Stay safe

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AetnaBetterHealth.com/California

Aetna Better Health® of California

California state of emergency: Coronavirus update.

The Department of Managed Health Care (DMHC) has issued several notices to all health plans in California regarding the actions expected to ensure that members are not met with barriers in receiving care. This notice includes the following topics:

- Waiver of cost-sharing amounts
- Timely access to care for enrollees
- DHCS 1135 waiver request for COVID-19 flexibilities
- Ombudsman updates
  - Implemented call scripts
  - Long-term care (LTC) disenrollment
- Medi-Cal Eligibility Division Information Letter (MEDIL)

Waiver of cost-sharing amounts

The DMHC directs an immediate reduction in cost-sharing (including but not limited to co-pay, deductibles or coinsurance) to zero for all medically necessary screening and testing for COVID-19, including hospitals (emergency department included), urgent care visits, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19 (coronavirus).

Enrollee timely access to care

Aetna Better Health of California and partner IPAs will:

- Maintain coverage for all medically necessary emergency care without

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Summer 2020
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Coronavirus update.

Continued from front page

prior authorization, whether that care is provided by an in-network or out-of-network provider

- Comply with the utilization review time frames for approving requests for urgent and non-urgent services, as required by Health and Safety Code § 1367.01
- Respond to authorization request as quickly as possible
- Have staff available 24 hours/7 days a week to authorize services, as necessary

As cases emerge, please contact Aetna Better Health of California or your contracted IPA if your office is not able to handle an influx of patients as more COVID-19 cases emerge in California.

Enrollees are not financially liable for services related to screening and testing. **Please do not bill Medi-Cal enrollees.**

DHCS Section 1135 waiver request

The DHCS has submitted a request for flexibilities under Section 1135 of the Social Security Act (42 U.S.C § 1320b-5), according to a national emergency declaration. It will include a waiver of certain provider enrollment requirements in order to maintain capacity to meet beneficiary access needs during the emergency and to enable payment to affected providers for rendering services.

Ombudsman update

To assist with moving beneficiaries from an acute long-term care facility to an LTC, the DHCS ombudsman will be able to do a current month of disenrollment for the member in order to facilitate the movement of the beneficiary to the LTC and to allow the provider to bill Fee-For-Service (FFS) as needed. This will occur when the provider and plan have worked together to move the beneficiary to an LTC facility and call the ombudsman to have them disenrolled into FFS.

Please contact us at **1-855-772-9076 (TTY: 711)** or call your local ombudsman.

Transportation

COVID-19 response: As you are aware, the coronavirus has infected millions around the globe and in the United States. Access2Care is part of the Global Medical Response (GMR) family, the nation's largest provider of ground and air ambulance services.

The GMR companies have access to tens of thousands of caregivers — physicians, nurses, paramedics and EMTs — across the country. We have been an active partner in many of the communities that have experienced COVID-19 confirmed cases, and GMR is coordinating directly with government authorities and hospital systems in response to COVID-19.

The broad GMR engagement helps make Access2Care well-informed and prepared.

We know that uncertainty can be disruptive and that good, reliable, well-informed information is critical. Our team of nurse navigators has been supporting efforts nationally through telephonic screening, direction for those who are concerned they may have been exposed to COVID-19, and remotely monitoring patients who are voluntarily quarantined.

We are always pleased to share our experience as subject matter experts.

Obviously, we must respect the confidentiality of patients involved, but we think there is room for information sharing and lessons learned.

Access2Care business continuity strategies

Access2Care has plans in place to maintain contact center services.

- **Geographic diversity.** Access2Care has opened two additional call intake centers (in Houston, Texas, and Arvada, Colorado) to support contact center functions. Having geographic diversity reduces risk, should COVID-19 disproportionately affect certain specific communities.
- **Escalate work from home (WFH).** We have invested additional significant funds to expand our WFH capacity. Our in-center work force has now completely transitioned to WFH.

Understanding our members: Improve your health literacy.

The *Health Literacy Universal Precautions Toolkit* (2nd edition) from the Agency for Healthcare Research and Quality is a free set of tools to help primary care practices improve interactions between patients and staff. The toolkit includes a short video and downloadable tools to practice communication skills. For the fastest engagement, begin with the Quick Start Guide.

Visit **AHRQ.gov/Health-Literacy/Quality-Resources/Tools/Literacy-Toolkit/HealthLitToolKit2-Quick.html**.

Non-emergency medical transportation (NEMT).

According to DHCS APL 17-010, Aetna Better Health of California covers NEMT and, in coordination with Access2Care, provides transportation to members in need of either non-emergency medical transportation (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 a 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 (included with this newsletter).
- Managed Care Plans (MCPs) and transportation brokers must use a DHCS-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 nor 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** 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.

Non-emergency medical transportation physician certification form.

Please complete all fields to request authorization for non-emergency medical transportation (NEMT) services. Submit the completed form to Aetna Better Health of California's transportation service, Access2Care, via secure email at **PCSWest@amr.net** or via fax to **1-866-700-4977**.

Member Information

Member Name:	Member DOB:
Member ID #:	Member Phone #:

Function Limitations Justification

Please 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.

Anticipated Duration

Please provide the anticipated duration for NEMT services. *Authorization for this service is not to exceed a maximum of 12 months.*

Start Date:	End Date:

Mode of Transportation Required

Please refer to the following page to determine the medically necessary mode of transport.

☐ Ambulance/Gurney Van	☐ Litter Van
☐ Wheelchair Van	☐ Air Transport

Certification Statement

I hereby certify that medical necessity was used to determine the type of transportation requested for the above member.

Requesting Provider Name:

Requesting Provider Signature:

Date:

Note: Payment for these services by Aetna Better Health of California is contingent upon member's eligibility for Plan coverage on the date of service.

Requesting Provider Information

Provider Email:	Provider Phone:

✂ *Clip and save*

Determination of NEMT services.

Level of NEMT service	Qualifications
Ambulance/ gurney van	The litter van can be used when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following: • Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation • Transfers from an acute care facility to another acute care facility • Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) • Transport for members with chronic conditions who require oxygen, if monitoring is required
Litter van	• Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport • Requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs or other forms of public conveyance
Wheelchair van	The wheelchair van can be used when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following: • Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport • Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation • Requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs or other forms of public conveyance • Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed physician certification statement (PCS) form (as described below): - Members who suffer from severe mental confusion - Members with paraplegia - Dialysis recipients - Members with chronic conditions who require oxygen but do not require monitoring
Air transport	Air transport may only be provided under the following conditions: • When transportation by air is necessary because of the member's medical condition, or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist or mental health or substance use disorder provider.

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.**[1]

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 the services may require prior authorization for medical services required in support of dental procedures.[2]

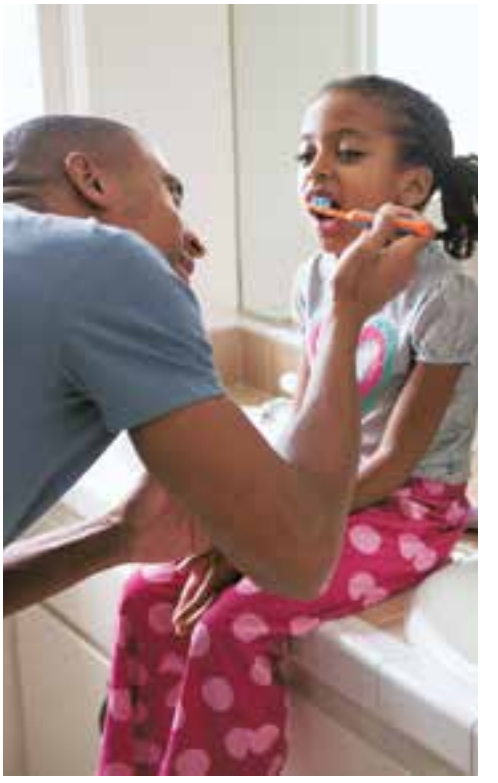
At Aetna Better Health of California, we inform members about the availability and importance of the EPSDT benefit, including information about dental services.

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.

[1] *"Percentage of Eligibles Who Received Preventive Dental Services: Ages 1-20." Medicaid.gov, Keeping America Healthy, 2017, medicaid.gov/state-overviews/scorecard/state-health-system-performance/prevention-and-treatment/dental-services/index.html.*

[2] *California Department of Health Care Services, All Plan Letter 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf.*



Share health with your patients.

Are you in need of health education information for your Aetna Better Health of California members? Visit the health and wellness section of our website to access Krames Health Sheets on hundreds of health topics: **AetnaBetterHealth.com/California/wellness/healthy**.

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 you if you 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 this handbook to share questions and concerns about your 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 is sensitive to your cultural or ethnic background
- Get interpretation services if you do not speak English or have a hearing impairment to help you get the medical services you need
- Receive information about advance directives or a living will, which tell how to have medical decisions made for you if you are not able to make them for yourself
- Know how Aetna Better Health pays providers, controls costs and uses services
- Get emergency health care services without the approval of your primary care provider (PCP) or Aetna Better Health when you have a true medical emergency
- Be told in writing by Aetna Better Health when any of your health care services requested by your PCP are reduced, suspended, terminated or denied — you must follow the instructions in your notification letter
- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your 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 primary care provider within Aetna Better Health of California's network
- To participate in decision making regarding your 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 your 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 your medical record
- To disenroll upon request; members that 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 your condition and ability to understand
- To have access to and receive a copy of your 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 you are treated by Aetna Better Health of California, your 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

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.

To learn more, please contact Aetna Better Health of California's Care Management team at **1-855-772-9076 (TTY: 711)**, Monday through Friday, 8 AM to 5 PM. After hours: **1-855-772-9076 (TTY: 711)**. A team member should provide you with their name, title and our organization when you call.

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 this evidence of coverage. It tells you about our services and how to file a grievance or appeal.
- Follow Aetna Better Health rules.
- Use your ID cards when you go to health care appointments or get services, and do not let anyone else use your cards.
- Make and keep appointments with doctors. If you need to cancel an appointment, it must be done at least 24 hours before your scheduled visit.
- Treat the doctors, staff and people providing services to you with respect.
- Know the name of your primary care provider
- and your care manager, if you have one.
- Know about your health care and the rules for getting care.
- Tell the plan and DHCS when you make changes to your address, telephone number, family size, moving out of state, employment change and other information that might affect enrollment.
- Understand your 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 you care.
- Schedule your appointments, be on time, and call if you are going to be late or miss your appointment. If you need to cancel an appointment, it must be done at least 24 hours before your scheduled visit. Use the emergency room for true emergencies only.
- Give all information about your health to Aetna Better Health and your doctor. This includes immunization records for members under age 21.
- Tell your doctor if you do not understand what they tell you about your health so that you and your doctor can make plans together about your care.

- Tell the plan and DHCS about your concerns, questions or problems.
- Ask for more information if you do not understand your care or health condition.
- Follow what you and your doctor agree to do. Make follow-up appointments. Take medicines and follow your doctor's care instructions.
- Schedule wellness check-ups. Members under 21 years of age need to follow the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule.
- Get care as soon as you know you are pregnant. Keep all prenatal appointments.
- Tell Aetna Better Health and the DHCS when your address changes. Tell them about family changes that might affect eligibility or enrollment. Some examples are change in family size, employment and moving out of the state/region of California.
- Tell us about any other insurance you have.
- Tell us if you are applying for or get any other health care benefits.
- Bring shot records to all appointments for children under 18 years old.
- Give your doctor a copy of your living will or advance directive.
- Keep track of the cost-sharing amounts you pay.

Electronic prior authorizations.

We are committed to making sure our providers receive the best possible information and the latest technology and tools available.

We have partnered with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of the Electronic Prior Authorization (ePA) program.

With ePA, you can look forward to:

- Time savings
  - Decreased paperwork, phone calls and faxes for requests for prior authorization
- Quicker determinations
  - Reduces average wait times; resolution often within minutes
- Helpfulness and security
  - HIPAA compliant
  - via electronically submitted requests

No cost required! Let us help get you started!

Getting started is easy. Choose one of these ways to enroll:

- Visit the CoverMyMeds® website at **CoverMyMeds.com/main**.
- Call CoverMyMeds® toll-free at **1-866-452-5017**.
- Visit the SureScripts website at **SureScripts.com/Enhance-Prescribing/Prior-Authorization**.
- Call SureScripts toll-free at **1-866-797-3239**.

Billing information:
BIN: 610591
PCN: ADV
Group: RX8808

Recently published Medi-Cal DUR bulletins.

You can read these bulletins at **https://files.medi-cal.ca.gov/pubsdoco/community/Pharmacy.aspx**.

- Clinical Guideline: Reproductive Health in Rheumatic and Musculoskeletal Diseases — May 2020
- Improving Quality of Care: Update of Risks Associated with Use of Fluoroquinolones — April 2020
- Drug Safety Communication: Withdrawal of All Ranitidine Products — April 2020
- Drug Safety Communication: Mental Health Side Effects from Montelukast — March 2020
- Improving the Quality of Care: Risks Associated with Use of Gabapentin — December 2019
- Alert: New Global Guidelines for the Treatment of Asthma — October 2019
- 2019 Immunization Updates: Flu, HepA, HPV, Measles, CA School Requirements — September 2019

Rx restrictions and preferences.

A current list of preferred pharmacies and formularies is 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 a "A" rated generic equivalent is available

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 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 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

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 recommendation
- Prenatal care
- 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

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 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-up to emergency department visits must be in accordance with ED attending provider discharge instructions.

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.

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/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.

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

If you would like additional information on any of these topics, call **1-855-772-9076 (TTY: 711)**:

- 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

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, 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 are held to the same accessibility standards, regardless if after-hours coverage is managed by the 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-hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all 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 voice mail. • 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 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 **AetnaBetterHealth.com/california/providers/clinical-guidelines-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.

Contact us

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