Provider Newsletter

Aetna Opens Healthcare Central - a Medicaid Guidance Center in Newark's Central Ward

Aetna Better Health of New Jersey opened a first-of-its-kind Medicaid Guidance Resource Center in Newark's Central Ward. Healthcare Central connects Aetna Better Health of New Jersey Newark members, other Medicaid beneficiaries and the community at-large to vital resources. Visitors to the store can get help with:

- Signing up for NJ FamilyCare
- Understanding the NJ FamilyCare renewal process
- Assistance in finding a provider
- Understanding Aetna Better Health of New Jersey benefits
- Accessing social and community resources

In addition, Aetna Better Health distributes 400 bags of free fruits and vegetables once a month to anyone in the community. The food giveaway on the **4th Thursday of every month** from 1 to 5 p.m. at Healthcare Central.

48A Jones St., Suite C-101, Newark, NJ 07103
Store Phone Number: **959-299-3102** (TTY: **711**)
Store Hours: Monday through Friday 10 a.m. to 6 p.m.
aetnanewarkhealthcarecentral.com

About us

At Aetna Better Health of New Jersey, we believe that our members should have the opportunity to be leaders in their care. We are a state-contracted Medicaid managed care health plan that offers Medicaid services, Children's Health Insurance Programs (CHIP) and Managed Long Term Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties. For more information visit **aetnabetterhealth.com/nj** or call **1-855-232-3596**.

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Aetna Better Health® of New Jersey

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NJ-19-09-02

URGENT NEED - Lead Screen your Patients NOW

Earn $25 per completed lead test result
Lead exposure and lead poisoning are a significant public health concern in New Jersey. Aetna Better Health of New Jersey is committed to addressing this public health issue together with our providers.

All children should be screened:
- Once between 9 and 18 months, preferably at 12 months, and
- Once between 18 and 26 months, preferably at 24 months

For any child up to 72 months of age NOT tested once at 12 months and again at 24 months, or whose test history is unknown, testing should occur IMMEDIATELY.

Earn an incentive
We are offering a special incentive to providers who send us a completed lead test result. Earn $25 for lead tests completed in 2019: applies to one blood lead test per member per year, for members 9 months to 72 months of age. Fax completed lead tests to the plan directly at **959-282-1622**. Be sure to include your provider or practice NPI and TIN with all submissions.

For ease of testing, and to ensure that you take advantage of our Provider Incentive Program for Lead Screening, complete lead testing in your office using the less-invasive filter paper method - MedTox. Contact MedTox Representative Joe Huffer at **1-877-725-7241** or **hufferj@labcorp.com** to get your account set up today!

We strongly encourage you to use the fingerstick method, which ensures that testing is completed while the family is in your office.

Lead Case Management Program
Remember to refer lead burdened children to the plan's Lead Case Management Program, which emphasizes prevention, continuity of care, coordination of care, and links members to services as necessary across providers and settings. All children with elevated blood lead levels of 5 or greater should be reported to the plan. You can report a member with an elevated blood lead level to the plan by:
1. Calling Provider Services at **1-855-232-3596** or
2. Faxing the completed lead test(s) to the plan directly at **959-282-1622**. When faxing, please include a note indicating that you are referring the member for Lead Case Management.

Remember health maintenance visits should include a Verbal Lead Risk Assessment for every member between the ages of 6 months and 72 months to help identify any infant or child who has higher risk and should have immediate testing by blood lead level.

HEDIS Tip: A capillary or venous blood lead test should be completed on ALL children **before** their second birthday. A Verbal Lead Risk Assessment does not count as testing. Remember to send a claim using the Lead Screening CPT Code: **83655**

Questions? Contact Provider Services at **1-855-232-3596**.

Health Rewards Program - $15 OTC Gift Cards for Members

Our incentive program rewards members for completing certain health screenings with a $15 gift card. We offer preventive care at no cost to our members and reward them for taking steps to be healthier.

All Aetna Better Health of New Jersey members are eligible for the program. We currently offer $15 OTC gift cards to members who are eligible for and complete the following health screenings:
- Adolescent Well-Care (ages 12-21)
- Mammogram - Breast Cancer Screening (every year from age 40-74)
- Cervical Cancer Screening (pap test) (starting at age 20)
- Lead Screening (ages 0-6)
- Postpartum Care (7-84 days after having a baby. C-section may require two visits)

Gift cards are mailed directly to the members' home following the claim submission to Aetna Better Health.

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's incumbent on providers 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 our providers

As part of our cultural competency program, we encourage our providers 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. To access the program, visit **aetnabetterhealth.com/newjersey/providers/training/cultural**.

Keeping directory information up-to-date

Help us keep your practice information updated in the directory. Having a correct listing is a prerequisite for proper handling of your claims and is important in ensuring uninterrupted care for our members. The following elements are critical to the accuracy of your listing:

- Street address
- Phone number
- Ability to accept new patients
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory.

Update your directory information by submitting the spot check form online **https://medicaid.aetna.com/MWP/myaccount/viewProviderDocuments.**

Limitations regarding the billing of Medicaid/NJ FamilyCare (NJFC) beneficiaries

The practice of balance billing Medicaid/NJFC beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance.

A provider enrolled in the Medicaid/NJFC FFS program or in managed care is required to accept as payment in full the reimbursement rate established by the FFS program or managed care plan.

All costs related to the delivery of health care benefits to a Medicaid/NJFC eligible beneficiary, other than authorized cost-sharing, are the responsibility of the FFS program, the managed care plan, Medicare (if applicable) and/or a third party payer (if applicable).

If 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 except for amounts described on the Explanation of Benefit as member responsibility. To learn more about limitations regarding balance billing, visit **msnj.org**.

Source: The New Jersey Division of Medical Assistance and Health Services and the New Jersey Department of Health

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 and 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.

aetnabetterhealth.com/newjersey/providers/resources/rights

Reminder: 21st Century Cures Act

Effective January 1, 2018, the 21st Century Cures Act P.L. 114 - 255, required all Medicaid managed care network providers to register with the state Medicaid program or risk being removed from the Aetna Better Health provider network. Registration does not require you to provide service to NJ FamilyCare Fee for Service beneficiaries.

If you are already enrolled or registered with the state Medicaid program then no action is needed. If you are not, then to safeguard your status in the Aetna Better Health of New Jersey provider network, you must register in the state Medicaid program. The 21st Century Cures Act Enrollment Application should be submitted to Molina Medicaid Solutions (which manages provider enrollment) as soon as possible. Providers can continue to provide services to NJ FamilyCare members while the application to register is processed by Molina.

The link for the 21st Century Cures Act registration process can be accessed directly by using the following link: **www.njmmis.com**.

The application can be downloaded and forwarded to the NJ Medicaid Provider Enrollment office (through Molina) for processing. If you have questions about the 21st Century Cures Act Registration process for NJ FamilyCare, please contact the NJMMIS provider enrollment unit at **609-588-6036**.

The mailing address to submit the application and credentials is: Molina Medicaid Solutions Provider Enrollment P.O. Box 4804 Trenton, NJ 08650.

If you receive this information from multiple managed care plans, you only need to submit a single NJ Medicaid registration form. You may be asked to provide evidence to us of your submission, so you are encouraged to keep a copy of your application. If you have any additional questions regarding how or why you were identified as a provider who needs to register with in the NJ FamilyCare Program, please contact Provider Services at Aetna Better Health of New Jersey **1-855-232-3596**.

Telephone accessibility standards

Providers have the responsibility 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 Aetna Better Health of New Jersey 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 whatever after hours coverage is managed by the PCP, current service provider, or the on call provider.

All primary care providers must have a published after hours telephone number and maintain a system that will provide access to primary care providers 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) among members, their PCPs, and practice staff. 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 telephone protocols for all of the following situations:
  - Answering the member telephone 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)

Aetna Better Health of New Jersey routinely conducts audits to validate telephone accessibility standards are being met.

Appointment availability standards

The table below shows 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 care	Preventive and routine care	Wait time in office standard
Primary Care Provider (PCP)	Same day	Within 24 hours	Within 72 hours	Within 28 days[1]	No more than 45 minutes
Specialty Referral	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 4 weeks	No more than 45 minutes
Dental Care	Within 48 hours[2]	Within 3 days of referral	N/A	Within 30 days of referral	No more than 45 minutes
Mental Health/Substance Abuse (MH/SA)	Same day	Within 24 hours	N/A	Within 10 days	No more than 45 minutes
Lab and Radiology Services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

[1] Non-symptomatic office visits will include but will not be 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, for injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider.

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

Prenatal Care

Members must be seen within the following timeframes:

- 3 weeks of a positive pregnancy test (home or laboratory)
- 3 days of identification of high-risk
- 7 days of request in first and second trimester
- 3 days of first request in third trimester

Initial	
Initial Pediatric Appointments	Within 3 months of enrollment
Supplemental Security Income (SSI) and New Jersey Care (ABD & Disabled Members)	Each new member will be contacted within 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 10 business days of enrollment and offered an expedited appointment.

Maximum number of Intermediate/Limited Patient Encounters:

- 4 per hour for adults
- 4 per hour for children

Aetna Better Health of New Jersey's waiting time standards require that members, on average, should not wait at a PCP's office for more than 45 minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating a member with a difficult medical need, the waiting time may be expanded to one hour. The above access and appointment standards are provider contractual requirements. Aetna Better Health of New Jersey monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.