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Aetna Better Health® of California

Our new web portal: Availity

We are thrilled to announce that Aetna Better Health of California has transitioned from our current provider portal to Availity. We are excited about the increase in online interactions available to support you as you provide services to our members. Our communications will be transitioning from fax blast to via email in the near future. Keeping our providers informed is our priority.

Some highlights of increased functionality include:

- Claims lookup
- EFT registration
- Grievance and appeal submission
- Online claim submission
- Prior authorization submission and lookup

Best of all, we will continue to build upon this platform by rolling out enhanced functions in 2021, such as:

- A new, robust prior authorization tool
- Eligibility and member lookup
- Panel searches
- Review of grievance and appeals cases

Be on the lookout over the next few months for co-branded emails directly from Availity as new products roll out and training plans are developed.

To enroll, please visit Availity's registration page at **Availity.com/HealthPlans**.

Fall 2021
72.22.800.0-FA A (8/21)

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

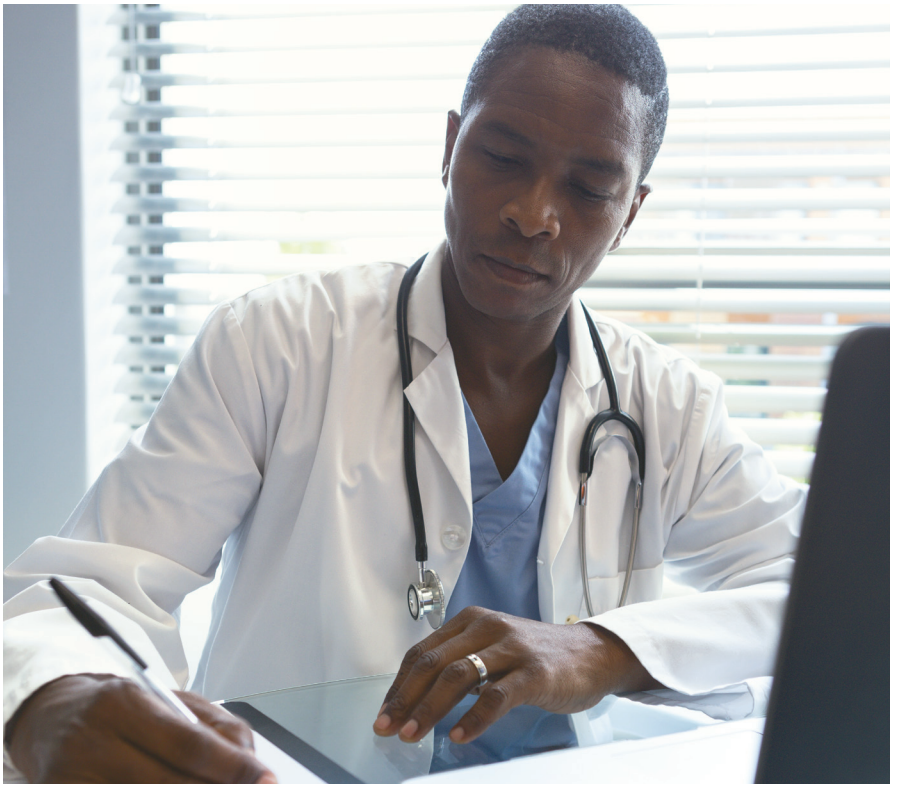
Medi-Cal Rx transition delayed

As previously reported, the Department of Health Care Services (DHCS) has delayed the planned go-live date for Medi-Cal Rx. Currently there is no set date for implementation.

DHCS is reviewing conflict of interest concerns brought about by Centene Corporation's (Centene's) announced plan to acquire Magellan Health, Inc., the parent company of Magellan Medicaid Administration, Inc. (MMA), the contracted vendor for Medi-Cal Rx. Centene operates — through subsidiaries — managed care plans and pharmacies that participate in Medi-Cal.

This transaction requires additional time for exploration of acceptable conflict avoidance protocols to ensure that there will be acceptable firewalls between the corporate entities to protect the pharmacy claims data of all Medi-Cal beneficiaries and to protect other proprietary information.

Medi-Cal Rx remains of utmost importance to the state of California as a tool to standardize the Medi-Cal pharmacy benefit statewide under one delivery system and as a means to improve access to pharmacy services, with a network that includes approximately 94% of the state's pharmacies. DHCS anticipates providing further updates as additional information becomes available.



NCQA accreditation gained

As of June 9, 2021, Aetna Better Health of California has received its official status of "Accredited" from the National Committee for Quality Assurance (NCQA). This news comes after a tremendous amount of hard work and preparation. Over the past year, Aetna Better Health of California conducted policy reviews, data analyses, extensive document gathering and quarterly file reviews in preparation for this first survey.

Our accredited status is a big achievement in advance of our upcoming request for proposal (RFP) and is documented proof of all our hard work and quality activities taking place within our organization for the benefit of our members. Our accredited status is effective as of May 27, 2021, and remains active until May 27, 2024.

Aetna Better Health of California will not be surveyed again until 2024; however, work continues to maintain our accredited status through multiple analyses that must be completed annually. In addition, quality management has submitted the application for NCQA's Multicultural Healthcare Distinction survey, which we have been scheduled to submit in February 2022.

Spotlight of the quarter

Aetna Better Health of California, the Medicaid managed care business of Aetna, a CVS Health company, would like to introduce you to Verne Brizendine as the CEO of the health plan. In this role, Brizendine will be responsible for the health plan's operations and strategy to help members achieve better health outcomes.

Aetna Better Health of California arranges for the delivery of health care services to families and individuals who are eligible for Medi-Cal, the state's Medicaid program. The health plan serves approximately 33,000 members in San Diego and Sacramento counties.

Brizendine joined Aetna in 2019 as director of business development, bringing more than 30 years of leadership experience in the health care industry. He previously held various leadership roles with managed care companies, including Blue Shield of California, LA Care and Anthem. Throughout his career, he has built long-standing partnerships with state and local officials, community stakeholders, health care providers, and community-based organizations.

"Verne's extensive knowledge and background in managed care, coupled with his strong track record at Aetna, will be instrumental in growing our California health plan," says Lorry Bottrill, Southwest Territory Leader for Aetna Better Health and CEO of Mercy Care. "His leadership and commitment to assisting

Verne Brizendine, CEO

vulnerable populations will guide our strategic initiatives throughout the state as we continue to support Medi-Cal beneficiaries on their path to better health."

Brizendine holds a Bachelor of Fine Arts from Stephen's College. He serves as a board member of the My Stuff Bags Foundation, a nonprofit organization serving foster children in the U.S.

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.

Opioids and antipsychotics

The most serious side effect associated with opioids is the risk of death stemming from depression of the central nervous system (CNS) and thus respiration. A growing body of research has documented that medications which depress the CNS may contribute to significantly increased risk of death when combined with opioids.

In 2016, the U.S. Food and Drug Administration (FDA) implemented black box warnings on labeling for opioids and benzodiazepines to warn patients and providers of the dangers of that specific combination.

Opioids involved in 58% of overdose deaths involving antipsychotics

While not issuing black box warnings on all drugs with CNS depressant effects, the FDA policy statement did reference studies which indicate that any CNS depressant, not only benzodiazepines, may be a contributing factor to opioid overdose and death.[1] Numerous antipsychotic medications have CNS depressant properties.

One study in *JAMA* suggests that opioids were involved in 58% of overall deaths involving antipsychotics.[2] There are numerous CYP450 liver enzyme interactions involving antipsychotics and opioids. Changes in the opioid dose or formulation may impact the potency of the antipsychotic and vice versa. Patients receiving antipsychotic medication may also have a greater likelihood of struggling with issues related to addiction or abuse of opioids.[3]

For these reasons, it is critically important that prescribers of either opioids or antipsychotics assess the patient for this combination and adjust therapy accordingly.

What can be done?

The Centers for Medicare & Medicaid Services (CMS) has already issued a requirement that states monitor the concurrent use of opioids and antipsychotics as required by the SUPPORT for Patients and Communities Act. It is hoped that this will increase the coordination of care between behavioral health and pain management providers.

You can play an important role in increasing this coordination in the following ways:

- Regularly screen patients for the combined use of opioids and antipsychotics.
- Educate patients on the signs of sedation or respiratory depression and when they should seek medical attention.
- Screen patients for risk of substance-use disorders, including opioid abuse and misuse, and warn them of the risk for overdose and death associated with the use of

additional CNS depressants, including alcohol and illicit or recreational drugs.
- Attempt to contact the other prescriber to establish lines of communication for patients receiving opioids and antipsychotics. Notify each other of dose adjustments or changes for either medication.
- Avoid abrupt discontinuation of opioids to reduce withdrawal symptoms. If dose modification or discontinuation is warranted, try to taper off the dosage slowly. The CDC Guideline for Prescribing Opioids for Chronic Pain suggests a dose reduction of 10% every week as a reasonable starting point.[4]

Sources:

1. Center for Drug Evaluation and Research. "Drug Safety and Availability — FDA Drug Safety Communication: FDA Warns about Serious Risks and Death When Combining Opioid Pain or Cough Medicines with Benzodiazepines; Requires Its Strongest Warning." U.S. Food and Drug Administration home page, Center for Drug Evaluation and Research, FDA.gov/downloads/Drugs/DrugSafety/UCM518672.pdf
2. Christopher M. Jones, PharmD, Karin A. Mack, PhD, and Leonard J. Paulozzi, MD, "Pharmaceutical Overdose Deaths, United States, 2010," *Journal of the American Medical Association*, February 20, 2013, Vol 309, No. 7, p. 658.
3. Jan Klimas, PhD, MSc, Laura Gorfinkel, Nadia Faribarn, MD, et al. *JAMA Network Open*. 2019 May; 2(5): e193365. Published online 2019 May 3. DOI: 10.1001/jamanetworkopen.2019.3365
4. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

Mandatory new standards (guidelines) training

The Department of Health Care Services (DHCS) has made updates to the site review process, which includes Facility Site Review (FSR) and Medical Record Review (MRR) policies.

DHCS has updated the FSR and MRR standards and criteria to reflect current guidelines of professional organizations by expanding certain criteria, reorganizing the criteria groups to help better identify deficiencies and adjusting the scoring methods to better generalize the scores.

DHCS has released a new All Plan Letter (APL) 20-006 to reflect these updates. This APL includes changes made to the criteria and scoring of DHCS' FSR and MRR tools and standards. This APL supersedes Policy Letters (PL) 14-004, PL 03-002, and APL 03-007.

DHCS recognizes the extent and impact of these changes. Providers and staff should remain informed of and begin training on the updates to FSR and MRR criteria and standards.

In the spirit of collaboration, 22 California managed care plans have partnered through collaborative efforts to provide training and resources to our primary care physicians.

The collaboration is proud to announce the completion of the first part of the FSR/MRR video series. This video series will explain changes to the current guidelines corresponding to the APL 20-006 and release date of the new standards.

To access the training video and regulatory requirements, visit **AetnaBetterHealth.com/california/providers/facility-site-review.html**.

Provider resources for HEDIS and EPSDT

In an effort to support providers, we would like to alert you to the following important resources, as California has fully reopened its economy: Health Effectiveness Data and Information Set (HEDIS) Provider Education Overview, Aetna Better Health of California Helpful HEDIS Documentation Tips, California Department of Public Health (CDPH) Don't Wait Vaccinate Campaign and the Department of Health Care Services (DHCS) All Plan Letter 20-016 "Blood Lead Screening of Young Children."

The **HEDIS Provider Education Overview** is a PowerPoint slide collection that details the overall structure and importance of HEDIS. It also explains how HEDIS data are collected, highlights the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, includes a HEDIS annual timeline and summarizes how you can improve your HEDIS scores.

Visit the Aetna Better Health of California provider website at **AetnaBetterHealth.com/california/providers/index.html** to access the HEDIS provider education.

The **Aetna Better Health of California Helpful HEDIS Documentation Tips** resource is a great tool for quick reference item guidelines and the appropriate coding related to various HEDIS measures. This comprehensive document includes tips to help ensure effective HEDIS management and compliance. Visit the Aetna Better Health of California provider website at **AetnaBetterHealth.com/california/providers/index.html** to access the HEDIS tips for primary care providers.

The **Don't Wait Vaccinate Campaign** is from the California Immunization Coalition and in collaboration with the CDPH. The collaborative has developed a communication campaign intended to address the

decrease in immunization rates observed during the ongoing COVID-19 pandemic. A campaign tool kit has been created that includes a library of social media messages, talking points, template letters and other tools that encourage patients to reconnect with their providers. You can visit **ImmunizeCA.org/DontWaitVaccinate** to access the campaign tool kit.

The **DHCS All Plan Letter 20-016 "Blood Lead Screening of Young Children"** contains information on requirements for providing timely blood lead screening of young children at appropriate intervals. Visit the DHCS website at **www.DHCS.CA.gov/FormsandPubs/Pages/AllPlanLetters.aspx** to access the DHCS APL 20-016.

Maternity Matters program

Aetna Better Health of California now has a new program called Maternity Matters for pregnant members and new moms. It is important to have a healthy pregnancy, and Maternity Matters is here for support. Pregnant members and members who are new moms who complete healthy activities can get rewards for items like diapers, wipes, pack 'n' plays and baby formula.

Members can call **1-855-772-9076** for more information and for help getting started with the Maternity Matters program.

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

Rx restrictions and preferences

A current list of preferred pharmacies and formularies is available 24/7 on our members website, located at **AetnaBetterHealth.com/California/members/pharmacy**.

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

- Injectables dispensed by a pharmacy provider
- Nonformulary 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

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.

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.

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

Integrated Care Management

Aetna Better Health of California's Integrated Care Management (ICM) Program uses a Bio-Psycho-Social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at highest risk of not doing well over the next 12 months and offer them intensive care management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary care provider (PCP). This relationship continues throughout the care management engagement.

We offer supportive care management services to members who are at lower risk. These include standard clinical care management and service coordination and support. Disease management is part of all care management services that we offer. To learn more, please contact Aetna Better Health of California 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.

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 department visits must be in accordance with ED 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.

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 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:

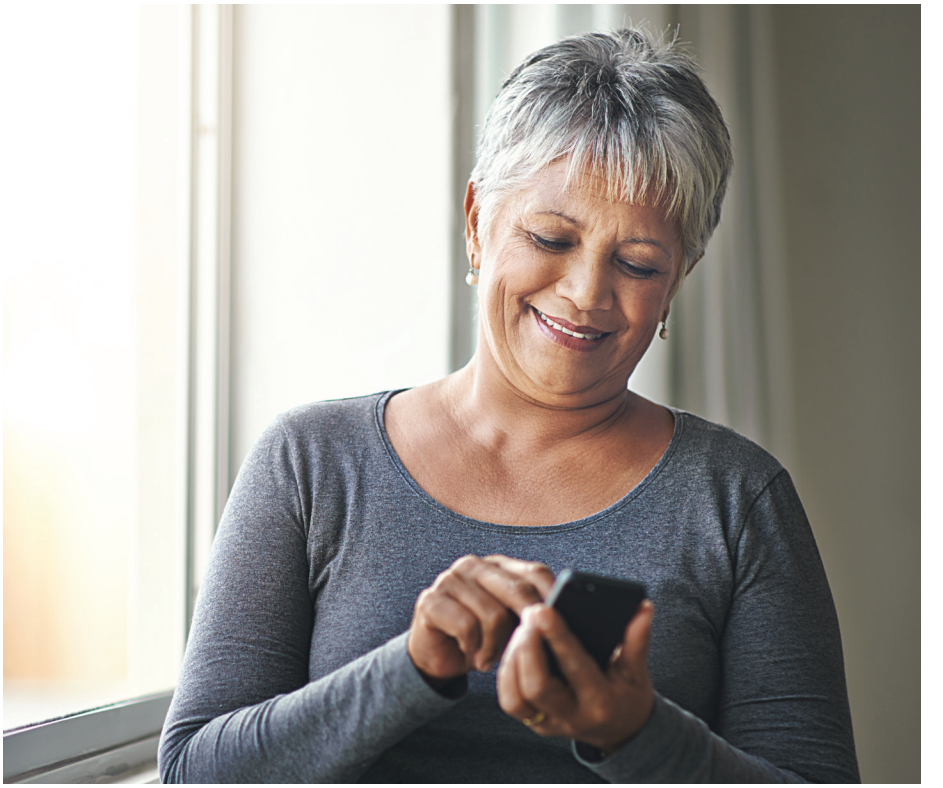
- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver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

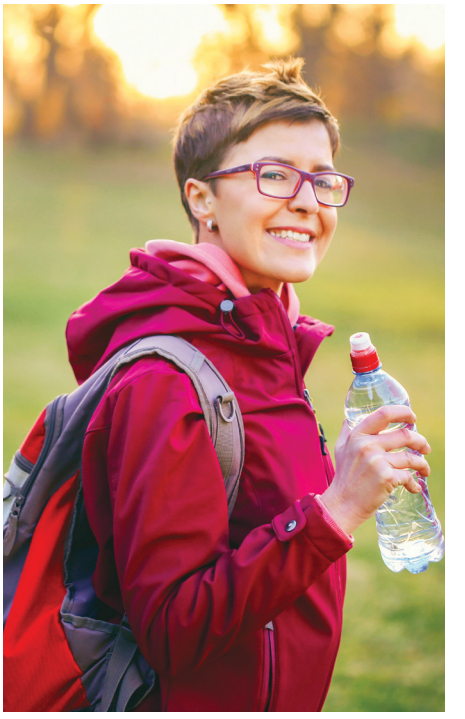
For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of California uses the medical review criteria listed below. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of California's population needs and updated as applicable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



2021 holidays

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

Monday, September 6: Labor Day

Thursday, November 25: Thanksgiving Day

Friday, December 24: Christmas Day (holiday on Saturday)

Friday, December 31: New Year's Day (holiday on Saturday)

Contact us

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