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Aetna Better Health® of California

Family time

Summer 2019

Quality Improvement Program

At Aetna Better Health of California, the quality of our member's health care is important to us. We have a Quality Improvement (QI) program that helps them get the best care possible. The goals and objectives of the QI program include the following:

- Implement a Quality Management program that effectively promotes and builds quality into the organizational structure and processes of the health plan.
- Conduct continual monitoring and assessment of patient care and services striving to provide health care and services to health plan members that meet accepted and appropriate medical practice standards and the needs of the health plan members and health care professionals.
- Identify and analyze opportunities for improvement with implementation of actions and follow-up.
- Encourage patient safety.
- Maintain compliance with local, state, and federal regulatory requirements and accreditation standards.

Some of our QI programs include:

- Sending helpful postcards and newsletters about your health
- Reviewing provider offices to make sure they meet California State standards
- Reviewing the quality of our services
- Reminding members and providers about preventive health care
- Measuring member's satisfaction with providers and with health care services
- Monitoring phone calls to make sure member's calls are answered quickly and that correct information is provided
- Working with providers and practitioners to make sure they get all the information they need from Aetna Better Health of California to provide quality care

For more information about other parts of the QI program, you can call us at **1-855-772-9076**.

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10260 Meanley Drive
San Diego, CA 92131

Communicate access

Appointment availability standards

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

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

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

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

In-office wait times

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

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

Referral options

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

Referrals are not needed for:

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

Minors also do not need a referral for:

- Outpatient mental health 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

Policies and procedures regarding collection, use and disclosure of PHI

Sometimes members, providers and Aetna Better Health employees may choose to do dishonest acts. These dishonest acts are called fraud and abuse. The following acts are the most common types of fraud and abuse:

- Members selling or lending their ID card to someone else
- Members trying to get drugs or services they do not need
- Members forging or altering prescriptions they receive from their providers
- Providers billing for services they didn't give
- Providers giving services members do not need
- Verbal, physical, mental, or sexual abuse by providers

Call our fraud, waste and abuse hotline at **1-855-321-3727** to report these types of acts right away. You can do this confidentially. We do not need to know who you are. You can also report fraud or abuse on this website.

You can also report suspected fraud or abuse, or elderly abuse to the State of California Bureau of Medi-Cal Fraud & Elderly Abuse hotline at **1-800-722-0432** or use the online complaint form.

Distribution of affirmative statements

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

Visit our website

Our website provides information about the following:

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

Grievances and Appeals

Members

Members or their designated representatives can file a request for reconsideration or express dissatisfaction with Aetna Better Health of California verbally or 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, 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.

Provider dispute

Network providers may file a payment dispute verbally or in writing direct to Aetna Better Health of California to resolve billing, payment and other administrative disputes. Reasons include but are 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
- Any other reason for billing disputes.

Provider payment disputes do not include disputes related to medical necessity. Providers can file a verbal dispute with Aetna Better Health of California by calling the Provider Services Department at **1-855-772-9076**. To file a dispute in writing, providers should write to:

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

Additional information can be located on our website at: **aetnabetterhealth.com/california/members/grievance**.

Population management

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

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

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

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

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

When to use Aetna Better Health of California Clinical Policy Bulletins and other guidelines

If Milliman Care Guidelines (MCG) states "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of California Clinical Policy Bulletins (CPBs), should be consulted and utilized.

For prior authorization of outpatient and inpatient services, Aetna Better Health of California uses:

- Criteria required by applicable state or federal regulatory agencies
- MCG as applicable
- LOCUS/CASII Guidelines/ American Society of Addiction Medicine (ASAM)
- Aetna Better Health of California CPBs
- Aetna Better Health of California Clinical Policy Council Review

Medical, dental and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Find it online! Additional information regarding Aetna Better Health of California is available in the provider manual located at **aetnabetterhealth.com/california/assets/pdf/providers/CA-ProviderManual.pdf**.

Member rights and responsibilities

Aetna Better Health members have these rights:

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

Aetna Better Health members have these responsibilities:

- Read their Evidence of Coverage. It tells them about our services, and how to file a grievance or appeal.
- Use their ID cards when they go to health care appointments or get services and do not let anyone else use their cards.
- Know the name of their PCP and care manager if they have one.
- Know about their health care and the rules for getting care.

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

Rx restrictions and preferences

A current list of preferred pharmacies and formularies are available 24/7 on our members website, located at **aetnabetterhealth.com/california/members/pharmacy**.

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

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

Integrated Care Management

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

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

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

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

Clinical medical necessity

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

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

These are to be consulted in the order listed:

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

Contact us

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

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

This newsletter is published as a community service for the providers of Aetna Better Health® of California. Models may be used in photos and illustrations.

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