-wedges, then cut crosswise into chunky pieces. Place tomatoes and any juice in prepared bowl.
- Add celery, onion and bread cubes. Arrange lettuce over chopped vegetables. Sprinkle on parsley, if using.
- For dressing, whisk vinegar, salt and sugar in small bowl until salt and sugar dissolve.
- Add oregano and 3 to 4 grinds of pepper. Whisk in oil.
- At table, pour dressing over salad and toss until well-coated and any extra dressing pools in bottom of bowl.
- Divide salad among 4 wide, shallow bowls, including liquid from bottom of salad bowl.

Nutrition information

Serving size: ¼ of recipe. Amount per serving: 158 calories, 8g total fat (1g saturated fat), 20g carbohydrates, 4g protein, 4g dietary fiber, 281mg sodium.

Source: American Institute for Cancer Research

Communicate access

Appointment availability standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Relations Department will routinely monitor compliance and seek corrective action plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the California Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

The tables below show appointment wait time standards for primary care providers (PCPs), obstetricians and gynecologists (OB-GYNs), and high-volume participating specialist providers (PSPs).

Emergency care	Urgent care	Non-urgent care	Specialty care	Ancillary services
Emergent or emergency visits: immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Urgent care for services that do not require prior authorization: within 48 hours. Services that do require prior authorization: within 96 hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by Aetna Better Health of California through other arrangements.	Non-urgent sick care: within 10 business days of request or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	Specialty care consultation, including non-urgent: within 15 business days of request or as clinically indicated.	For the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of request.

Prenatal care	Preventive care	Mental health care
First prenatal visit: within 10 business days	Within 10 business days (call your provider to make an appointment). Examples of preventive care: physicals, checkups, shots and follow-up appointments.	Within 10 business days
First trimester: within 14 days		
Second trimester: within 7 days		
Third trimester: within 3 days		
High-risk pregnancies: within 3 days of identification of high risk by Medi-Cal or maternity care provider or immediately if an emergency exists		

In-office wait times

In-office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and exam room. If a provider is delayed, patients must be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient must be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

Please note that follow-up to emergency department visits must be in accordance with emergency department attending provider discharge instructions.

Distribution of affirmative statements

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health of California does not specifically reward providers or other individuals for issuing denials of coverage or care or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

Visit our website

Our website provides information about the following:

- U.S. Preventive Services Task Force A and B recommendations
- Advisory Committee for Immunization Practice (ACIP) vaccine recommendations
- American Academy of Pediatrics periodicity schedule
- Prenatal care
- Domestic violence screening
- Hepatitis C screening
- HIV screening
- Centers for Disease Control and Prevention vaccine recommendations for pregnant women

Population management

To help provide our members with consistent, high-quality care that uses services and resources effectively, we have chosen certain clinical guidelines to help our providers. These include treatment protocols for specific conditions, as well as preventive health measures.

These guidelines are intended to clarify standards and expectations. They should not:

- Take precedence over your responsibility to provide treatment based on the member's individual needs
- Substitute as orders for treatment of a member
- Guarantee coverage or payment for the type or level of care proposed or provided

If you would like additional information on any of these topics, call **1-855-772-9076**.

- ADHD
- Alcohol abuse — National Institute on Alcohol Abuse and Alcoholism's clinician's guide
- Asthma
- Chronic heart failure
- Coronary artery disease
- Diabetes — American Diabetes Association's current clinical practice recommendations
- Major depressive disorder — American Psychiatric Association's guidelines
- Opioid use for chronic pain — Centers for Disease Control and Prevention's guidelines
- Hypertension — JNC8 guidelines
- Chronic obstructive pulmonary disease
- Tobacco cessation

Rx restrictions and preferences

A current list of preferred pharmacies and formularies are available 24/7 on our members website, located at **AetnaBetterHealth.com/California/Members/Pharmacy**.

Aetna Better Health of California's pharmacy prior authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a state's Medicaid program
- Prescriptions that do not conform to Aetna Better Health of California's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand-name drug requests, when an "A" rated generic equivalent is available

Member rights and responsibilities

Aetna Better Health members have these rights:

- To be treated with respect, giving due consideration to the member's right to privacy and the need to maintain confidentiality of the member's medical information
- To be provided with information about the plan and its services, including covered services
- To be able to choose a primary care provider (PCP) within Aetna's network
- To participate in decision-making regarding their own health care, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care received
- To receive oral interpretation services for their language
- To formulate advance directives
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and emergency services outside the Aetna's network pursuant to the federal law
- To request a state hearing, including information on the circumstances under which an expedited hearing is possible
- To have access to and, where legally appropriate, receive copies of, amend or correct their medical record
- To disenroll upon request
- To access minor consent services
- To receive written member-informing materials in alternative formats (including Braille, large-size print and audio formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how they are treated by Aetna, providers or the state

Aetna Better Health members have these responsibilities:

- Read their Evidence of Coverage. It tells them about our services, and how to file a grievance or appeal.
- Use their ID cards when they go to health care appointments or get services and do not let anyone else use their cards.
- Know the name of their PCP and care manager if they have one.
- Know about their health care and the rules for getting care.
- Tell the Plan and DHCS when they make changes to their address, telephone number or family size and when they move out of state, have an employment change or other information that might affect enrollment.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be respectful to the health care providers who are giving them care.
- Schedule their appointments, be on time, and call if they are going to be late to or miss their appointment. If they need to cancel an appointment, it must be done at least 24 hours before their scheduled visit.
- Use the emergency room for true emergencies only.
- Give their health care providers all the information they need.
- Tell the Plan and DHCS about their concerns, questions or problems.
- Ask for more information if they do not understand their care or health condition.
- Follow their health care provider's advice.
- Schedule wellness checkups. Members under 21 years of age need to follow the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule.
- Get care as soon as they know they are pregnant. Keep all prenatal appointments.
- Tell us about any other insurance they have.
- Tell us if they are applying for or get any other health care benefits.
- Bring shot records to all appointments for children under 18 years old.
- Give their doctor a copy of their living will or advance directive.
- Keep track of the cost-sharing amounts they pay.

Integrated Care Management

Aetna Better Health of California's Integrated Care Management (ICM) Program uses a bio-psycho-social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time.

We use evidence-based practices to identify members at highest risk of not doing well over the next 12 months and offer them intensive care management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary care provider (PCP). This relationship continues throughout the care management engagement.

We offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support.

Disease management is part of all care management services that we offer. To learn more, please contact Aetna Better Health of California Care Management team at **1-855-772-9076**, Monday through Friday, 8 a.m. to 5 p.m. After hours: **1-855-772-9076**. A team member should provide you with their name, title and our organization.

Clinical medical necessity

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health of California does not specifically reward providers or other individuals for issuing denials of coverage or care or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of California uses the medical review criteria listed at right. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of California's population needs and updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting or reviewing criteria. The criteria are consistently applied, consider the needs of the members and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health of California Provider Relations representative at **CAProviderRelationsTeam@Aetna.com**.

These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- Applicable MCG Guidelines as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health of California Clinical Policy Bulletins (CPBs): **Aetna.com/health-care-professionals/clinical-policy-bulletins.html** and **Aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html**.

Contact us

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1-855-772-9076
Hearing-impaired MD Relay: **711**

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