



Provider newsletter

Summer 2026



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Transportation reminders for members

Medicaid members can get to their doctor visits and the pharmacy with free rides. It's a covered benefit. Here are a few helpful things you can share with members about their transportation benefits.

Encourage members to schedule rides early when possible

Members should schedule rides at least 3 business days before their appointment, unless the trip is urgent.

Members do not need 3 business days of notice for these urgent trips:

- Hospital admissions and discharges
- Dialysis and dialysis-related appointments
- Wound care
- Chemotherapy or radiation treatment
- Urgent care visits
- Most urgent cares have walk-in availability after normal working hours.
- Pre-op and post-op surgery follow-up visits
- Transplant services
- Rides are not available for emergency rides. Call 911 in an emergency.

If a trip is not urgent, it will not be scheduled without the required notice.

Out-of-state transportation is limited to up to 20 miles into bordering states and Washington, D.C.

Trip limits for non-medical rides

Non-medical trips are a value-added benefit. They are for members aged 18 years and older. Eligible members can get up to 30 one-way trips each year, or 15 round trips.

These trips are limited to 30 miles one way. In rural counties, the limit is 40 miles one way.

Mileage reimbursement limits

Mileage reimbursement may be available if members or their family members drive them to a covered appointment. Reimbursement is based on a reasonable travel distance to nearby care.

Members may choose an in-network provider that meets their care needs. Our transportation service can also help arrange a ride to a nearby provider.

If members choose to travel farther than a reasonably available provider in their area, their mileage reimbursement may be limited to the closer distance.



Close gaps in care with our texting program

This program helps providers use text reminders to bring patients in for needed exams and screenings, close gaps in care, and improve quality results.

Frequently asked questions

What expenses are providers responsible for if enrolled in the program?

There is no cost to participate. Each group may choose up to five HEDIS campaigns.

What approval processes are in place?

All outreach follows TCPA and privacy requirements.

How will patients be selected?

We use your practice TIN to identify attributed members with open care gaps.

Who is the contract between?

The agreement is between mPulse and the provider or practice. It stays in effect until ended, with 30 days' notice.

We are part of a large organization. How many practices can participate?

There is no limit. Any interested practice may join.

We already have a texting program. Can this be integrated?

mPulse is a separate vendor. Integration may be discussed but is not guaranteed.

Ready to get started?

Email our Quality team at QualityManagementPrograms@Aetna.com

Quality management spotlight

Home and community-based services

Aetna Better Health understands that improving members' health outcomes requires increased collaboration between you, the professional who provides care, and us, the health plan that covers that care. Our goal is to support waiver providers with resources and offer best practice recommendations to ensure our community-based members receive the best quality care.

You can access the updated CCC Plus Waiver Provider Manual through the [Medicaid Enterprise System \(MES\) portal](#). The website includes valuable information, such as provider enrollment, training, FAQs, memos, bulletins, user guides, and more.

DMAS CCC Plus Waiver Provider Manual spotlight

Correcting errors in documentation

Corrections to any form in the record must be made by drawing a line through the incorrect

entry, then re-enter and initial and date the correct information. Correction fluid ("white-out") must never be used for correction in medical records.

Service Facilitation (SF)

Verification of work hours: The SF shall review attendant hours worked quarterly or more frequently as appropriate to ensure that the hours of service provided are consistent with the Plan of Care. Attendant hours worked may be viewed on the F/EA web portal.

If discrepancies are identified in the work hours in relation to the plan of care, etc., the SF must contact the individual or EOR to resolve discrepancies. Changes in the Plan of Care are warranted if the individual's needs or circumstances have changed. Services provided should be consistent with the Plan of Care. If there are consistent discrepancies in the work hours and training has been offered to the individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).



Help your patients use their value-added benefits

Use our guide

Many Medicaid members feel lost when it comes to understanding and using their benefits. So, we created a simple, comprehensive guide to help.

Share the [Value-Added Benefits Member Guide](#) with your patients and let them discover:

- What their benefits are
- If they are eligible
- How and where they can use them



Help your patients find help with our Community Resource Directory

Finding help for your patients just got easier, thanks to our Community Resource Directory (CRD). The CRD is a tool found in the [Member Portal](#). There, members can find support and services where they live, from food and housing services to wellness and mental health support and more.

How to direct your Aetna Medicaid patients to the CRD

Members can log in to the [Member Portal](#) (or sign up if they don't already have an account). Under the "Resources" column, go to "Community Resource Directory."

Access and availability standards

We use accessibility/availability standards based on requirements from NCQA, state, and federal regulations. These standards are communicated to providers and members via newsletter, our website, and as part of the provider manual.

Federal law requires that participating providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid wfee-for-service members.

Providers who do not meet these access standards are provided recommendations for improvements in order to meet the set standard.

The timely access standards for PCPs, behavioral health providers, and prenatal providers can be reviewed in the chart below.

Provider	Appointment	Availability standard
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
Behavioral Health	Non-life-threatening emergency	Within 6 hours
	Urgent care	Within 24 hours
	Initial visit routine care	Within 5 business days
Prenatal	First trimester	Seven calendar days
	Initial second trimester	Seven calendar days
	Third trimester and high risk	Three working days from date of referral or immediately, if an emergency exists

