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Aetna Better Health®
of New Jersey

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# Provider Newsletter

Fall 2024

## Hysterectomy and Sterilization Requests

Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information form (FD 189). A copy of the form is available at on our website. You must attach it to the claim prior to submission. Claims for hysterectomy and sterilization must be sent by mail/paper and cannot be electronic.

We require providers to submit a properly completed FD-189 form with the request for precertification for all non-emergent hysterectomies.

**Claim payment for a hysterectomy that lacks a copy of the Hysterectomy Receipt of Information form may only be made if the physician performing the hysterectomy certifies that:**

- The woman was already sterile and the cause of sterility is stated
- The hysterectomy was required because of a life-threatening emergency and a description of the emergency is stated.

Specific Medicaid requirements must be met and documented on the HHS 687 Consent for Sterilization form. The form must be completed and signed by the member at least 30 days in advance of both female and male sterilization procedures.

If the procedure is performed less than 30 days from the consent form execution date due to a premature birth, the expected date of birth must be noted in the consent form. A copy of the form is on our website. The form must be attached to the claim prior to submission. The individual who has given voluntary consent for a sterilization procedure must be at least 21 years old at the time the consent is obtained and must be a mentally competent person.

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# Member Language Profile: Understanding Our Members' Communication Needs

Communication and language barriers are associated with inadequate quality of care and poor clinical outcomes, such as higher hospital readmission rates and reduced medication adherence. People with limited English proficiency or those who experience limited vision or hearing may need an interpreter, and those with vision impairment may need materials presented in alternative formats while receiving care in order to ensure equitable care.

Primary language is reported by members upon enrollment. While most our members' primary languages are unknown (66.0%), nearly 24% are English-speaking, followed by Spanish at approximately 6%.

| | Language Reported at Enrollment | 2022 | |
|---|---|---|---|
| | | # | % of Membership |
| 1 | UNKNOWN | 86,986 | 66.0% |
| 2 | ENGLISH | 31,447 | 23.8% |
| 3 | SPANISH | 7,259 | 5.5% |
| 4 | No Language | 4,605 | 3.5% |
| 5 | PORTUGUESE | 153 | 0.1% |
| 6 | RUSSIAN | 145 | 0.1% |
| 7 | ARABIC | 125 | 0.1% |
| 8 | MANDARIN | 110 | 0.1% |
| 9 | FRENCH | 97 | 0.1% |
| 10 | GUJARATI | 82 | 0.1% |
| | Other Languages (57) | 849 | 0.6% |
| | Total | 131,858 | 100% |

To assist with translation and interpretation services, you or the member can call our Interpretation Services at **1-800-385-4104 (TTY: 711)**.

For more information on our member demographics, please see Aetna Better Health of New Jersey's 2024 Population Assessment found on Availity.

# Doula Services Are Covered for Members

A doula supports the pregnant mom through pregnancy and the postpartum period with education and emotional and physical support.

Please review the Medicaid Newsletter on the program and also the next steps if you are interested in offering Doula Services. Once a doula is enrolled in NJ Medicaid and has their Medicaid FFS identification number, please email Alexander Mclean, Chief Operating Officer. He will arrange for a contracting representative to reach out to you to walk you through our simplified enrollment process.

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# HEDIS Measures

Please review the details for the following HEDIS measures.

### URI – Appropriate treatment for Upper Respiratory Infection

**Measure Definition:** Members with a diagnosis of upper respiratory infection who were not dispensed an antibiotic. For members 3 months of age and older.

**Measure Requirements:** Submit all diagnoses on claims if more than one diagnosis is present when prescribing antibiotics.

**Service Date Range:** July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

**LOB:** Commercial, Medicaid and Medicare

### CBP – Controlling High Blood Pressure

**Measure Definition:** Members with a diagnosis of hypertension (HTN) and adequately controlled blood pressure (<140/90 mm HG) during the measurement year. For members 18 to 85 years of age.

**Measure Requirements:** Most recent systolic and diastolic blood pressure reading and service date or exclusion code.

**Service Date Range:** Measurement year

**LOB:** Commercial, Medicaid and Medicare

### SPC – Statin Therapy for Patients with Cardiovascular Disease

**Measure Definition:** Percentage of members who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

1. Received statin therapy Members who were dispensed at least one high- intensity or moderate- intensity statin medication in the measurement year.
2. Statin adherence 80 percent Members who remained on a high-intensity or moderate- intensity statin medication for at least 80% of the treatment period.

For male members 21 to 75 years of age and female members 40 to 75 years of age.

**Measure Requirements:** No special requirements

**Service Date Range:** Measurement year

**LOB:** Commercial, Medicaid and Medicare

### HDO - Use of Opioids at High Dosage

Measure Description: The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Numerator Compliance: Members whose average MME was ≥90 during the treatment period.

**LOB:** Commercial, Medicaid and Medicare

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# HEDIS Measures (continued)

### DEV-CH - Developmental Screening in the First Three Years of Life

**Measure description:** For members 1-3 years of age, percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second or third birthday.

Strategies for increasing developmental screening understanding and utilization

- Educate parents to monitor for developmental milestones such as taking a first step, smiling for the first time, waving "bye, bye" crawling, walking, etc.
- Educate on risk factors for developmental delays that include:
  - Preterm birth
  - Low birth weight
  - Lead exposure
  - Long lasting health problems or conditions.
- Advise parents that developmental screening tools will not provide a diagnosis but can assist in determining if a child is developing according to standard developmental milestones.

### CCP - The Contraceptive Care

**Measure description:** Postpartum Women measure (CCP) looks at women ages 15 to 44 who had a live birth, and among those, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period.

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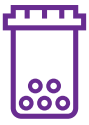
## Behavioral Health Integration

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.

## Prescribing Opioids



**Research shows that opioids are not always the best pain relief options for chronic pain. Safer alternatives that don't use opioids should always be tried if possible.**

Our Prior Authorization process assures that, when they are needed, current treatment recommendations are being used. All Long-Acting opioids require Prior Authorization, review our guides for more information.

All Short Acting opiates in New Jersey have a five-day supply limit for members 18 years and older or a three-day supply limit for members less than 18 years of age. In addition, all opiates are limited to a 90 Morphine Equivalent Dosing (MED) per day. Members with pain due to active cancer, palliative care, or end-of-life care are exempt from these requirements. Evidence of a treatment plan, risk assessment and counseling must be submitted along with a completed Opioid Prior Authorization (PA) form. Visit our website to download prior authorization form.

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# Partnering with ECHO Health, Inc. for EFT/ERA services

In **January 2023,** Aetna Better Health® launched an electronic funds transfer (EFT)/ electronic remittance advice (ERA) registration services program (EERS), in conjunction with Change Healthcare/Optum (CHC). However, due to a CHC service disruption in **February 2024**, we made the business decision to transfer EFT/ERA enrollment services to ECHO Health Inc. (ECHO). ECHO is a national payment solutions supplier, and we feel confident in this vendor partnership.

**Reminders on how to enroll with ECHO.**
For your ***initial*** payment from ECHO, all providers receive a paper check that includes a draft number.

To enroll in EFT/ERA services, ECHO requires you to include an ECHO payment draft number and payment amount. This is for security reasons as part of the enrollment authentication process. The ECHO draft number can be found on your explanation of provider payments (EPP). This is typically located above the first claim on your EPP. For **no-fee processing,** be sure to enroll using the **Aetna Better Health/ECHO Provider EFT/ERA Enrollment portal.** You can also update your payment/ERA distribution preferences for Aetna Medicaid claims payment there. Again, no fees apply when using the portal and it is free to enroll.

**Important:** If you are choosing to enroll in ECHO's automated clearing house (ACH) all payer program, you will be charged fees.

**Viewing Your Electronic Remittance Advice (ERA):** ERA files are available for immediate viewing when a payment is issued as a paper check or EFT/ACH. Payments issued as virtual cards or MPX (Medpay) electronic checks require the payment be processed or deposited before the ERA file is available for viewing.

**Payment Types With ECHO. Your Preference is Important.**
**Virtual Credit Card (VCC).** ECHO's standard practice is when they receive an initial payment directive for a provider who has not previously enrolled for EFT delivery, ECHO will send the provider a virtual credit card (VCC) payment. This functionality is activated at the direction of each Aetna Better Health plan and may not be applicable in every market. If you would like to opt out of the virtual credit card (VCC) option, you can manage your payment preference on the portal.
**MPX Payments.** If you enrolled in ECHO's Medical Payment Exchange (MPX) program through another payer (not Aetna Better Health) and you did not enroll in EFT, you will receive your payments in the MPX portal. MPX may appear as an email that you need to print off your computer and confirm the watermark.
**Paper Check.** If you opted out of the MPX program and have not enrolled in EFT and you opted out of VCC you will receive a paper check via regular mail to your address on file. We encourage you to confirm your address on file with ECHO.
If you have any questions about creating your account, updating your information or viewing your payments on the **Aetna Better Health/ECHO portal**, review the **ECHO Provider Payments Portal User Guide.** You can also contact ECHO Provider Services directly at **1-800-830-5831** Monday through Friday 9 AM to 7 PM (ET).

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# Clinical Practice Guidelines Location

Respected professional and public health organizations create clinical practice guidelines that document best practices and recommendations for care. We've chosen certain clinical guidelines to help our providers give members high-quality, consistent care with effective use of services and resources. These include treatment protocols for specific conditions, as well as preventive health measures.

**The intention of these guidelines is to clarify standards and expectations. They should not:**

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

Please review our Clinical Practice Guidelines for more information.

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# 2024 CAHPS Survey Results

| | Measure | NJ 2024 CAHPS Results Summaries | 2024 CSS Medicaid Avg. | 2023 NCQA QC National Avg. Medicaid HMO |
|---|---|---|---|---|
| Adult CAHPS Survey | Rating of Personal Doctor | 64.02% | 68.41% | 80.99% |
| | Rating of Specialist Seen Most Often | 68.79% | 67.04% | 66.20% |
| | Rating of All Health Care | 53.19% | 56.78% | 55.65% |
| | Rating of Health Plan | 54.52% | 59.78% | 61.24% |
| | Getting Needed Care | 81.24% | 80.58% | 80.99% |
| | Getting Care Quickly | 77.22% | 79.24% | 80.36% |
| | How Well Doctors Communicate | 93.04% | 92.65% | 92.49% |
| | Customer Service | 89.11% | 88.84% | 89.18% |
| | Coordination of Care | 82.41% | 83.58% | 84.61% |
| Child CAHPS Survey | Rating of Personal Doctor | 74.35% | 75.52% | 775.63% |
| | Rating of Specialist Seen Most Often | 69.63% | 71.26% | 71.07% |
| | Rating of All Health Care | 65.81% | 69.70% | 68.33% |
| | Rating of Health Plan | 62.27% | 70.52% | 70.87% |
| | Getting Needed Care | 77.48% | 82.31% | 82.71% |
| | Getting Care Quickly | 81.74% | 85.91% | 85.46% |
| | How Well Doctors Communicate | 93.33% | 92.86% | 93.62% |
| | Customer Service | 87.51% | 87.56% | 87.64% |
| | Coordination of Care | 80.98% | 83.09% | 83.81% |
| | **Children With Chronic Conditions (CCC)** | | | |
| | Access to Prescription Meds | 87.22% | 88.52% | 89.14% |
| | Access to Specialized Services | 55.64% | 69.10% | 70.56% |
| | Getting Needed Information | 89.42% | 89.92% | 90.38% |
| | Doctor Who Knows Child (% Yes) | 89.98% | 90.28% | 90.92% |
| | Care Coordination for CCC (% Yes) | 74.55% | 76.27% | 77.55% |

Note: For 2024 CAHPS, NCQA will be releasing 2024 Health Plan Ratings in the Fall of 2024.

The results presented in this report use the 2023 benchmarks released by NCQA to estimate the 2024 Health Plan ratings; therefore, the Health Plan Ratings scores presented in this report should be treated as estimates. Results are presented for NCQA's top-box rates (% 9+10 or % Usually+Always). At least 100 valid responses must be collected for a measure to be reportable by NCQA. A lighter display is used to indicate that a result is not reportable by NCQA due to insufficient denominator (less than 100 responses). In such cases, CSS calculates measure results only for internal plan reporting. This is the first year the Health Plan conducted the CCC survey, previous year results are not available for comparison.

# 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 healthcare 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 Medicaid 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.<br>Notify patients by text, phone or in the waiting room if there are wait time delays. This helps manage patient expectations.<br>Advocate for your patient and ask if they have transportation available for their appointment. Resources For Living (RFL), offered by Aetna can put your patients in touch with transportation resources. |
| 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.<br>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? | |
| **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? | |



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# CAHPS: Reference guide for physicians, with best practices

| CAHPS member survey questions | Industry best-practices for physicians |
|---|---|
| **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.<br><br>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.<br><br>New and established patients without an appointment in the last year should be encouraged to schedule their Medicaid Annual Wellness Visit and a physical to ensure the conversations about their health, medications, and the care they receive from other providers. 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:<br>• someone from the doctor's office follow-up to give you those results?<br>• 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 healthcare 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. |

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# CAHPS: Reference guide for physicians, with best practices

| CAHPS member survey questions | Industry best-practices for physicians |
|---|---|
| **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? | |

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# Lead Screening in Children

## Fact Sheet

## Pediatric Lead Screening in Children FAQs

| | Early and Periodic Screening, Diagnostic and Treatment (EPSDT) | Healthcare Effectiveness Data and Information Set (HEDIS) |
|---|---|---|
| Definition | The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid | HEDIS is a comprehensive set of standardized performance measures used in the managed care industry to monitor performance and opportunities for quality improvement |
| Blood Lead Screening Requirements | Every child enrolled in the **NJ FamilyCare program (Medicaid)**, must be given a blood lead test at the following ages:<br>• Complete a blood lead test at **12 months** old (between 9 and 18 months)<br>• **AND** again at **24 months** old (between 18 and 26 months)<br>• Children between 26 and 72 months old who have **NOT** previously had a blood lead test should be tested immediately | Any blood lead test **after the age of 2** is considered late in HEDIS reporting<br>Providers should educate parents/guardians regarding the importance of having their child tested for lead as well as keeping appointments<br>Blood lead screenings should be completed **on or before their second birthday** – it must be a capillary or venous blood lead test |
| Verbal Risk Assessment | The verbal risk assessment must be asked at every visit with children who are between **6 months and 72 months** old. The verbal risk assessment must be documented in the medical record for each well-child visit starting at 6 months to 72 months old.<br>To view a list of questions, visit aetnabetterhealth.com/newjersey/providers/resources/lead<br>If any answer is 'yes" or 'I don't know', the risk is considered high. All children at high risk need a blood lead test immediately, even if younger than 6 months old<br>**The questions must be asked at every subsequent visit since risk can change** | Not required to be completed under HEDIS guidelines. To better evaluate a child for a blood screening, we recommend completing a verbal risk assessment |

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## Improving lead screening compliance

To help you complete testing on our members, we have contracted with Laboratory Corporation of America (LabCorp), including **MedTox Laboratories**, to provide our contracted physicians with a filter paper lead screening method that is fast, less invasive and easy. Supplies are provided at no charge to your office and, after the sample card(s) have been placed in the mail, results are delivered to you within 72 hours of receipt. **This is the best way to assure members are tested before leaving your office and to improve provider screening rates.**

For more information on using the MedTox technique and to set up your account, contact at 1-877-725-7241 or visit medtox.com/program-services/filter-paper-lead-testing.

## More questions about lead screening in children?

- Contact Provider Services at 1-855-232-3596 or email AetnaBetterHealth-NJ-ProviderServices@aetna.com
- Visit the plan's website at www.aetnabetterhealth.com/newjersey/providers/resources/lead for up-to-date lead screening in children resources