Aetna Better Health®
of New Jersey

Aetna Assure Premier
Plus (HMO D-SNP)

Behavioral Health Integration Provider Training Session

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Aetna Overview

Aetna NJ Info

Who we serve

New Jerseyans of all ages who qualify for NJ FamilyCare & NJ FIDE SNP.

We provide services statewide in all 21 counties

Our Philosophy

“At Aetna we believe in improving every life we touch as good stewards to those we serve.”

Membership

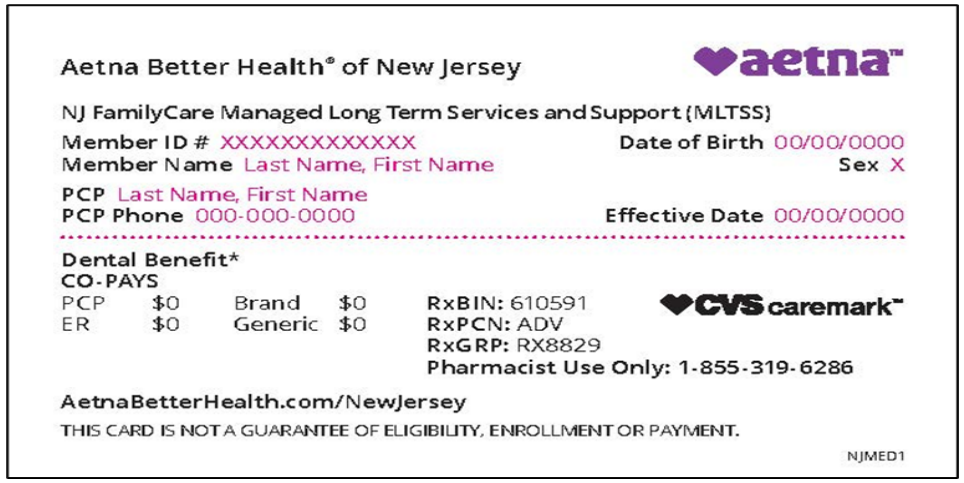
- ❑ **Medicaid – Over 100K members**
- ❑ **MLTSS – Over 6K members**
- ❑ **DDD – Just under 1K members**
- ❑ **FIDE SNP – Over 7K members**

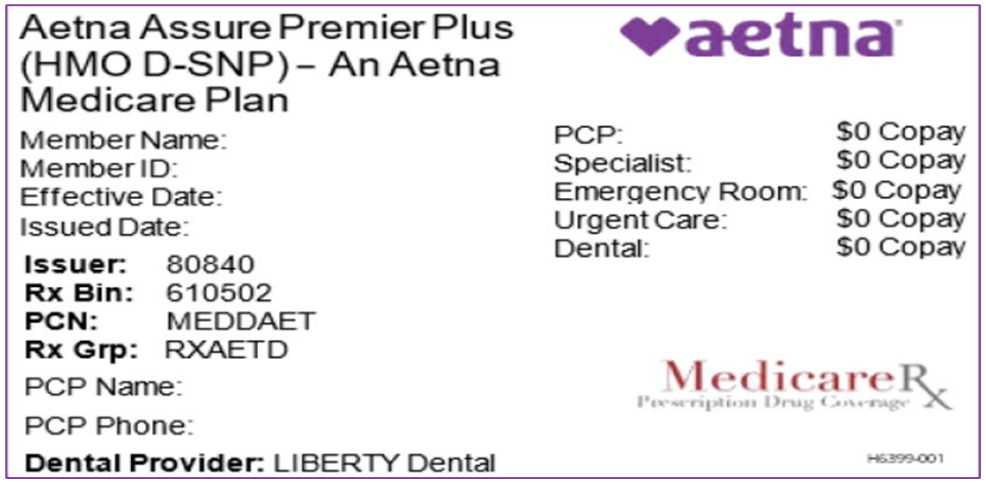
Aetna NJ Products

Aetna Better Health of New Jersey is a Medicaid health plan that offers no-cost and low-cost health care for adults and children through the NJ FamilyCare program. We cover Medicaid services including Medical, Dental, Vision, Behavioral Health, Managed Long Term Services and Supports (MLTSS), and Pharmacy services.

Aetna Assure Premier Plus (HMO D-SNP) is a Medicare Advantage plan which includes a fully integrated Special Needs Plan for dual eligible members provided through Aetna. It covers all Medicare and Medicaid services including prescriptions drugs, behavioral health, Managed Long Term Services and Supports (MLTSS) and additional supplemental benefits at $0 cost sharing for all members

These sample Member Identification cards will help you determine which coverage the member you delivering BH care to has:





Behavioral Health Integration

BH Integration Overview

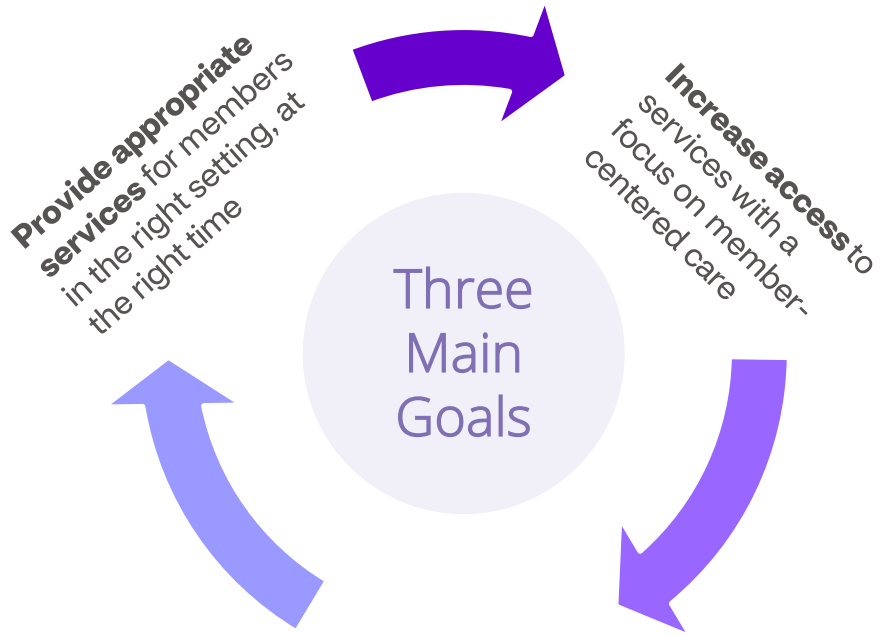
Behavioral health (BH) care encompasses mental health (MH) and substance use disorder (SUD) services.

To prioritize whole-person care where all healthcare services – both physical and behavioral health services – across the care continuum are managed under the same entity, NJ is embarking on a BH integration effort.

Currently the New Jersey health plan has;

- Partially integrated benefits for certain membership populations
- Full benefits integrated for MLTSS, DDD and FIDE-SNP populations
- Majority of benefits for Medicaid enrollees exclusively covered by fee-for-service (FFs)

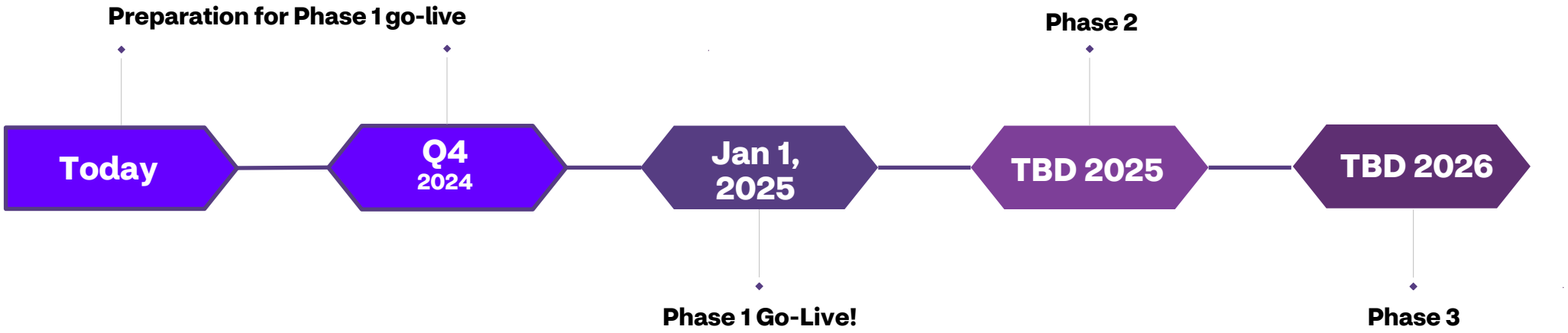
The purpose of the Behavioral Health Integration is to bring all behavioral benefits and services "in house", under the management of the health plan over the course of three phases.



1. Outpatient BH services are currently covered by managed care for members enrolled in MLTSS/DDD/FIDE-SNP programs, and will be integrated for general managed care population during Phase 1
2. https://www.nj.gov/humanservices/dmhas/information/stakeholder/index.html

BH Integration Timeline

BH services are being integrated into managed care over three phases:



Phase 1 – Outpatient BH Services[1]

- MH outpatient counseling
- MH partial hospitalization
- MH partial care in outpatient clinics
- MH outpatient hospital and clinic services
- SUD outpatient counseling
- SUD intensive outpatient
- SUD outpatient clinics (incl. ambulatory withdrawal mgmt.)
- SUD partial care

Phase 2 – Residential & OTP

- Adult MH rehabilitation services
- SUD short term residential
- SUD medically monitored inpatient withdrawal mgmt.
- SUD long term residential
- Opioid treatment programs (OTP)

Phase 3 – Other additional BH services

Timings of phase 2 and 3 of integration and the specific services covered will be determined after Phase 1 implementation

What does this mean for Providers?

Starting January 1, 2025, for members enrolled with Aetna receiving Phase 1 BH services, providers must bill Aetna rather than NJ Medicaid FFS (Gainwell).

Providers should prepare by:

1. Taking this first step. Your participation in this training is appreciated and has set you on the path for success!
2. Joining the Aetna network by completing our contracting and credentialing process to ensure continuity of care for members. If you don't join our network, you will be required to obtain a single case agreement (SCA) for every visit.
3. Familiarizing yourself with our procedures to ensure prior authorization, claims submission, partnering with our care management staff, and other necessary engagements go seamlessly post go live.
4. Staying up to date with DMAHS and Aetna guidance by checking the following websites weekly:

DMAHS Behavioral Health Integration Stakeholder Information

Aetna Better Health of NJ – Providers

Aetna Assure Premier Plus (HMO D-SNP) - Providers

Provider Network 101

State Requirements

For Aetna

In support of the BH Integration, Aetna has a State contractual commitment to ensure we have a Provider Network to facilitate the specialized BH Covered Services. This is known as "Any Willing Qualified BH Provider" (Ref. 4.8.1P Provider Network)

Additionally, Behavioral Health Services established rates are specified on the NJ Medicaid Management Information System (NJMMIS) website at www.njmmis.com. Aetna is required to pay 100% of the fee-for-service (FFS) rate.

For Providers

Effective January 1, 2018, the 21st Century Cures Act 114 P.L. 255, requires **all Medicaid managed care network providers to enroll with the state Medicaid program**. You cannot apply to the Aetna network until you have obtained your NJ Medicaid Provider Identification Number.

The application is available for download at www.njmmis.com (under Communications, see Provider Enrollment Application). The mailing address to submit the application and credentials is:

Provider Enrollment
Gainwell Technologies
P.O. Box 4804
Trenton, NJ 08650

You may be asked to provide evidence to Aetna Better Health of New Jersey of your submission, so we encourage you to keep a copy of your application. **Reminder you MUST recredential every 5 years!**

Existing In-Network (PAR) BH Providers

THANK YOU for being part of our Provider Network! Together we can improve health care access and quality.

To further increase our partnership, we encourage our participating BH Provider community to join our Provider Advisory Committee by sending an email to: AetnaBetterHealth-NJ-ProviderServices@Aetna.com

Your representation and feedback is valuable to us!

How to Submit Provider Demographic Changes

When a participating provider requires updates to their demographic profile, they should be submitted in writing to the applicable provider relation team via email:

- Aetna Better Health of NJ: AetnaBetterHealth-NJ-ProviderServices@aetna.com
- Aetna Assure Premier Plus (HMO D-SNP): NJ_FIDESNP_Providers@aetna.com

Tips for submitting common provider demographic updates:

- Mailing address changes require W9
- In general, please include effective date, company letterhead, NPI and Tax ID in your submission
- For link letters (providers already credentialed with the health plan) submit completed Provider Spreadsheet to the mailbox

Future In-Network BH Providers

THANK YOU for your decision to contract with Aetna. This ensures continuity of care for our members receiving BH services. It also reduces administrative burden, enhances collaboration for service coordination, and improves member health outcomes.

How to Join the Network

Step 1

Enroll with NJ Medicaid

- Complete 21st Century Cures Act registration
- Obtain your NJ Medicaid Provider Identification Number

Step 2

Contact Us

Send an email with your W9 to one of Aetna's Senior Network Management Professionals:

Angelica Miranda
mirandaa2@aetna.com
609-515-4817

Kimberly Lees
LeesK1@aetna.com
856-271-7446

June-Delina Parkes
parkesj@aetna.com
845-427-1261

Step 3

Documentation Needed

- Application
- Disclosure Statement
- Certificate of Insurance
- Employment Attestation
- W9 Form
- Business License
- Special Needs Survey
- Provider Roster (if applicable)

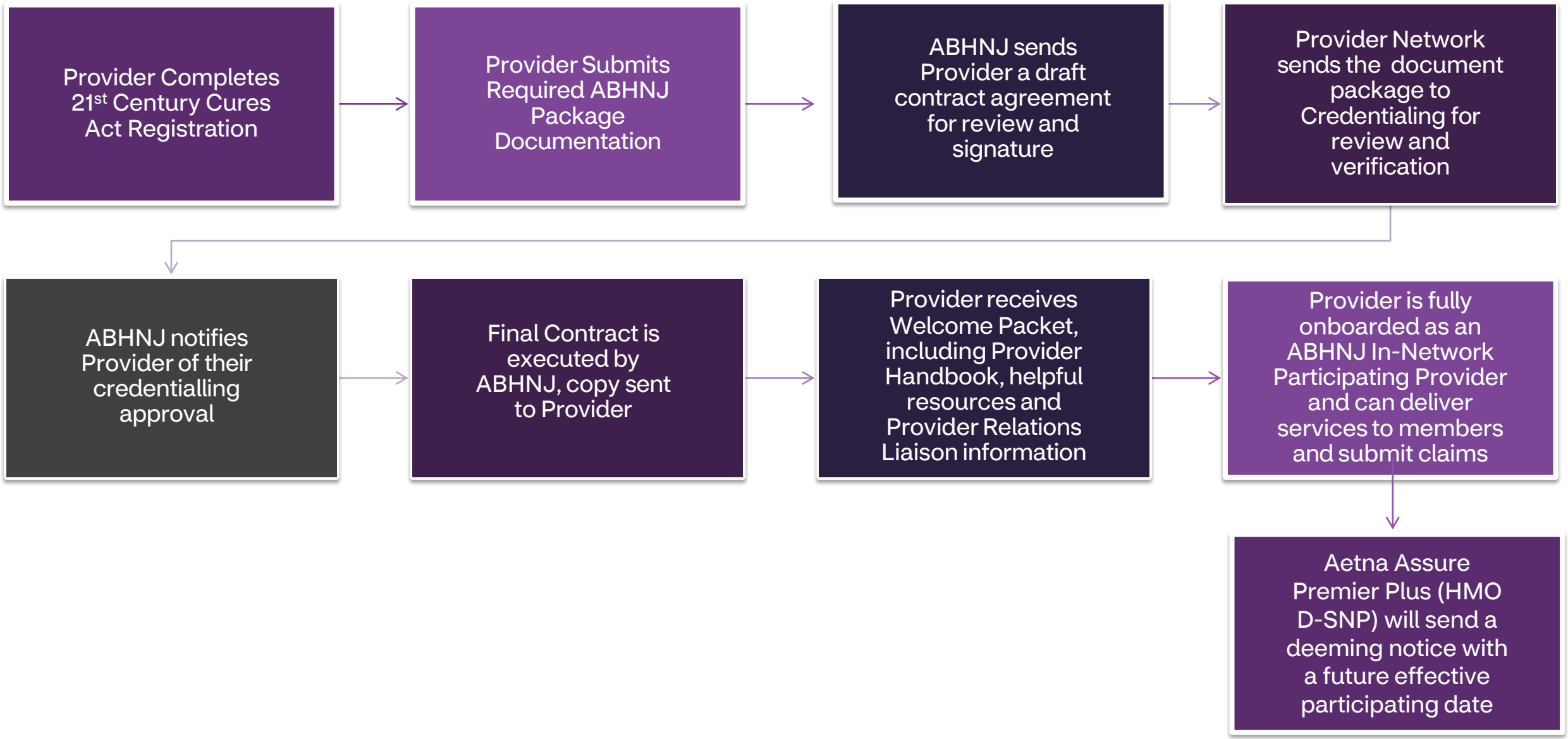
Step 4

Timing

- ABHNJ conducts the credentialing and contracting process simultaneously
- Upon receipt of a clean package, the full contracting and credentialing process takes approximately 60 days for completion.
- Credentialing may reach out for additional information, if documentation is incomplete.

- Contracting – Providers participating with ABHNJ will participate with Assure Premier Plus (HMO D-SNP) either through their existing Aetna Medicare Advantage agreement in New Jersey or the Assure Premier Plus (HMO D-SNP) amendment. Providers do not have to recontract, Aetna Assure Premier Plus (HMO D-SNP) will send a deeming notice with a future effective participating date once the ABHNJ contract is executed.
- Credentialing – Aetna Better Health of NJ and Aetna Assure Premier Plus (HMO D-SNP) process is the same and centralized for both lines of business.

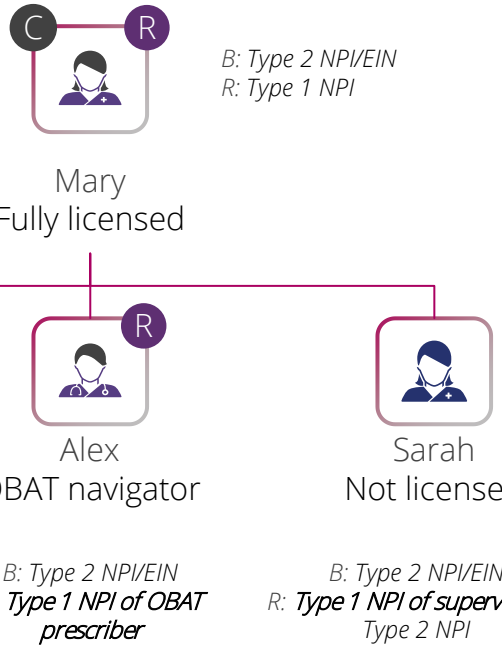
Visual Contracting/Credentialing Workflow



Credentialing and Rostering Requirements

Aetna Better Health of New Jersey & Aetna Assure Premier Plus (HMO-DSNP)

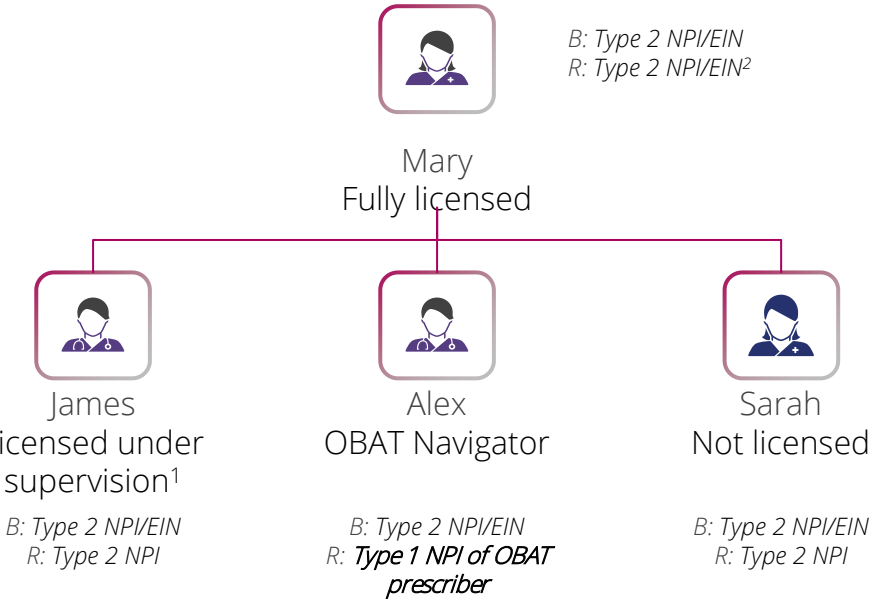
Individuals / Group



- Require licensed practitioners (including licensed under supervision) to individually credential
- Providers without full license can submit claims with supervisor or group as rendering provider; supervisor is preferred
- Must include fully licensed, licensed under supervision and OBAT navigators on group roster

Licensed Facility / Agency

C



- Credential at the Facility/Agency level; do not credential individually
- If billing with CMS 1500, use Facility Type 2 NPI as rendering; however, UB04 billing is preferred
- No rostering of individuals associated with facility/agency
- Only facility/agency shown in network directory; individuals only shown if they are individually credentialed

1. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), and Licensed Associate Marriage and Family Therapists (LAMFT); 2. Some facility contract alignments allow for Type 1 NPI providers to bill as rendering on facility claims. Check your specific contract or with contract manager for this information

C Organization credentialed C Individually credentialed R Listed on roster

Provider Resources

Provider Relations

We are here for you. Need help or have questions? Contact Provider Services or your dedicated liaison:

Call Us

- Aetna Better Health of NJ: 1-855-232-3596
- Aetna Assure Premier Plus (HMO D-SNP): 1-844-362-0934

Provider Relations Liaison

Aetna Better Health of NJ
Liarra Sanchez, Manager, Network Relations
609-455-8997
SanchezL7@Aetna.com

Aetna Assure Premier Plus (HMO D-SNP)
Joshua Jones, Manager, Network Relations
401-526-6767
JonesJ18@aetna.com

Availity Provider Portal

In the upcoming slides we will review processes for common provider activities including Prior Authorization Requests, Claims/Billing, and Grievances/Appeals. Aetna recommends all providers register in our Availity Provider Portal, as these features are available within this centralized system.

Provider Portal Benefits include:

- Electronic Prior Authorization Submissions
- Payer Spaces
- Claim Submission Link
- Contact Us & Messaging
- Claim Status Inquiry
- Grievance and Appeals Submission & Status
- Provider Data Management
- Ambient (Business Intelligence Reporting)
- Clear Claim
- ProPAT
- Provider Intake
- Dynamo (Case Management)

If you are already registered in Availity, you will simply select Aetna from your list of payers to begin accessing the portal and all of the features.

Aetna Better Health of NJ
Provider Portal

Aetna Assure Premier Plus (HMO D-SNP)
Provider Portal

Provider Payment Tools

As an ongoing commitment to simplify and streamline payment transactions, Aetna Better Health of NJ and Aetna Assure Premier Plus (HMO-DNP) encourages Providers to use the ECHO portal free of charge.

What is EFT/ERA Registration Services (EERS)?

EERS offers providers a standardized method of electronic payment and remittance. Providers will be able to use the ECHO tool to manage ETF and ERA enrollments with multiple payers on a single platform.

How does it work?

Please complete the ERA/EFT Enrollment. Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process.

If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 888.834.3511.

To validate your account, please make sure you have an ECHO Health draft number and payment amount so they can validate your enrollment request. A draft number is listed as the EPC draft # on ECHO Health explanation of payments. If you do not have an ECHO draft number available please dial 888.834.3511.

Prior Authorization Process

Verifying Eligibility

All providers must verify a member's enrollment status prior to the delivery of non-emergent, covered services. Member eligibility can be verified through one of the following ways:

Telephone Verification

- Aetna Better Health of NJ (Medicaid) at **1-855-232-3596**
- Aetna Assure Premier Plus (HMO D-SNP) at **1-844-362-0934**

Website – Via Provider Portals

- ABHNJ Medicaid: Click Here
- Aetna Assure Premier Plus (HMO D-SNP): Click Here

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Submitting Prior Authorization Requests

You may submit prior authorization requests 24/7 through one of the following options:

Option 1

Call us at:
- Aetna Better Health of NJ: 1-855-232-3596
- Aetna Assure Premier Plus (HMO D-SNP): 1-844-362-0934

Option 2

Click the Authorization form below and fax the request:

Aetna Better Health of NJ	Aetna Assure Premier Plus (HMO D-SNP)
Medical Authorization Form	Medical Authorization Form
Fax: 1-844-404-3972	Fax: 1-833-322-0034

Option 3

Availity Provider portal. Click below to register.

- Aetna Better Health of NJ: Provider Portal
- Aetna Assure Premier Plus (HMO D-SNP): Provider Portal

***Please note that all Phase 1 SUD authorizations will go through NJSAMS on January 1, 2025.*

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Prior Authorization Management Tips

To ensure the request is processed correctly and in a timely manner, it is important to submit the following information with each authorization request:

- Completed Prior Authorization Request Form (Outpatient Services only)
- Member Demographic Information (correct and legible spelling of name, ID number, date of birth, etc.)
- Diagnosis Code(s)
- Treatment or Procedure Codes
- Anticipated start and end dates of service(s)
- All supporting relevant clinical documentation to support the medical necessity in legible format
- Include an office/department contact name, telephone and fax number

Prior Authorization Fact Sheet

Topic	Description	Medicaid, HMO-DSNP, or Both
Authorization Requests First 90 Days	In the first 90 days the Phase 1 BH authorizations will be auto-approved. Providers should request authorizations through the standard process outlined on preceding slides.	Medicaid
Authorization Durations	Minimum duration of initial authorization: • MH Acute Partial Hospital and Partial Hospital: min 14 days • MH Partial Care: min 14 days • SUD Partial Care & IOP: min 30 days • Short Term Residential: min 14 days • Long Term Residential: min 60 days	Both
Existing Approvals	Should you have services approved by FFS you should contact ABH NJ on the first uncovered day for continued authorization.	Medicaid
Continued Stay Reviews	Aetna will need the following information: • Any updates to the treatment plan • Social Work, Therapist, RN, and MD notes (if applicable) • Discharge Plan	Both
Continuity of Care	• Aetna Better Health of NJ will assist with coordination of services for members receiving active BH services previously determined to be medically necessary and scheduled. • Member will continue to receive services from existing Provider until a new plan of care is established by Aetna's clinical staff. • Aetna Better Health of NJ will work with the providers to ensure all necessary authorizations are entered into the system. • All services that are currently active with FFS will be transitioned over to the health plan prior to 1/1/2025. • In the event an Aetna member is a new enrollee and was receiving services that were approved by another MCO previously, Aetna will honor the existing approved authorization. Provider should follow the same Prior Authorization process outlined on preceding slides, but also include existing member's approved authorization in their submission request.	Medicaid
Out of Network (OON)	When a member needs a service that is not able to be provided through a contracted provider, we will authorize service through an out of network Single Case Agreement (SCA) and refer the provider to our Network staff for recruitment to join the provider network.	Both
SUD	All Phase 1 SUD authorization requests should go through the NJSAMS portal on January 1, 2025.	Both

Claims and Billing

Claims Submissions

For both Aetna Better Health of New Jersey and Aetna Assure Premier Plus (HMO D-SNP) the process is the same.

Please ensure **Payer ID# 46320** is listed on the claim.

Providers can submit claims in three ways:

Your Provider Claim Clearinghouse

- *Providers should verify their clearinghouse is compatible with ECHO using 837 file format.*

Availity

- To submit claims online via Availity, choose the button labeled "Medicaid Claim Submission – Office Ally." This link will take you directly to the Office Ally website where you can submit claims using their online claim entry feature or by uploading a claim file free of charge.

Paper Claims

- Mail to: P.O. Box 982967, El Paso, TX 79998-2967

Claims Fact Sheet

Topic	Description	Medicaid, HMO-DSNP, or Both
Claims Form Types	CMS 1500 or UB-04 (also known as CMS 1450)	Both
Clean Claim	A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or a third party.	Both
BH Medicaid Claims Processing Timeframes	• Electronically Submitted – within 15 calendar days of receipt • Manually Submitted – within 30 calendar days of receipt • All claims – with 45 days of receipt	Both
Corrected Claims	Claims must be submitted within 365 days from the date of service.	Both
Timely Filing	Claims must be submitted within 180 calendar days from the date of service.	Both
Common Claims Barriers	• 5010 Requirements (Rendering NPI and pay-to NPI; Both are required) • NDC Codes Missing or Incomplete for drugs • Lack of Prior Authorization	Both
Balanced Billing	Balance billing is strictly prohibited. You cannot bill members for any services that are covered by NJ Medicaid.	Both
Coordination of Benefits Non-Integrated Primary Plan	• Members must submit the primary insurance EOB along with claim for the secondary ABHNJ benefits to apply.	Medicaid
Coordination of Benefits FIDE Primary Plan	• Using the member’s ID number from the plan ID card, you’ll only need to submit one claim. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits. Medicare processing timeframes apply.	HMO-DSNP
Remittances	• You’ll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There’s no need to resubmit a secondary claim to Aetna.	HMO-DNSP

Grievances, Appeals & Disputes

No Wrong Door

Grievance, Appeals and Claim Dispute Submissions

Par providers can submit via Availity provider portal, phone, fax or mail:

	Aetna Better Health of New Jersey	Aetna Assure Premier Plus (HMO D-SNP)
Availity:	Provider Portal	Provider Portal
Phone:	855-232-3596	1-844-362-0934
Fax:	844-321-9566	855-883-9555 (Grievances and non-par)
Mail:	PO Box 81040 5801 Postal Road Cleveland, OH 44181	PO Box 982967 El Paso, TX 79998-2967
Forms:	Provider Appeal	Provider Dispute Form (Par)

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Appeals Fact Sheet

Topic	Description	Medicaid, HMO-DSNP, or Both
UM Appeals	Members, authorized representatives or Providers can file on a member's behalf and request a consideration to a decision.	Both
Submission Timing – Par	Appeals must be submitted within 90 calendar days from date on the Notice of Action. The expiration date to file an appeal is included in the Notice of Action.	Medicaid
Submission Timing - Par	Appeals for Medicaid services must be submitted within 60 calendar days from the date on the Notice of Action. Appeals for Medicare services should follow the dispute process.	HMO D-SNP
Submission Timing – Non Par	Non-Participating Providers have the right to appeal ABHNJ claims determination(s) within sixty (60) calendar days of receipt of the claim denial. To appeal ABHNJ claims determination(s), providers must utilize the Health Care Provider Application to Appeal a Claims Determination. For Aetna Assure Premier Plus (HMO-DSNP) the right to appeal claims is within sixty five (65) calendar days of receipt of the claim denial.	Both
Gaps	Incomplete or missing information may cause the decision to be upheld or returned to Provider.	Both
Decision Timing	Decisions are rendered within 30 calendar days of receipt.	Both
Levels	• Level 1 appeals are internally conducted for both participating and non-participating providers. • Level 2 ABHNJ appeals also called Alternative Dispute Resolutions may be initiated for an independent external binding arbitration process, on or before the 90th calendar day following the receipt of determination of an internal process. • Non-par Assure Premier Plus upheld appeals are automatically sent for to our Independent Review Entity. • More information can be found in the Provider Manual.	Both

Thank you!