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of New Jersey

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Provider Newsletter

Winter 2024

New TBI Prior Authorization Process

We have a new process for submitting prior authorizations requests. Effective **December 1. 2024**, please fax TBI prior authorization requests to MLTSS Profax at **855-444-8694**.

MLTSS Care Managers will process authorizations. For any questions, you can call MLTSS Care Management Line **833-346-0122**.

Health Equity Clinical Education Hub

We've created a **clinical educational hub** for you that features courses on health equity and related topics. The hub provides resources and activities to empower you with the knowledge and tools you need for everyday interactions with your patients.

You can access these free accredited courses on demand to earn digital badges in:

- Culturally Responsive Care
- LGBTQ+ Responsive Care
- Culturally Responsive Behavioral Health Care

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Topical Fluoride Varnish for Children

Role of Primary Care Providers (PCPs) in Dental Care

PCPs must perform basic oral screening for all members, remind them of the need for two annual preventive dental visits and perform yearly cavity assessments on all children through age twenty (20). A referral to a dentist by one year of age or soon after the of eruption the first primary tooth is recommended.

We encourage medical providers to apply fluoride varnish to children's teeth, perform dental assessments and promote routine oral heath visits for our young members. These services combine for reimbursement as an all-inclusive service and bill with a CPT code. They can be provided up to four times a year. This frequency is separate from services a dentist provides.

PCPs play a critical role in their patient's dental health by referring them to their dental home and dentist after they are seen for a medical visit. The member's dental home is listed on the front of their Aetna Better Health® of New Jersey dental ID card.

The member can also call Liberty Dental Plan at **1-855-225-1727** to find at dentist or to answer any questions they may have.

Importance of Oral Health in Children

Children begin to get their primary teeth during the first year of life. By age 6 or 7 years, they start to lose their primary teeth, which eventually are replaced by permanent teeth. Preventive dental care helps prevent tooth decay and identify other oral diseases. Tooth decay that is not treated can lead to pain, loss of teeth, and loss of self-confidence. Children who experience tooth pain may have difficulty eating or sleeping properly and may miss days of school. Early dental care will establish a lifetime of good oral habits.

Advance Directives

Please remind your patients to creative an advance directive for you to have in the medical record.

There are two types of advance directives in New Jersey:

1. Proxy directive
2. Living will (also known as an instruction directive) Your patients, our members can decide whether they want to have one of these or both.

If the member already has an advance directive, we suggest you remind them to:

- Sign and date it
- Keep a copy for yourself
- Give a copy to your health care surrogate
- Give a copy to all your providers
- Take a copy with you if you go to the hospital or emergency room
- Keep a copy in your car (if you have one).

Learn more on the State of New Jersey site.

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Family Planning

This article outlines the expectations of participating health care providers related to family planning services and minors' rights to consent and confidentiality.

Please note this article relates to expectations under participating provider contracts with Aetna Better Health of New Jersey and is not legal or compliance advice.

In accordance with maintaining and implementing our Quality Assessment and Performance (QAPI) program, participating health care providers must:

- Maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards.
  - Establish a policy/procedure for *managing minor patients' right to consent and confidentiality related to family planning.*
  - Provide a copy of this policy/procedure to Aetna Better Health® of New Jersey for audit purposes and upon request.

The below summarizes the expectations of participating providers under state law:

- Health care providers, that manage health needs of minors, must comply with state laws that govern the right to consent and privacy for minors.
- Minors in the state of NJ have the right to provide consent for:
  - Contraceptives/family planning: with limitations
  - STI care
  - HIV/AIDS care
  - Pregnancy care
  - Mental health outpatient care
  - Alcohol/drug abuse treatment
  - Sexual Assault treatment/examination
- For treatments that minors have a right to provide consent, health care providers are permitted, but not required, to inform the parents/guardians of a minor. Special standards on disclosure include the following:
  - HIV/AIDS: confidential and may only be disclosed with written informed consent of the minor.
  - Mental health information: mental health professionals are limited in disclosing certain information to parents or others without a minor's consent.
  - Drug/alcohol: confidential information between health care provider and minor patient.
  - Sexual assault: parents or guardian must be notified immediately, unless the medical provider feels disclosure would not be in the minor patient's best interest.

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Breast Cancer Prevention

Many factors over the course of a lifetime can influence your patient's breast cancer risk.

Please remind your patients, our members they can help lower their risk of breast cancer by taking care of their health in the following ways:

- Keep a healthy weight
- Be physically active
- Choose not to drink alcohol, or drink alcohol in moderation
- If they are taking, or have been told to take, hormone replacement therapy or oral contraceptives (birth control pills), ask their doctor about the risks and find out if it is right for them
- Breastfeed their children, if possible
- Talk to you if they have a family history of breast cancer or inherited changes in their BRCA1 and BRCA2 genes.

Source: Centers for Disease Control & Prevention

Cervical Cancer Prevention

To prevent cervical cancer, remind your patients, our member to get vaccinated early and have regular screening tests.

The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers.

Two screening tests that can help prevent cervical cancer or find it early:

- The Pap test (or Pap smear) looks for precancers, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- The HPV test looks for the virus (human papillomavirus) that can cause these cell changes.

Source: Centers for Disease Control & Prevention

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Behavioral Health Integration

At Aetna Better Health® of New Jersey, we focus on the whole health of our members and encourage our providers to collaborate across disciplines. The continuity and coordination of care between behavioral health and physical health providers is of the utmost importance. The collaboration and timely exchange of information facilitates accurate and prompt diagnosis, treatment and referral for behavioral disorders. It ensures the appropriate use of psychotropic medications, especially where there is the management of coexisting medical and behavioral concerns. Lastly, it ensures that the special healthcare needs of those members experiencing severe and persistent mental illness are being met.

Starting on **January 1, 2025,** most outpatient behavioral health services for traditional NJ FamilyCare Plans will be managed by Aetna Better Health of New Jersey. This means our members will call us to find mental health and substance use providers that are in our network. Up until now, Medicaid fee-for-service has provided the network and payment for these services. Our network team is working with all providers to minimize impacts to our members, but it is important to be having these discussions with members in advance of the change.

If your Aetna Better Health of New Jersey,patients are currently in outpatient behavioral health services, it is important to discuss how this change may impact their ongoing treatment and how it may impact your collaboration with other providers. If our member is having difficulty locating or continuing their care, we encourage that they call our Member Services at **1-855-232-3596 (TTY 711)** and request care management.

Risk of Continued Opioid Use (COU)

Assesses potentially high-risk opioid analgesic prescribing practices. The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

Source: **ncqa.org/hedis/measures/risk-of-continued-opioid-use/**

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Vaccine Reminder

Members staying up-to-date on their immunizations is important now more than ever. As an accessible health care professional, you are afforded the ideal opportunity to remind patients to get their immunizations.

Please remind your patients, our members to stay up to date on their influenza (flu) vaccine, COVID-19 vaccine, and pneumococcal vaccine.

Flu: Everyone 6 months & older should receive a yearly flu vaccine.

COVID-19: CDC recommends COVID-19 vaccines for everyone ages 6 months and older, and boosters for everyone 5 years and older, if eligible.

Pneumococcal:

CDC recommends PCV13 or PCV15 for:

- All children younger than 5 years old
- Children 5 through 18 years old with certain medical conditions that increase their risk of pneumococcal disease.

For those who have never received any pneumococcal conjugate vaccine, CDC recommends PCV15 or PCV20 for:

- Adults 65 years or older
- Adults 19 through 64 years old with certain medical conditions or other risk factors
- CDC recommends PPSV23 for children 2 through 18 years old with certain medical conditions that increase their risk of pneumococcal disease
- Adults 19 years or older who receive PCV15.

Source: cdc.gov

Use of Opioids from Multiple Providers (UOP)

Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers. Three rates are reported.

1. Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
2. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
3. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Note: A lower rate indicates better performance for all three rates.

Source: **ncqa.org/hedis/measures/use-of-opioids-from-multiple-providers/**

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Enhance patient health with Aetna Better Care rewards

As a valued provider, we encourage you to inform your patients about the Aetna Better Care rewards program. This initiative rewards members for engaging in healthy activities such as annual dental visits, lead screening for children, and timely initial prenatal visits.

Incentive program details:

1) **Annual Dental Visit:** Members aged 0-20 years who complete one dental visit per calendar year can earn a $30 gift card.

2) **Lead Screening for Children:** Children aged 6 months to 2 years can earn a $30 gift card for completing one lead screening by age 2. One incentive is offered per calendar year.

Benefits and usage

Patients can use these gift cards to purchase essential items at participating stores like CVS, Walmart, Dollar General and many more. Each member can earn a maximum of $50 per year. If a member qualifies for two rewards, the first reward is $30, and the second is $20. Please inform patients that it may take up to 60 days following the completion of the qualifying service for the gift card to arrive.

Registration process

Patients can register by calling Member Services at **1-855-232-3596 (TTY: 711).**

Encouraging your patients to participate in this program can lead to better health outcomes and provide them with tangible rewards for their proactive health management.

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Member Acuity and Risk Adjustment (Long Term Institutionalization)

Aetna Better Health® of New Jersey's members have a broad distribution of health status, ranging from good health to multiple chronic illnesses. Collectively, the sickest members of any health plan require the most attention and care; they also drive the highest cost of care. To address this, New Jersey Medicaid funds Medicaid Managed Care plans based on a complex calculation that includes members' degree of morbidity (referred to as acuity) through the State's Risk Adjustment Payment Model. In this model, the more a plan's members have certain chronic conditions, the higher the Risk Score the State assigns to the plan. Accurate Risk Scoring requires that members with these conditions have all of their chronic conditions addressed at least yearly, recorded in medical records and documented in claims. Reporting on member acuity starts and ends with the provider.

Diagnosis coding in claims

Encounters are electronic documents created in the claims process and reported to the State of New Jersey, showing each service provided to members. The diagnosis codes in each encounter drive the calculation of each plan's Risk Score. Each time a member with a chronic condition has that condition addressed at a visit, the diagnosis should appear on the claim. It is critical that providers document all chronic illness diagnosis codes on every applicable claim. Evaluation of the codes and subsequent Risk Adjustment analysis is done by the State on a bi-annual basis. Thus, providers should include the diagnosis code on every patient claim at every visit when it was addressed to ensure that the diagnosis is captured and utilized in the most current encounter analysis.

Acute visits

Members with chronic conditions who may not have seen their provider for periodic checkups may still present for episodic or acute conditions. These visits are opportunities to address their chronic conditions. If your member visits you for an episodic or acute condition and a chronic condition is currently present and addressed during the visit, the chronic condition diagnosis should be coded and included on the claim.

For example, a member with type 2 diabetes presents to the office with bronchitis. During the visit, along with treatment of bronchitis, you also provide reminders on the management of diabetes and the risk of elevated blood-glucose levels related to the acute bronchitis. The claim should include both the diagnosis of acute bronchitis and the diagnosis of diabetes.

Our partnership

Aetna Better Health® of New Jersey is your partner in caring for all of our members, including our highest acuity members. We offer Integrated Care Management and our Quality program mails visit reminders and calls members, all in an effort to get them the care that they need.

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Balance Billing is Prohibited

Providers may not bill Aetna Better Health® of New Jersey members for any services that are covered by NJ Medicaid and/or Aetna Better Health® of New Jersey.

- Any member copayments you must collect are included in the benefit listing on our website. Please note that copayments are not considered balance billing.
- Per your contract with us, when a provider receives a Medicaid/NJFC FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

NOTE: Providers can make payment arrangements with a member for services that are not covered by NJ Medicaid and Aetna Better Health® of New Jersey only when they notify the member in writing in advance of providing the service(s), and the member agrees. We want to make sure you are aware of these requirements because we value your partnership with us.

Federal and State laws are clear that providers are prohibited from balance billing Medicaid beneficiaries (42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n), 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9 and/or 15.2(b)7ii.

Before you decide to send accounts to any collection agency you may be using, it is critical that you **NOT** include Aetna Better Health® of New Jersey member accounts.

Providers who balance bill members could face the following consequences:

- Termination from the ABHNJ network
- Referral to the NJ Medicaid Fraud Division to open an investigation into the provider's action
- Referral to the Federal Department of Health & Human Services, US Office of Inspector General (HHS-OIG).

Extra Help During Pregnancy

Is any parent ever prepared enough for a new baby? If you have patients, our members that feel overwhelmed, we can help them stay healthy through their pregnancy and get the care they need.

Our team can help our members:

- Learn more about your pregnancy
- Make a care plan that's right for them
- Get services and care
- Work with health care providers, agencies and groups
- Get services after hours in a crisis
- Arrange services for children with special health care needs

Just call Member Services at **1-855-232-3596 (TTY: 711)**.

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Telephone and Appointment Availability Access

Reminder: The upcoming telephone access and appointment accessibility secret shopper calls will occur between Q4 2024 and Q1 2025.

Please remember to develop and use telephone protocols for all of the following situations:

a. Answering the enrollee telephone inquiries on a timely basis.
b. Prioritizing appointments.
c. Scheduling a series of appointments and follow-up appointments as needed by an enrollee.
d. Identifying and rescheduling broken and no-show appointments.
e. Identifying special enrollee needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs. (See also Article 4.5.)
f. Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.
g. Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues - within thirty (30) to forty-five (45) minutes; same day for non-symptomatic concerns; fifteen (15) minutes for crisis situations.
h. Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental/MLTSS personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

Appointment Availability

- **Emergency Services.** Immediately upon presentation at a service delivery site.
- **Urgent Care.** Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening.
- **Symptomatic Acute Care.** Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention.
- **Routine Care.** Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.
- **Specialist Referrals.** Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral.
- **Urgent Specialty Care.** Within twenty-four (24) hours of referral.
- **Baseline Physicals for New Adult Enrollees.** Within one hundred-eighty (180) calendar days of initial enrollment.
- **Baseline Physicals for New Children Enrollees and Adult Clients of DDD.** Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines. (48) hours for urgent care.

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Telephone and Appointment Availability Access (cont.)

Appointment Availability

- **Prenatal Care**. Enrollees shall be seen within the following timeframes:
  - Three (3) weeks of a positive pregnancy test (home or laboratory)
  - Three (3) days of identification of high-risk
  - Seven (7) days of request in first and second trimester
  - Three (3) days of first request in third trimester
- **Routine Physicals.** Within four (4) weeks for routine physicals needed for school, camp, work or similar.
- **Lab and Radiology Services.** Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care.
- **Waiting Time in Office.** Less than forty-five (45) minutes.
- **Initial Pediatric Appointments.** Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees.
- **For dental appointments,** the Contractor shall be able to provide:
  - 1Emergency dental care, which is the immediate care, treatment and/or referral for emergent dental conditions, and defined previously as serious orofacial conditions which require immediate medical intervention, to avoid placing the health of the individual in jeopardy.
  - 2. Urgent dental care, which is defined as oral and/or dental conditions which require timely treatment to alleviate pain, address infection risk and avoid additional degradation of the teeth and/or other oral structures, within forty-eight (48) hours of member request.
  - 3. Routine non-symptomatic care and/or specialist referrals within twenty-eight (28) days of member request.
- **For MH/SUD appointments,** the Contractor shall provide:
  - 1. Emergency services immediately upon presentation at a service delivery site.
  - 2. Urgent care appointments within twenty-four (24) hours of the request.
  - 3. Routine care appointments within ten (10) days of the request.
- **Maximum Number of Intermediate/Limited Patient Encounters.** Four (4) per hour for adults and four (4) per hour for children.
- **For SSI and New Jersey Care** – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment.

CAHPS: Reference guide for physicians, with best practices

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** program is a tool for assessing patients' experiences with their health plan, personal doctor, specialists and health care in general. This survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans. CAHPS is a mandated regulatory/accreditation survey sent to a randomly selected number of health plan members.

The suggestions below are provided to help you enhance your patients' health care experience.

CAHPS member survey questions	Industry best-practices for physicians
Getting appointments and care quickly	
When care was needed right away, how often did you get care as soon as you needed it?	Patients who are aware of potential scheduling timelines can plan for time needed and adjust accordingly. Notify patients by text, phone or in the waiting room if there are wait time delays. This helps manage patient expectations. Advocate for your patient and ask if they have transportation available for their appointment.
How often did you see the person you came to see within 15 minutes of your appointment time?	
How often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	
Getting needed care	
How often did you get an appointment to see a specialist as soon as you needed?	Patients who understand why types of care, tests or treatments are essential are more likely to adhere to a care plan and seek the care that is recommended and needed. Encourage practice staff to provide patients with support in identifying in-network specialist care and services (e.g., labs, imaging, radiology).
How often was it easy to get the care, tests, or treatment needed?	

CAHPS member survey questions	Industry best-practices for physicians
How well doctors communicate	
Were things explained to you in a way you could understand?	Effective communication with patients is key to improving patient engagement. Health literacy techniques, such as not using medical jargon and having the patient (or their caregiver) repeat back their plan-of-care instructions in their own words, can break down communication barriers.
How often did your personal doctor spend enough time with you?	
Coordination of care	
For scheduled appointments, how often did your doctor have your medical records or other information about your care?	Patients report having a more optimal experience when their providers are familiar with their history at the time of their appointments. Offering to walk through registration and use of your patient portal will go a long way in helping patients access their medical records and test results in a timely manner. New and established patients without an appointment in the last year should be encouraged to schedule their Medicare Annual Wellness Visit and a physical. This will ensure annual preventive exams are scheduled and care is coordinated on behalf of the patient.
When your doctor ordered a blood test, X-ray, or other test for you, how often did: • someone from the doctor's office follow up to give you those results? • you get results as soon as you needed them?	
How often did your doctor seem informed and up to date about the care you got from specialists?	
How often did you and your doctor talk about the prescription medicines you were taking?	
How often did you get the help that you needed from your doctor's office to manage your care among different providers and services?	
Overall rating of health care quality	
Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	Patient councils are great for helping clinical practices understand the patient's experience with the practice's process-improvement initiatives.

CAHPS member survey questions	Industry best-practices for physicians
Flu shot	
Have you had a flu shot this year?	Patients who are well informed of the benefits and safety of the flu vaccine are more likely to get the vaccine. Knowing it is protective and won't make them sick also helps.
Cultural competence	
When you needed an interpreter at your doctor's office or clinic, how often did you get one?	Understand language preference and interpretation needs in advance of appointments to ensure resources are available.
Getting needed prescription drugs	
How often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?	Consider these factors: drug availability and affordability, timely prescribing and up-to-date patient pharmacy choice. This results in patients getting the drugs they need.
How often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?	
How often was it easy to use your prescription drug plan to fill a prescription by mail?	