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AetnaBetterHealth.com/California

Aetna Better Health® of California

Aetna Better Care Rewards program now live!

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

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

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

For more information about the Aetna Better Care Rewards program, please contact the provider experience team at **CaliforniaProviderRelationsDepartment@aetna.com**.

Winter 2021
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Aetna Better Health® of California
10260 Meanley Drive
San Diego, CA 92131

COVID-19 vaccine incentive

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

Aetna Better Health will automatically mail $50 gift cards to members when they get their first dose.

The California Department of Health Care Services (DHCS) has made $100 million in total direct incentives available to Medi-Cal members who get their first vaccination dose beginning in September 2021.

San Diego Medi-Cal members 40% behind county average

DHCS reports that in San Diego County, just 54.9% of eligible Medi-Cal members are vaccinated, compared to 95.9% of eligible Californians in the county (as of August 22, 2021).

Certain communities are disproportionately affected:

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

Encourage your community to get vaccinated today!

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

Did you know?

- The U.S. Food and Drug Administration (FDA) has fully approved the Pfizer vaccine and granted emergency use for Moderna and Johnson & Johnson.
- As of November 11, 2021, more Americans have died of COVID-19 than perished in World War I and World War II combined.
- COVID-19 vaccines are 94% effective against serious illness and hospitalization.
- The COVID-19 vaccine is proven safe and effective for ages 12 and older with no reports concerning child development.
- The vaccine is **free**. You **do not** have to pay out of pocket or go through your insurance.
- The COVID-19 vaccine is safe if you are planning to become pregnant, currently pregnant and/or breastfeeding.
- The COVID-19 vaccine cannot give you COVID-19. Those who have had COVID-19 should still get vaccinated.
- The COVID-19 vaccines are effective against the Delta variant and limit severity if breakthrough infection occurs.
- COVID-19 vaccines include ingredients such as fats, sugars and mRNA but do not contain any fetal tissue or microchips.
- If you are fully vaccinated, you can resume many activities that you did before the pandemic, in accordance with guidance from the Centers for Disease Control and Prevention.

Spotlight of the quarter

Rafael Amezcua, MD, is the chief medical officer for Aetna Better Health of California. He is a board-certified internist who has a passion for bringing team-based, innovative solutions to complex health care challenges.

Throughout his career, Dr. Amezcua has been an active participant in local and national events. For over 10 years he served as medical commentator for San Francisco-based Univision KTVU and hosted a live TV weekly medical segment. Dr. Amezcua was selected by the National Institutes of Health to co-chair the Council of Public Representatives and a national workshop on patient research participation. He also served in a national advisory group to the Robert Wood Johnson Foundation.

Dr. Amezcua has participated on multiple boards and has given numerous talks and presentations. He is a graduate of the California Health Care Foundation/UCSF Healthforce Center Health Care Leadership Program.

Rafael Amezcua, MD

Mom's Meals

Nutritious, home-delivered meals can help patients manage diabetes

Managing chronic conditions like diabetes isn't always easy, but ensuring that members have access to the right nutrition is a start. That is why Aetna Better Health of California has partnered with Mom's Meals® to offer a pilot program designed to help members with diabetes get the nutrition they need, with nutritious meals delivered directly to their homes — at no cost to them.

Mom's Meals is a leading provider of fully prepared, refrigerated meals delivered to homes nationwide, providing members access to nutritious options that help address many common health conditions and are tailored to members' needs. In this pilot program, members will receive up to 21 meals per week for 12 weeks. These meals are designed by chefs and dietitians and are developed in accordance with guidelines from the American Diabetes Association. Once approved by the state, the pilot program will be offered to the first 200 people who meet the following criteria:

- Be 18 to 75 years of age
- Have type 1 or type 2 diabetes
- Have an HbA1c level over 9% or did not have an HbA1c test

Participants will be required to take an HbA1c test **before** and **after** the 12-week program.

For more information, please call Aetna Better Health of California's Provider Services at **1-855-772-9076 (TTY: 711)**.

Language assistance, interpretation and translation

Aetna Better Health of California offers sign language, face-to-face and over-the-phone interpreter services at no cost to the provider or member. Please call Aetna Better Health of California at **1-855-772-9076 (TTY: 711)** for more information on how to schedule these services prior to an appointment.

Medi-Cal Rx support services and key payer sheet details

Medi-Cal Rx support before January 1, 2022

The Medi-Cal Rx transition will resume January 1, 2022. For information on Medi-Cal Rx, visit the provider portal at **Medi-CalRx.DHCS.CA.gov** or the Medi-Cal Rx Transition page on the DHCS website. For general questions related to Medi-Cal Rx, please send an email to **RxCarveOut@dhcs.ca.gov**.

Medi-Cal Rx Customer Service Center beginning January 1, 2022

MMA will implement a Medi-Cal Rx Customer Service Center (CSC) to assist providers (including, but not limited to, pharmacists and prescribers) and beneficiaries.

The Medi-Cal Rx CSC will be available beginning January 1, 2022. The toll-free number for the CSC, **1-800-977-2273**, will be available 7 days a week, 24 hours a day and 365 days a year. The telephone menu options are included in the chart to allow providers to update processes and any automation they may have in place today.

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

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

- Claims processing/messaging
- Drug coverage
- Beneficiary eligibility

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

Please note that prior to January 1, 2022, for general questions about Medi-Cal Rx, providers should contact the general Medi-Cal Member Help Line at **1-800-541-5555**, Monday through Friday, 8 AM to 5 PM.

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.

Collecting social determinants of health data (APL 21-009)

The California Department of Health Care Services (DHCS) released its California Advancing and Innovating Medi-Cal (CalAIM) proposal in 2019 and revised it on January 8, 2021.[1] CalAIM is a multi-year program to improve health outcomes and quality of life for Medi-Cal beneficiaries through broad delivery system, program and payment reform.

Population Health Management (PHM) is an initiative of CalAIM that identifies and manages member risk and need through whole-person care approaches while focusing on and addressing social determinants of health (SDOH).

The DHCS recognizes that consistent and reliable collection of SDOH data is vital to the success of CalAIM's PHM initiative. To advance improvements, the DHCS is providing guidance on collecting SDOH data to:

- Support managed care plans (MCPs) and their network providers and subcontractors in identifying member health, social and risk needs, to ensure that members receive the specific services and programs that they require. The data will also aid network providers and subcontractors in care planning and coordination and will contribute to the MCPs' population needs assessment. The intent is for MCPs to focus on health-related social factors that can be improved through Medi-Cal programs and services.
- Assist the DHCS in evaluating population health statewide through the analysis of member characteristics and health, social and risk needs, with an emphasis on driving improvements in health equity and identifying health disparities and their root causes. The intended use for this data, in addition to the statewide standardized member risk tiers that MCPs will report to the DHCS, is to support future PHM policy and program development.

Please visit **www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx** for more information regarding the CalAIM proposal.

The new standards release date has been verified to be January 1, 2022

The DHCS has released a new All Plan Letter (APL) 20-006 to reflect updated Facility Site Review (FSR) and Medical Record Review (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.

Training on the updates to FSR and MRR criteria and standards is mandatory.

Since these standards affect every primary care clinic, organization, group, solo practice, rural health setting and community-based clinic, Aetna Better Health of California has provided the training at **AetnaBetterHealth.com/california/providers/facility-site-review.html**. This is the first phase of training for FSR. The second phase, coming soon, will be for the MRR portion of the standards. Please take the time now and be prepared for your assigned health plan and reviewer.

Enhanced Care Management requirements (APL 21-012)

The Department of Health Care Services (DHCS) released its California Advancing and Innovating Medi-Cal (CalAIM) proposal on October 29, 2019, in anticipation of the expiration of its Medi-Cal 2020 1115 Demonstration and 1915(b) Specialty Mental Health Services Waiver authorities.

The DHCS postponed the planned implementation of the CalAIM initiative, which was originally scheduled for January 1, 2021, due to the COVID-19 public health emergency, and released a revised CalAIM proposal on January 8, 2021. The DHCS also submitted its CalAIM Section 1115 Demonstration and 1915(b) Waiver applications to the Centers for Medicare and Medicaid Services on June 30, 2021.

The DHCS obtained statutory authority to establish the CalAIM initiative to support the stated goals of identifying and managing the risks and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes.

CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad-delivery system, program and payment reforms across the Medi-Cal program. The Enhanced Care Management (ECM) benefit is a component of the CalAIM initiative that will be delivered through Medi-Cal managed care.

ECM is a whole-person, interdisciplinary approach to comprehensive care management intended to address the clinical and nonclinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch and person-centered.

ECM will build on the Whole-Person Care (WPC) pilots and Health Homes Program (HHP) efforts and activities. The care coordination and care management services that are currently being provided under WPC pilots and HHP will transition to and be replaced by ECM.

The ECM benefit will be phased in over time and available statewide through the managed care delivery system starting January 1, 2022. The WPC pilots and HHP are scheduled to conclude on December 31, 2021.

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.

Health and Wellness Quick Reference Guide

Please pull out and save this eight-page section of the newsletter as an overview of member outreach campaigns, health and wellness programs, and member incentives programs.

Please visit **AetnaBetterHealth.com/california/providers/newsletters.html** for more information.

We are bringing some exciting new changes to our members.

Evidence of Coverage/Member Handbooks

Your Evidence of Coverage (Member Handbook) has your health care benefits, rights and responsibilities, and how you can get care and services. A digital, searchable version of the handbook is available online at **AetnaBetterHealth.com/California**. You can also call Member Services and ask for a hard copy to be sent to you. All member information is available in other languages and formats.

Your primary care provider (PCP)

You will find the name of your PCP on your member ID card. If you would like to choose a new PCP, select one from our provider search tool on our website, **AetnaBetterHealth.com/California**. Call Member Services to get a hard copy of our provider directory sent to you.

If you want to change your PCP, you can do so:
- Through the secure member portal
- Using our Aetna Better Health app
- By calling Member Services

Covered drugs/formulary lookup

To find out if a drug is covered and on our preferred drug list (PDL), also called a formulary, or to get a hard copy of the PDL, call Member Services. You can also find the PDL on our website at **AetnaBetterHealth.com/California/members/pharmacy**.

Need a ride to the pharmacy, food store, WIC office or to apply for food stamps?

You can take up to five trips a month with three days' advance notice. Just call Member Services to set up a ride.

Get information from us in new ways

We are now offering members other ways to receive some health and plan information. You can get information by text messaging, email or voice call. To make your selection:
- Visit **Aet.na/ca-preference**
- Text "JOIN" to **85886**
- Scan the QR code with your phone

Maternity Matters program

We have a new program for pregnant members and new moms. Pregnant members and new mom members who complete healthy activities can get rewards for items like diapers, wipes, Pack 'n Plays and baby formula. Call **1-855-772-9076** for more information or to get started with the Maternity Matters program. Healthy activities that qualify are:
- $50: Completing Notice of Pregnancy
- $2: First prenatal visit
- $1: More prenatal visits (up to 12)
- $2: Postpartum visit

Here's to your better health!

Health & Wellness Programs — Quick Reference Guide

The purpose of this Quick Reference Guide is to provide an overview of Aetna Better Health of California health and wellness and member incentive programs.

Please contact the Member Services team at **1-855-772-9076 (TTY: 711)** with any questions regarding member benefits, health plan programs or services.

Health and Wellness Programs — Quick Reference Guide

(**AetnaBetterHealth.com/california/health-wellness-programs.html**)

Program name	Purpose	Target population	How to enroll	Member incentive program
Diabetes Program	Provides education, resources, support and care coordination to assist with techniques to prevent onset of type 2 diabetes for high-risk members and management of those with a diagnosis of diabetes.	Members 18 and over with a body mass index (BMI) of ≥ 25 kg/m2 (≥ 23 kg/m2, if Asian American), hyperglycemia, prediabetes or diagnosis of diabetes	Call Member Services at **1-855-772-9076**	NA
Chronic Condition Management	Provides education, resources and care coordination to close gaps in care for members diagnosed with specific conditions. Supports member in management of chronic conditions, including development of individualized care plan with an emphasis on identification of member goals, coordination of services and interdisciplinary care collaboration.	Members with the following chronic conditions: • Depression • Diabetes • Heart Health: congestive heart failure (CHF), coronary artery disease (CAD), hypertension (HTN) • Lung Health: asthma, chronic obstructive pulmonary disease (COPD) • Other CM qualifying conditions	Call Member Services at **1-855-772-9076**	NA
Adults and Pediatric Palliative Care	Members identified with serious illness/conditions are provided with emotional and spiritual support, a palliative care team, coordination of care, symptom management, advanced care planning and assistance in health decisions.	Palliative Care Criteria/Requirements Members must meet five general eligibility criteria and meet one of the four disease-specific eligibility criteria; pediatric members must meet pediatric palliative care eligibility criteria as outlined in DHCS APL 18-020	Call Member Services at **1-855-772-9076**	NA
Neonatal Abstinence Syndrome (NAS)	To offer care management for moms and infants during pregnancy and after birth who are identified at risk for or who have a baby with NAS. NAS is a form of drug withdrawal in newborn babies. It can happen when a mom uses certain medicines or drugs during pregnancy.	Mothers at risk of having a baby with NAS or mothers who have a baby with NAS — the NAS program assists these mothers and babies up to one year after birth	Call Member Services at **1-855-772-9076**	NA
Maternity Matters	Provide pregnancy education, resources, support and care management for new parents and baby.	Currently pregnant and new moms	Call Member Services at **1-855-772-9076**	My Maternity Matters
Health Homes Program (HHP)	Provide social support, health promotion and care coordination for members with multiple chronic conditions. Collaborate with community-based care management entities (CB-CMEs) to assist with coordination of care services, such as physical health, behavioral health and community-based long-term services and supports (LTSS).	Eligible criteria include but not limited to: 1. Three or more chronic conditions 2. A required high level of acuity/complexity 3. Hospital stays in the last year 4. ER visit three or more times in the last year 5. Currently without stable shelter	Call Member Services at **1-855-772-9076**	NA
Opioid Management	Provide member support, education and resources on appropriate usage of opioids and benzodiazepines with goal to taper off or reduce the use of medications in a safe and medically appropriate way.	Members who use opioids for pain management and their prescribing providers to explore evidence-based alternatives when appropriate	Call Member Services at **1-855-772-9076**	NA
Flu Program	Program to promote members receiving the annual flu vaccination.	All age-appropriate members (6 months of age and older)	NA (All age-appropriate members receive program benefits)	NA
Healthy Adults	Promotes recommended health screenings and Aetna Better Health of California health and wellness programs for improved health outcomes in all adult members.	All adult members over 18 years of age for whom preventive screenings are recommended, such as breast cancer screening, cervical cancer screening, colorectal cancer screening and chlamydia screening		Aetna Better Care Rewards
Healthy Kids	Promotes recommended health screenings and appropriate wellness programs for improved health outcomes in all pediatric members.	All pediatric members for whom preventive and wellness screenings are recommended		
COVID-19 Vaccine Program	Promotes access, education and appointment scheduling for the COVID-19 vaccine.	All eligible members as outlined by current state regulations and federal COVID-19 vaccine guidelines		

AetnaBetterHealth.com/California

Member Incentive Program Grid

Member incentive program	Target population	Healthy activity	Healthy activity description(s)
My Maternity Matters	Currently pregnant or new moms	• $50: Notice of Pregnancy (NOP) • $25: First prenatal visit • $10: Subsequent prenatal visits (up to 12) • $25: Postpartum visit	**IMPORTANT:** *Member must call the health plan at **1-855-772-9076 (TTY: 711)** to complete NOP form and after each provider visit with the date and provider contact information.* • Notified health plan of pregnancy and complete NOP form • Completed prenatal visit in the first trimester • Completed perinatal visit (up to 12) • Completed postpartum visit 7 to 84 days post-delivery
Aetna Better Care Rewards	All pediatric members for whom preventive and wellness screenings are recommended	• $50: Childhood Immunizations • $25: Adolescent Immunizations • $25: Lead Screening in Children • $25: Child and Adolescent Well-Visit(s)	• Completed ALL childhood immunizations by 2 years of age, including four diphtheria, tetanus and acellular pertussis (DTap), three polio (IPV), one chicken pox (VZV), four pneumococcal conjugate (PCV), one hepatitis A (HepA), two or three rotavirus (RV) and two influenza (flu) vaccines • Completed ALL adolescent immunizations by 13 years of age, including one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap), and the human papillomavirus (HPV) vaccine series • Completed lead blood test by 2 years of age • Completed six or more well-child visits in first 15 months of life • Completed two or more well-child visits and turned 30 months old during the year • Completed annual well-visit and 3 to 21 years of age
	All age-appropriate members for whom preventive and wellness screenings are recommended	• $25: Breast Cancer Screening • $25: Cervical Cancer Screening • $25: Chlamydia Screening	• Completed mammogram to screen for breast cancer by women 50 to 74 years of age • Completed screening for cervical cancer by women 21 to 64 years of age • Completed test for chlamydia in sexually active women who are 16 to 24 years of age
	All Aetna Better Health of California members who have not been fully vaccinated	• $50: COVID-19 Vaccine (first dose; 9/21/21–3/6/22)	• Completed first dose of any FDA-approved COVID-19 vaccine between September 21, 2021, and March 6, 2022

Member Communications — Quick Reference Guide

The purpose of this Quick Reference Guide is to provide an overview of Aetna Better Health of California health and wellness and member incentive programs. Please contact Aetna Better Health of California Member Services at **1-855-772-9076 (TTY: 711)** with any questions regarding member benefits, health plan programs or services.

Choose your communication preferences

We at Aetna Better Health of California want to create the best experience for you. You can select how you want to get reminders and updates about your health care and benefits, including by text, interactive voice call, email, mobile application or by mail. See page 1 of the reference guide to make your selections.

Interactive voice response (IVR) and text (SMS)

Campaign name	Modality	Purpose	Target population	Frequency	Status
Women's Health	IVR/SMS	Educate members on importance and need for preventive care.	• Women who are due for breast cancer screening (50 to 74 years of age), cervical cancer screening (21 to 64 years of age) or chlamydia screening (16 to 24 years of age)	Monthly	Ongoing
Well Child	IVR/SMS	Educate members on importance and need for preventive care and well-child check-up.	• Members with open care gaps for recommended immunizations and well-child visits up to age 21	Quarterly	Ongoing

Interactive voice response (IVR) and text (SMS)

Campaign name	Modality	Purpose	Target population	Frequency	Status
Care Management (CM) Satisfaction Survey	IVR	Member satisfaction survey for members enrolled in CM.	Members in CM that meet the following criteria: Monthly Survey: • Open CM episode after six months of CM assignment • Has not been pulled for survey within the last 3 months Annual Survey: • Open CM episode and last annual survey more than 364 days ago	Monthly/annually	Ongoing
Condition Management Satisfaction Survey	IVR	Member satisfaction survey for members with diagnosis of diabetes and enrolled in CM.			Ongoing
Comprehensive Diabetes Care	IVR	Encourage members to follow up with recommended diabetes screening(s), such as HbA1c testing, eye exam, kidney screening and foot exam.	Members 18–75 years of age with diabetes identified as needing one or more of the following tests: HbA1c, microalbumin, diabetes eye exam	Quarterly	Ongoing
Emergency Room Utilization	IVR/SMS	Educate members about options outside of the ER for their care, when appropriate, such as the 24-hour nurse line, their primary care physician (PCP) and/or Urgent Care Centers.	Members that have used the ER recently	Monthly — post discharge	Ongoing
Behavioral Health (BH) Resources	IVR/SMS	Inform all members about BH resources.	All members	Semiannual	Paused
Controlling High Blood Pressure	IVR	Educate members on how to manage high blood pressure (BP), and encourage appointment with PCP to measure BP.	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was not adequately controlled (<140/90 mm Hg) during the measurement year	Quarterly	Paused
Flu Reminder	IVR/SMS	Encourage members to get flu shot.	All members eligible to receive the flu shot	Annually (October)	Ongoing
New Member Survey	IVR/SMS	New member satisfaction survey with the new member marketing and benefit materials.	New members enrolled in January	Annually	Paused
New Member Welcome	IVR	Welcome new members to the health plan and remind them of the importance of scheduling an initial health assessment with their PCP.	New members	Month of enrollment	Ongoing
Postpartum Care	IVR	Remind mothers to schedule a postpartum visit between 7 and 84 days after delivery.	Women who delivered a live birth	Postpartum	Paused
Redetermination	IVR/SMS	Remind members to renew Medi-Cal coverage.	Members due for Medi-Cal renewal	Annually	Paused
COVID-19 Vaccine	IVR/SMS	Inform members of ways they can schedule their COVID-19 vaccine and provide incentive information.	All eligible members who have not received their first dose by September 21, 2021	Ad hoc	Ongoing

By Mail

Campaign name	Purpose	Target population	Frequency	Status
New Member Welcome Packet	The New Member Welcome Packet outlines coverages under Aetna Better Health of California and provides information about the benefits and services under the plan, including the Evidence of Coverage, Welcome Notice and CM booklet.	New members	Upon enrollment	Ongoing
Member Newsletters	Provides members with up-to-date information on important health benefits, health education and upcoming events. The member newsletters are uploaded to the Aetna Better Health of California website.	All members	Quarterly	Ongoing
Chronic Conditions Newsletter	Member newsletters that address the following topics: depression, diabetes, heart health and lung health. These newsletters support members based on their personal health risks and provide healthy tips on condition management.	Members with the following chronic conditions: • Depression • Diabetes • Heart Health: congestive heart failure (CHF), coronary artery disease (CAD), hypertension (HTN) • Lung Health: asthma, chronic obstructive pulmonary disease (COPD)	Semiannual	Ongoing
EPSDT Mailer	Provides reminder to members, or parents/guardians of members, who are below 21 years of age for periodic health screenings, immunizations and other services, such as vision, dental and hearing.	Members up to age 21	Annually (birthday month)	Ongoing

AetnaBetterHealth.com/California

By Mail

Campaign name	Purpose	Target population	Frequency	Status
Well Woman Mailer	Provides reminder to members who are due for cervical screening, mammogram or a combination of both.	Members with a gap in the following screenings: • Breast Cancer: Women 50–74 years of age • Cervical Cancer: Women 21–64 years of age • Chlamydia: Women 16–24 years of age	Annually (birthday month)	Paused
Flu Mailer	Serves to remind members to receive their annual flu vaccination.	All age-appropriate members (CDC recommends all individuals 6 months and older)	Annually (October)	Ongoing
Diabetes Booklet	Mailing out diabetes booklet to members with diagnoses of diabetes to provide education on the condition and support in self-management.	Members 18–75 years of age with diabetes diagnosis	Annual (September)	Paused
COVID-19 Vaccine Postcard	Postcard sent to members with important information about the COVID-19 vaccine and the Aetna Better Health of California incentive for receiving their first dose.	All eligible members who have not received their first dose by September 21, 2021	Ad hoc	Ongoing

Other

Campaign name	Purpose	Target population	Frequency	Status
Member Services (MS) Hold Line Message — Flu Reminder	Encourage members to get flu shot.	All members who call in to Member Services	Annually (September)	Ongoing
Rx Health Tag — Flu	Tag attached to medication that encourages members to get flu shot.	Members who fill a prescription at CVS pharmacy	Annually (September)	Ongoing

Non-emergency medical transportation (NEMT)

Aetna Better Health of California covers NEMT and, in coordination with Access2Care, provides transportation to members in need of NEMT or non-medical transportation (NMT).

Members may use NEMT when:

- Members are physically or medically unable to use car, bus, train or taxi to get to a medical appointment.
- Assistance is needed from the driver to and from member residence, vehicle or place of treatment due to physical or mental disability.
- Provider is requesting transportation by means of ambulance, litter van, wheelchair van or transport.
- Approved by Aetna Better Health of California in advance by an authorization with provider request.

Provider requirements for NEMT are the following:

NEMT Physician Certification Statement (PCS) forms (included with this newsletter). Managed care plans (MCPs) and transportation brokers must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency among all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

Members may use NMT when:

- Traveling to and from an appointment for Medi-Cal services authorized by a provider.
- They do NOT require assistance from a driver or need an ambulance, litter van or wheelchair van.
- The service is a Medi-Cal covered benefit.

All effective members of Aetna Better Health of California are eligible to receive the transportation benefit. Members or providers may call Aetna Better Health of California at **1-855-772-9076 (TTY: 711)** to schedule transportation or call Access2Care at **1-888-334-8352** at least 48 hours before the medical appointment or as soon as possible for urgent medical needs. Member identification and validation must be provided upon scheduling transportation, including member address, member DOB and phone number, as well as the trip reason, service location, time and day of the medical appointment.

Population health management

To help provide our members with consistent, high-quality care that uses services and resources effectively, we have chosen certain clinical guidelines to help our providers. These include treatment protocols for specific conditions, as well as preventive health measures. These guidelines are intended to clarify standards and expectations. They should not:

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

Call **1-855-772-9076 (TTY: 711)** if you would like additional information about any of these topics:

- ADHD
- Alcohol abuse — National Institute on Alcohol Abuse and Alcoholism's clinician's guide
- Asthma
- Chronic heart failure
- Coronary artery disease
- Diabetes — American Diabetes Association's current clinical practice recommendations
- Major depressive disorder — American Psychiatric Association's guidelines
- Opioid use for chronic pain — Centers for Disease Control and Prevention's guidelines
- Hypertension — JNC 8 guidelines
- Chronic obstructive pulmonary disease (COPD)
- Tobacco cessation

Rx restrictions and preferences

A current list of preferred pharmacies and formularies is available 24/7 on our member 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

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. Practitioners, caregivers and members can self-refer into care management. 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 room (ER) visits must be in accordance with ER attending provider discharge instructions.

Emergency	Urgent	Non-urgent	Specialty	Mental health
Immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Services that do not require prior authorization: within 48 hours; for services that do require prior authorization: within 96 hours. Provisions must be available for obtaining urgent care 24 hours a day, 7 days per week.	Within 10 business days of request or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	Within 15 business days of request or as clinically indicated.	Members can expect to be seen by the provider within 10 business days.

Prenatal care. Members will be seen within the following time frames:

- First prenatal visit: within 10 business days
- First trimester: within 14 days
- Second trimester: within 7 days
- Third trimester: within 3 days
- High-risk pregnancies: within 3 days of identification of high risk by Medi-Cal or maternity care provider, or immediately if an emergency exists

Physicals. This is regular care to keep members and their children healthy. When a member calls to make an appointment for preventive care, they can expect to be seen within 10 business days. Examples of preventive care are checkups, shots and follow-up appointments.

Ancillary services. For the diagnosis or treatment of injury, illness or other health condition: within 15 business days of request.

Wait times:

- Scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.
- If a provider is delayed, patients must be notified immediately.
- If the wait is anticipated to be more than 90 minutes, the patient must be offered a new appointment.
- Walk-in patients with non-urgent needs should be seen, if possible, or scheduled for an appointment consistent with written scheduling procedures.

Please note: Pursuant to Health & Safety Code § 1367.27(j)(2), if a provider who is not accepting new patients is contacted by a member or potential member seeking to become a new patient, the provider shall direct the member or potential member to both Aetna Better Health of California for additional assistance in finding a provider and to the DMHC to report any inaccuracy with the plan's directory or directories.

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.

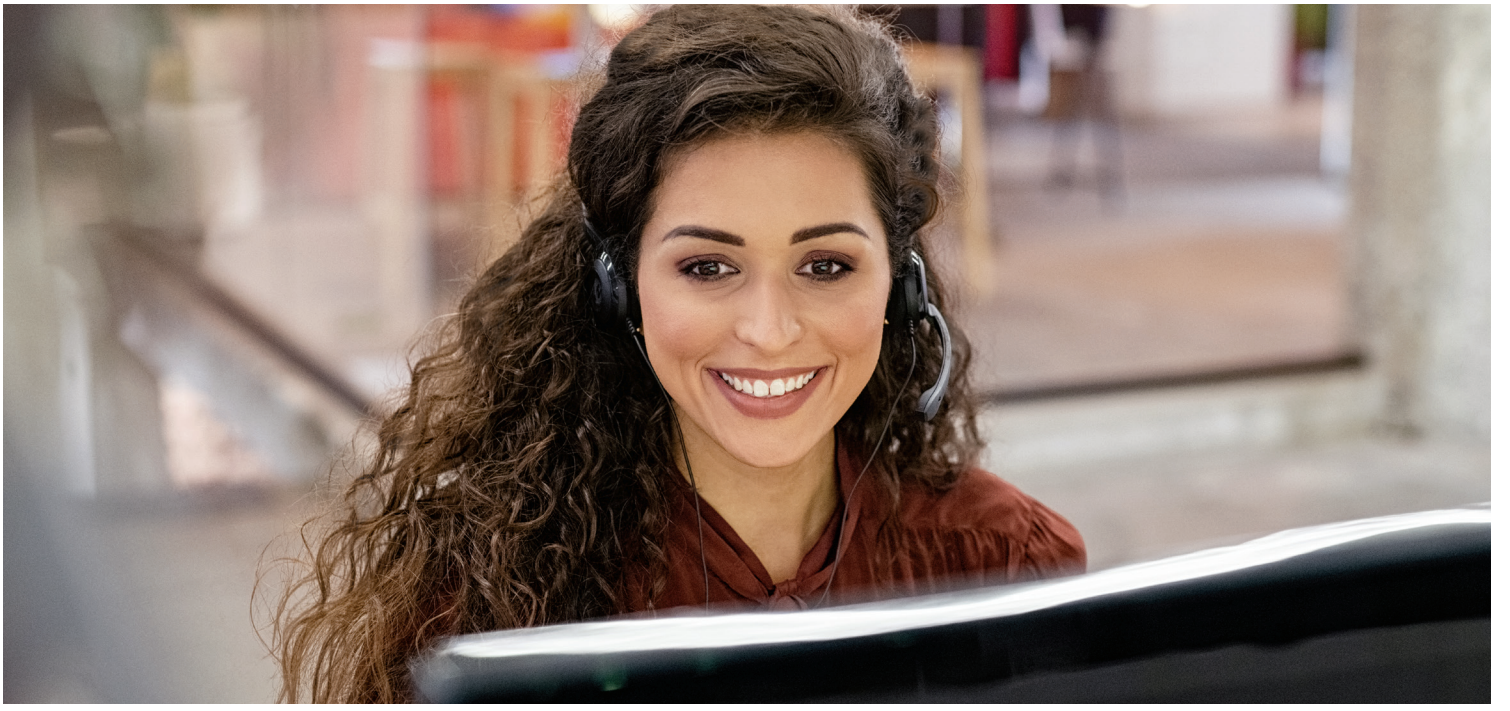
All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we encourage our providers to offer open-access scheduling, expanded hours and alternative options for communication (e.g., scheduling 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.

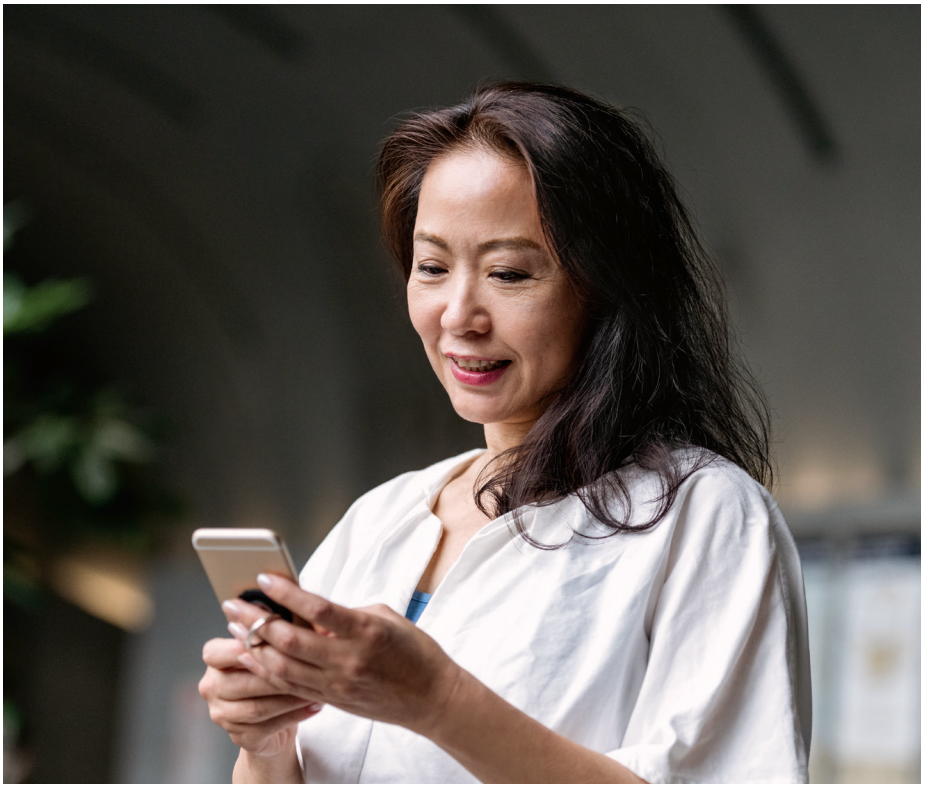
Providers must comply with telephone protocols for all the following situations:

- 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:

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

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

Contact us
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10260 Meanley Drive
San Diego, CA 92131

1-855-772-9076
Hearing-impaired MD Relay: **711**
AetnaBetterHealth.com/California

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