Aetna Better Health of California

Provider Orientation - 2022

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Orientation Agenda

Member Eligibility

Populations We Serve:

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

Voluntary Enrollment:

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

Member Rights and Responsibilities:

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

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

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

Give their health care provider all the information they need.

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

Tell their provider about any other insurance they have.

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

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

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

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

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

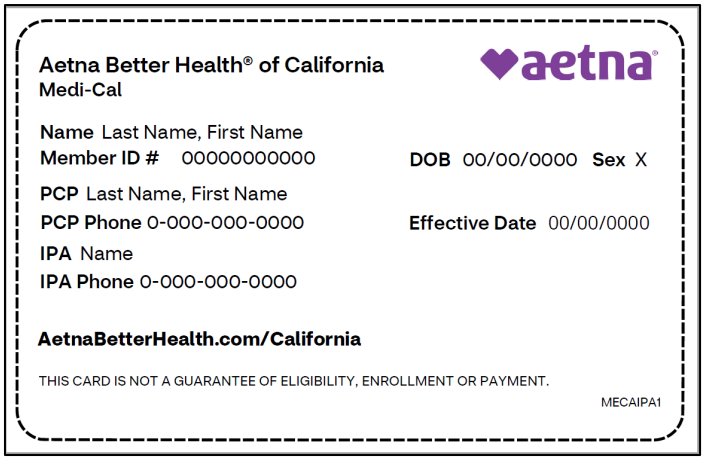
- Race
- National Origin
- Creed
- Sexual Preference
- Religion
- Age
- Physical/Mental Disability
- Color
- Gender/Gender Identity

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

Member Insurance Cards

Front: Direct ABHCA Assigned

Front: IPA Assigned



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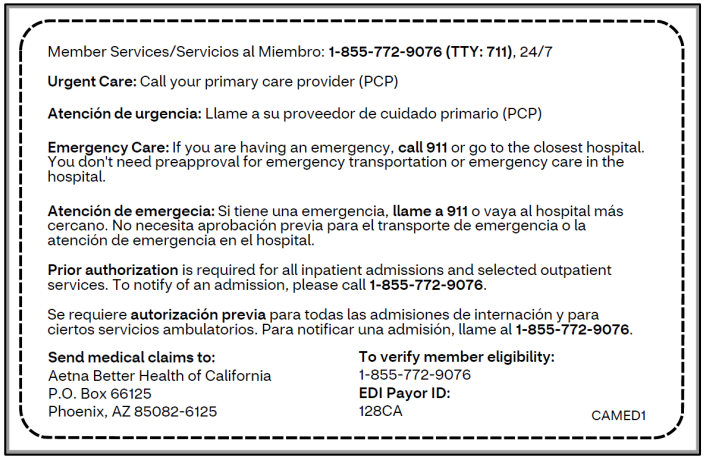


Member Services and Enrollment

Overview

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

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

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

How Can Members Enroll?

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

Online

Covered California Website

Phone

Health Care Options
1-800-430-4263

In Person

Several Locations
County Social Services Office

Mail

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

Application found:
Medi-Cal Single Streamlined Application

Language Services

Language Services can be accessed via Member Services at 1-855-772-9076 (TTY 711)

- **Interpretation (Face to Face)**
  - Nationwide network of qualified interpreters offering interpretation in 15+ languages, including American Sign Language (ASL)
- **Interpretation (Over the Phone)**
  - Access to interpreters supporting 200+ languages via telephone

Additional Resources:

Industry Collaboration Effort (ICE)

Interpreter Quality Standards Guidance

http://www.iceforhealth.org/library.asp?sf=&scid=4265#scid4265

Office for Civil Rights

https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Member Advisory Committee

- **Member Advisory Committee**

This group is made up of ABHCA staff, members, individuals and providers with knowledge of and experience with serving elderly people and people with disabilities, representatives from community agencies and community advocates. Meetings are held Quarterly, and members receive a $50.00 gift card for their participation.

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

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

If you would like to be part of this group or have a member that would be interested, call **1-855-772-9076 (TTY 711)** or email Memberservices_CA@Aetna.com.

Additional Services Provided

Transportation

Members/Providers
1-888-334-8352
Access2Care

Vision

Available to members by calling

1-800-877-7195

Pharmacy Vendor

Vendor and RX prior authorizations are handled by **Magellan**

1-916-323-1945

Cultural Competency and Health Equity

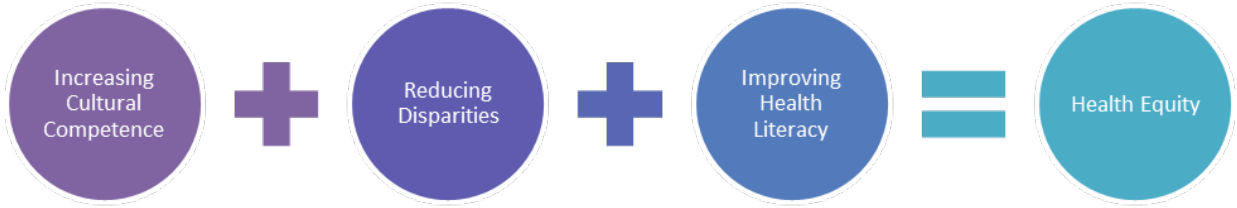
Cultural Competency:

The ability to understand, appreciate and interact with people from cultures or belief systems different from one's own

Health Equity:

All people have opportunity to be as healthy as possible and no one is limited in achieving good health because of their social position or any other social determinant of health.

Our goal of health equity is achieved through the delivery of culturally sensitive services, communications, and programs through a focus on three pillars, increasing cultural competence, reducing disparities and improving health literacy:



Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

Cultural Competency and Health Equity Resources

ABHCA Provider Manual, Cultural Competency begins on page 35 or search *Cultural Competency*

ABHCA Provider Website, orientation and training page.

CVS Health You Tube Channel

Live Well San Diego

Robert Wood Johnson Foundation

U.S. Department of Health and Human Services-Think Cultural Health (CLAS Standards)

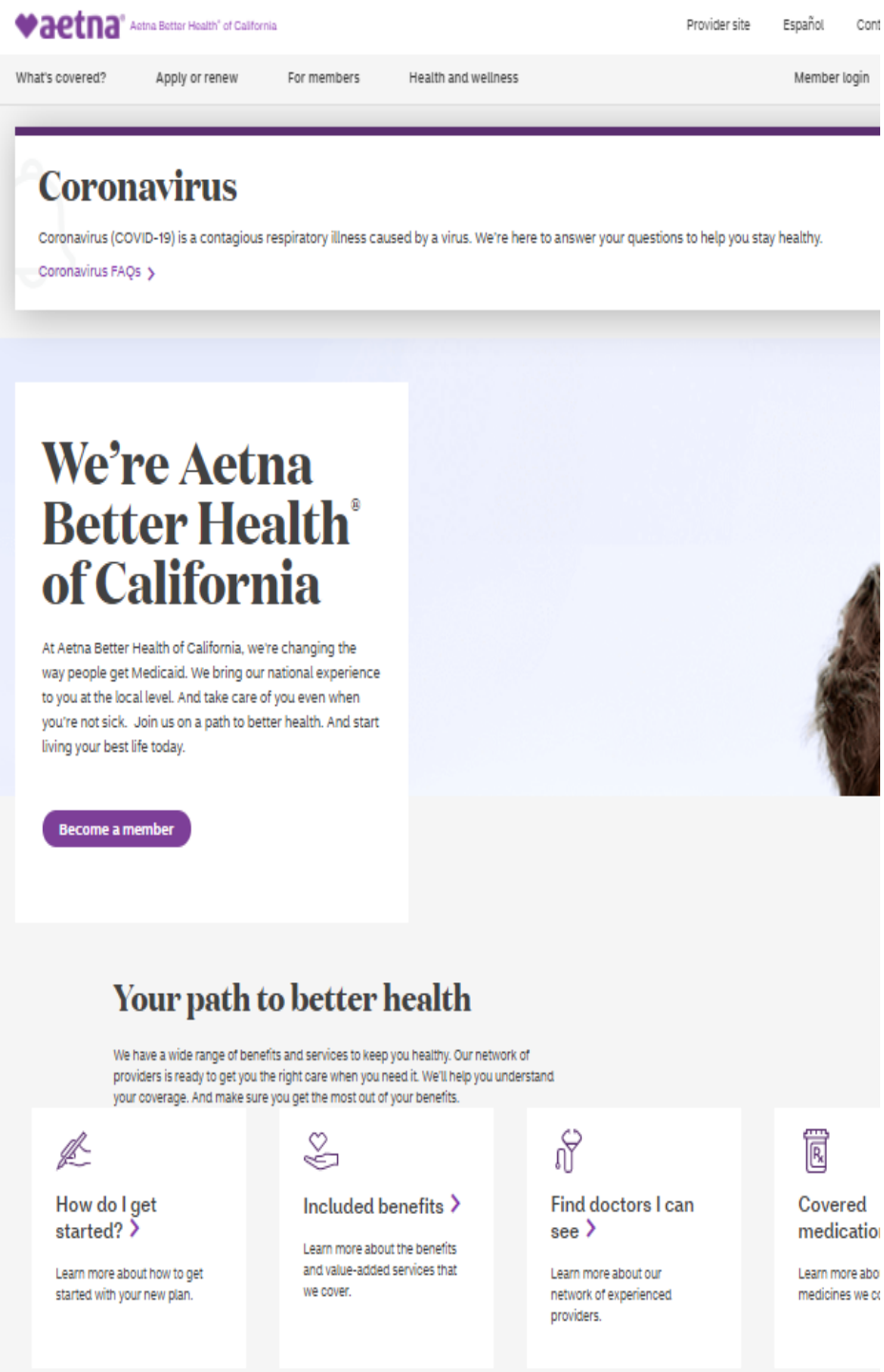
Office of Minority Health, Think Cultural Health

Credentialing

Adding a New Practitioner to an Existing Practice or Clinic

- Each new practitioner must be credentialed before s/he can render care to an ABHCA Member.
- Mid-levels must have a supervising physician.
- ABHCA utilizes CAQH for credentialing applications.
- In CAQH ProView, practititoners need to:
  - Complete Attestation & Documentation
  - Authorize ABH to view CAQH Profile
- Contact the Credentialing Department with the applicable CAQH number.

CAprovidercredentialing@aetna.com



Our Website

Tools

List of Participating Providers

Pharmacy Search Tool

Provider Manual

24/7 Secure Provider Portal

Clinical Guidelines Forms

Provider Education

BH Screeners

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

- **SBIRT Training Link**

Website: Aetna Better Health of California

Availity (Provider Secure Web Portal)

We are thrilled to announce that Aetna Better Health of California will be transitioning 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.

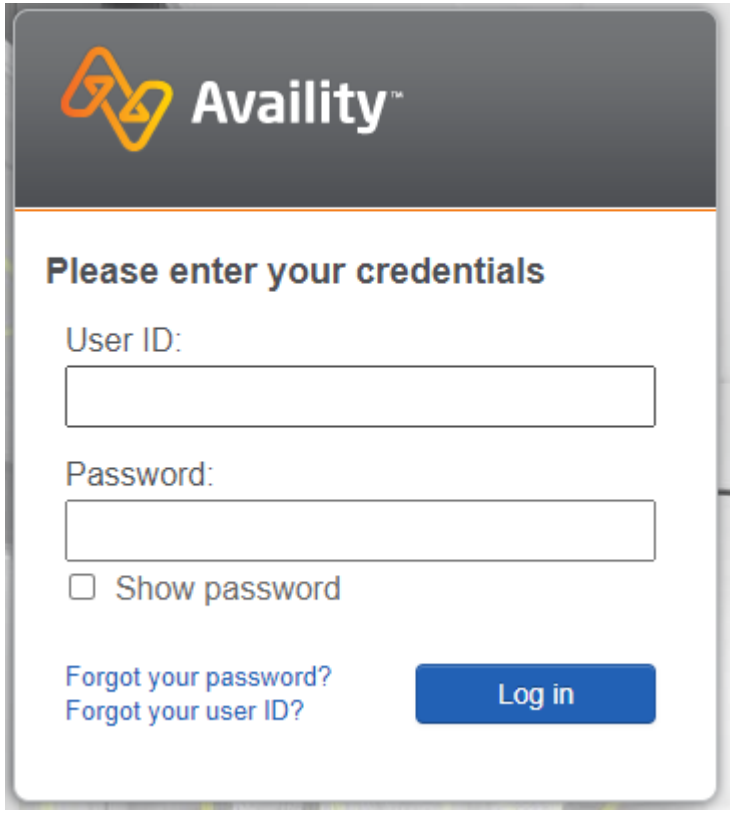
Some highlights of increased functionality include:

- EFT registration
- Claims look up
- Online claim submission
- Prior authorization submission and look up
- Grievance and Appeals submission

And best of all, we will continue to build upon this platform by rolling out enhanced functions in 2022 such as:

- Panel searches
- A new robust prior authorization tool
- Review of Grievance and Appeals cases
- Eligibility and member look up

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.



Availity

Pharmacy: Medi-Cal RX

Medi-Cal Rx Provider Portal

https://medi-calrx.dhcs.ca.gov/provider/

Register Now!

Pharmacy Providers and Prescribers: Register with the User Administration Console (UAC) in order to access:

- Saba℠ Learning Management System
- Secured Chat and Messaging
- Finance Portal – Available Now (with limited features)
- Batch Claims Information
- Beneficiary Eligibility Lookup
- Prior Authorization
- Web Claims Submission

If you need assistance with registration, please refer to the UAC Quick Start Guide.

This website offers publicly available content with general Medi-Cal Rx resources and information for providers to be able to successfully conduct pharmacy business.

Sign up for our subscription service to be notified when something new is posted to Bulletins & News.

All Medi-Cal Rx beneficiaries will need to have a Benefits Identification Card (BIC) or Client Index Number (CIN) to receive services. If the beneficiary does not have their BIC or CIN, they can obtain a new card by contacting their local county office.

Medi-Cal RX Drug Lookup – Search Tool:

https://medi-calrx.dhcs.ca.gov/provider/drug-lookup

Welcome to Medi-Cal Rx:

https://medi-calrx.dhcs.ca.gov/home/

Medi-Cal Rx is Live! All administrative services related to Medi-Cal pharmacy benefits billed on pharmacy claims from the existing Medi-Cal Fee-for-Service (FFS) or Managed Care Plan (MCP) intermediaries have transitioned to Medi-Cal Rx.

Claims and Claims Submission

Clearinghouse & Clean Claims
We accept both paper and electronic claims
ConnectCenter is the preferred clearing house for electronic claims
- **Payer ID:** 214569

EDI claims received directly from Change Healthcare & processed through pre-import edits to:
- Evaluate Data Validity
- Ensure HIPAA Compliance
- Validate Member Enrollment
- Facilitate Daily Upload to ABHCA System

Claims Submissions
ABHCA requires clean claims submissions for processing.
To submit a clean claim, the participating provider must submit:
- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure code

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

Claim Resubmission
Must be filed within 90 days from the date of adverse determination of a claim.
- Providers may resubmit a claim that was originally denied because of:
  - Missing documentation
  - Incorrect Coding
  - Incorrectly Paid or Denied because of Processing Errors

How to Submit a Claim:

Online	Mail	Phone
ConnectCenter Payer ID: 214569 1-800-527-8133 Option # 2	Aetna Better Health of California PO Box 66125 Phoenix, AZ 85082-6125 Hard Copy CM 1500 or UB 04	Claims Investigation & Research Department (CICR) 1-855-772-9076

Provider Dispute Resolution Processing Timeframe

DESCRIPTION		TURNAROUND TIME FRAME
DEADLINE FOR PLAN RECEIPT OF PROVIDER DISPUTES	Dispute related to an individual claim, billing dispute, or contractual dispute; OR Dispute related to a demonstrable and unfair payment pattern by the Plan	Deadline: 365 days after the most recent action, or in the case of inaction, 365 days after time for contesting or denying claims has expired.
	Dispute regarding a Plan notice of overpayment	Deadline: Within 30 working days of receipt of the Plan notice of overpayment of a claim
	Amended Provider Dispute	Deadline: Within 30 working days of the date of the provider's receipt of a returned dispute with written Plan notice
TIME PERIOD FOR ACKNOWLEDGEMENT	Electronic Provider Dispute (directly into the system)	Provided within 2 working days of the date of receipt of the date of receipt of the electronic provider dispute
	Paper Provider Dispute (mail, fax, e-mail, physical delivery)	Provided within 15 working days of the date of receipt of the date of receipt of the paper provider dispute
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Plan's goal is to resolve and issue written determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
PAST DUE PAYMENTS AND INTEREST AND PENALTIES	Resolution of a dispute involving a claim, which is determined in whole or part in favor of the provider, shall include the payment of any outstanding monies determined to be due and all interest due.	Plan goal is to issue payment with the resolution letter and in all cases payment will be made no later than within 5 working days of the issuance of the written determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.

Claim Submission Resources

Claim Submission Assistance/Links

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

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

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

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

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

Quality Management Program

Overview

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

Medical Records Standards

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

Quality Management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

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

What is Our Ultimate Goal

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

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

Medical Management: Care Management

Integrated Care Management Program (ICM)

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

Specialized Care Plans for:

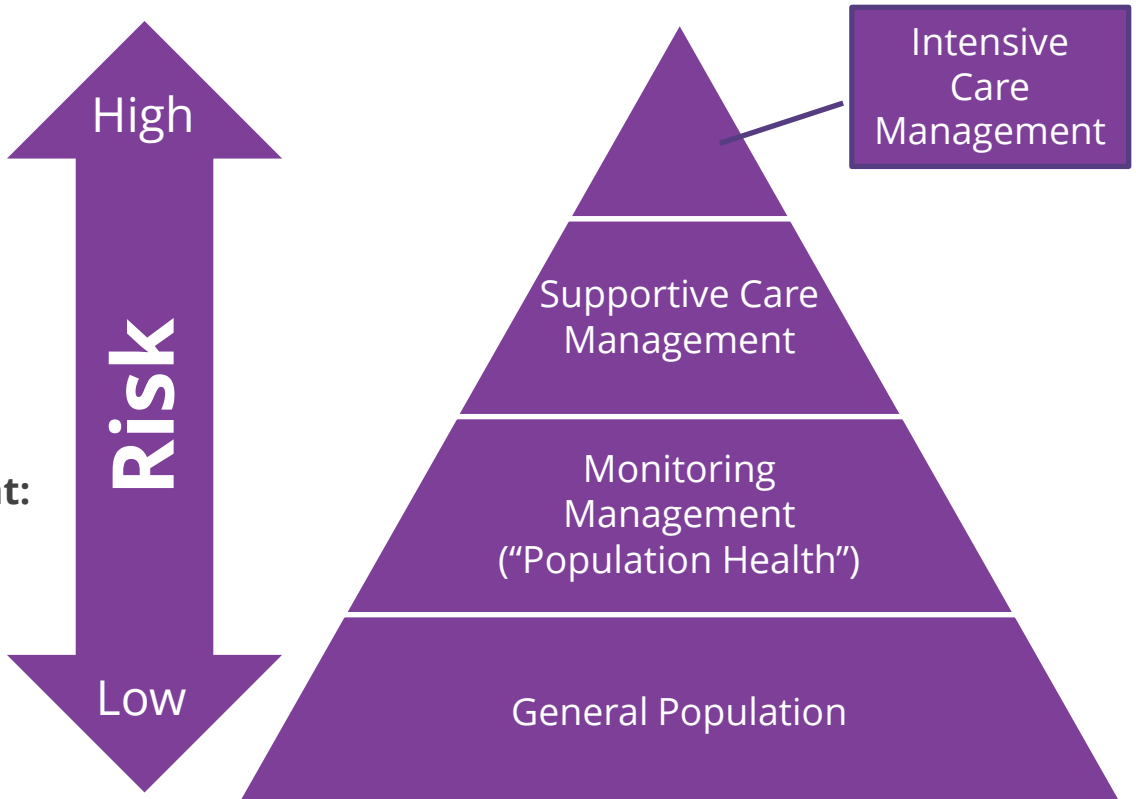
- COPD
- Asthma
- Depression
- Heart Failure
- Diabetes
- Hypertension

How to Refer to Care Management:

Phone: 1-855-772-9076

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

Email:
AetnaBetterHealthCACM@aetna.com



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How to Refer to Care Management

Referral Process:

Phone: 1-855-772-9076

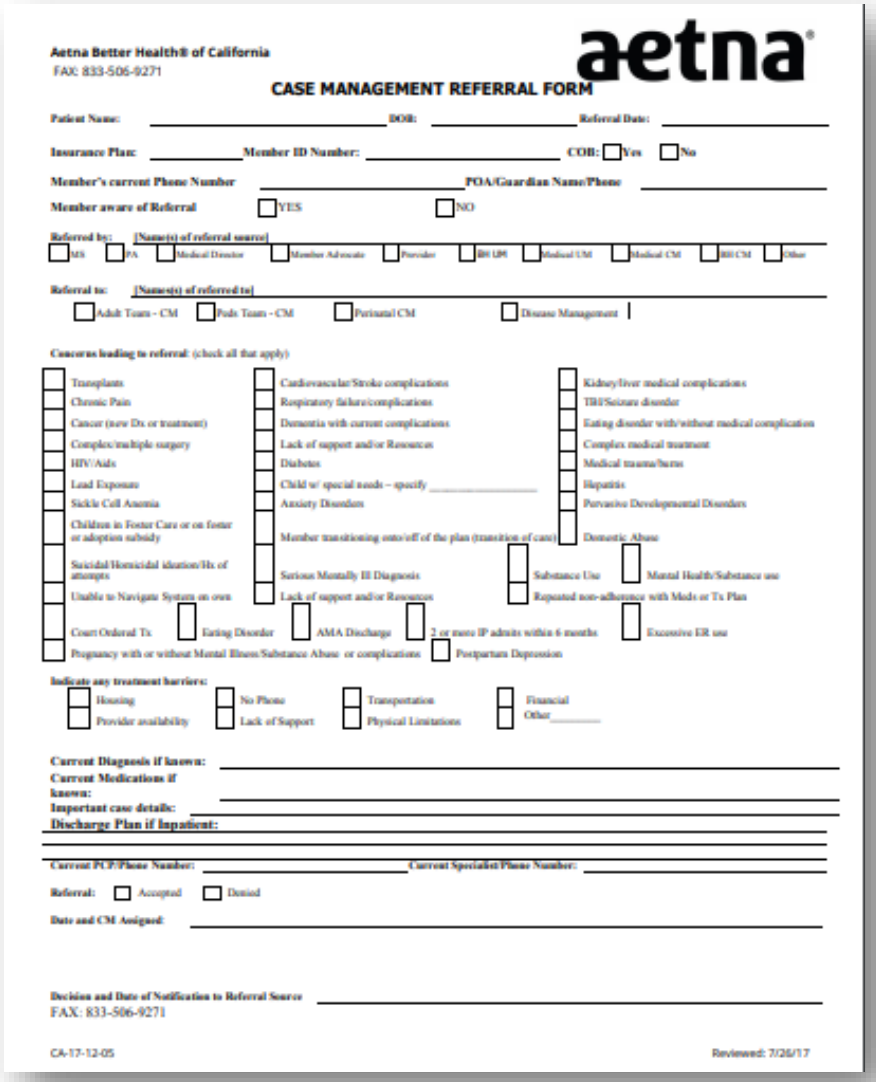
Email:
AetnaBetterHealthCACM@Aetna.com

Fax:

San Diego: 1-866-584-4450

Sacramento: 1-866-489-7441

Case Management Referral Form



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

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CASE MANAGEMENT REFERRAL FORM

Patient Name: _____ DOB: _____ Referral Date: _____

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

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

Member aware of Referral ☐ YES ☐ NO

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

☐ MS ☐ PA ☐ Medical Director ☐ Member Advocate ☐ Provider ☐ BH UM ☐ Medical UM ☐ Medical CM ☐ BH CM ☐ Other

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

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

Concerns leading to referral: (check all that apply)

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

Indicate any treatment barriers:

- ☐ Housing
- ☐ Provider availability
- ☐ No Phone
- ☐ Lack of Support
- ☐ Transportation
- ☐ Physical Limitations
- ☐ Financial
- ☐ Other _____

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

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

Referral: ☐ Accepted ☐ Denied

Date and CM Assigned: _____

Decision and Date of Notification to Referral Source _____
FAX: 833-506-9271

CA-17-12-05 Reviewed: 7/26/17

Concurrent Review Process

Overview

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

What does that mean?

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

Initial Health Assessments

Purpose

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

Initial Health Assessment Requirements (IHA)

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

Initial Health Assessments - Continued

Who?

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

What?

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

Then?

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

Additional information located in the Provider Manual

Medical Prior Authorizations

You may submit PA Requests by:

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

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

Additional timeframes and authorization information, is in the Provider Manual

Documentation requirements for authorization request:

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

Prior Authorization Form

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

What is EPSDT?

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

Provider Responsibilities:

- ✓ Complete the required screenings according to the current American Academy of Pediatrics "Bright Futures" periodicity schedule and guidelines
- ✓ Fully document all elements of EPSDT assessments, including anticipatory guidance and follow-up activities
- ✓ Report EPSDT visits by submitting the applicable CPT codes on claim submission

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

EPSDT Services

Screening services must include, at a minimum,

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

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

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

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

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

Behavioral Health

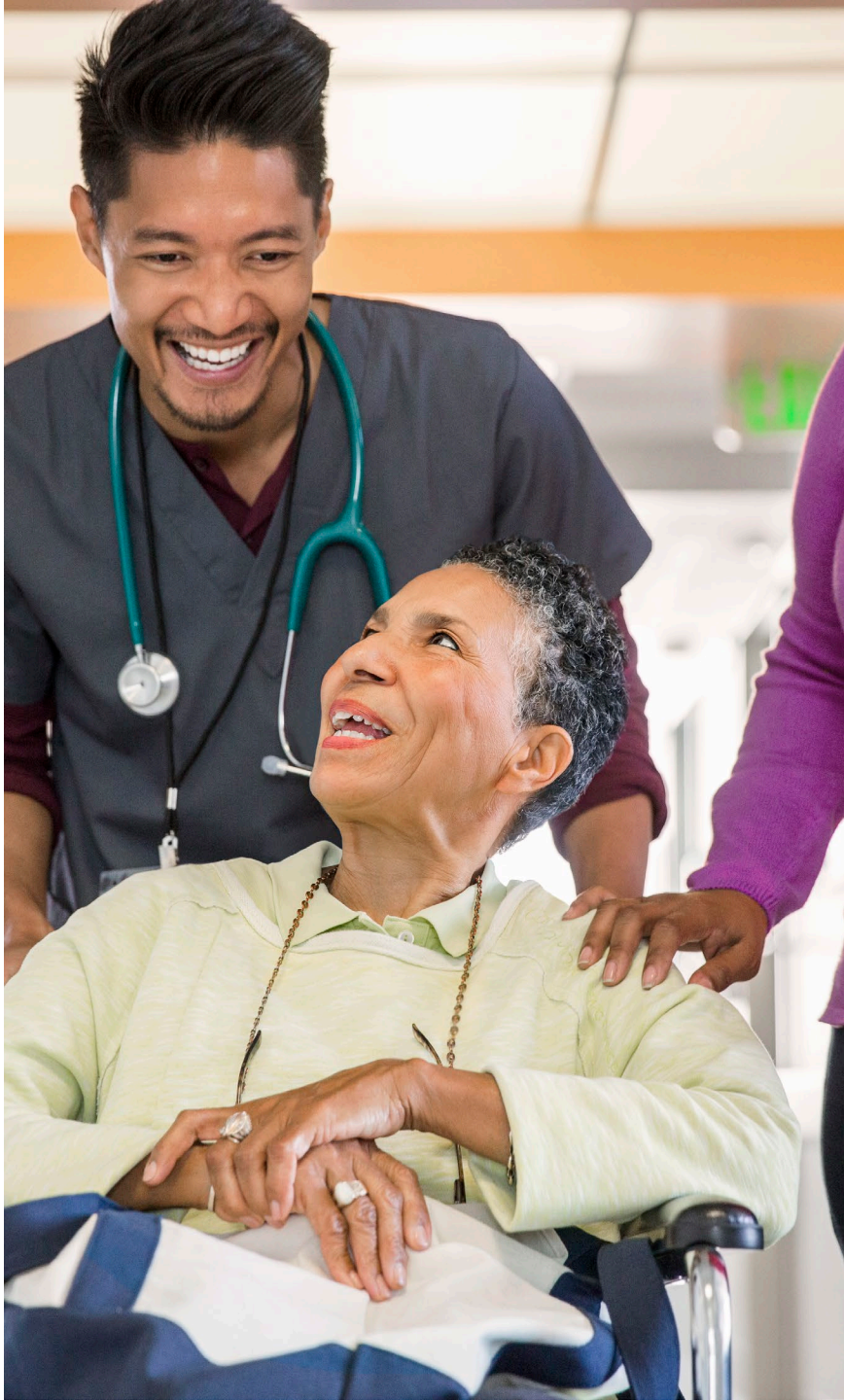
Basic Behavior Health Services

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

Primary Care Provider Referral

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

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



Behavioral Health - continued

Multiple Access Points for Behavioral Health Services

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

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

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

Discharge Notification

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

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

Behavioral Health Resources

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

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

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

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

Additional Resources:

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

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

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

Resources and Materials

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

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

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

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

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

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

California Children Services (CCS)

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

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

Eligible CCS Conditions

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

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

Access to Care Guidelines

Appointment Availability Standards

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

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

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

Access to Care Guidelines - continued

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

Prenatal Care -- Members will be seen within the following timeframes:

- First prenatal visit within 10 business days
- Within their first trimester within 14 days
- Within the second trimester within 7 days
- Within their third trimester within 3 days
- High risk pregnancies within 3 days of identification of high risk by Medi-Cal or maternity care provider, or immediately if an emergency exists.

Physicals -- This is regular care to keep you and your child healthy. Call your provider to make an appointment for preventive care. You can expect to be seen within ten business days. Examples: of preventive care are checkups, shots and follow up appointments.

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

Waiting Time –

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

Please note: Pursuant to Health & Safety Code § 1367.27(j)(2), if a provider who is not accepting new patients is contacted by 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 must return calls within 30 minutes. We will routinely measure the PCP's compliance with these standards as follows:

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

• Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

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

• Answering the member telephone inquiries on a timely basis

• Prioritizing appointments

• Scheduling a series of appointments and follow-up appointments as needed by a member

• Identifying and rescheduling broken and no-show appointments

• Identifying special member needs while scheduling an appointment

• Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

Telephone Accessibility Standards - continued

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Telephone Accessibility Standards - continued

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable:	Unacceptable:
• Telephone is answered by provider, office staff, answering service, or voice mail. • The answering service either: ○ Connects the caller directly to the provider ○ Contacts the provider on behalf of the caller and the provider returns the call ○ Provides a telephone number where the provider/covering provider can be reached • The provider's answering machine message provides a telephone number to contact the provider/covering provider.	• The answering service: ○ Leaves a message for the provider on the PCP's/covering provider's answering machine ○ Responds in an unprofessional manner • The provider's answering machine message: ○ Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. ○ Instructs the caller to leave a message for the provider. • No answer • Listed number no longer in service • Provider no longer participating in the contractor's network • On hold for longer than ten (10) minutes • Answering Service refuses to provide information for after-hours survey • Telephone lines persistently busy despite multiple attempts to contact the provider

**Providers must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.*

Grievance & Appeals

Member Grievance System Overview

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

How to file an Appeal or Grievance:

Phone: 1-855-772-9076

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

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

Online: Availity & Member Portal

Email: CAMedi-CalAppealandGrievance@aetna.com

Mail:

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

Additional Information on G &A

Provider Dispute

Provider Dispute Resolution Form

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

Provider Grievance

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

Provider Appeal

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

Fraud, Waste, and Abuse

Fraud

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

Waste

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

Abuse

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

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

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

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

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

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

Your Aetna Better Health of California Team

Title	Name
Network & Provider Experience Director	Jane Flanagan Brown
Provider Relations Manager	Juan Troy
Provider Relations Consultants	Andrea Ramirez
	Melinda Myer
	Scott Thomas
	Victor Reyes
Provider Relations Specialists	Turkesa Truhill
	Michelle Dillard

ABHCA Phone Line:

1-855-772-9076

Email:

CaliforniaProviderRelationsDepartment@aetna.com

Attestation

This form is in the Welcome Packet. It is to be completed after viewing the Orientation materials. We are required by DHCS to collect this completed form.

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

Thank you for you time and partnership!

aetna®

ATTESTATION OF NEW PROVIDER ORIENTATION

I have received and completed the New Provider Orientation from Aetna Better Health of California (ABHCA). I have been oriented about the essential components of ABHCA's Medi-Cal plan including but not limited to; basic information about programs available to ABHCA Medi-Cal members, language assistance and interpreter services and provider tools to care for diverse populations.

I understand my responsibilities related to ABHCA's Medi-Cal managed care program services, policies, procedures, ways to communicate with members, other ABHCA network providers, and ABHCA. I understand how to access and find information on ABHCA's provider website about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management. I understand that our organization is responsible for providing this orientation to all current providers, and any additional providers that may join our practice.

The training was completed: ☐Self-guided (Online/Hard copy) ☐Instructor-led (Online/In-Person)

Practice/Group Name (Print)	
Provider Name and NPI (Please complete page 2 of this form if more than one individual in your organization)	
Group NPI	
IPA Affiliation(s)	
Tax Identification number (TIN)	
Completed by	
Title	
Telephone number	
Email address	

Important: ABHCA requires completion of this Attestation, in addition to a signed contract and credentialing, to complete the ABHCA provider enrollment process.

Note: Failure to complete this Attestation may result in a delay of active status with ABHCA.

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

Internal Use Only

Received by_____Date_____

Active Status Date_____