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Provider Newsletter

Fall 2022

2022 CAHPS Survey and Member Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures member satisfaction. Patients report on and evaluate their experiences with health plans, providers, and healthcare facilities.

Aetna Better Health® of New Jersey (ABHNJ) uses the National Committee for Quality Assurance (NCQA) HEDIS CAHPS 5.0H Membership Satisfaction Survey to assess member satisfaction. Members surveyed are selected from a random sample of all eligible members.

Here are 10 tips that can help improve CAHPS scores:

1. **Friendly, helpful front desk experience**
   From the first call to schedule an appointment to the last person they see before leaving the office, be sure to make that experience great for the patient. If it is possible, have bilingual staff or interrupter service available for patients.

2. **Time management**
   Everyone's time is valuable. Be conscious of the patient's time and try to adhere to scheduled appointment times. On occasion, things come up, but remember to update them on any changes and apologize for any delays.

3. **Effective communication with patients**
   The ability to communicate information effectively and compassionately is key to successful patient-provider relationships. Listen carefully to the patient and respect their point of view. Be empathetic and acknowledge their feelings. Provide information to the patient that is easily understood.

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4. **Work as a team**
   Involve the patient in the decision-making process. Review the patient's care plan and together come up with a plan for their health.

5. **Facility access**
   Patients need to be able to access their doctor easily. Be sure ramps and walkways are paved and cleaned at all times. In addition, make sure your office is Americans with Disabilities Act (ADA) compliant to provide medical care to people with disabilities, such as handicap-accessible entrances/exits and bathroom access.

6. **Cleanliness**
   Take pride in your office appearance. Make sure your waiting rooms, examination rooms, bathrooms, etc. are always clean and tidy.

7. **Accurate billing**
   Many of the complaints received relate to patients being balance billed. Staff can help by asking patients for a copy of their member ID card to ensure that claims will process correctly. If the patient does not have their member ID card at the time of service, please check eligibility. ABHNJ patients who obtain covered services should never be balance billed except for applicable co-payments.

8. **Patient loyalty**
   Patients that have a positive health care experience will most likely return. In fact, patients might refer friends or family to your practice so they can also benefit from a positive health care experience.

9. **Provider follow-up**
   Provide patients with an office summary note to help patients easily follow up. After a procedure or sick visits, follow up with the patient to ensure they are doing well. This is a great time for the patient to ask additional questions or make follow up appointments, as needed.

10. **HIPAA compliance**
    Be sure your office is Health Insurance Portability and Accountability Act (HIPAA) compliant at all time. Protect all patients' private information. In an area where multiple patient/staff communications routinely occur, be mindful of voice tones so personal health information isn't passed to others.

As participating providers, the care you give our members impacts their satisfaction with ABHNJ. Below are measures that are related to the care you give, how to enhance time with your patients, and the results of the 2022 CAHPS survey.

Physician-related measures for future improvement:

- Personal MD Overall
- Specialist MD Overall
- Getting Care Quickly
- Getting Needed Care
- Health Care Overall

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Enhance your time with your patients:

- Be an active listener.
- Ask the member to repeat instructions in their own words.
- Rephrase instructions in simpler terms, if needed.
- Clarify words with multiple meanings to the member.
- Limit use of medical jargon.
- Be aware of cultural or language barriers.

2022 CAHPS Survey Results

	Measure	NJ 2022 CAHPS Results Summaries	2022 CSS Medicaid Avg.	2021 NCQA QC National Avg. Medicaid HMO
Adult CAHPS Survey	Rating of Personal Doctor	66.67%	66.54%	69.31%
	Rating of Specialist Seen Most Often	59.15%	66.58%	68.99%
	Rating of All Health Care	58.77%	56.74%	57.67%
	Rating of Health Plan	59.78%	59.07%	58.67%
	Getting Needed Care	81.92%	81.72%	83.58%
	Getting Care Quickly	80.67%	81.06%	81.83%
	How Well Doctors Communicate	94.61%	92.01%	92.17%
	Customer Service	88.51%	88.88%	88.94%
	Coordination of Care	93.75%	82.62%	85.36%
Child CAHPS Survey	Rating of Personal Doctor	73.06%	76.36%	78.01%
	Rating of Specialist Seen Most Often	70.34%	71.57%	73.84%
	Rating of All Health Care	67.77%	70.53%	74.30%
	Rating of Health Plan	62.93%	70.90%	72.19%
	Getting Needed Care	75.36%	84.82%	85.65%
	Getting Care Quickly	83.82%	86.70%	86.90%
	How Well Doctors Communicate	92.47%	93.70%	94.39%
	Customer Service	88.21%	88.33%	88.32%
	Coordination of Care	75.86%	83.91%	86.61%

Note: For 2022 CAHPS, NCQA will be releasing 2022 Health Plan Ratings in the fall of 2022.

The results presented in this report use the 2021 benchmarks released by NCQA to estimate the 2022 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.

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Healthy Mouth, Healthy Body

Oral health is tied to overall health. Gingivitis and periodontal disease, also known as gum disease, are more common in people with certain chronic diseases.

Periodontal disease can lead to pain and loss of teeth. Illnesses that lower the body's ability to fight infection may also raise the risk of periodontal disease. Some chronic diseases that occur at the same time of periodontal disease are:

- Rheumatoid arthritis
- Diabetes
- Some forms of heart disease
- High blood pressure
- Osteoporosis
- Stroke

Primary Care Physicians (PCPs) should refer their patients to a dentist for biannual exams and preventive treatment. Children must be referred to a dentist after tooth eruption or by one year of age. All ABHNJ members are assigned to a dental home. Dental home information is listed on the member's dental ID card.

Professional Technicians, Inc. (PTI)

We've partnered with LabCorp and Professional Technicians, Inc. (PTI), a reliable mobile laboratory, that offers lead testing by a trained technician in the comfort of our member's home. This is a covered service at no cost to our members and results will be sent to your office once processed.

You can contact PTI directly at **215-364-4911** to schedule an appointment for your patients, our members. For additional questions or assistance please contact Provider Services at **1-855-232-3596**.

Reminder: 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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Cultural Competency Resources and Training

Culture is a major factor in how people respond to health services.

It affects their approach to:

- Coping with illness
- Accessing care
- Taking steps to get well

Patient satisfaction and even positive health outcomes are directly related to good communication between a member and his or her provider.

A culturally competent provider effectively communicates with patients and understands their individual concerns. It is important to make sure patients understand their care regimen. Each segment of our population requires special sensitivities and strategies to embrace cultural differences.

Training resources for you

As part of our cultural competency program, we encourage you to access information on culturally competent care through the Office of Minority Health's web based program: A Physician's Guide to Culturally Competent Care. You can access this program and other cultural competency resources in the Cultural competency section of our website.

Member Rights and Responsibilities

It is our policy that no provider unfairly discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please refer to the member Rights and Responsibilities Section of our Provider Manual. Ensure your staff members are aware of these requirements and the importance of treating members with respect and dignity.

In the event that we receive information that a member is not being treated in accordance to our policy, we will initiate an investigation and report the finding to the Quality Management Oversight Committee. Further action may be taken by us if deemed necessary.

You can review the Rights and responsibilities section of our website for more information.

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Telephone Accessibility Standards

Providers are responsible to make arrangements for after hours coverage in accordance with applicable state and federal regulations, either by being available or having on call arrangements in place with other qualified participating ABHNJ providers for the purpose of rendering medical advice, determining the need for emergency and other after hours services including authorizing care, and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and/or emergent health care issues is held to the same accessibility standards regardless of the after hours coverage managed by the PCP, current service provider, or the on call provider.

All PCPs must have a published after hours telephone number and maintain a system that will provide access to PCPs 24 hours a day, 7 days a week. In addition, we encourage our providers to offer open access scheduling, expanded hours and alternative options for communication among members, their PCPs and practice staff (e.g. scheduling appointments via the web or communication via email). We routinely measure the PCP's compliance with these standards as follows:

Helpful Tips

- Our medical and provider management teams 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 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 phone protocols for all of the following situations:
  - Answering the member phone 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 (e.g., wheelchair and interpretive linguistic needs)

ABHNJ routinely conducts audits to validate telephone accessibility standards are being met.

Finding a Provider

If you or a member need help to find a provider in the ABHNJ network, visit our online provider directory.

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EVV Phase 2 Provider Training

ABHNJ values our partnership with your practice to serve the people in the state of New Jersey by providing quality health care and accessible medically-necessary services. Our providers are one of the most critical components of our service delivery approach and we are grateful for your participation.

Register: https://www.aetnabetterhealth.com/newjersey/providers/training-orientation.html

We want to keep you informed and up-to-date on all pertinent information. Register to attend one of the upcoming live training dates listed below. Meeting invites will be issued the day prior to the training.

- November 18, 2022
- December 2, 2022
- December 16, 2022

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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Provider Satisfaction Survey

Thank you for partnering with ABHNJ to provide quality health care for our members.

As your partner, we want to ensure that your experience with us is positive and rewarding. You are essential to providing the highest quality health care possible for our members, and your satisfaction is important to us.

We conduct an annual provider satisfaction survey to gauge our performance and obtain provider feedback. The results of the survey helps us identify key opportunities for improving the experience of providers. The purpose of this survey is to assess overall provider satisfaction and identify specific key areas of satisfaction around finance, utilization and quality management, network coordination of care, pharmacy, health plan call center, and provider relations. Our goal is for providers to be highly satisfied and consider our plan Well Above Average.

In 2021, over 78 percent of providers who participated in the survey stated that they would recommend ABHNJ. Overall satisfaction was over 67 percent.

Our 2021 annual survey results show improvements in several areas. The survey results have helped reveal strengths as well as some areas for improvement.

Provider satisfaction improved in the following areas:

- All other plans (Comparative Rating)
- Finance
- Utilization and Quality Management

Provider satisfaction opportunities for improvement exist in the following areas:

- Network/coordination of care
- Health plan call center service staff
- Provider relations

Many interventions have been implemented to continue to improve our service and provider experience, including additional provider trainings. We have also created an experience work group to continuously strategize ways to improve the provider experience.

Your feedback is crucial to delivering excellent provider experience. Satisfaction surveys for 2022 will be sent out around October. If you receive a survey, please be sure to complete.

If we are not meeting your expectations and needs, please let us know by contacting a provider relations representative.

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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.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

APM assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.

Antipsychotic prescribing for children and adolescents has increased rapidly over the year. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.

For more information, visit the NCQA website.

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How to Refer Members to Our Care Management Program

Do you have a patient in need of care management?

We can help your patients, with the conditions below, enhance their self-management skills.

- Behavioral health and substance abuse
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Coronary artery disease
- Diabetes
- Other conditions
- Pregnancy outreach and high-risk obstetrics (OB)
- Special health care needs

Care managers educate members about their condition and how to prevent worsening of their illness or any complications. The goal is to maintain, promote or improve their health status.

To create a quality-focused, cost-effective care plan, care managers collaborate with:

- The member
- Member's family
- PCP
- Psychiatrist
- Substance abuse counselor
- Other health care team members

To identify members that are the right fit for care management, we may use referrals from:

- Our health information or special needs lines
- Members
- Caregivers
- Providers
- Practitioners

Integrated care management means your patient only has one care manager, even if they also take part in:

- Care Management
- Condition Management

To refer your patients, our members to Care Management, you can call or email the Care Management Team:

Malvina Williams
Supervisor, Clinical Health Services
609-468-6916
WilliamsM5@Aetna.com

Ann Marie McGinnis
Supervisor, Clinical Health Services
609-282-8183
McGinnisA@aetna.com

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Appointment Availability Standards

The table below show the standard appointment wait times for primary and specialty care. The table also reflects the standard for acceptable wait time in the office when a member has a scheduled appointment.

Provider Type	Emergency Services	Urgent Care	Non Urgent	Preventative & Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Same day	Within twenty-four (24) hours	Within seventy-two (72) hours	Within twenty-eight (28) days [1]	No more than forty-five (45) minutes
Specialty Referral	Within twenty-four (24) hours	Within twenty-four (24) hours of referral	Within seventy-two (72) hours	Within four (4) weeks	No more than forty-five (45) minutes
Dental Care	Within forty-eight (48) hours (2)	Within three (3) days of referral		Within thirty (30) days of referral	No more than forty-five (45) minutes
Mental Health/ Substance Abuse (MH/ SA)	Same day	Within twenty-four (24) hours		Within ten (10) days	No more than forty-five (45) minutes
Lab and Radiology Services	N/A	Within forty-eight (48) hours	N/A	Within three (3) weeks	N/A

Acceptable Appointment Wait Time Standards

1. Non-symptomatic office visits include, but are not limited to, well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.
2. Emergency dental treatment no later than forty-eight (48) hours or earlier, as the condition warrants, of injury to natural teeth and/or surrounding tissue and follow-up treatment by a dental provider.

Physicals	
Baseline Physicals for New Adult Members	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Child Members and Adult Clients of DDD	Within ninety (90) days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine Physicals	Within four (4) weeks for routine physicals needed for school, camp, work, or similar.

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Prenatal Care: Members 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

Initial	
Initial Pediatric Appointments	Within three (3) months of enrollment
Aged, Blind & Disabled Members	Each new member will be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within ten (10) business days of enrollment and offered an expedited appointment.

Maximum number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children.

Pediatric ADHD HEDIS Follow Up and Tips

All children who are prescribed medications to treat attention-deficit/hyperactivity disorder (ADHD) need follow-up care to assure that the response to medication and dosage is appropriate. Please review the ADHD HEDIS measure information below and tips on how to meet the measure.

HEDIS measure: ADD–Follow Up Care for Children Prescribed ADHD Medication

Measure definition: Children 6–12 years of age, newly prescribed with ADHD medication, who had at least 3 follow-up visits within a 10-month period, one of which was within 30 days of when the ADHD medication was dispensed.

Two rates are reported:

- **Initiation Phase:** A follow up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- **Continuation Phase:** Children that remained on the ADHD medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Tips:

1. When prescribing a new ADHD medication for a patient, schedule the initial follow up appointment before the patient leaves the office.

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2. Only prescribe 14-21 days worth of the medication when starting or changing prescription.
3. Schedule the initial follow up for the 2-3 week period corresponding to the prescription.
4. Explain to the parent the importance of follow up care with the provider who prescribed the medication and who will evaluate the medication.
5. Provide no refills unless the child has the initial follow up visit.
6. After the initial follow up visit, schedule at least 2 more visits over the next 9 months to check the child's progress.
7. Encourage parents/caregivers to ask questions about their child's ADHD symptoms.
8. Always coordinate care between all clinicians in your patient's treatment team.

HEDIS Tips in Caring for People Diagnosed with a Serious Mental Health Issue

HEDIS measure: SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Measure definition: Patients 18 – 64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test annually.

Tips:

1. Encourage members to share contact information among all Medical, Behavioral/Mental Health or Substance Use Disorder Providers.
2. Facilitate coordination of care between Medical and Behavioral/Mental Health and Substance Use Disorder Providers to ensure tests are administered and results shared in a timely manner.
3. Engage members in treatment discussions explaining the importance of having these tests administered.
4. Create an HbA1c and LDL-C testing reminder in your EHR for each member who is taking antipsychotic medications, regardless of known diabetes diagnosis.