Aetna Better Health of California

Provider Orientation - 2019

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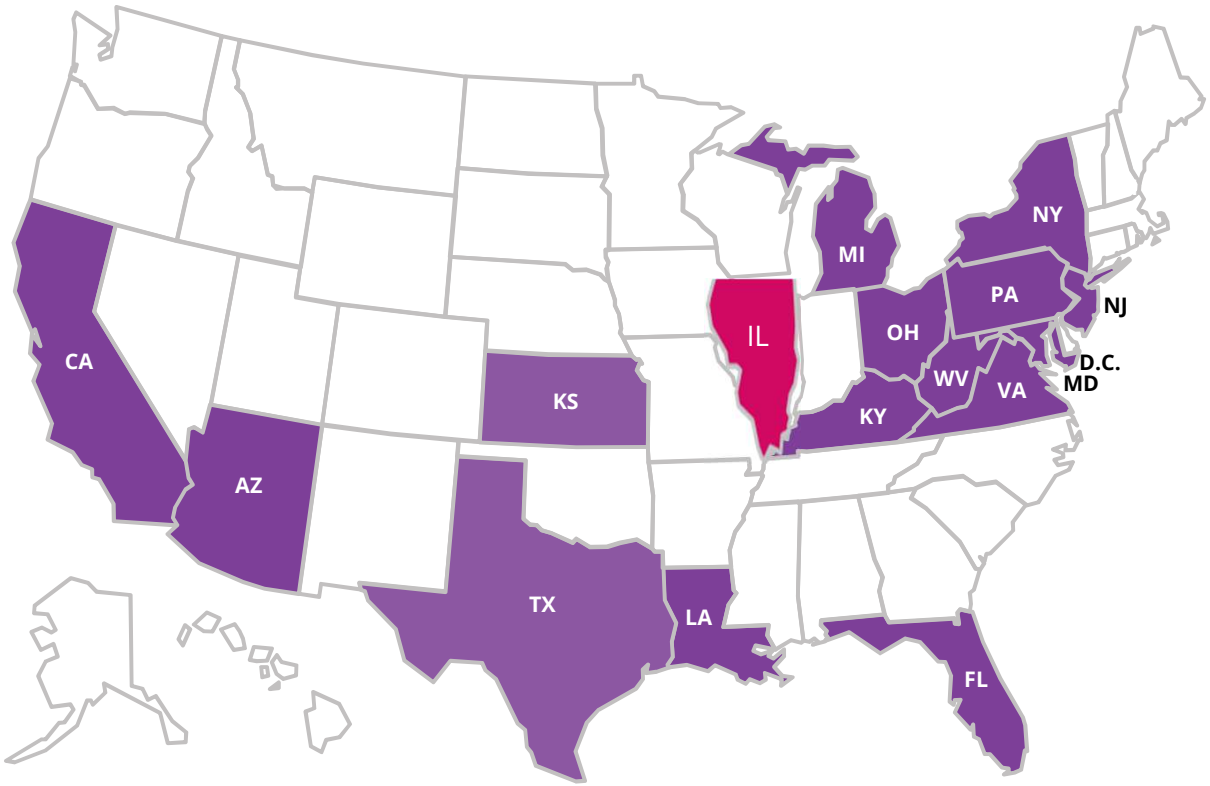
Orientation Agenda

2019 Aetna Medicaid Overview

Leader in managing medically complex populations at the local, community-based level by integrating physical health, behavioral health, and social economic status of members.

- We provide services for over 2.8 million members with a large national presence. (1)



(1) Aetna Medicaid. (n .d.). Retrieved December 17. 2018, from https:www.aetnabetterhealth.com/

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Member Eligibility

Populations We Serve:

- Aged, Blind, and Disabled (ABD)
- Children in Foster Care (DFC)
- Children's Health Insurance Program (CHIP)
- Long Term Services and Supports (LTSS)
- Medicaid Expansion
- Developmentally Disabled (DD)
- Dual Eligible (SD County)
- General or Serious Mental Illness (GMH/SMI)
- Temporary Aid To Needy Families (TANF)

Voluntary Enrollment:

- Native Americans and those who qualify for services from an Indian Health Center
- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a care provider.

Member Rights and Responsibilities:

To be provided with information about the plan and its services, including Covered Services.

To be able to choose a Primary Care Provider within Aetna's network.

To participate in decision making regarding their own health care, including the right to refuse treatment.

Give their health care provider all the information they need.

Ask for more information if they do not understand their care or health condition.

Tell their provider about any other insurance they have.

Anti-Discrimination Policy and Americans with Disabilities Act (ADA)

It is our policy not to discriminate against members based on:

- Race
- National Origin
- Creed
- Color
- Age
- Gender/Gender Identity
- Sexual Preference
- Religion
- Health Status
  - Physical/Mental Disability
- Other Basis Prohibited by Law

Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity. If we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

The **ADA** gives civil rights protections to individuals with disabilities like those provided to individuals based on:

- Race
- National Origin
- Creed
- Sexual Preference
- Religion
- Age
- Physical/Mental Disability
- Color
- Gender/Gender Identity

The ADA guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

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Member Services and Enrollment

Overview

- ABHCA Member Services Department is available to:
  - Answer questions about members health plan and covered services
  - Help choose primary care provider (PCP)
  - Tell member where to get the care needed
  - Offer interpreter services if primary language is not English
  - Offer information in other languages/formats
  - Assist with access and questions on the Member Web Portal

If you need help, call 1-855-772-9076 (TTY 711). Aetna Better Health of California is here 24 hours a day, 7 days a week. The call is toll free.

You can also visit online at any time at **aetnabetterhealth.com/california**.

How Can Members Enroll?

The State is responsible for determining eligibility and members can enroll:

Online

Covered California Website

Phone

Health Care Options
1-800-430-4263

In Person

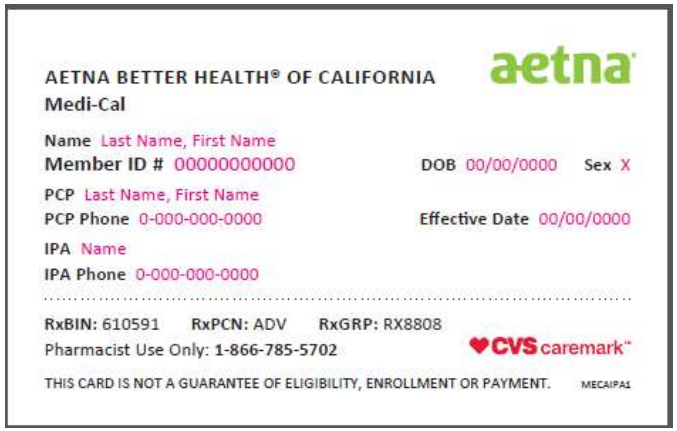
Several Locations
County Social Services Office

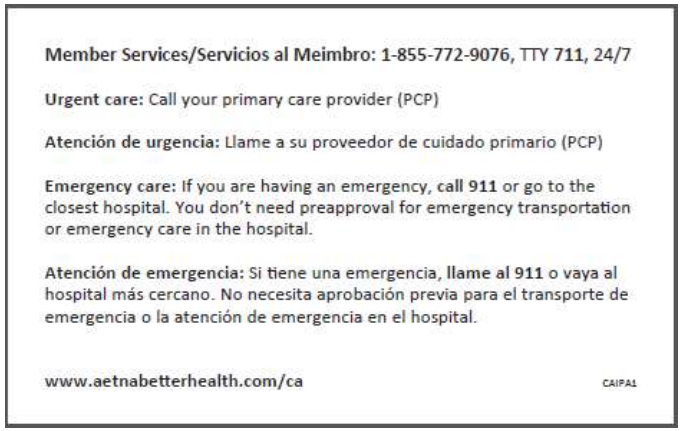
Mail

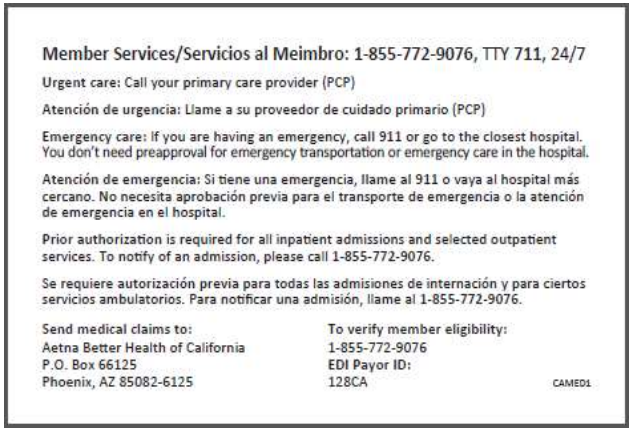
Covered California
PO Box 989725
West Sacramento, CA
95798-9725

Application found:
Medi-Cal Single Streamlined Application

Member Insurance Cards







Language Services and Transportation

Translation Services Provided by Aetna:

Interpretation (Face to Face)

- Nationwide network of qualified interpreters offering interpretation in 15+ languages, including American Sign Language (ASL)
- In person

Interpretation (Over the Phone)

- Access to interpreters supporting 200+ languages via telephone

Transportation Services

Provides members with FREE transportation to and from visits including PCP, Rx, Ancillary visits.

Member Advisory Committee

- **Member Advisory Committee**

This group is made up of ABHCA staff, members, individuals and providers with knowledge of and experience with serving elderly people and people with disabilities, representatives from community agencies and community advocates.

The group talks about how to improve ABHCA policies and is responsible for:

- Providing input on cultural and linguistic needs
- Providing feedback on member materials so they are more effective and user-friendly
- Suggesting ways to contact hard to reach members
- Suggesting ways to improve telephone services
- Suggesting ways to better communicate proper ER usage and transportation services

If you would like to be part of this group, call **1-855-772-9076 (TTY 711).**

Additional Services Provided

Transportation

Members/Providers
1-888-334-8352
Access2Care

Vision

Available to members by calling

1-800-877-7195

Pharmacy Vendor

Vendor and RX prior authorizations are handled by ABHCA directly.

1-855-772-9076

(TTY 711)

Cultural Competency

What is it?

- Our way to improve patient health and build healthy communities by providers recognizing and addressing the unique culture, language and health literacy of diverse patients and communities.
- Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

Aetna Better Health of California expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds.

Cultural Competency Program: Aetna Medicaid strives to exemplify a Culture of Caring

- Embed cultural awareness throughout our organization
- Increase culturally competent care resources
- Drive cultural data collection & analysis community impact and
- Become an industry leader in addressing social determinants of health and health care disparities

To increase member engagement and reduce health care disparities for all our members regardless of race, ethnicity, age, gender or special needs.

Cultural Competency Resources

Resources

National Center for Cultural Competence-Georgetown University:
http://nccc.georgetown.edu/

U.S. Department of Health and Human Services-Think Cultural Health (CLAS Standards):
https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Are you practicing Cultural Humility:
http://www.cahealthadvocates.org/news/disparities/2007/are-you.html

Association of State and Territorial Health Officials Health Equity:
http://www.astho.org/Programs/Health-Equity/

Unnatural Causes Documentary: http://www.unnaturalcauses.org/

Office of Minority Health: http://minorityhealth.hhs.gov/Default.aspx

Credentialing

Adding a New Provider to Existing Practice

(Physicians/Mid-Levels)

- Each new provider must be credentialed before s/he can render care to an ABH Member.
- Mid-levels must have supervising physician.
- Utilize CAQH for credentialing or the California Standardized Credentialing Application.
- CAQH ProView
    - Complete Attestation & Documentation
    - Authorize ABH to view CAQH Profile
- Contact the Credentialing Department with the applicable CAQH number.

CAprovidercredentialing@aetna.com

Our Website

Tools

List of Participating Providers

Pharmacy Search Tool

Provider Manual

24/7 Secure Provider Portal

Clinical Guidelines Forms

Provider Education

BH Screeners

Screening, Brief Interventions, & Referral to Treatment (SBIRT) Information & Training

- **SBIRT Training Link**

Website: Aetna Better Health of California

Pharmacy: Formulary Search Tool

What Will You Have Access to?

- Pharmacy Authorization Guidelines
- Pharmacy Prior Authorization Forms
- Specialty Medications
- Step Therapy and Quantity Limits
- Formulary Search

Please review our formulary for any restrictions and/or recommendations regarding prescription drugs before prescribing a medication to an ABHCA patient.
Members must fill their prescriptions at an ABHCA network pharmacy and follow other plan rules.

Formulary Search Tool

Prior Authorization Opioid Guideline- Clinical Guideline
All Long-Acting opioids require PA
All Short Acting opioids have a 7 day supply limit
All Opioids will be limited to a 90 MED (Morphine Equivalent Dosing) per day
Members with pain due to active cancer, palliative care, or end-of-life care will be exempt from the guideline requirements for all preferred medications.
A signed treatment plan along with a completed Opioid Prior Authorization (PA) form must be submitted.

- For a complete guide to the General Authorization Criteria, please review ABHCA Prior Authorization Guidelines.
- General Authorization Criteria

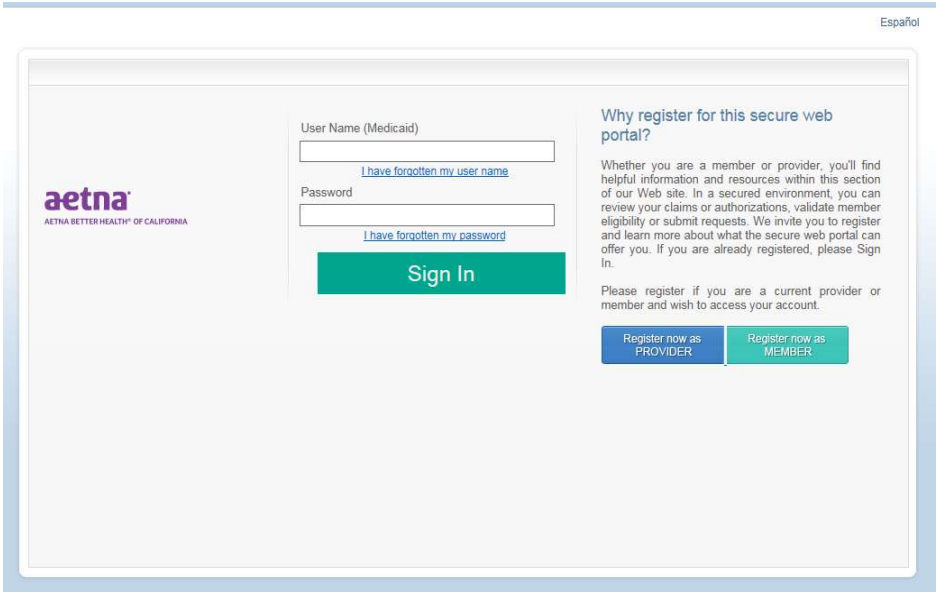
- **Prescription Drug Prior Authorization Fax:** 844-823-5478
- **Prescription Appeals Fax:** 844-360-0034
- **Phone:** 1-855-772-9076
- **Online:** www.caremark.com
- **Mail:** CVS Caremark
  PO Box 2110, Pittsburg
  PA 15320-2110

Provider Secure Web Portal

What Will You Have Access to?

- ProPAT (Provider Authorization Tool)
- Panel Rosters
- HEDIS Data
- Claims
- Member Eligibility
- Send & Receive Secure Messages
- Submit Authorization Requests
- View Remittance Advice Status
- Sign up to receive electronic funds transfers and remittance advices

Secure Provider Portal



Claims and Claims Submission

Clearinghouse & Clean Claims

We accept both paper and electronic claims
Change Healthcare is the preferred clearing house for electronic claims

- Payer ID: 128 CA

EDI claims received directly from Change Healthcare & processed through pre-import edits to:

- Evaluate Data Validity
- Ensure HIPAA Compliance
- Validate Member Enrollment
- Facilitate Daily Upload to ABHCA System

Claims Submissions

ABHCA requires clean claims submissions for processing.
To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure code

New Claim Submissions

- Submitted within 180 calendar days from the date the service unless there is a contractual exception.
- For hospitals inpatient claims (date of service means the entire length of stay for the member).
- For FQHC and RHC providers, please list the rendering provider on your claims.

Claim Resubmission

Must be filed within 90 days from the date of adverse determination of a claim.

- Providers may resubmit a claim that was originally denied because of:
  - Missing documentation
  - Incorrect Coding
  - Incorrectly Paid or Denied because of Processing Errors

How to Submit a Claim:

Online	Mail	Phone
Change Healthcare Payer ID: 128CA 1-800-845-6592	Aetna Better Health of California PO Box 66125 Phoenix, AZ 85082-6125 Hard Copy CM 1500 or UB 04	Claims Investigation & Research Department (CICR) 1-855-772-9076

Claim Submission Resources

Claim Submission Assistance/Links

- Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

  - How to fill out a CMS 1500 Form:
    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

  - Sample CMS 1500 Form:
    http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf

  - How to fill out a CMS UB-04/1450 Form:
    http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

  - CHDP:
    http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx

Quality Management Program

Overview

- QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. The process enables us to:
- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

Medical Records Standards

- ABHCA's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).
- All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the ABHCA Provider Manual.

Quality Management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

- Two ways data is collected for HEDIS measures.
  - Administrative- measures use claims/encounters for hospitalizations, medical office visits and procedures or pharmacy data only.
  - Hybrid- measures use data obtained directly from the member's medical record in addition to administrative data.

What is Our Ultimate Goal

- For providers to submit claims/encounters with coding that administratively captures all required HEDIS data via claims. This decreases or removes the need for medical record (hybrid) review.

Please see HEDIS Tips for PCPs located on our website at aetnabetterhealth.com/California/providers

For further questions, please contact: Melissa Gora, HEDIS Manager at GoraM@aetna.com

Medical Management: Care Management

Integrated Care Management Program (ICM)

A member-centered approach that addresses physical and behavioral health, psychosocial needs and collaboration with the members' system of care and relationships.

Specialized Care Plans for:

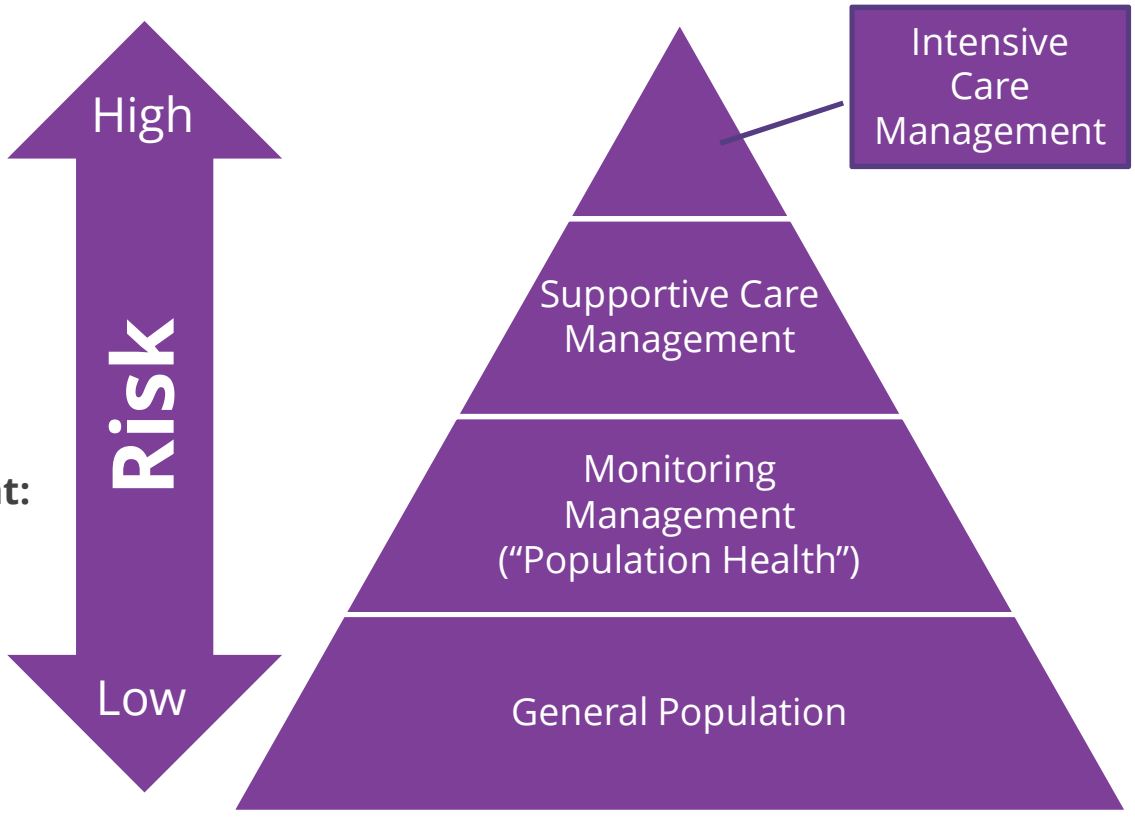
- COPD
- Asthma
- Depression
- Heart Failure
- Diabetes
- Hypertension

How to Refer to Care Management:

Phone: 1-855-772-9076

Fax: 1-866-489-7441 (SAC)
1-866-584-4450 (SD)

Email:
AetnaBetterHealthCACM@aetna.com



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How to Refer to Care Management

Referral Process:

Phone: 1-855-772-9076

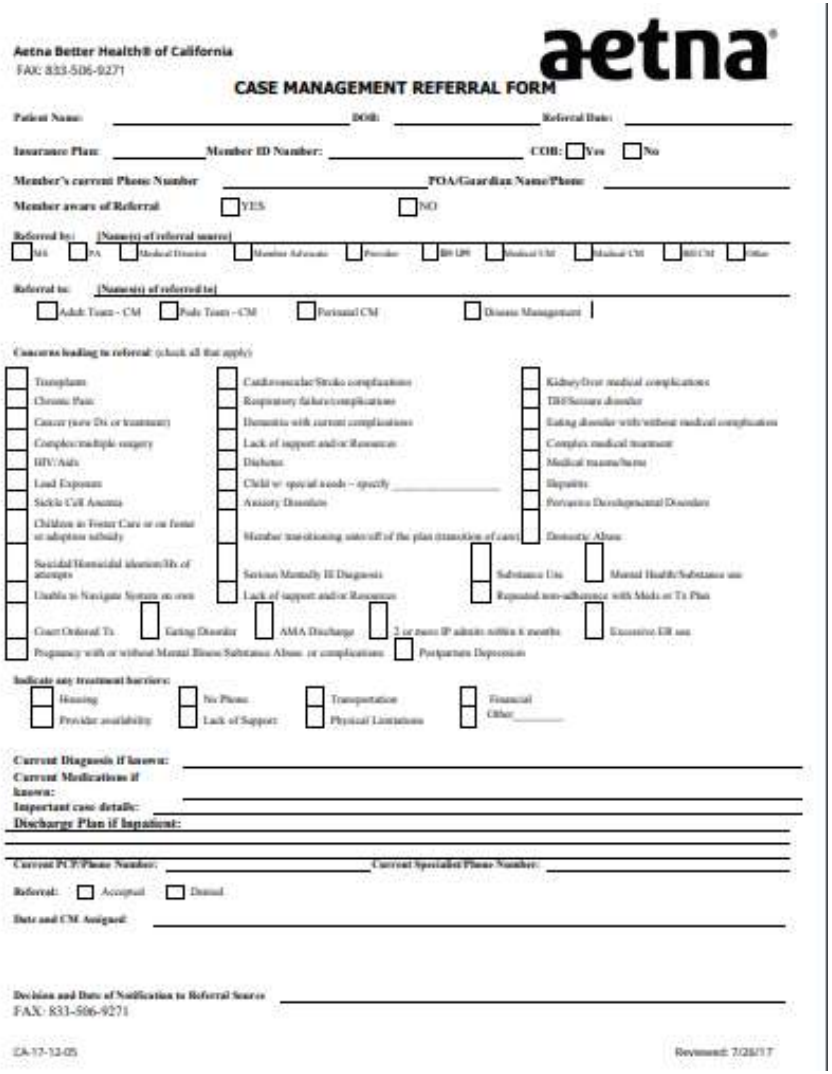
Email:
AetnaBetterHealthCACM@Aetna.com

Fax:

San Diego: 1-866-584-4450

Sacramento: 1-866-489-7441

Case Management Referral Form



Aetna Better Health® of California
FAX: 833-506-9271

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CASE MANAGEMENT REFERRAL FORM

Patient Name: _____ DOB: _____ Referral Date: _____

Insurance Plan: _____ Member ID Number: _____ COB: ☐ Yes ☐ No

Member's current Phone Number _____ POA/Guardian Name/Phone: _____

Member aware of Referral ☐ YES ☐ NO

Referred by: [Name(s) of referral source]

☐ MA ☐ PA ☐ Medical Director ☐ Member Advocate ☐ Provider ☐ BH DN ☐ Medical CM ☐ Medical CM ☐ BH CM ☐ Other

Referral to: [Name(s) of referred to]

☐ Adult Team - CM ☐ Peds Team - CM ☐ Perinatal CM ☐ Disease Management

Concerns leading to referral: (check all that apply)

☐ Transplants
☐ Chronic Pain
☐ Cancer (new Dx or treatment)
☐ Complex/multiple surgery
☐ HIV/Aids
☐ Lead Exposure
☐ Sickle Cell Anemia
☐ Children in Foster Care or on foster or adoption subsidy
☐ Suicidal/Homicidal ideation/Hx of attempts
☐ Unable to Navigate System on own
☐ Court Ordered Tx ☐ Eating Disorder
☐ Pregnancy with or without Mental Illness Substance Abuse or complications
☐ Cardiovascular/Stroke complications
☐ Respiratory failure/complications
☐ Dementia with current complications
☐ Lack of support and/or Resources
☐ Diabetes
☐ Child w/ special needs – specify _____
☐ Anxiety Disorders
☐ Member transitioning onto/off of the plan (transition of care)
☐ Serious Mentally Ill Diagnosis
☐ Lack of support and/or Resources
☐ AMA Discharge
☐ Postpartum Depression
☐ Kidney/liver medical complications
☐ TBI/Seizure disorder
☐ Eating disorder with/without medical complications
☐ Complex medical treatment
☐ Medical trauma/burns
☐ Hepatitis
☐ Pervasive Developmental Disorders
☐ Domestic Abuse
☐ Substance Use ☐ Mental Health/Substance use
☐ Repeated non-adherence with Meds or Tx Plan
☐ 2 or more IP admits within 6 months ☐ Excessive ER use

Indicate any treatment barriers:

☐ Housing ☐ Provider availability
☐ No Phone ☐ Lack of Support
☐ Transportation ☐ Physical Limitations
☐ Financial ☐ Other_____

Current Diagnosis if known: _____
Current Medications if known: _____
Important case details: _____
Discharge Plan if Inpatient: _____

Current PCP/Phone Number: _____ Current Specialist Phone Number: _____

Referral: ☐ Accepted ☐ Denied

Date and CM Assigned: _____

Decision and Date of Notification to Referral Source _____

FAX: 833-506-9271

CA-17-12-05 Reviewed: 7/28/17

Concurrent Review Process

Overview

Aetna Better Health of California conducts concurrent utilization review on each *member admitted to an inpatient facility*, including skilled nursing facilities (SNF) and freestanding specialty hospitals.

What does that mean?

- Admission certification
- Continued stay review
  - Conducted before the expiration of the assigned length of stay
    - Providers will be notified of approval or denial of stay
- Review of the member's medical record to assess medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines
- The nurses work with the medical directors in reviewing medical record documentation for hospitalized members

Initial Health Assessments

Purpose

Aetna Better Health mandates Initial Health Assessment (IHA), including administration of the Staying Healthy Assessment (SHA)/ Individual Health Education Behavioral Assessment (IHEBA), and their use for identifying members whose health needs require care management interventions and coordination with appropriate community resources and other agencies.

Initial Health Assessment Requirements (IHA)

- Conducted on all newly enrolled Aetna Better Health members within one hundred twenty (120) calendar days
- Must include the Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA) administered at appropriate age levels
- At least three (3) documented attempts to contact a member and must include one telephone call and one mail notification
- Attempts to perform the IHA at subsequent office visit(s) until all components of the IHA are **completed & documented** in the member's medical record-Member refusals are documented in the member's medical record
- Member's completed IHA and SHA/IHEBA is contained in the member's medical record for subsequent visits

Initial Health Assessments - Continued

Who?

- All contracted PCPs, perinatal care providers, IPA Providers and non-physician mid-level practitioners

What?

- All Providers must evaluate the responses and coordinate referrals, schedule follow-ups to complete the assessment, follow up on member's missed appointments and identify opportunities for further evaluation and care planning

Then?

- The PCP must review previously completed SHA/IHEBA assessments with the member every year, except years when the assessment is re-administered.
  - Contracted PCP's are responsible for generating reports that include, but not limited to:
    - Number of IHAs that have been completed
    - Number of individual health education and behavioral assessments that have been completed
    - Number of attempts made to members for incomplete assessments

Additional information located in the Provider Manual

Medical Prior Authorizations

You may submit PA Requests by:

Phone	Secure	Fax
1-855-772-9076	Provider Portal	866-489-7441 (Sac) 844-854-4450

Service Authorization Decision Timeframes	Turnaround Times
Urgent pre-service approval	Seventy-two (72) hours from receipt of request
Non-urgent pre-service approval	Five (5) calendar days from receipt of the request
Urgent concurrent approval	Twenty-four (24) hours of receipt of request
Post-service approval	Thirty (30) calendar days from receipt of the request.

Additional timeframes and authorization information, is in the Provider Manual

Documentation requirements for authorization request:

- Member Information
- Diagnosis Code(s)
- Treatment or Procedure Code(s)
- Anticipated Start and End Dates of Service(s)
- All Supporting Clinical Documentation to Support Medical Necessity
- Include:
  - Office/Department Contact Name
  - Telephone
  - Fax Number

Prior Authorization Form

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

What is EPSDT?

- It is a federally defined health program for children under age 21 who are enrolled in Medicaid.
- The EPSDT benefit is more robust than the Medi-Cal benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.
- The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

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 submission

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - continued

EPSDT Services

Screening services must include, at a minimum,

- comprehensive health and developmental history (including assessment of both physical and mental health development);
- comprehensive unclothed physical exam;
- appropriate immunizations;
- laboratory tests (including blood lead level assessment appropriate for age and risk factors);
- health education (including anticipatory guidance).

Vision services - diagnosis and treatment for defects in vision, including eyeglasses

Dental services – dental screening/oral health assessment must be performed as part of every periodic assessment; referred for treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

Hearing services - diagnosis and treatment for defects in hearing, including hearing aids.

Other necessary health care, diagnostic services, treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services

Behavioral Health

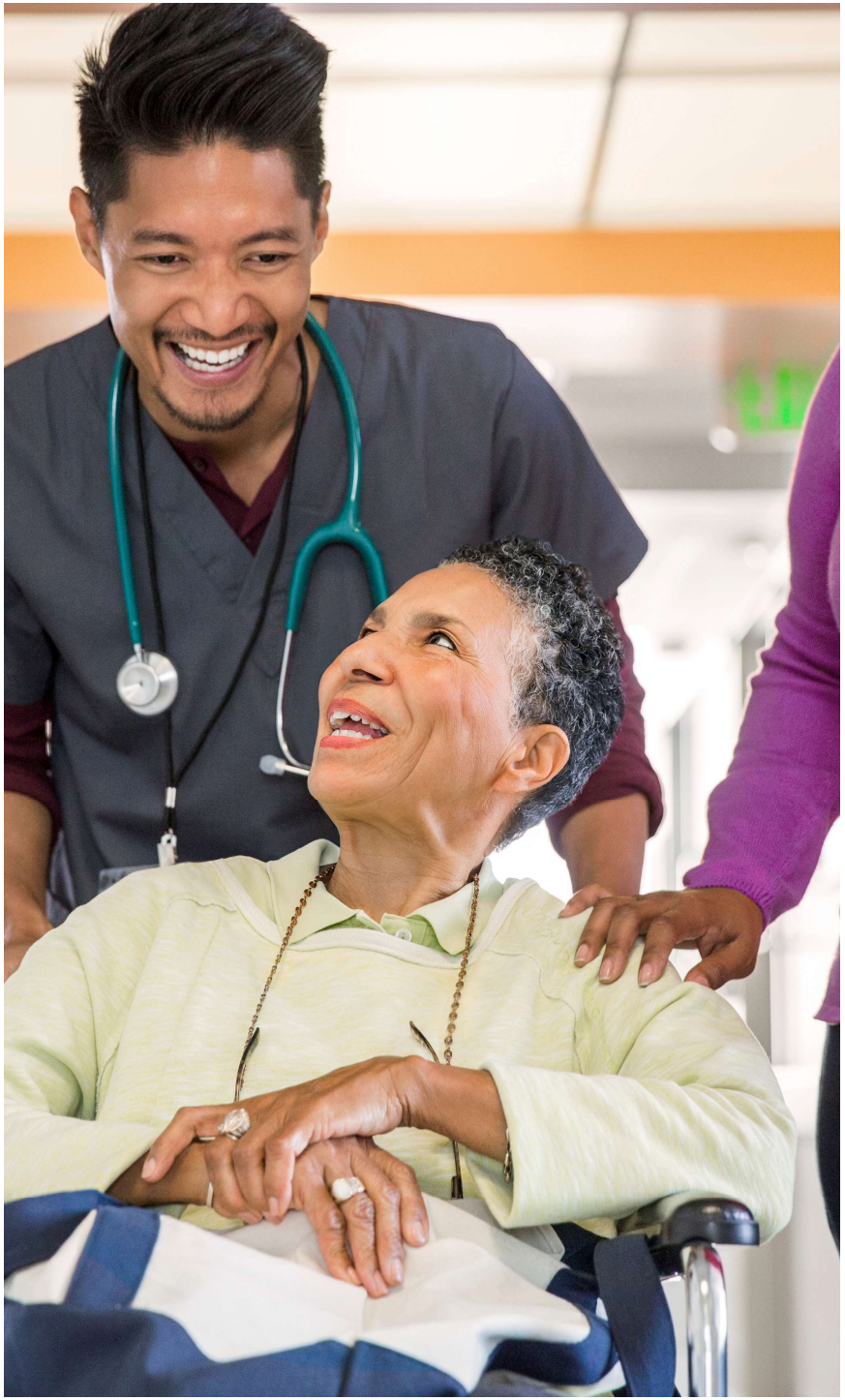
Basic Behavior Health Services

- Services provided for the assessment and treatment of problems related to mental health and substance use disorders.
  - Substance use disorders include abuse of alcohol and other drugs.
- Members can receive inpatient behavioral health services under the Medicaid Fee-for-Service (FFS) program

Primary Care Provider Referral

ABHCA promotes early intervention and health screening for identification of behavioral health problems and patient education. To that end, ABHCA providers are expected to:

- Screen, evaluate, treat and refer (as medically appropriate), any behavioral health problem/disorder.
- Treat mental health and substance use disorders within the scope of their practice.
- Inform members how and where to obtain behavioral health services.



Behavioral Health - continued

Multiple Access Points for Behavioral Health Services

- Mild to Moderate Impairment
- Moderate to Severe Impairment
- Substance Use Disorder

Responsibility of Aetna Better Health of California, includes Mild to Moderate Impairment:

- PCP
- OP
- Counseling
- Psychiatric Evaluation & Medication Management
- Psychiatric Testing
- ABA Services
- Intensive Outpatient Program (IOP) (provider offices only)

Discharge Notification

Must notify ABHCA of all discharge medications PRIOR to member's planned discharge from inpatient (IP) stay:

1) IP Mental Health 2) IP Detox 3) Residential

Behavioral Health Resources

Screening, Brief Interventions, & Referral to Treatment (SBIRT)

Screening: assess patient for risky substance use behaviors using standardized screening tools

Brief Intervention: healthcare professional engages patient in a short conversation, providing feed back and advice

Referral to Treatment: healthcare professional provides referral to brief therapy or additional treatment for patients who screening demonstrates the need for additional services

Additional Resources:

California Dept. of Health Care Services/ SBIRT services: http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx

Free SBIRT Trainings: http://www.uclaisap.org/sbirt/

SBIRT Trainings: http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT_Trainings.aspx

Resources and Materials

CMS overview document www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf

Effective September 1, 2016, Aetna Better Health of California implemented the Milliman Care Guidelines Behavioral Health Guidelines (MCG BHG) as the primary medical necessity criteria for behavioral health

- MCG BHG is nationally recognized, evidence-based clinical guidelines used for determining medical necessity, appropriate levels of care: www.mcg.com/content/behavioral-health-care

Mental Health Services Division (MHSD): http://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx

County Mental Health Depts: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

SAMHSA-HRSA SBIRT information: http://www.integration.samhsa.gov/clinical-practice/SBIRT

California Children Services (CCS)

California Children's Services (CCS) is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS). Currently, approximately 70 percent of CCS-eligible children are also Medi-Cal eligible. The Medi-Cal program reimburses their care. The cost of care for the other 30 percent of children is split equally between CCS Only and CCS Healthy Families. The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds.

Eligible CCS Conditions

- Infection Diseases (ICD 10: A00-B99)
- Neoplasm (ICD 10: C00-D49)
- Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders (ICD 10: E00-E89)
- Disease of Blood and Blood-Forming Organs (ICD 10: D50-D89)
- Mental Disorders and Mental Retardation (ICD 10: F01-F99)
- Diseases of the Nervous System (ICD 10: G00-G99)
- Medical Therapy Program
- Diseases of the Eye (ICD 10: H00-H59)
- Diseases of the Ear and Mastoid (ICD 10: H60-H95)
- Diseases of the Circulatory System (ICD 10: I00-I99)
- Diseases of the Respiratory System (ICD 10: J00 – J99)
- Diseases of the Digestive System (ICD 10: K00-K95)
- Diseases of the Genitourinary System (ICD 10: N00-N99)
- Diseases of the Skin and Subcutaneous Tissues (ICD 10: L00-L99)
- Diseases of the Musculoskeletal System and Connective Tissue (ICD-10: M00-M99)
- Congenital Anomalies (ICD-10: Q00-Q99)
- Accidents, Poisonings, Violence, and Immunization Reactions (ICD-10: S00-T88)
- Perinatal Morbidity and Mortality (ICD-10: P00-P96)

*Please refer to the California Code of Regulations, Title 22, Division 2, Subdivision 7, Chapter 3, Article 2, Sections 41515.1-41518.9 for full description.

Access to Care Guidelines

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 tables below has appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), and high-volume Participating Specialist Providers (PSPs).

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

Access to Care Guidelines - continued

Emergency	Urgent	Non-Urgent	Specialty	Mental health
Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Services that do not require prior authorization within forty- eight (48) hours; for services that do require prior authorization within 96 hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week.	Non-urgent sick care within 10 business days of request or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	Specialty care consultation, including nonurgent, within 15 business days of request or as clinically indicated.	You can expect to be seen by the provider within ten (10) business days
Prenatal Care -- Members will be seen within the following timeframes: • First prenatal visit within 10 business days • Within their first trimester within 14 days • Within the second trimester within 7 days • Within their 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 you and your child healthy. Call your provider to make an appointment for preventive care. You can expect to be seen within ten 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.				
Waiting Time – • 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 an 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.

Telephone Accessibility Standards

Providers must return calls within 30 minutes. We will 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 the 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

Telephone Accessibility Standards - continued

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Telephone Accessibility Standards - continued

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 ten (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.*

Grievance & Appeals

Member Grievance System Overview

- Members or their designated representative can file a request for reconsideration or express dissatisfaction with Aetna Better Health of California orally or in writing.
  - A representative is someone who acts on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney.
  - Representatives must be designated in writing.
- Requests for *reconsideration* are classified as an *appeal*.
- All other *expressions of dissatisfaction* are classified as a *grievance*.
  - When the grievance is received by phone and can be resolved by the next business day and it is not related to reconsideration or an appeal it is classified as an exempt grievance.
- ABHCA informs members and providers of the grievance system processes for exempt grievances, grievances, appeals, IMRs and Medi-Cal State Fair Hearings.

How to file an Appeal or Grievance:

Phone: 1-855-772-9076

Fax: (SD) 1-844-854-4450

Fax: (SAC) 1-844-489-7441

Online: Provider Portal & Member Portal

Email: CAMedi-CalAppealandGrievance@aetna.com

Mail: Aetna Better Health of California
Attn: Appeal and Grievance Manager
10260 Meanley Drive
San Diego, CA 92131

Additional Information on G &A

Provider Dispute

Provider Dispute Resolution Form

- Network providers may file a payment dispute verbally or in writing direct to ABHCA to resolve billing, payment and other administrative disputes for any reason including but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the provider; or any other reason for billing disputes. Provider Payment Disputes do not include disputes related to medical necessity.

Provider Grievance

- Both network and out-of-network providers may file a formal grievance in writing directly with ABHCA in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action within one hundred eighty (180) calendar days from when they became aware of the issue.

Provider Appeal

- A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with ABHCA within one hundred eighty (180) calendar days from the Aetna Better Health of California Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

Fraud, Waste, and Abuse

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste

Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse

Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

•By phone to the confidential Aetna Better Health of California Compliance Hotline at 1-855-321-3727

•By phone to our confidential Special Investigation Unit (SIU) at 1-800-338-6361

https://www.aetnabetterhealth.com/california/fraud-abuse

You can also report provider fraud to DHCS, at 1-800-822-6222 or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at 1-800-HHS-TIPS (1-800-447-8477).
https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

Your Aetna Better Health of California Team

Executive Team	Chet Uma, Chief Executive Officer
	Jeffrey Dziedzic, Chief Operations Officer
	Robert Weis, Chief Financial Officer
	Dr. Rafael Amezcua, Chief Medical Officer
Grievance and Appeals	Chandra Dillard, Grievances and Appeals, Supervisor
	CAMedi-CalAppealandGrievance@aetna.com
Medical Management	Isis Montalvo, VP Medical Management
	Jennifer Matoske, Case Management Manager
	Sandra Carson, Utilization Management Manager
	AetnaBetterHealthofCA-CMReferral@aetna.com
Member Services	Anthony Larrarte, Member Services Manager
	MemberServices_CA@aetna.com
Cultural Competency	Jill Webber, Cultural Competency & Health Equity Director
Community Engagement	Lisa Mariani, Marketing & Community Development Manager
	Maria Gutierrez (San Diego County)
	Martin Gonzalez (Sacramento County)
	Cherry Moua (Sacramento County)
Network (Contracts) Development	Linda Aquila, Network Manager (Sacramento County)
	Mary Lou Rahn, Network Manager (San Diego County)
	Dorn Heeb, Contract Negotiator
Quality Management	Melissa Gora, HEDIS Manager

Provider Relations	Jane Flanagan Brown, Network & Provider Experience Director
	Lisa Lovett, Provider Relations Manager
	Sonja Hamel, Provider Relations Representative - Sacramento County
	Jose Iniguez, Provider Relations Representative - Sacramento County
	Pany (Tracy) Sameuchay, Provider Relations Representative - Sacramento County
	William Lester, Jr. Provider Relations Representative - San Diego County
	Alexandria (Sandie) Reed, Provider Relations Representative - San Diego County
	Monica Rodriguez, Provider Relations Representative - San Diego County
	Melanie Molina, Provider Relations Representative - San Diego County
	CaliforniaProviderRelationsDepartment@aetna.com
Behavioral Health	Merrett Sheridan, Behavioral Health Liaison

ABHCA Phone Line:

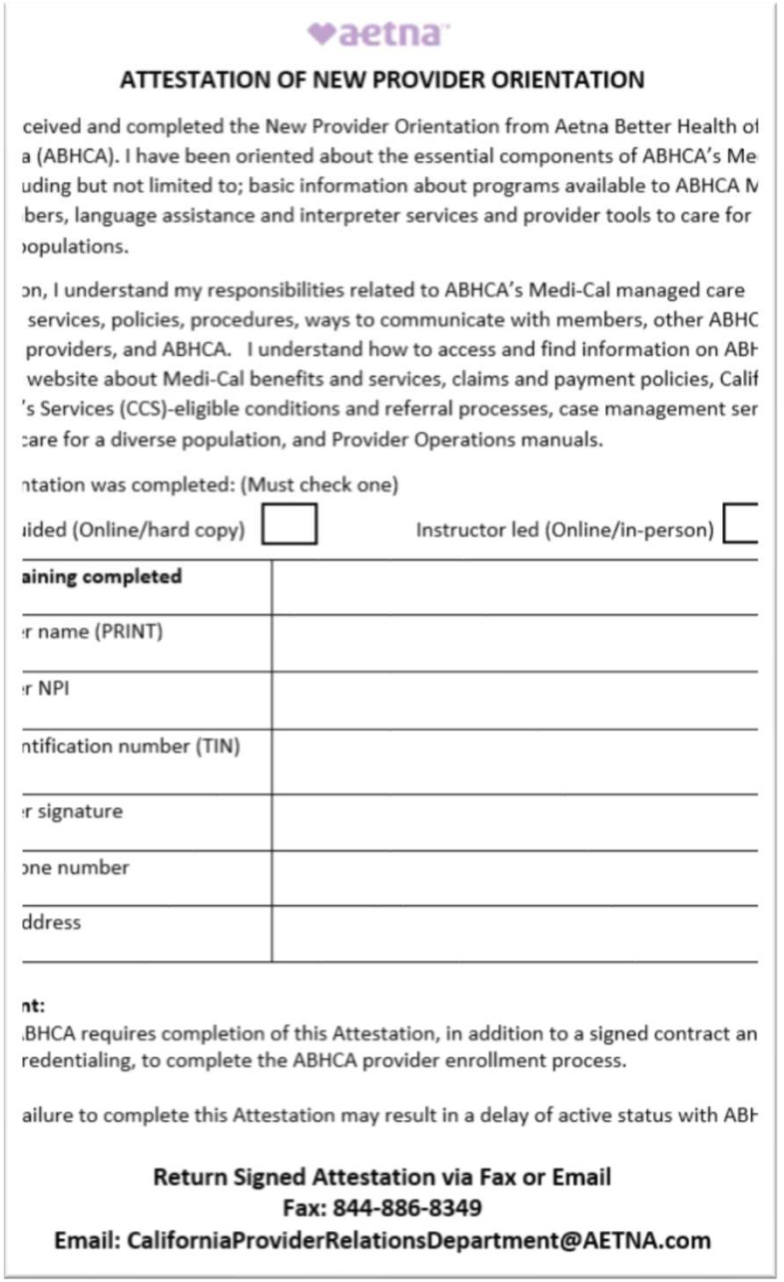
1-855-772-9076

aetna™

Attestation

As required by DHCS and ABHCA, please complete and forward a copy of this attestation.

Thank you for you time and partnership!



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ATTESTATION OF NEW PROVIDER ORIENTATION

ceived and completed the New Provider Orientation from Aetna Better Health of a (ABHCA). I have been oriented about the essential components of ABHCA's Me uding but not limited to; basic information about programs available to ABHCA M bers, language assistance and interpreter services and provider tools to care for opulations.

on, I understand my responsibilities related to ABHCA's Medi-Cal managed care services, policies, procedures, ways to communicate with members, other ABHC providers, and ABHCA. I understand how to access and find information on ABH website about Medi-Cal benefits and services, claims and payment policies, Calif 's Services (CCS)-eligible conditions and referral processes, case management ser care for a diverse population, and Provider Operations manuals.

ntation was completed: (Must check one)

ided (Online/hard copy) ☐ Instructor led (Online/in-person) ☐

aining completed	
r name (PRINT)	
r NPI	
ntification number (TIN)	
r signature	
one number	
ddress	

nt:

BHCA requires completion of this Attestation, in addition to a signed contract an redentialing, to complete the ABHCA provider enrollment process.

ailure to complete this Attestation may result in a delay of active status with ABH

Return Signed Attestation via Fax or Email
Fax: 844-886-8349
Email: CaliforniaProviderRelationsDepartment@AETNA.com