aetna®

AetnaBetterHealth.com/California

Aetna Better Health® of California

Members can get rewarded for getting the COVID-19 vaccine

As of September 2021, Aetna Medi-Cal members get a $50 gift card after COVID-19 vaccination.

Aetna Better Health of California will automatically mail $50 gift cards to members when they get their first dose. The California Department of Health Care Services (DHCS) has made $100 million in total direct incentives available to Medi-Cal members who got their first vaccination dose beginning in September 2021.

Certain communities are disproportionately affected by COVID-19, such as these groups here:

- People who are homebound
- People ages 50 to 64 with chronic disease
- Black or African American people
- Native American or Alaska Native people
- Youth ages 12 to 25

Encourage your members to get vaccinated today!

They can:

- Schedule appointments at **MyTurn.CA.gov**.
- Find the nearest walk-in location for a free COVID-19 vaccine at **Vaccines.gov**.

Please note: **Members are eligible to receive a booster shot** as long as they meet the time criteria since their last dose.

Spring 2022
86.22.827.0-SP A (3/22)

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

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.

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. Call **1-855-772-9076 (TTY: 711)** or email **CaliforniaProviderRelationsDepartment@Aetna.com**.

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

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative led by the California Department of Health Care Services. It 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 it takes a person-centered approach that targets social determinants of health and reduces health disparities and inequities.

Enhanced Care Management

Effective January 1, 2022, Aetna Better Health of California implemented and now covers Enhanced Care Management (ECM) services for members with highly complex needs. ECM is a benefit that provides extra services to help members get the care they need 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 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 (CS)

Community Supports (CS) are considered In Lieu of Services (ILOS) and may be available under your 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. CS do not replace benefits already covered under Medi-Cal.

Community Supports (ILOS) menu of options

- Housing transition and navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care (medical respite)
- Respite services
- Nursing facility transition/ diversion to assisted living facilities
- Community transition services
- Personal care and homemaker services
- Asthma remediation
- Environmental accessibilty adaptations
- Sobering centers
- Medically supportive food/meals or medically tailored meals

Health Homes Program (HHP)/Whole Person Care (WPC) Transition to ECM/Community Supports (ILOS)

Current state	Future state
WPC	**ECM**
• Pilot program • FFS and managed care members • Administrator: Lead Entities	• Benefit • Managed care members only • Administrator: MCPs
HHP	**Community Supports (ILOS)**
• Benefit (state plan service) • Managed care members only • Administrator: MCPs	• Optional, but strongly encouraged • Managed care members only

ECM/Community Supports (ILOS) implementation timeline

ECM go-live will occur in stages, by population of focus. Community Supports (ILOS) launched as an option statewide in January 2022.

Populations of focus	Go-live timing
1. Individuals and families experiencing homelessness 2. Adult high utilizers 3. Adults with serious mental illness (SMI)/substance use disorder (SUD)	**January 2022** (WPC/HHP counties) **July 2022** (other counties)
4. People who were incarcerated and are transitioning to the community 5. People at risk for institutionalization and eligible for LTC 6. Nursing facility residents transitioning to the community	**January 2023**
7. Children/youth populations of focus	**July 2023**

*Note: This timeline is simplified. Stakeholders in WPC counties should refer to the more detailed timelines at **www.DHCS.CA.gov/Pages/ECMandILOS.aspx**.*

Medi-Cal Rx

Effective **January 1, 2022,** the Medi-Cal pharmacy benefit transitioned from the previous **Medi-Cal** managed care delivery system to fee-for-service under **Medi-Cal Rx**. All benefits that were billed on a pharmacy claim have transitioned to Medi-Cal Rx, and all pharmacy prior authorizations will be reviewed by Medi-Cal Rx. This transition is a critical step for the success of the California Advancing and Innovating Medi-Cal (CalAIM) initiatives, proposed by the California Department of Health Care Services. Medi-Cal Rx will:

- Standardize the Medi-Cal pharmacy benefit under one statewide delivery system. This means that no matter what county a person lives in, the same access to their prescriptions is possible.
- Improve access to pharmacy services.
- Centralize pharmacy policy, transactions and reimbursements, leading to greater efficiency for pharmacies, prescribers and the Medi-Cal program.

Use the telephone menu options at right to update processes and any automation you may have in place today.

Medi-Cal Rx customer service representatives will be able to respond to questions that include, but are not limited to, the following:

- Claims processing/messaging
- Drug coverage
- Beneficiary eligibility

Be sure to subscribe to the Medi-Cal Rx Subscription Service (MCRxSS)[1] to stay up-to-date with the latest Medi-Cal Rx news. For questions, please contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**, available 24 hours a day, 365 days a year, or via email at **MediCalRxEducationOutreach@MagellanHealth.com**.

NOTE: For members who are dually enrolled in Medicaid and Medicare, beneficiaries should be directed to **1-800-MEDICARE (1-800-633-4227)** or to the Help Desk of their Medicare Part D Prescription Drug Plan.

[1]mcrxsspages.dhcs.ca.gov/Medi-CalRxDHCScagov-Subscription-Sign-Up

Nationwide toll-free number: 1-800-977-2273	**Main menu options**
	Beneficiaries, **press 1**
	Pharmacies, **press 2**
	Prescribers, **press 3**
	Authorized MCP representatives, **press 4**
	TTY callers, **press 5**
	All other callers, **press 6**

Language assistance, interpretation and translation

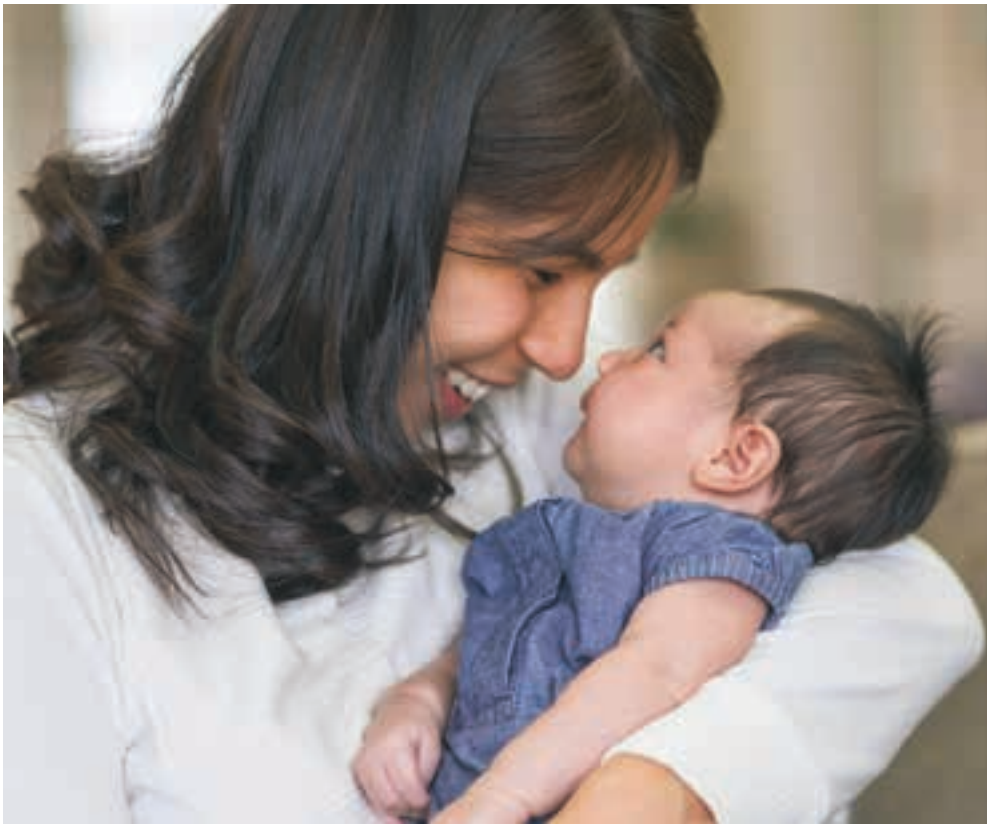
Providers are required to identify the language needs of members and to provide oral translation, oral interpretation and sign language services to members. To assist providers with this, Aetna Better Health of California makes its telephonic and face-to-face language interpretation service available 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**. 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, and these formats can by requested by contacting Member Services.

Aetna Better Care Rewards program now live!

Aetna Better Health of California is excited to announce the Aetna Better Care Rewards program — which went live in the fourth quarter of 2021 — that provides members with the opportunity to earn rewards for completing approved healthy activities.

Each time a healthy activity is completed, the corresponding reward amount is automatically added to a unique Visa card that is issued to members upon completion of their first healthy activity. Qualified healthy activities include:

- Breast cancer screening, $25
- Cervical cancer screening, $25
- Chlamydia screening, $25
- Childhood immunizations (childhood immunization status combo 10: DTaP, IPV, MMR, Hib, HepB, VZV, PCV, HepA, RV, influenza), $50
- Adolescent immunizations (immunizations for adolescents combo 2: meningococcal, Tdap, HPV), $25
- Lead screening in children, $25
- Child and adolescent well-visit (well-child visits in the first 30 months of life: W30, child and adolescent well-care visits [WCV]), $25
- COVID-19 vaccination, $50



The Aetna Better Health® community resource

We want to help our members be healthy and find the resources they need to stay healthy.

We know finding the right resources can be tough. **The Aetna Better Health® community resource** is a free website that links you to community resources. All you do is type in your ZIP code to find local resources and services that can help meet your needs.

Now it's easy to search for free or reduced-cost services like housing, food, transportation, job training and more.

Anyone can access Aetna's community resource website using a laptop, desktop computer or smartphone.

Members can visit **Aetna-CA.AuntBertha.com** to find help near their area.

Members can call **1-855-772-9076 (TTY: 711)** for more information.

Members can get information from us in new ways

To comply with DHCS and the Telephone Consumer Protection Act (TCPA) requirements, Aetna Better Health of California has implemented a member communication preference strategy to obtain member consent (e.g., text, IVR, email, direct mail). As our trusted plan partner, we ask that you promote this strategy with our members by informing and directing them to select their communication preferences.

Members can get information from Aetna Better Health of California by text, email, voice or direct mail. To make their selections, they can:

- Select the "Communication choices" link within the footer of the Aetna Better Health of California website or member portal
- Scan the QR code with their phone
- Text **JOIN** to **85886**
- Visit **Aet.na/ca-preference**
- Call Member Services

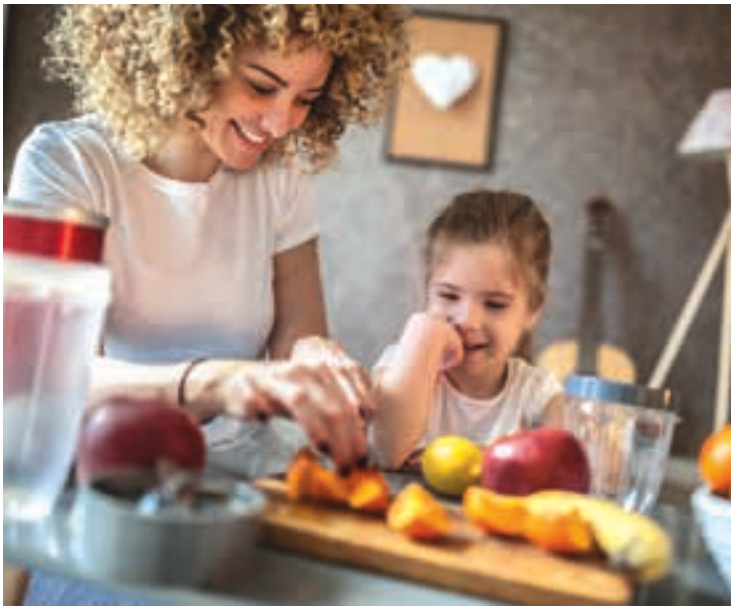
Member rights

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 is 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



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 DHCS 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 the DHCS when their 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 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.

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:

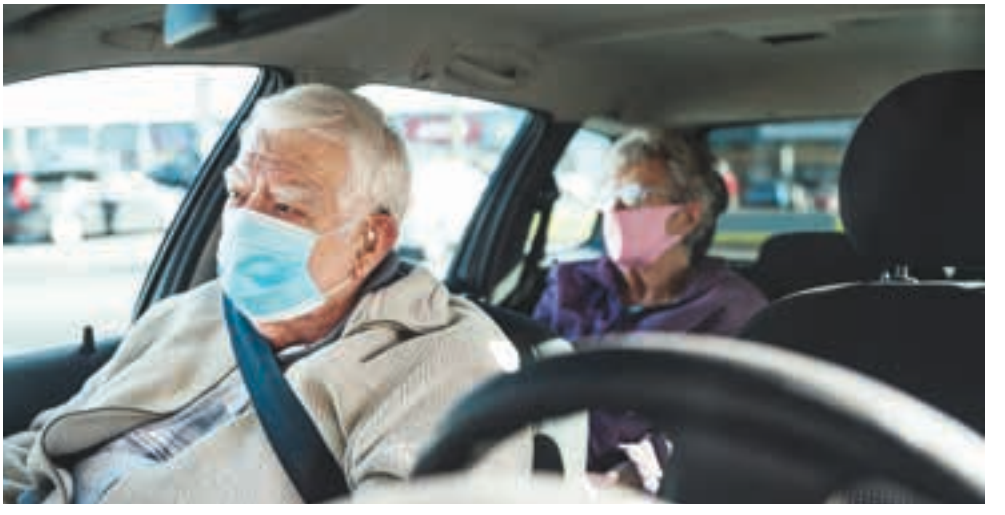
NEMT Physician Certification Statement (PCS) forms (included with this newsletter). Managed care plans (MCPs) and transportation brokers must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, 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 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** 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, time and day of the medical appointment.



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

FSR and MRR standards are changing

Effective January 1, 2022, Facility Site Review (FSR) and Medical Record Review (MRR) standards and criteria are changing to reflect current guidelines of professional organizations. Changes include expanding certain criteria, reorganizing the criteria groups to help better identify deficiencies and adjusting the scoring methods to better generalize the scores per APL 20-006.

Training on the updates to FSR and MRR criteria and standards is mandatory, since these standards affect every primary care clinic, organization, group, solo practice, rural health setting or community-based clinic.

Providers can access the first phase of the training at **AetnaBetterHealth.com/California/providers/facility-site-review.html**. This is for the FSR standards. The second phase, covering the MRR portion of the standards, will be coming soon.

Please take the time now and be prepared for your assigned health plan and reviewer.

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.

Visit our website

Our website provides information about the following:

- U.S. Preventive Services Task Force A and B recommendations
- Advisory Committee for Immunization Practice (ACIP) vaccine recommendations
- 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

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

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.

Language services are available to members

Aetna Better Health of California understands that language is important in health care. Studies have shown that effective communication between patients and health care providers enable gathering of information to arrive at diagnoses, explaining treatment strategies, and ensuring understanding and joint decision-making.[1]

In an effort to promote effective communication and the attempt to promote shared language between Aetna Better Health providers and members, it is important to know the more prevalent languages of the membership population and the services available to assist with effective communication.

As of December 7, 2021, the language demographics of the health plan representative of the Sacramento and San Diego service areas are as follows:

- English (85.6%)
- Spanish (11.7%)
- Other non-English (1.5%)
- Russian (0.6%)
- Farsi (0.6%)

If no staff members within your respective offices speak these languages, Aetna Better Health of California offers language assistance services to help. These services can be assessed by contacting the Aetna Better Health of California Member Services Department at **1-855-772-9076**. Language services include telephonic interpretation, face-to-face interpretation and oral translation. Face-to-face interpretation requires a 48-hour advance notice of the member's appointment. These services are provided by professional interpreters, which is required for language assistance services. All language services are provided free of cost to you and members.

[1]*Language and Health Care Diabetes Spectrum*

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 are 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 the Aetna Better Health of California's population needs and updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting or reviewing criteria. The criteria are consistently applied, consider the needs of the members and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health of California Provider Relations representative at **CaliforniaProviderRelations Department@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: **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.

2022 holiday closures

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

Monday, May 30: Memorial Day

Monday, July 4: Independence Day

Monday, September 5: Labor Day

Thursday, November 24: Thanksgiving

Monday, December 26: Christmas Day

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