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Provider Newsletter

Summer 2024

Provider Directory

Members can access the provider directory by visiting AetnaBetterHealth.com/NewJersey/find-provider or calling Member Services at **1-855-232-3596**. For a listing of NJ Smiles Dental providers (for children 0-3 years old), visit AetnaBetterHealth.com/NewJersey/members/benefits/dental.

Pharmacy Guidelines (Restrictions/Preferences)

Aetna Better Health® of New Jersey's pharmacy prior authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate.

Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State's Medicaid program
- Prescriptions that do not conform to Aetna Better Health® of New Jersey's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when an "A" rated generic equivalent is available

Pharmacy authorization guidelines and PA forms are available on our website.

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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.

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Critical Incidents for MLTSS Member

Critical Incident is an occurrence involving the care, supervision, or actions involving a Member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the Member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a facility/ institution/school.

Examples of a Critical Incident:

1. Unexpected death of a member
2. Media involvement or the potential for media involvement
3. Physical abuse (including seclusion and restraints both physical and chemical)
4. Psychological/verbal abuse
5. Sexual abuse and/or suspected sexual abuse
6. Fall resulting in the need of medical treatment
7. Medical emergency resulting in need for medical treatment
8. Medication error resulting in serious consequences
9. Psychiatric emergency resulting in need for medical treatment
10. Severe injury resulting in the need of medical treatment
11. Suicide attempt resulting in the need for medical attention
12. Neglect/mistreatment, caregiver (paid or unpaid)
13. Neglect/mistreatment, self
14. Neglect/mistreatment, other
15. Exploitation, financial
16. Exploitation, theft
17. Exploitation, destruction of property
18. Exploitation, other
19. Theft with law enforcement involvement
20. Failure of member's Back-up Plan
21. Elopement/wandering from home or facility
22. Inaccessible for initial/on-site meeting
23. Unable to contact
24. Inappropriate or unprofessional conduct by a provider involving member
25. Cancellation of utilities
26. Eviction/loss of home
27. Facility closure, with direct impact to member's health and welfare
28. Natural disaster, with direct impact to member's health and welfare
29. Operational breakdown
30. Other

If you encounter a critical incident with a MLTSS member, please complete the MLTSS Critical Incident Reporting Form.

You can report Critical Incidents by phone to **1-833-346-0122 o**r by fax to **959-900-6054**. Provider Services**1-855-232-3596**.

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Monitoring Metabolic Risks of Antipsychotic Meds

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.

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.

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.

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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.
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.

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health® of New Jersey's Member Services Department at **1-855-232-3596 (TTY 711)**. Member Services is available 24 hours a day, 7 days a week.

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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:

- 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)

We routinely conduct audits to validate telephone accessibility standards are being met.

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Do you have a patient in need of care management?

We can help your patients (who have 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:

Jennifer Coleman, RN Health Services Manager
Concurrent Review
Office: **863-221-6010**
ColemanJ2@CVSHealth.com

Natasha Sealey, RN
Health Services Manager
Prior Authorization
Office: **954-858-3374**
SealeyN@CVSHealth.com

Stephanie Haney
Senior Manger
Clinical Health Services
Office: **304-953-0765**
HaneyS1@Aetna.com