Aetna Better Health®
of New Jersey

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Provider Newsletter

Summer 2025

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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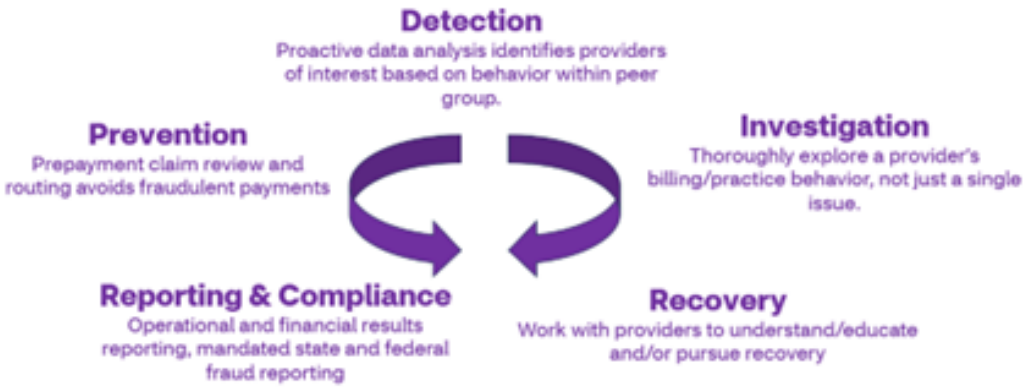
Suspect Fraud? Report it – Aetna's Special Investigations Unit (SIU)

Billions of dollars are lost to healthcare fraud each year.

It impacts the quality of healthcare and results in higher costs. The SIU is responsible for Aetna's anti-fraud program and leads the fight against health care fraud, waste, and abuse (FWA). Through our efforts to combat FWA, we help preserve the integrity and availability of healthcare resources. And that's how we help people on their path to better health.

Mission Statement

To protect the health and financial wellness of the people we serve by leading the fight against health care fraud, waste, and abuse as we help to build a healthier world.



Provider FWA

- Falsifying medical records
- Billing for services or items they didn't receive
- Giving services that members don't need (medically unnecessary)

Member FWA

- Lending, selling, or giving a health plan ID card to someone else
- Getting medicines or services they don't' need
- Forging or changing prescriptions from providers

Click to Report FWA

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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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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Healthy Homes/Housing Support Program

Aetna Better Health of New Jersey will place members in Healthy Homes program units according to the Healthy Homes Program Guidance issued by DMAHS to the Contractor before **January 1, 2024** and updated thereafter. Members placed in a Healthy Homes unit may be eligible for Housing Support once they become available. While members are waiting for housing, Aetna Better Health of New Jersey will evaluate the member for any other available services that would help maintain the member in the Healthy Homes unit prior to the expansion of Housing Support Services.

Our Housing Specialist will contact the members entering Healthy Homes units as well as coordinate available services. The Housing Specialist will work with other staff including care managers to integrate the services provided to the member in a Healthy Homes unit with any physical or behavioral health services the member may be receiving.

Aetna Better Health of New Jersey will also:

- Identify and prioritize members for placement in units allocated to the Contractor, according to timeframes identified in Healthy Homes Program Guidance
- Assist members to complete needed housing assessments and applications including acquiring necessary documentation and confirm member eligibility for Healthy Homes and the chosen housing unit
- Support members in their housing transition into a Healthy Homes unit
- Communicate regularly with DMAHS to support program function including quarterly reports on Healthy Homes member status to the DMAHS Office of Managed Healthcare
- Liaise with landlords as needed throughout the identification, placement and support processes

The Housing Supports program is a set of housing services created to ensure Medicaid/NJ FamilyCare members can live in a safe, healthy, and affordable home. The program is intended to provide much needed support to some of Medicaid's most vulnerable members including those with complex medical or behavioral health needs who are also homeless or at-risk of homelessness.The Housing Supports program consists of four services:

- Pre-tenancy Services (case management)
- Tenancy Sustaining Services (case management)
- Move-in Supports
- Residential Modification and Remediation Services

To be considered eligible for the Housing Supports program an individual must meet each of the following:

- Enrolled with an MCO
- Meet at least one social-risk criteria (homeless, at-risk of homelessness, transitioning from an institution, or recently released from correctional facilities)
- Meet at least one clinical-risk criteria (such as: chronic health condition, mental health condition, substance misuse, pregnancy, complex medical health due to disability, sexual / domestic violence, assisted living needs, repeated emergency use / hospitalization)

For detailed information on the Housing Supports program, please see the NJ FamilyCare Provider Guidance: https://camdenhealth.org/official-hsp-documents/

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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 (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 Member Services at **1-855-232-3596 (TTY: 711).**

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: • Complete a blood lead test at **12 months** old (between 9 and 18 months) • **AND** again at **24 months** old (between 18 and 26 months) • 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 Providers should educate parents/guardians regarding the importance of having their child tested for lead as well as keeping appointments 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. To view a list of questions, visit **aetnabetterhealth.com/newjersey/providers/resources/lead** 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 **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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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. Notify patients by text, phone or in the waiting room if there are wait time delays. This helps manage patient expectations. 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. 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. 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. 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: • someone from the doctor's office follow-up to give you those results? • 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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