AetnaBetterHealth.com/California

Aetna Better Health® of California

What providers should know about EPSDT/Bright Futures

As a health plan, we are proud to take this opportunity to remind you about the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/ Bright Futures program that helps the child and adolescent Medicaid population.

What is EPSDT?

- A federally defined health program for children under age 21 who are enrolled in Medicaid.
- EPSDT benefits for children and adolescents are designed to ensure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible.
- EPSDT services include screening, vision, dental, hearing and other necessary health care diagnostic services.

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2023 holiday closures

Aetna Better Health of California will be closed for the following holiday:

Monday, May 29: Memorial Day

Spring 2023
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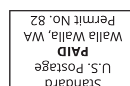


Aetna Better Health® of California
10260 Meanley Drive
San Diego, CA 92131

Community health workers

Effective July 1, 2022, DHCS added the community health worker (CHW) benefit to Medi-Cal plans. If you are a CHW provider currently providing the benefit or a provider who plans to provide this benefit in the future, please let us know by reaching out to Aetna Better Health of California's Provider Relations Department at **CaliforniaProviderRelationsDepartment@Aetna.com**.

What is a CHW?

CHW services are preventive health services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health. CHWs may include individuals known by a variety of job titles, including promoters, community health representatives, navigators and other non-licensed public health workers, including violence prevention professionals.

For more information regarding the CHW benefit, you can refer to the following website: **www.DHCS.CA.gov/Community-Health-Workers**.

What providers should know about EPSDT/Bright Futures

Continued from front page

Provider responsibilities

- Complete the required screenings according to the current American Academy of Pediatrics Bright Futures periodicity schedule and guidelines.
- Fully document all elements of EPSDT assessments, including anticipatory guidance and follow-up activities.
- Report EPSDT visits by submitting the applicable CPT codes on claim submissions.

As a reminder, we also want to highlight some incentive programs for any members who completed their healthy activities.

- Adolescent immunizations: $25
- Childhood immunizations: $50
- Child and adolescent well-visit: $25
- Lead screening in children: $25

Healthy activities for children and adolescents

- Completed **all** childhood immunizations by 2 years of age, including four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines
- Completed **all** adolescent immunizations by 13 years of age, including one dose of meningococcal vaccine; one tetanus, diphtheria toxoids and acellular pertussis (Tdap); and the human papillomavirus (HPV) vaccine series
- Completed lead blood test/screening by 2 years of age
- Completed six or more well-child visits in first 15 months of life or completed two or more well-child visits and turned 30 months old during the year
- Completed annual well-visit at 3 to 21 years of age

We want to ensure that our child and adolescent members receive the appropriate care in the right setting. Please refer to the Aetna Better Health of California Provider Manual (Chapter 8, starting on page 51) for more information.

Aetna and Availity

How to view your payments

The only way providers can access their remittances outside of the claim status inquiry is if they elect to have their 835 electronic file sent from Change Healthcare to Availity.

In addition to this, the provider must also enroll in Availity Essentials Plus, and there is a fee associated with enrollment. We know this is not a viable option for our providers, and the business team is working hard to identify a permanent solution.

In the meantime, all providers with access to the Medicaid Web Portal can continue using the "Search Remittances" functionality at no cost. Please visit **AetnaBetterHealth.com/california/providers/forms.html** to access the Medicaid Web Portal registration in the event your staff needs access to the Medicaid Web Portal.

Please fax the completed form to our Provider Relations Department at **1-844-886-8349 (TTY: 711)** or send it via email to: **CaliforniaProviderRelationsDepartment@Aetna.com**.

What is Availity?

Availity is a single log-in, multi-payer provider portal with self-service tools and provider-initiated transactions in one convenient location. Once registered, providers can simply add the Aetna instances to their registration at any time.

Availity operates Aetna's provider portal for multiple lines of business, including Commercial, Medicaid, Medicare and DSNP/MMP products. There are now two instances of Availity for Aetna products: "Aetna" instance is for Medicare/Commercial, and the "Aetna Better Health" instance is for Medicaid/DSNP/MMP. Providers will need to add both instances to their Availity profile to access our entire population. Availity will eventually replace the Aetna Better Health Medicaid Web Portal.

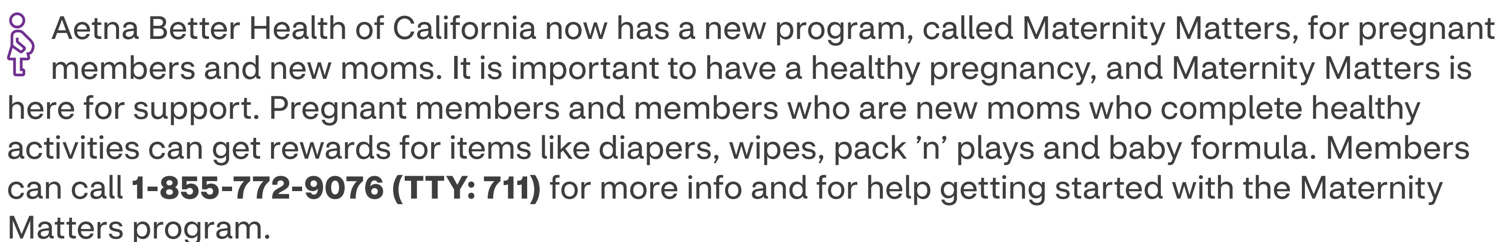
Availity allows providers to verify member eligibility and benefit coverage, submit claims and subsequent disputes, document encounters, submit appeals and grievances, and update their rosters. You can learn about the additional functions in one of the training options offered by Availity.

How to receive training

In addition to Availity Client Services, Availity offers a wide range of training sessions for all users via the Availity Essentials Provider Portal. You can simply click on the "Help & Training" drop-down to access both upcoming sessions as well as pre-recorded webinars.

You can call Availity directly at **1-800-AVAILITY** (**1-800-282-4548**), Monday through Friday from 8 AM to 8 PM ET (excluding holidays). Availity can also be reached through direct messaging when available. Availity should be contacted for any connectivity or account concerns. Any concerns with an Aetna decision or information on Availity should be directed to the respective provider services.

Maternity Matters program



Aetna Better Health of California now has a new program, called Maternity Matters, for pregnant members and new moms. It is important to have a healthy pregnancy, and Maternity Matters is here for support. Pregnant members and members who are new moms who complete healthy activities can get rewards for items like diapers, wipes, pack 'n' plays and baby formula. Members can call **1-855-772-9076 (TTY: 711)** for more info and for help getting started with the Maternity Matters program.

It's time for our annual behavioral health survey!

As an ongoing effort to understand, analyze and increase member satisfaction, the annual behavioral health survey season is here! This survey will be run through the end of the year. Unlike the other administered survey, this survey specifically targets member experiences and satisfaction with the behavioral health care received by Aetna Better Health of California members in both Sacramento and San Diego counties.

Listed below are some of the objectives that this survey is trying to assess:

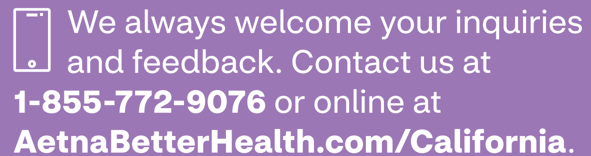
- Access to and timeliness of behavioral health
- Communications with clinicians
- Patients' rights
- Member services and assistance
- Overall rating of behavioral health care provider

Please encourage your patients/members to complete the survey and share their experience. At the plan level, our overarching goal is to provide actionable performance feedback to help improve member experience based on the results.

By working together to impact member experience, we will continue to strive to:

- Improve members' overall experience and health outcomes
- Build rapport between clinicians and members
- Ensure that members have access to and timeliness of their care
- Provide additional resources

As always, thank you for partnering with us to serve the communities of Sacramento and San Diego counties by providing quality health care and accessible, medically necessary services.



We always welcome your inquiries and feedback. Contact us at **1-855-772-9076** or online at **AetnaBetterHealth.com/California**.

You can also contact Merrett Sheridan, Aetna Better Health of California Behavioral Health Clinical Liaison, directly at **SheridanM1@Aetna.com**.

Visit our website

Our website provides information about the following:

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

We have a new Provider Dispute Resolution Request (PDR) mailing address. The new address is on the current PDR form on the provider website.

For claims questions, please contact our Claims Inquiry and Research Department Monday through Friday from 8 AM to 5 PM at **1-855-772-9076**.

COVID-19 guidance for Medi-Cal managed care health plans

The Department of Health Care Services (DHCS) has issued several All Plan Letters (APLs) to Medi-Cal managed care providers in response to the ongoing COVID-19 crisis. Aetna Better Health of California will periodically share summaries of these APLs with providers. We want to make sure you're aware of the information so that you can apply the information to your practice or facility operations, where appropriate.

The purpose of APL 22-009 is to provide information to Medi-Cal managed care health plans on changes to federal and state requirements for COVID-19 testing, treatment and prevention. This article contains a summary of APL 22-009 in the next few pages. However, providers should review the APL in its entirety to stay up-to-date on COVID-19 guidance at **www.DHCS.CA.gov/Documents/COVID-19/APL-22-009.pdf**.

In accordance with APL 22-009, providers are also encouraged to educate members about at-home kits and the availability of the kits through their provider offices or through Medi-Cal Rx.

To locate an eligible pharmacy, members can visit **Medi-CalRx.DHCS.CA.gov/home/find-a-pharmacy**.

Background information on APL 22-009

The Centers for Medicare & Medicaid Services (CMS) issued guidance on Medicaid-eligible COVID-19-related treatment under the American Rescue Plan Act of 2021 (ARP). The ARP not only covers acute COVID-19-related symptoms, but also encompasses post-COVID-19 conditions such as "long COVID-19," which includes a range of symptoms that can last months after a member is first infected with the COVID-19 virus.

Post-COVID-19 complications, occasionally referenced as "long COVID-19," can also occur weeks or months after initial infection. Changes to covered services were made to improve health outcomes and reduce health disparities, especially for those disproportionately impacted by the pandemic.

Section 9811(a) of the ARP added a new mandatory Medicaid benefit at section 1905(a)(4)(F) of the Social Security Act. Under these amendments, as of March 11, 2021, state Medicaid programs have been required to cover treatments for COVID-19, including specialized equipment and therapies (including preventive therapies). Additionally, under these amendments, as of March 11, 2021, state Medicaid programs must cover the

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COVID-19 guidance for Medi-Cal managed care health plans

Continued from page 5

treatment of any condition that may seriously complicate the treatment of COVID-19, if otherwise covered under the state plan (or waiver of such plan, including a section 1115 or 1915(b) demonstration) for individuals who are diagnosed with or presumed to have COVID-19 during the period if such an individual has (or is presumed to have) COVID-19.

Members with conditions that may seriously complicate the treatment of COVID-19 include those with underlying comorbidities that create a higher risk of progressing to severe COVID-19.

Examples of conditions that may seriously complicate the treatment of COVID-19 include but are not limited to:

- Cardiovascular diseases
- Chronic lung diseases
- Diabetes
- Cancer
- Obesity
- Down syndrome
- Organ transplants or immunosuppressive therapy

The determination of whether a condition could seriously complicate treatment for COVID-19 should be based on a member-specific assessment performed by a provider.

CMS interprets the ARP coverable services requirements as similar to the

Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements in section 1905(r)(5) of the Social Security Act (Act). Under federal EPSDT requirements, states are required to furnish all appropriate and medically necessary services that are coverable under a Medicaid State Plan (as described in section 1905(a) of the Act), regardless of whether those services are covered in the state's Medicaid plan.

Therefore, any non-pharmacological item or service, to include specialized equipment and therapies and preventive therapies, must be covered under ARP if it is considered medically necessary for the treatment of COVID-19 and post-COVID-19 conditions or "long COVID-19" and is otherwise coverable under a state plan, regardless of whether it is covered under California's Medicaid state plan.

These coverage requirements generally end on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. However, under section 1902(a)(10)(A)(ii)(XXIII) of the Act and the statutory language following section 1902(a)(10)(G) of the Act, states can provide Medicaid coverage to the optional COVID-19 group only through the last day of the COVID-19 public health emergency (PHE).

California Senate Bill (SB) 510 also delineates new requirements for diagnostic and screening testing, as well as health care services related

to the testing of COVID-19 or any future disease declared to be a PHE by the governor of the state of California.

The bill addresses retroactive coverage of these services beginning from when the governor declared a state of emergency for the COVID-19 pandemic on March 4, 2020. The bill also addresses coverage for an item, service or immunization intended to prevent or mitigate COVID-19 that is recommended by the U.S. Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.

COVID-19 vaccinations and vaccination administration are carved out for managed care plans and covered through Medi-Cal fee-for-service (FFS). Managed care plans are contractually required to ensure the provision of all USPSTF Grade A and B preventive services for adults and children and all American Academy of Pediatrics Bright Futures recommendations for members less than 21 years of age, and they are also contractually required to ensure the provision of vaccines in accordance with ACIP recommendations.

Additionally, President Biden and Gov. Newsom have emphasized the importance of rapidly connecting people who test positive for COVID-19 with treatment as an effective way to decrease morbidity and mortality from COVID-19. Several treatments are available, effective and recommended for treatment of non-hospitalized adults and children at high risk of progressing to severe COVID-19. However, to be effective, these treatments must be initiated as soon as possible after diagnosis and within five to seven days of symptom onset, and current use remains low. Medi-Cal Rx has issued guidance on appropriate billing practices for carved-out treatments.

Test-to-treat programs are often referenced in regard to COVID-19 therapeutics. The concept highlights the importance of expediting treatment so that all those who test positive are expeditiously funneled into assessment for therapeutic treatment interventions. The federal government has set up test-to-treat physical sites that enable this to occur within a single encounter for a member at a physical site; information to assist with finding these test-to-treat sites is being added to My Turn. However, test-to-treat as a concept applies to generally ensuring the key elements of assessment and treatment (i.e., (1) testing, (2) prescribing and (3) therapeutic) occur expeditiously regardless of whether they are occurring in a single encounter or physical visit. With the advent of at-home antigen tests and telehealth, expedited access may not necessarily mean members must have (1) testing, (2) prescribing and (3) therapeutic occurring at a single encounter or at a physical site and may instead be provided in a more streamlined process expediting COVID-19 care delivery.

For more information and guidance on APL 22-009, please visit **www.DHCS.CA.gov/Documents/COVID-19/APL-22-009.pdf**.

COVID-19 updates and office closures

During these unprecedented times, we understand that providers may experience hardships or be required to close, either temporarily or permanently, due to complications or hardships experienced due to the COVID-19 pandemic. The health and safety of our members and providers is very important to us, and we want to assure you that Aetna Better Health of California is here to support and assist our providers through these times.

Masks are no longer required indoors in California, with a few exceptions. But they are still strongly recommended.

When to wear a mask

These are the statewide guidelines for masks. Your local area may require masks where the state doesn't. Check your area's COVID-19 website at **COVID19.CA.gov/get-local-information/#County-websites**.

Should your office need to make changes to your hours of operation or close your office either temporarily or permanently, please let us know so that we can support your office through these changes at **1-855-772-9076 (TTY: 711)** or via email at **CaliforniaProviderRelationsDepartment@Aetna.com**.

Please visit **COVID19.CA.gov/vaccines** for information on the state's vaccination planning efforts.

What you need to know about electronic visit verification

The California Electronic Visit Verification (CalEVV) program is pleased to announce that, as of October 2022, Home Health Care Service (HHCS) providers will be able to register in the CalEVV system.

Am I subject to EVV?

Please visit the Department of Health Care Services (DHCS) EVV website at **www.DHCS.CA.gov/provgovpart/Pages/EVV.aspx** and review our Provider Types and Codes document at **www.DHCS.CA.gov/provgovpart/Documents/EVV-Provider-Types-Codes.pdf** to access "EVV Provider Type, Procedure, and Place of Service Codes" to determine which providers will be impacted by EVV requirements. Please note that DHCS may amend this document at any time due to federal requirements.

Exclusions

The following services are not subject to EVV requirements:

- HHCS or personal care services (PCS) that do not require an in-home visit are not subject to EVV requirements.
- HHCS or PCS provided in congregate residential settings where 24-hour service is available are not subject to the EVV requirements.
- HHCS or PCS rendered by an individual living in the member's residence does not constitute an "in-home visit" and is not subject to EVV requirements.
- Any services rendered through the Program of All-Inclusive Care for the Elderly or Hospice services.
- HHCS or PCS that are provided to inpatients or residents of a hospital; nursing facility, including skilled nursing facility or residence of nursing facility; intermediate care facility for individuals with intellectual disabilities;

or an institution for mental diseases.
- Durable Medical Equipment is not subject to EVV requirements.

Step 1: Provider self-registration

Please go to **VendorRegistration.CalEVV.com** to register in the CalEVV system. Provider Agencies of HHCS are required to register in the provider self-registration portal. For additional guidance on registration, the following links may help:
- **www.DHCS.CA.gov/provgovpart/Documents/CalEVV-Provider-Self-Registration-QRG.pdf**
- **Sandata.ZenDesk.com/hc/en-us/articles/8614759432211-CalEVV-New-Provider-Self-Registration-and-Onboarding-Video**

HHCS providers who have not already registered to provide EVV for personal care services must complete the self-registration process to gain access to the state-sponsored EVV system. Providers of PCS who also provide HHCS services do not register again. New HHCS providers are to be registered in the online self-registration portal, trained on how to operate the solution and capture the six data elements with each in-home visit by January 1, 2023.

Each HHCS provider will need to identify a jurisdictional entity (JE) for the CalEVV program. A JE is a business entity responsible for the delivery or coordination of care for one or more Medicaid programs. For DHCS, examples of JEs include home- and community-based waiver agencies, managed care plans, counties, and DHCS in some cases.

Open vendor approach

The CalEVV will utilize an open vendor approach that will allow providers to choose between the state's EVV solution or an alternate EVV solution that meets state and federal EVV requirements.
- State EVV vendor: Commonly called CalEVV solution
  - The state contracted with Sandata Technologies, LLC (Sandata) to provide a state-sponsored EVV system. Sandata is providing California with an EVV system that includes the ability to capture data elements during the visit.
- Alternate EVV system
  - HHCS providers have the option to implement EVV requirements using an alternate EVV system. However, the alternate EVV system must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to the CalEVV aggregator. HHCS providers who choose to use an alternate EVV system are required to register in the EVV self-registration portal and must participate in state-sponsored training provided by Sandata.

If using the CalEVV state-provided system:
- After registration is complete, you will receive a CalEVV identifier number. Save this number.
- You will receive an email on how to complete the required initial CalEVV system training. Use the links in the email to access this training. Save the available certificate from the training screen, including links to register for this training.
- After you've completed the required initial training, you will receive an email with information on how to set up your CalEVV account. Set up your account. Use the information from the CalEVV system data entry training, if needed.

Continued on next page

What you need to know about electronic visit verification

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- Provide staff training (if applicable) using the webinars and recorded videos that you can access after completing your initial CalEVV system training.

If you are using an alternate EVV vendor system:
- After registration is complete, you will receive a CalEVV identifier number. Save this number.
- Ensure that your selected alternate EVV vendor successfully completes testing with Sandata Technologies, LLC, to send EVV data to the CalEVV aggregator.
- Take CalEVV aggregator training using the link you will receive via email from the California alternate EVV customer support team.

For more information about the California alternate EVV technical specifications and alternate EVV certification process, visit **Sandata.ZenDesk.com/hc/en-us/sections/4409817882387-California-CalEVV** or email alternate EVV customer support at **CAAltEVV@Sandata.com**.

Step 2: Register and complete training

Once your provider agency is registered in the CalEVV system, your agency administrator will then receive an email with your CalEVV ID and a training link for the agency administrator. Please keep and save this ID.

Agency administrators will register for and take initial training courses.
- Provider agency administrators will take the two initial mandatory training courses through the Learning Management System (LMS), EVV Overview and Security, which provides the basics on how to manage user setup and security in the EVV portal.
- Courses located in Sandata's LMS training are self-paced and approximately 90 minutes of content.
- Once initial training courses are complete, the agency administrator will receive production credentials and a confirmation email with next steps.

Following agency administrator initial trainings:
- Approximately 24 to 48 hours after training is completed, the agency administrator will receive an email with directions on how to log in to the eTRAC system and download your agency's Welcome Kit.
- Initial login credentials.
  - Information needed to log visits using the telephonic system.
  - Other helpful system information as you get started in CalEVV.
- Send CalEVV ID and training link to staff.
- Create staff account(s) and add recipient information.

Please sign up to attend live webinar training at **Go.OnceHub.com/CalEVVProviderTraining**. HHCS providers will gain access to extensive training and technical assistance, including self-guided learning modules and EVV system demonstrations, provided by Sandata.
The following CalEVV video library can be accessed at any time by staff or as a refresher to current staff on ensuring provider compliance: **https://protect-us.mimecast.com/s/P7XECQWBOEuonO5gMIODP7f?domain=gcc02.safelinks.protection.outlook.com**.

Step 3: Submitting all 6 data elements for each in-home visit

The EVV solution or the alternate EVV solution must capture all six data elements listed below for each in-home visit:
- The type of service performed
- The individual receiving the service
- The date of the service
- The location of service delivery
- The individual providing the service
- The time the service begins and ends

Provider compliance

Per the federal CURES Act, if a provider (enrolled, contracted or subcontracted) renders Medi-Cal services that are subject to EVV, that provider is required to be registered, trained using either the CalEVV system or an alternate EVV solution, and submit EVV visit data no later than **January 1, 2023**. Otherwise they will be considered out of compliance. As a result, DHCS may take disciplinary action(s) to address the noncompliant provider, per W & I §14043.51.

Next steps
- HHCS providers to register in the CalEVV solution starting **immediately** and begin training.
- JEs may participate in EVV webinars and may forward all DHCS EVV communications to their HHCS providers and INPs for awareness.
- HHCS providers must be compliant with EVV requirements as of January 1, 2023.
- If you are receiving this letter in error or EVV does not impact your agency, please email us so that our EVV team can remove your contact information from our distribution list.

Contacts and resources

Please visit our DHCS EVV webpage at **www.DHCS.CA.gov/provgovpart/Pages/EVV.aspx** for up-to-date guidance and information related to the implementation of EVV in California.

If you have comments, questions or suggestions regarding EVV or would like to be added to the EVV stakeholder process interested parties email list, please email **EVV@DHCS.CA.gov**.

For technical assistance with the CalEVV solution, please call or email your Customer Support team at **1-855-943-6070** or **CACustomerCare@Sandata.com**.

For alternate EVV assistance, please call or email your Customer Support team at **1-855-943-6069** or **CAAltEVV@Sandata.com**.

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multi-year initiative led by the Department of Health Care Services that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program. CalAIM leverages Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents and takes a person-centered approach that targets social determinants of health and reduces health disparities and inequities.

For the latest Aetna Better Health of California Enhanced Care Management and Community Supports providers, please visit **AetnaBetterHealth.com/california/index.html**.

Enhanced Care Management

As of January 1, 2022, Aetna Better Health of California covers Enhanced Care Management (ECM) services for members with highly complex needs. ECM is a benefit that provides extra services to help Aetna Better Health of California members get the care needed to stay healthy. ECM providers help coordinate primary care, acute care, behavioral health, developmental health, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

Members who qualify may be contacted about ECM services. You or members can also call Aetna Better Health of California to find out if and when members can receive ECM.

Covered ECM services

Qualifying members for ECM will have their own care team, including a care coordinator. Care coordinators will talk to members and affiliated doctors, specialists, pharmacists, case managers, social services providers and others to make sure everyone works together to provide needed care. A care coordinator can also help you find and apply for other services in your community. ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Cost to member

There is no cost to the member for ECM services.

Community Supports

Community Supports (CS), considered in lieu of services (ILOS), may be available under an individualized care plan. ILOS are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal state plan. These services are optional for members to receive. If a member qualifies, these services may help them live more independently. Community Supports do not replace benefits already covered under Medi-Cal. Examples of Community Supports are housing transition navigation services, personal care attendants or medically tailored meals.

County	Organization name	ECM	CS
Sacramento and San Diego	24-hour home care		Y
Sacramento and San Diego	G.A. Food Services of Pinellas County, LLC		Y
Sacramento and San Diego	MedZed Physician Services	Y	Y
Sacramento and San Diego	Mom's Meals		Y
Sacramento and San Diego	Roots Food Group Holdings, Inc.		Y
Sacramento and San Diego	City of Samaritan PDC		Y
Sacramento and San Diego	Serene Health IPA	Y	Y
Sacramento and San Diego	Titanium Healthcare	Y	Y
Sacramento	Sacramento Covered	Y	Y
Sacramento	Sacramento Self-Help Housing		Y
Sacramento	The Salvation Army, Sacramento County		Y
Sacramento	WellSpace Health	Y	Y
Sacramento	Sacramento Native American Health Center	Y	
Sacramento	Elica Health Centers	Y	
San Diego	Family Health Centers of San Diego, Inc.	Y	Y
San Diego	Foundation for Senior Care		Y
San Diego	Interfaith Community Services		Y
San Diego	La Maestra Family Clinic Inc.	Y	Y
San Diego	Mama's Kitchen		Y
San Diego	McAlister Institute		Y
San Diego	Metro Community Ministries, Metro Pathways		Y
San Diego	North County Lifeline, Inc.		Y
San Diego	PATH San Diego (People Assisting The Homeless)	Y	Y
San Diego	San Diego Healthcare Quality Collaborative		Y
San Diego	Grondin Construction Inc.		Y
San Diego	Father Joe's Villages		Y

As a reminder, if you are a provider enrolled with Find Help, please be sure to complete your screener as soon as possible. In addition, if you require an overview or training with FindHelp, please reach out to **CaliforniaProviderRelationsDepartment@Aetna.com**.

Managing chronic conditions

Current type 2 diabetes (T2DM) guidelines (American Diabetes Association 2022) recommend the use of **sodium/glucose cotransporter-2 inhibitors (SGLT2i)** and **glucagon-like peptide-1 receptor agonists (GLP-1RA)** in patients with type 2 diabetes **who have comorbidities,** such as heart failure, chronic kidney disease and/or previous atherosclerotic cardiovascular disease.

Additionally, heart failure guidelines (AHA/ACC/HFSA 2022) recommend SGLT2i in patients with symptomatic chronic HFrEF, irrespective of the presence of T2DM, to reduce hospitalization for heart failure and cardiovascular mortality.

The following table illustrates drugs in this class in more detail, along with their respective coverage under the Medi-Cal Rx benefit.

Drug class	Effects	CV benefits		Renal benefits	Safety	Medi-Cal Rx coverage
		ASCVD	HF			
SGLT2i	HbA1c reduction 0.5-0.7% Weight loss	**Empagliflozin (Jardiance)*** Canagliflozin (Invokana)†	**Empagliflozin (Jardiance)*** **Dapagliflozin (Farxiga)*** Canagliflozin (Invokana)† Ertugliflozin (Steglatro)†	**Empagliflozin (Jardiance)*** **Dapagliflozin (Farxiga)*** Canagliflozin (Invokana)†	• DKA risk • Risk of bone fractures (canagliflozin) • Genitourinary infections • Risk of volume depletion • Increase in LDL cholesterol • Risk of Fournier's gangrene	**Covered w/o PA** • Jardiance • Farxiga • Synjardy • Trijardy XR • Glyxambi **Covered w/ PA** • Invokana • Steglatro • Invokamet XR • Xigduo XR • Segluromet • Qtern • Steglujan
GLP-1RA	HbA1c reduction 0.5-1.5% Weight loss	**Dulaglutide (Trulicity)*** **Liraglutide (Victoza)*** **Semaglutide (Ozempic)***		**Dulaglutide (Trulicity)*** **Liraglutide (Victoza)*** **Semaglutide (Ozempic)***	• FDA Black Box: risk of thyroid C-cell tumors in rodents (liraglutide, dulaglutide, exenatide ER, semaglutide) • GI side effects • Injection site reactions • Pancreatitis	**Covered w/o PA** • Trulicity • Victoza • Ozempic **Covered w/ PA** • Xultophy

Covered by Medi-Cal Rx (last updated: January 2023)
†Requires PA by Medi-Cal Rx (last updated: January 2023)

Non-emergency medical transportation (NEMT)

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

Members may use NEMT when:

- Members are physically or medically unable to use a car, bus, train or taxi to get to a medical appointment.
- Assistance is needed from the driver to and from the member's residence, vehicle or place of treatment due to physical or mental disability.
- Provider is requesting transportation by means of ambulance, litter van, wheelchair van or transport.
- Approved by Aetna Better Health of California in advance by an authorization with provider request.

Provider requirements for NEMT are the following:

NEMT Physician Certification Statement (PCS) forms. Managed care plans (MCPs) and transportation brokers must use a Department of Health Care Services-approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency among all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

Members may use NMT when:

- Traveling to and from an appointment for Medi-Cal services authorized by a provider.
- They do NOT require assistance from a driver or need 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 (TTY: 711)** to schedule transportation or call Access2Care at **1-888-334-8352 (TTY: 711)** 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 the member's address, date of birth and phone number, as well as the trip reason, service location, and time and day of the medical appointment.

Member rights

Members, their families and their guardians have the right to information related to Aetna Better Health of California, its services, its providers, and member rights and responsibilities in a language they can understand.

Members have the following rights:

- Know the cost to them if they choose to get a service that Aetna Better Health does not cover
- Receive information about how to submit a complaint, grievance, appeal or request for a hearing, including information on the circumstances under which an expedited state hearing is possible, about Aetna Better Health or the care received
- Use the methods described in the Member Handbook to share questions and concerns about their health care or about Aetna Better Health
- Tell us about ways to improve our policies and procedures, including the member rights and responsibilities
- Receive treatment and information that are sensitive to their cultural or ethnic background
- Get interpretation services if they do not speak English or have a hearing impairment to help them get the medical services they need
- Receive information about advance directives or a living will, which tell how to have medical decisions made for them if they are not able to make them for themselves
- Know how Aetna Better Health pays providers, controls costs and uses services
- Get emergency health care services without the approval of their primary care provider (PCP) or Aetna Better Health when they have a true medical emergency
- Be told in writing by Aetna Better Health when any of their health care services requested by their PCP are reduced, suspended, terminated or denied — they must follow the instructions in their notification letter
- To be treated with respect, giving due consideration to their right to privacy and the need to maintain confidentiality of their medical information
- To be provided with information about the network practitioners and providers, the plan and its services, including covered services
- To be able to choose a PCP within Aetna Better Health of California'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 care coordination
- To request an appeal of decisions to deny, defer, or limit services or benefits
- To receive oral interpretation services for their language
- To receive free legal help at their local legal aid office or other groups
- To formulate advance directives
- 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; members who can request expedited disenrollment include, but are not limited to, those receiving services under the Foster Care or Adoption Assistance Programs and those with special health care needs
- To access Minor Consent Services
- To receive written member-informing materials in alternative formats (such as Braille, large-size print and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions 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 and discuss information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand
- To have access to and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §§ 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how they are treated by Aetna Better Health of California, their providers or the state
- To have access to family planning services, freestanding birth centers, federally qualified health centers, Indian Health Service facilities, midwifery services, rural health centers, sexually transmitted disease services and emergency services outside Aetna Better Health of California's network, pursuant to federal law

What you need to know about new facility site review requirements

We want to remind our network primary care providers that, while the DHCS Facility Site Review "New Standards" went into effect July 1, 2022, APL 22-017 (All Plan Letter), that governs facility site review requirements, went into effect January 1, 2023.

Below are some of the changes that will impact future facility site reviews per APL 22-017:

1. Critical Elements have gone from 9 to 14.
2. Corrective plans have changed from 45 days to 30 calendar days.
3. Relocated sites or new sites that do not pass the initial facility site review after two attempts will not be added to the network and may reapply in six months. Members assigned to sites that do not pass the initial facility site review will be reassigned to other network PCPs.
4. Provider sites that must be terminated due to noncompliance either with the facility site review process or the CAP timeline process, according to APL 22-017, will not be able to protest that termination but may reapply for Medi-Cal network status in three years.

(Please note: All MCPs will terminate Medi-Cal contracts due to noncompliance.)

There are full trainings on Facility and Medical Records standard changes on Aetna's website at **AetnaBetterHealth.com/california/providers/facility-site-review.html**.

We hope this helps with understanding some of the changes in APL 22-017.

For more information and guidance on APL 22-017, please refer to **www.DHCS.CA.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-017.pdf**.

Member responsibilities

Aetna Better Health of California encourages members to be responsible for their own health care by becoming informed and active participants in their care. Aetna Better Health of California members, their families or guardians have these responsibilities:

- Read their evidence of coverage. It tells them about our services and how to file a grievance or appeal.
- Follow Aetna Better Health rules.
- Use their ID cards when they go to health care appointments or get services, and to not let anyone else use their cards.
- Make and keep appointments with doctors. If they need to cancel an appointment, it must be done at least 24 hours before their scheduled visit.
- Treat the doctors, staff and people providing services to them with respect.
- Know the name of their primary care provider and their care manager, if they have one.
- Know about their health care and the rules for getting care.
- Tell the plan and the Department of Health Care Services when they make changes to their address, telephone number, family size, employment and other information, such as moving out of state, 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 or miss their appointment. If they need to cancel an appointment, it must be done at least 24 hours before their scheduled visit.
- They should use the emergency room for true emergencies only.
- Give all information about their health to Aetna Better Health and their doctor. This includes immunization records for members under age 21.
- Tell their doctor if they do not understand what their doctor tells them about their health so that the member and their doctor can make plans together about their care.
- 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 what they and their doctor agree to do. Make follow-up appointments. Take medicines and follow their doctor's care instructions.
- 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 Aetna Better Health and DHCS when their address changes. Tell them about family changes that might affect eligibility or enrollment. Some examples are changes in family size, employment and moving out of the state/region of California.
- 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.

Population health 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

Call **1-855-772-9076 (TTY: 711)** if you would like additional information about any of these topics:

- 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 — JNC 8 guidelines
- Chronic obstructive pulmonary disease (COPD)
- Tobacco cessation

Language assistance, interpretation and translation

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation and sign language services to members. To assist providers with this, Aetna Better Health of California makes its telephonic and face-to-face language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider.

Language services can be accessed by contacting the Aetna Better Health of California Member Services Department at **1-855-772-9076 (TTY: 711)**. Be advised that face-to-face interpretation requires a 48-hour advance notice of the member's appointment. Aetna Better Health of California also provides alternative methods of communication for members who are visually impaired, including large print and other formats, which can by requested by contacting Member Services.

Referral options

Referrals from PCPs will be provided to specialists, 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 they think 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 or OB-GYN visits
- Urgent or emergency care visits
- Family planning (to learn more, call the 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 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

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.

Provider Relations 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, considering the urgency of and the need for the services.

The table at the top right has appointment wait time standards for primary care providers (PCPs), obstetricians and gynecologists (OB-GYNs), and high-volume participating specialist providers (PSPs).

Please note that follow-ups to emergency room (ER) visits must be in accordance with ER attending provider discharge instructions.

Emergency	Urgent	Non-urgent	Specialty	Mental health
Immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Services that do not require prior authorization: within 48 hours; for services that do require prior authorization: within 96 hours. Provisions must be available for obtaining urgent care 24 hours a day, 7 days per week.	Within 10 business days of request or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	Within 15 business days of request or as clinically indicated.	Members can expect to be seen by the provider within 10 business days.

Prenatal care. Members will be seen within the following time frames:

- First prenatal visit: 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

Physicals. This is regular care to keep members and their children healthy. When a member calls to make an appointment for preventive care, they can expect to be seen within 10 business days. Examples of preventive care are checkups, shots and follow-up appointments.

Ancillary services. For the diagnosis or treatment of injury, illness or other health condition: within 15 business days of request.

Wait times:

- Scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining 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.

Please note: Pursuant to Health & Safety Code § 1367.27(j)(2), if a provider who is not accepting new patients is contacted by a member or potential member seeking to become a new patient, the provider shall direct the member or potential member to both Aetna Better Health of California for additional assistance in finding a provider and to the DMHC to report any inaccuracy with the plan's directory or directories.

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 supportive care management services to members who are at lower risk. These include standard clinical care management and service coordination and support. Disease management is part of all care management services that we offer. Practitioners, caregivers and members can self-refer into care management. To learn more, please contact the Aetna Better Health of California Care Management team at **1-855-772-9076 (TTY: 711)**, Monday through Friday, 8 AM to 5 PM. Our after-hours team is also available to take your call. A team member should provide you with their name, title and our organization.

Telephone accessibility standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available or having on-call arrangements in place with other qualified participating Aetna Better Health of California providers for the purpose of rendering medical advice and determining the need for emergency and other after-hours services, including authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage response for routine, urgent and emergent health care issues is held to the same accessibility standards, regardless if after-hours coverage is managed by the primary care provider (PCP), current service provider or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we encourage

our providers to offer open-access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web or communication via email) between members, their PCPs and practice staff.

Providers must return calls within 30 minutes. We routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver and provider grievances regarding after-hours access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable	Unacceptable
• Telephone is answered by provider, office staff, answering service or voicemail. • The answering service either: - Connects the caller directly to the provider - Contacts the provider on behalf of the caller, and the provider returns the call - Provides a telephone number where the provider/ covering provider can be reached • The provider's answering machine message provides a telephone number to contact the provider/covering provider.	• The answering service: - Leaves a message for the provider on the PCP's/covering provider's answering machine - Responds in an unprofessional manner • The provider's answering machine message: - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations - Instructs the caller to leave a message for the provider • No answer • Listed number no longer in service • Provider no longer participating in the contractor's network • On hold for longer than 10 minutes • Answering service refuses to provide information for after-hours survey • Telephone lines persistently busy despite multiple attempts to contact the provider

Providers must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.

Clinical medical necessity

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of California uses the medical review criteria listed below. Criteria sets are reviewed annually for appropriateness to 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.

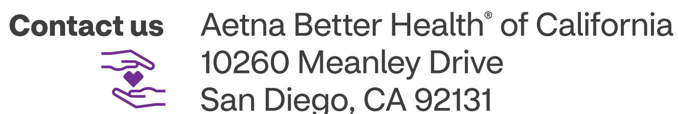
Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health of California Provider Relations representative at **CaliforniaProviderRelationsDepartment@Aetna.com**.

These are to be consulted in the order listed:

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

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.



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Hearing-impaired MD Relay: **711**
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