



2024 Medicaid Provider Summit

Aetna Better Health® of Illinois

September 2024



All Aetna presentation materials are confidential and proprietary and may not be copied, distributed, captured, printed or transmitted (in any form) without the written consent/authorization of Aetna, Inc.

Agenda

Introductions & overview

Care management

Pharmacy

Business Enterprise Program

Community outreach

Marketing

2024 member value-added benefits

Quality management

Availity portal & reporting

Value-based partnerships

Tools & resources

Claims Corner

Provider escalations

Mandated training

Welcome from our senior leaders



Rushil Desai
Chief Executive Officer



Melanie Fernando
Chief Operating Officer



Dr. Lakshmi Emory
Chief Medical Officer



Dianne Robinson
Chief Financial Officer



Mary Cooley
Health Services Officer



Elizabeth Leonard
Executive Director, Marketing



Sally Szumlas
Chief Quality Officer



Fallon Moore-Huff
Chief Network Officer



Hassan Gardezi
Chief Compliance Officer



Andrew Hyosaka
Lead Director, Service Operations



Steve Sproat
Principal Clinical Leader, Pharmacy



Terriana Robinson
Lead Director, Provider Relations



Denise Gaines
Lead Director, Government Affairs



Shaan Trotter
Health Equity Officer

Introduction to our Provider Relations leadership



Terriana Robinson
Lead Director, Provider Relations



Christine Fox-Zapata
Senior Director, Provider Experience



Steve Inzerello
Senior Director, Provider Experience

Our footprint



**3200 Highland Avenue
Downers Grove, IL 60515**

**333 W. Wacker Drive
Chicago, IL 60606**

Our local approach

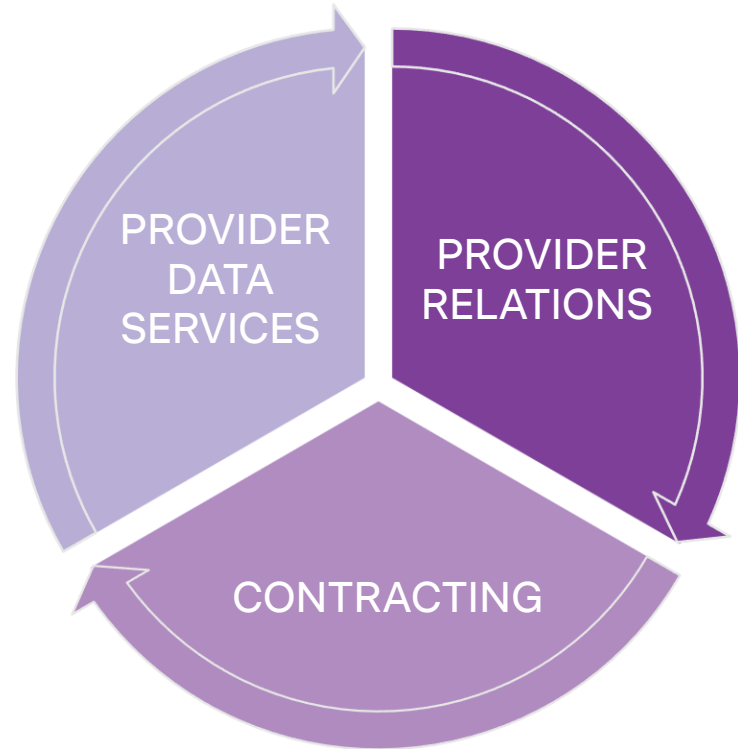
- **Illinois-based staff for local member and provider servicing**
- **Over 900 Illinois-based employees**
- **Currently serving approximately 368,000 Medicaid members in the State of Illinois**
- **Network of more than 46,000 providers statewide**
- **Dedicated, local contracting and provider relations staff, with Illinois-based executive leadership**

Who we are



- Aetna Better Health® of Illinois, a CVS Health® Company.
- Our mission: **Helping people on their path to better health**
- Taking care of the whole person—body, mind and spirit.
- Creating unmatched human connections to transform the health care experience

Provider network overview



Sr. Analyst, Network Relations (PR Rep):

Training & servicing for our provider network

Network Management Rep (Contracting Rep):

Contracting activities, SCA & settlement for our provider network

Top 10 reasons to connect with a provider network team member

1. For claims questions, inquiries and reconsiderations
2. To find a participating provider or specialist for referral or member inquiry
3. To request a change for provider demographics
4. To request assistance navigating or accessing our secure web portal
5. To schedule trainings, site visits and other provider meetings
6. For inquiries about joining the Aetna Better Health of Illinois network and requirements for participation
7. For questions related to contractual language or terms
8. For clarification or updates on bulletins or policies
9. To escalate concerns related to claims, demographics or authorizations
10. To request a copy of your Provider Data Setup and/or Participating Provider Agreement

Locating your network relations representative



Outreach to Provider Relations via email
ABHILProviderRelations@aetna.com



Locate your assigned rep via our online assignment listing:
[AetnaBetterHealth.com/illinois-medicaid/providers/provider-resources.html](https://www.aetnabetterhealth.com/illinois-medicaid/providers/provider-resources.html)



Outreach to Provider Services via phone
1.866.329.4701

Network Relations contact information and coverage areas

Aetna Better Health® of Illinois takes great pride in our network of physicians and related professionals who serve our members with the highest level of quality care and service. We are committed to making sure our providers receive the best and latest information, technology and tools available to ensure their success and their ability to provide for our members. We focus on operational excellence, constantly striving to eliminate redundancy and streamline processes for the benefit and value of all our partners.

Our Network Relations Team is assigned to designated areas throughout the state and are located within the communities in which they serve. This team is dedicated to meeting the needs of our providers. We are subject matter experts and are available to providers for education, training and support. We assign every participating provider a Network Relations Manager or a Network Relations Analyst.

Network Relations Managers are assigned to specific providers identified below. If a provider is not identified below, they will work directly with their Network Relations Analyst. All Network Relations Analysts are assigned by county/zip. If you are unable to locate your county/zip below, please send email communication (including TIN) to ABHILProviderRelations@aetna.com.

Aetna Better Health of Illinois offers a provider services line by calling **(866) 329-4701** (Monday through Friday 7 AM-7 PM)

Please submit demographic updates by sending the completed IAMHP roster to:
ABHILProviderUpdateRequests@AETNA.com

General Questions, Forms, and ERA/EFT enrollments can be sent to:
ABHILProviderRelations@aetna.com

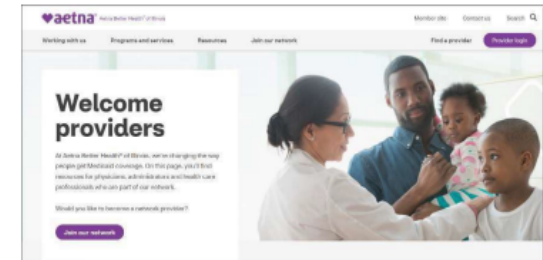
Save time by accessing our online resources
Be sure to check out our convenient web tools, available 24/7.

Health plan website

The health plan website is a resource for members and providers. Providers will find information such as the member handbook, provider manual and the formulary on the health plan website: <https://www.aetnabetterhealth.com/illinois-medicaid/providers>

Availity

Aetna Better Health of Illinois is excited to have transitioned from our Provider Portal to Availity. This transition allows for an increase in digital interactions available to support you as you provide services for. Once you are registered you can go to <https://apps.availity.com/availity/web/public.elegant.login> and sign on. The Availity Learning Team offers regularly scheduled live webinars on a variety of topics.



Mandatory IMPACT Revalidation

Mandatory



Revalidation

All Medicaid providers must revalidate their enrollment

Important notes

- Starting in September 2024, all providers will be required to revalidate based on their enrollment date.
- Revalidation notices will be sent in rolling stages and regular every-five-year revalidation will be ongoing. Providers are encouraged to watch their email inbox for revalidation instructions. Currently enrolled Medicaid providers will receive two email notifications: 90 days and 30 days before their Revalidation Due Date.
- Failure to revalidate will result in a provider being removed from Medicaid. When removed, providers will not be able to bill for some of their most vulnerable patients and clients.
- Authorized staff may complete the revalidation on behalf of a provider. Instructions for individuals and organizations are [available here](#).

HFS will offer virtual information sessions to support providers with revalidation and answer questions. Sessions will be offered on the dates shown below. [Register here.](#)

- **September 5, 10-11 AM**
- **September 26, 1:30-2:30 PM**
- **October 24, 3-4 PM**

Need more info?

More information about revalidation — including a list of Frequently Asked Questions — is available from HFS at HFS.Illinois.gov/Impact.

Providers who need assistance completing their revalidation may call HFS Provider Enrollment at **1-877-782-5565**.

Care management

Care management

Role of care management:

- Assess, educate, advocate, connect.
- Integration of services across continuum of care
- Holistic
- Support the member and provider plan of care.

How to refer to care management

Providers can also refer members to our care management programs. These programs support members and provide information, resources, and advocacy to help members control their diabetes, heart disease and asthma among other complex conditions to achieve their integrated health goals.

To refer for Care Management, please call [1-866-329-4701](tel:1-866-329-4701) and request a care manager or email ABHILCOMMUNITYCMFAX@aetna.com




Health Risk Screener (HRS): provider partnership

Goal: Collaborate with Aetna Better Health® of Illinois to understand member's whole health and enhance delivery of quality care

Provider support requested: Outreach to new members within first 60 days of enrollment to complete the HRS to support continuity, quality and access to timely care. Once completed, fax to **1-877-668-2075** or send to ABHILCommunityHealth@aetna.com

Partnership benefits:

- Provides additional insight into member's overall health and identifies personal health challenges and barriers
- Outreach encourages new members to schedule appointments with their PCP as soon as possible
- Enrolls high-risk members into a care management program to ensure care continuity and coordination
- Improves quality of care by actively engaging members to complete screenings, monitor medication adherence, and reduces barriers to care
- Enables providers to offer HRS during scheduling to make HRS more accessible to members
- Offers members and providers incentives for their support in completing HRS

Aetna Better Health® of Illinois
Health Risk Screening (HRS) 

Tell us about your health. We use your HRS to find out about any health changes you've had. By having this information, we can meet your specific health needs with any additional services or assistance. If you would like to answer these questions by phone, please call Aetna Better Health of Illinois at 1-866-329-4701 (TTY:711). Please have your insurance card with you as we will need your Member ID number from the front of the card.

Member Information (Please circle selection) **Risk:** Intensive / Supportive / Population health **Region:** 1 / 2 / 3 / 4 / 5 **Refer to:** RN / BH / CMC

*Member Name (Last, First)

*Member ID *Date of Birth (MMDDYYYY)

*Preferred Phone Number -

*Email Address

Provider playbook:



Provider
Playbook

Notification of Pregnancy (NOP): Provider partnership

Goal: Collaborate with Aetna Better Health® of Illinois to understand member's whole health and enhance delivery of quality care

Provider support requested: During the first Prenatal visit complete the *Maternity Notification and Risk Screen* form and fax to 1-833-799-1463 or send to ABHILNotifyPregnancyNOPFax@AETNA.com .

Partnership benefits:

- Provides additional insight into member's overall health and identifies personal health challenges and barriers
- Outreach encourages members to schedule appointments with their Maternal specialist as soon as possible and for prenatal care.
- Improves quality of care by actively engaging members to complete screenings, monitor medication adherence, and reduces barriers to care
- Enables providers to offer NOP during scheduling to make the NOP more accessible
- Offers members and providers incentives for their support in completing NOP

Aetna Better Health® of Illinois

Maternity Notification and Risk Screen

Date: _____

Please complete this form during the first prenatal visit for all insured members. Completed forms may be faxed to 1-833-799-1463 or sent to ABHILNotifyPregnancyNOPFax@AETNA.com. If you have questions or would like to speak to an OB care manager, please call 1-866-329-4701.

Demographics

Patient Name:	Date of Birth:	ID#
Address (Physical Address: Street, Apt #, State, Zip): [REDACTED]		
Home Phone:	Cell Phone:	Race/Ethnicity:
Preferred Spoken Language:		Preferred Written Language:

Patient History

Date Initiated Prenatal Care:	LWP:	EDC:	Sonogram performed (date):
Pre-Pregnancy Weight: (lbs.)	Current Weight: (lbs.)	Height: (in)	
Gravida:	Para:	Live Births:	Ectopic: Enrolled in WIC: <input type="radio"/> <input type="radio"/>
Obstetrician:		OB Provider ID:	
Office Phone:		PCP:	

Risk Assessment-Current Pregnancy

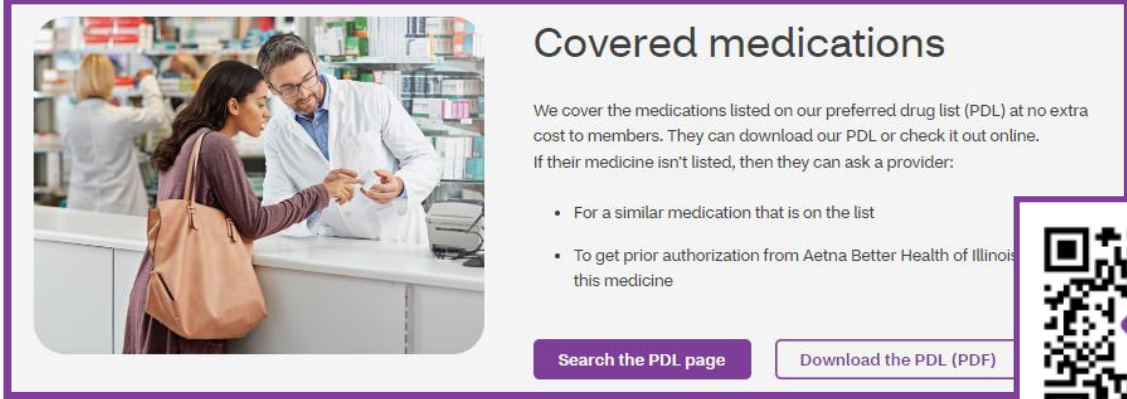
<input type="radio"/> Planned C-Section	Indication:			
Current Dx: <input type="checkbox"/> IUGR	<input type="checkbox"/> Incompetent Cervix	<input type="checkbox"/> Uterine Abnormality	<input type="checkbox"/> Maternal Bleeding	<input type="checkbox"/> Preeclampsia
<input type="checkbox"/> Multiple Fetus	<input type="checkbox"/> HTN	<input type="checkbox"/> Renal Infection	<input type="checkbox"/> Depression	<input type="checkbox"/> Nutritional deficit

Pharmacy

Pharmacy resources

Preferred drug list

- Drug list available in PDF format as well as in the Aetna search tool.

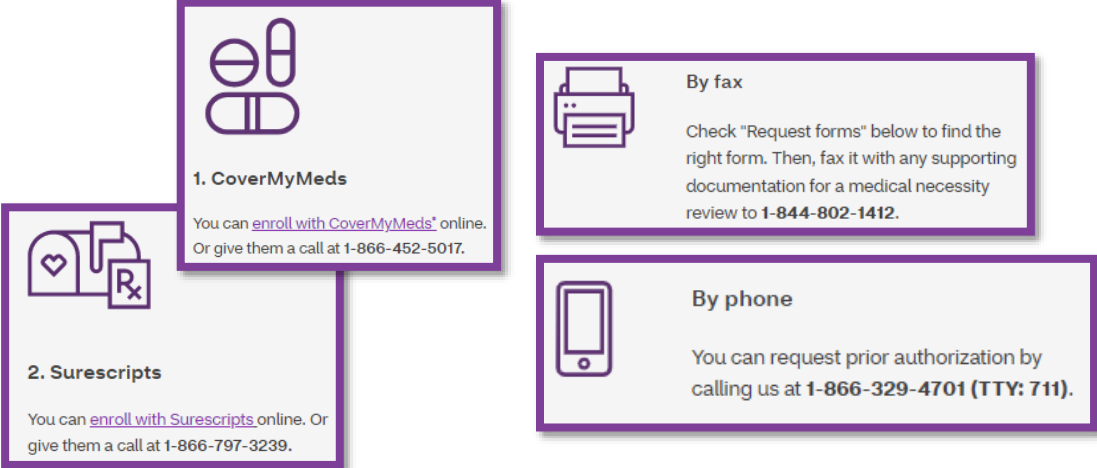


The screenshot shows a webpage titled "Covered medications". On the left is a photo of a pharmacist assisting a customer. The main text states: "We cover the medications listed on our preferred drug list (PDL) at no extra cost to members. They can download our PDL or check it out online. If their medicine isn't listed, then they can ask a provider:" followed by two bullet points: "• For a similar medication that is on the list" and "• To get prior authorization from Aetna Better Health of Illinois this medicine". Below the text are two buttons: "Search the PDL page" and "Download the PDL (PDF)". On the right side of the screenshot is a QR code with a purple heart in the center.

<https://www.aetnabetterhealth.com/illinois-medicaid/providers/pharmacy.html>

Medication prior authorization resources

- All Rx prior authorizations reviewed within 24 hours.
- Full PA criteria are available on the provider website.
- All criteria are preloaded into CoverMyMeds in question format.



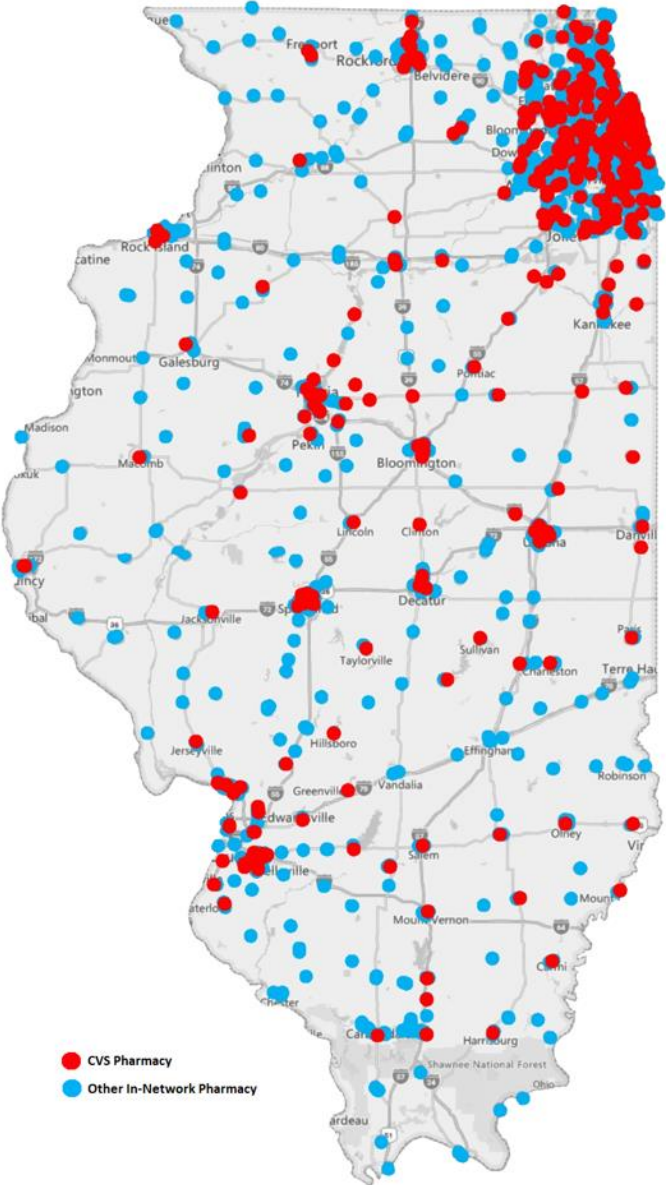
The infographic consists of four boxes with icons and text:

- 1. CoverMyMeds**: Icon of two pills. Text: "You can [enroll with CoverMyMeds](#) online. Or give them a call at 1-866-452-5017."
- 2. Surescripts**: Icon of a heart, a document, and a prescription symbol. Text: "You can [enroll with Surescripts](#) online. Or give them a call at 1-866-797-3239."
- By fax**: Icon of a printer. Text: "Check 'Request forms' below to find the right form. Then, fax it with any supporting documentation for a medical necessity review to **1-844-802-1412**."
- By phone**: Icon of a smartphone. Text: "You can request prior authorization by calling us at **1-866-329-4701 (TTY: 711)**."

2024-2025 Flu and COVID vaccines now available at our in-network pharmacies

Drug ID (NDC)	Product/Drug Label Name
33332-0124-10	AFLURIA INJ 2024-25
70461-0024-03	FLUAD INJ 2024-25
58160-0884-52	FLUARIX INJ 2024-25
49281-0724-10	FLUBLOK INJ 2024-25
70461-0654-03	FLUCELVAX INJ 2024-25
19515-0810-52	FLULAVAL INJ 2024-25
49281-0124-65	FLUZONE HD INJ 2024-25
49281-0424-50	FLUZONE INJ 2024-25

Drug ID (NDC)	Product/Drug Label Name
00069-2432-10	COMIRNATY INJ 2024-25
80777-0110-96	SPIKEVAX INJ 2024-25



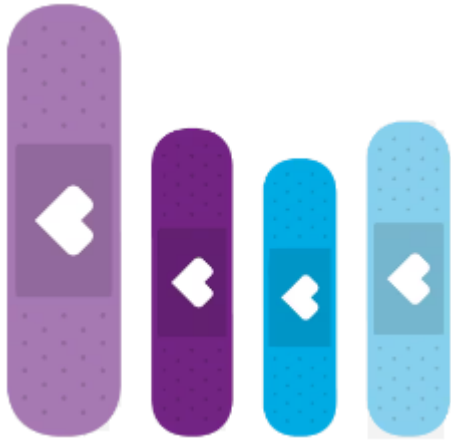
Health Tag campaign (8/30/2024 – 11/28/2024)

A message from Aetna Better Health of Illinois.
 Great news! Your health plan covers flu shots in addition to COVID-19 vaccines and Boosters at no cost to you.

- Both the flu and COVID-19 can cause mild to severe illness and be harmful to young children, older adults, and people with health conditions
- COVID-19 boosters help improve protection against the virus, as immunity begins to lessen over time.

Protect yourself! Talk with your provider, pharmacist, or MinuteClinic to learn more.

Schedule an on-site vaccine clinic with CVS Health®



To initiate a request, begin by creating an account using the Vaccine Clinic Scheduler (VCS) using the link:

[Vaccine Clinic Scheduler \(cvs.com\)](https://www.cvs.com/vaccine-clinic-scheduler)

- Facility must be within 30 miles of a CVS Pharmacy® in the same state.
- The minimum number of immunizations for a vaccine clinic is 48.
- Clinics must be requested a minimum of 28 days in advance.
- Clinic length is determined by the rate of 12 appointments per immunizer per hour.
- Digital appointment registration is available for clinic participants, which includes request for insurance/voucher information and consent for services. Otherwise, a PDF version of the consent form can be requested from your local point of contact.

OTC Health Solutions

- Members receive a \$25 monthly benefit
- Products can be ordered via:
 - In-store CVS location
 - Online
 - By Phone
- No prescription required
- No cost to Aetna members



OTC Healthy Foods

OTC Health Solutions has been expanded to now include **OTC Healthy Foods**.

The new program adds over 200 food items to the OTC Health Solutions Program.

Members will continue to receive the \$25 monthly, which can be spent on both OTC and food items.

ISOTONICS	CANNED FRUIT/VEGETABLES	PASTA/SAUCE
JUICE AND DRINKS	NUTS	SHELF STABLE SEAFOOD
EGGS	COFFEE/TEA	SOUP
MILK AND MILK ALTERNATIVES	CONDIMENTS	SUGAR SUBSTITUTE
BREAD & PASTRY	DESSERTS	COOKIES/CRACKRS
BAKING NEEDS	DRY GROCERY	HEAT & SERVE
BREAKFAST	ETHNIC FOOD	HEALTHY SNACKS



Business Enterprise Program (BEP)

Business Enterprise Program (BEP) overview

What is BEP?

- Business Enterprise Program (BEP) was established in 1989 to serve the State of Illinois's interest in promoting open access in the awarding of State contracts to disadvantaged small business enterprises.
- The Business Enterprise Program for businesses owned by minorities, women, and persons with disabilities is committed to fostering an inclusive and competitive business environment that will help business enterprises increase their capacity, grow revenue, and enhance credentials.

Who can become certified?

- Businesses **at least 51% owned and controlled** by a **minority** or **woman** or designated as a **disabled business** are eligible. The owner must be a **United States citizen** or resident alien and the business must have an annual gross sale of **less than \$150 million**. Applications must be submitted and fully approved to receive certification.



What are the benefits?

- A BEP certification is nationally recognized and can open doors for additional business opportunities. All BEP certified companies are listed within the CMS BEP directory which is used by multitudes of cross-industry businesses seeking diverse suppliers. BEP certification is no cost and ABH IL offers certification support at no cost as well.

Community outreach

Community events

Each month our team hosts events across Illinois including:

- Health and resource fairs
- Fresh produce giveaways
- Laundry & Literacy events
- And more

Get each month's schedule at

[AetnaBetterHealth.com/IL-Medicaid](https://www.aetna.com/better-health/illinois)

Interested in hosting an event? Send an email to ABHILCommunity@aetna.com.



2024 Signature event schedule

Date	Event	Event description
July	Back-to-School Events	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, family-friendly activities and provide back-to-school supplies.
August	Laundry & Literacy Events	Laundry & Literacy events support basic living needs and encourages healthy living. Events include health awareness education, community resources, free laundry services and childhood literacy development.
September	Fresh Produce Giveaways	These events aim to combat food insecurity within underserved communities throughout the state. The health plan will partner with youth organizations, park districts, libraries and subsidized housing authorities to provide community members access to fresh produce.
October	Pamper Me Pink	Pamper Me Pink events are designed to educate, encourage, and coordinate access for community members to receive or schedule mammograms and raise awareness on the impact of breast cancer.
November	Giving Thanks for Your Health Resource Fair	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, family-friendly activities and holiday themed food boxes.
December	Winter Wellness Health & Resource Fair	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, family-friendly activities and cold weather gear.

Value-added benefits

2024 Value-added benefits

Baby essentials

- Car seat or highchair or play yard, plus a diaper bag
- \$45 a month to spend on diapers for each child 30 months and under

Behavioral health wellness app

- Voucher for digital behavioral health wellness support for ages 12 and older

Fitness and weight management

- Voucher for monthly memberships at participating gyms. Digital membership for ages 13 and up; Digital or in-person membership for ages 18 and older
- Personalized nutrition counseling for ages 18 and older. Members may also qualify for food assistance.
- Voucher for digital weight management support for ages 18 and older

School clothes

- Voucher for clothing for members in grades K-12 (ages 5-18)

Educational support

- Career training, skill building and GED support for ages 18 and older

Members may qualify for value-added benefits when they complete certain wellness activities such as:

- **Health risk screening**
- **Annual wellness visit**
- **Immunizations**
- **Prenatal visits**

Learn more about how members can qualify at

[AetnaBetterHealth.com/
Illinois-Medicaid/Whats-Covered](https://www.aetna.com/illinois-medicaid/whats-covered)

Quality and practice performance

Our quality mission

The Aetna Better Health of Illinois Quality Program strives to design intervention through the lens of health equity that improve the health outcomes of our members and optimize their experience across the healthcare eco system.

Provider enablement strategies

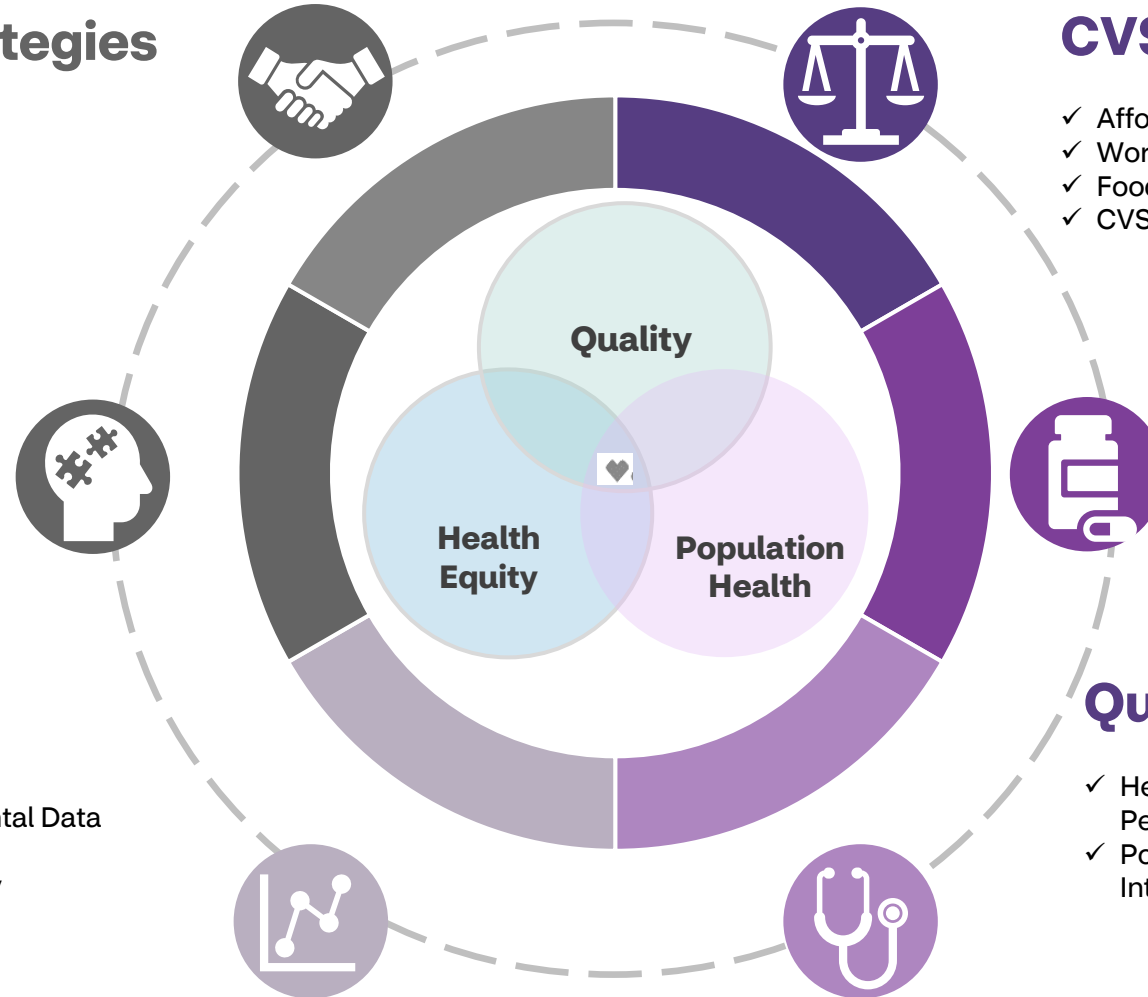
- ✓ Value-Based Contracting
- ✓ P4P Program

Clinical solutions

- ✓ Community Health Workers as Trusted Resources
- ✓ Culturally Competent Clinicians and Providers
- ✓ Care Management and Embedded CMs

Data & technology

- ✓ Health Equity & SDOH Assessments
- ✓ Health Information Exchanges (HIEs), Supplemental Data System (SDS) Feeds
- ✓ Improved Provider Portal and Reporting Capacity



CVS community solutions

- ✓ Affordable Housing Investments
- ✓ Workforce Initiatives
- ✓ Food Insecurity Solutions
- ✓ CVS MinuteClinics

Pharmacy

- ✓ CBO Partners with Rx Delivery in Rural and Hard to Reach Members
- ✓ Health Tag reminders with Rx for Open Gaps in Care

Quality management

- ✓ Health Equity Accreditation and Focus on Advancing Performance to Standards
- ✓ Population Health Model Leveraging Multi-channel Interventions in Sub-Populations

Bringing the quality strategy to life

Our approach begins with identifying the unique needs of the member and solutions at all levels of influence



Cancer prevention interventions support

Let's coordinate an onsite Roseland Mobile mammography event

The details:

- Complete event inquiry form by **scanning QR code below**
- If event can be supported, Roseland coordinator, Dr. Penny Dodson (Aetna), & provider intake meeting will be scheduled
- Onsite events can support up to 20 patients; scheduling is 9:00am – 2:00pm
- **Member double incentive: \$50 if completed before 11/1/2024**



equal  hope

Equal Hope outreach campaign targeting high-risk CCS & BCS

- New community-based partnership
- Outreach campaign started on 8/1/2024
- Member list targets high-risk CCS and BCS members across the state
- Provides comprehensive support throughout the continuum of the member's cancer care journey (initial outreach, SDOH assessment, screening appointment scheduling, appointment reminders, navigate a positive screening diagnosis and treatment, annual follow-up screening, etc.)
- Aetna outreach campaign kicked off 8/15/2024 to collect BCS orders and preferred screening facility
- **Member double incentive for both or either CCS and BCS: \$50 completed for each before 11/1/2024 & \$100 for completing both by 11/1/2024**

ABHIL Healthy Kids 2024 Initiatives

Provider enablement

- P4Q Incentives are available for well-child visit measures. Payments will be made in Q2 2025 for services rendered in 2024.

Measures, targets and payment tiers							
Measure	Submeasure	33rd Percentile	50th Percentile	75th Percentile	Tier 1 33rd	Tier 2 50th	Tier 3 75th+
Well-Child Visits 3-11 Years	WCV 3-11	52.40%	55.66%	62.89%	\$10	\$10	\$20
Well-Child Visits 12-17 Years	WCV 12-17	45.57%	49.20%	56.32%	\$10	\$10	\$20
Well-Child Visits 18-21 Years	WCV 18-21	21.72%	24.02%	29.23%	\$10	\$10	\$20
Well-Child Visits 0-14 Months	W15 6+	55.21%	58.38%	63.34%	\$15	\$15	\$30
Well-Child Visits 15-30 Months	W30	63.73%	66.76%	71.35%	\$15	\$15	\$30

- Eblasts and newsletter articles on immunizations, well-child visits, and Availity resources for providers
- Webinar opportunities

Member outreach

- ABHIL partners with Member Services for targeted outreach calls to non-compliant members to close care gaps monthly
- Special focus is given to outreach and events in localities identified as having high concentrations of pediatric members with 3 or more open quality care gaps
- ABHIL participates in the Pfizer Vaccine Adherence in Kids (VAK) postcard program, a national program for kids from birth to 24 months who have either missed vaccine dose(s) or need reminder of upcoming well-child visits
- Members can receive incentives: \$25 for WCV 3-21 and \$10 for WCV 0-30 mos. per calendar year

Host a community event!

Join an **ABHIL event** near you or host your own. Your Practice Transformation Advisor or QPL can assist with scheduling and coordination.



Healthcare Effectiveness Data and Information Set

Measuring health plan quality

HEDIS® - Healthcare Effectiveness Information Data Set

- **96 standardized, population-based measures in 6 domains**
- Illinois Health Choice contract requires reporting on 38 HEDIS® measures and sub measures (6 non-HEDIS®).
- Reported annually for prior calendar year, benchmarked nationally by NCQA
- Make improvements to quality of care and services
- Award accreditation status to health plans that assists customers in selecting health plans and providers
- Publicly reported and displayed on national and state level report cards

CAHPS® - Consumer Assessment of Health Care Providers and Systems

- Surveys consumers and patients to report on and evaluate health care experiences
- Randomized population of ~**2,000 members** with 6 months' continuous enrollment
- Survey period February to May
- Reported annually for current calendar year

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

NCQA health plan ratings and summary score

- Calculated STARS based on **percentile rankings of HEDIS® and CAHPS subsets**
- Published annually in October
- Annual 'Accreditation Status' (summary score) updated based on measure rankings



HEDIS® reporting cycle

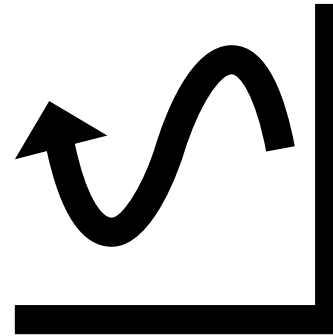
Measurement year

The year in which the HEDIS® services are completed

2024 measurement year

During the measurement year, Aetna Better Health® of Illinois works with providers to close gaps in care before year end

- **HEDIS® hits*** may be captured using **administrative data** (claims, pharmacy, or supplemental data)
- Engage members early and code accurately, including CPT II's
- Align practice with evidence-based management
- Utilize Availity reports daily



Reporting year

The year the completed HEDIS® services will be reported to NCQA

2025 reporting year

Though services must be completed in 2024, a retrospective review of the services will continue from **January to April of 2025**

- This is what most providers and health plans recognize as “**HEDIS® Hybrid season**”
- HEDIS® hits may be captured using **hybrid data** a combination of administrative data and medical record review
- Year Round **EMR** access and Year-Round chart retrieval

2024 P4P

Pay-for-Performance overview

2024 Pay-for-Performance Program

Eligibility

Participating providers with a member panel of 100 or more are eligible. Incentive earning now begins in each measure by reaching the 33rd percentile for gap closure performance.

P4P targets and benchmarks

Providers will receive financial incentives for completing services on several HEDIS[®] measures. There are three tiers of payment:

- Reaching the 33rd percentile
- Reaching the 50th percentiles
- Reaching or exceeding the 75th percentile

Per Member incentives are issued at a flat rate for the measurement year.

First payments will be made in Q3 2024 for services rendered in 2024.

Measures, targets and payment tiers							
Measure	Submeasure	33rd Percentile	50th Percentile	75th Percentile	Tier 33rd	Tier 2 50th	Tier 3 75th+
Adult access to primary care	AAP	69.59%	72.91%	78.08%	\$10	\$10	\$20
Breast Cancer Screening	BCS	48.06%	52.20%	58.35%	\$25	\$25	\$50
Blood Pressure Control for Patients with Diabetes	BPD	59.85%	63.99%	70.07%	\$25	\$25	\$50
Childhood Immunization Status (Combo 10)	CIS	26.76%	30.90%	37.64%	\$50	\$50	\$100
Controlling High Blood Pressure	CBP	57.66%	61.31%	67.27%	\$25	\$25	\$50
Hemoglobin A1c<8	HBD	49.39%	52.31%	57.18%	\$25	\$25	\$50
Immunizations for Adolescents (Combo 2)	IMA	30.66%	34.31%	40.88%	\$35	\$35	\$70
Pharmacotherapy for Opioid Use Disorder	POD	23.38%	28.49%	33.85%	\$25	\$25	\$50
Well-Child Visits 3-11 Years	WCV 3-11	52.40%	55.66%	62.89%	\$10	\$10	\$20
Well-Child Visits 12-17 Years	WCV 12-17	45.57%	49.20%	56.32%	\$10	\$10	\$20
Well-Child Visits 18-21 Years	WCV 18-21	21.72%	24.02%	29.23%	\$10	\$10	\$20
Well-Child Visits 0-14 Months	W15 6+	55.21%	58.38%	63.34%	\$15	\$15	\$30
Well-Child Visits 15-30 Months	W30	63.73%	66.76%	71.35%	\$15	\$15	\$30
Annual Flat Rate Per Member							
Cervical Cancer Screening	CCS						\$50
Follow-Up After ED Visit for Alcohol	FUA (30-Day: 18+)						\$80
Follow-Up After ED Visit for Alcohol	FUA (7-Day: 18+)						\$80
Follow-Up After ED Visit for Mental Illness	FUM (30-Day: 6-17)						\$80
Follow-Up After ED Visit for Mental Illness	FUM (7-Day: 6-17)						\$150
Follow-Up After Hospitalization for Mental Illness	FUH (30-Day: 18-64)						\$80
Follow-Up After Hospitalization for Mental Illness	FUH (7-Day: 18-64)						\$150
Follow-Up After Hospitalization for Mental Illness	FUH (30-Day: 6-17)						\$80
Follow-Up After Hospitalization for Mental Illness	FUH (7-Day: 6-17)						\$150
Postpartum Care	PPC						\$50
Timeliness of Prenatal Care	TOPC						\$50

* Value-Based Contracted providers must continue to see at least 50% of their assigned membership during the measure year.

Partnership bonuses

Health Risk Survey (HRS) completion



- Providers will receive \$25 for every HRS completed for a new member in the first 60 days.
- Providers can also receive \$10 per HRS completed for all other members.

[Adult Link to Form](#)
[Child Link to Form](#)

Notification of Pregnancy



- In addition to the Timeliness of Prenatal Care measure performance, providers can earn \$30 per notification of pregnancy.

[Link to Form](#)

Data exchange



- Providers with more than a thousand members will receive a one-time \$1,000 bonus for a new supplemental data source (SDS)

Assess and enter Z-code (Z59.x) for problems related to housing and economic circumstances

- Providers will receive an additional \$25 per member per day for entry of this code.

[Link to Form](#)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

CPT II coding to optimize your earning potential

Opportunities

- The **Quality Care Gaps report is live in Availity** and updated monthly, the report empowers you to:
 - See members with open care gaps assigned to your practice
 - Correct claims with data gaps by adding appropriate CPT II codes
 - Correct 'Provider Pay To' location address
 - Watch your earnings grow

Measures

- Diabetes - Blood Pressure Control (<140-90) (BPD)
- Diabetes – Hemoglobin A1c Control (<8) (HBD)
- Blood Pressure (CBP)
- Childhood Immunizations (CIS CO10)
- Immunizations for Adolescents (IMA CO2)

2024 HEDIS Reference Tool



AETNA
HEDIS REFERENCE TOOL
HRT

Numerator codes for CDC

There is a large list of approved NCQA codes used to identify services included in the CDC measure. Below are a few of the approved codes. For a complete list, see [NCQA.org](https://www.ncqa.org).

Diabetes diagnosis

ICD- 10	E10.9	Type 1 diabetes mellitus without complications
ICD- 10	E11.9	Type 2 diabetes mellitus without complications
ICD- 10	E13.9	Other specified diabetes mellitus without complications

HbA1c tests

CPT	83036; 83037	HbA1c tests
-----	--------------	-------------

HbA1c levels: the most recent results

CPT	3051F	HbA1c level greater than/equal to 7.0 and less than 8.0
CPT	3052F	HbA1c level greater than/equal to 8.0 and less than/equal to 9.0
CPT	3046F	HbA1c level greater than 9.0
CPT	3044F	HbA1c level less than 7.0

Example HEDIS tip sheets
[Link to HEDIS Tip Sheets](#)

Numerator codes for CBP

There is a large list of approved NCQA codes used to identify services included in the CBP measure. Below are a few of the approved codes. For a complete list, see [NCQA.org](https://www.ncqa.org).

Identifying Patients with Hypertension

ICD-10	I10	Essential primary hypertension
--------	-----	--------------------------------

Identifying Representative Blood Pressure

CPT	3077F	Systolic Greater Than/Equal To 140
CPT	3074F	Systolic Less Than 130
CPT	3075F	Systolic 130-139
CPT	3079F	Diastolic 80-89
CPT	3080F	Diastolic Greater Than/Equal To 90
CPT	3078F	Diastolic Less Than 80

Supplemental Data Exchange (SDS)

Supplemental Data Exchange (SDS)



Questions?

Contact your Quality Practice Liaison (QPL) for support to set up an SDS feed

ABHILQUALITYOUTREACH@AETNA.com

New 2024 Program

- Providers with more than a thousand members will receive a one-time \$1000 bonus for new Supplemental Data Sources.

SDS -Supplemental data exchange

- A standardized tool used to capture HEDIS data in a flat (readable) file format.
- Simplifies data sharing between Providers and ABHIL
- Set up directly with ABHIL

Goal

- Can help providers meet pay-for-performance (P4P) goals

Set-up guide

- The guide can be emailed to you upon request

Data sharing requirements

- Medical records reporting requirements must be adequate to provide for acceptable Continuity of Care to members
- Managed File Transfer form (MFT) – needed for SFTP set up
- Supplemental Data Source Requirement Document – information about the Provider and data
- Medicaid Supplemental Data Layouts – Required layout for data feeds

Availity Reporting

—

Quality

Availity P4P provider reporting

Measure Description	Provider Numerator	Provider Denominator	Provider Rate	Plan Rate	Provider Tier	Tier 1 33rd-50th	Tier 2 50th-75th	Tier 3 75th+	Current Earnings	Max Earnings	Total # Needed to Reach 33%ile	Total # Needed to Reach 50%ile	Total # Needed to Reach 75%ile	Achieved Tier 1	Achieved Tier 2	Achieved Tier 3
Adult Access to Preventive/Ambulatory Health Services	2,847	7,102	40.09%	39.43%		\$10	\$10	\$20	\$0.00	\$142,040	2,096	2,332	2,699			
Breast Cancer Screening	331	767	43.16%	38.17%		\$25	\$25	\$50	\$0.00	\$38,350	38	70	117			
Blood Pressure Control for Patients With Diabetes	267	711	37.55%	18.35%		\$25	\$25	\$50	\$0.00	\$35,550	159	188	232			
Controlling High Blood Pressure	328	960	34.17%	18.76%		\$25	\$25	\$50	\$0.00	\$48,000	226	261	318			
Cervical Cancer Screening	1,507	3,102	48.58%	37.41%		\$25	\$25	\$50	\$0.00	\$155,100	149	265	411			
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	144	711	20.25%	10.52%		\$25	\$25	\$50	\$0.00	\$35,550	208	228	263			
Childhood Immunization Status – Combo 10	28	203	13.79%	12.66%		\$50	\$50	\$100	\$0.00	\$20,300	27	35	49			
Follow-Up After ED Visit for Alcohol – 30 day (18yrs +)	13	37	35.14%	28.98%	33rd-49th	\$40	\$40	\$80	\$520.00	\$2,960	0	1	3	Y		
Follow-Up After ED Visit for Alcohol 7 day (18yrs +)	9	37	24.32%	19.55%	33rd-49th	\$40	\$40	\$80	\$360.00	\$2,960	0	1	3	Y		
Follow-Up After Hospitalization for Mental Illness - 30 day ages 18 – 64 yrs	14	49	28.57%	35.60%		\$40	\$40	\$80	\$0.00	\$3,920	9	11	17			
Follow-Up After Hospitalization for Mental Illness – 30 day ages 6 – 17 yrs	3	5	60.00%	62.56%		\$40	\$40	\$80	\$0.00	\$400	1	1	1			
Follow-Up After Hospitalization for Mental Illness - 7 day ages 18 – 64 yrs	8	49	16.33%	20.54%		\$75	\$75	\$150	\$0.00	\$7,350	5	7	12			
Follow-Up After Hospitalization for Mental Illness - 7 day ages 6 – 17 yrs	2	5	40.00%	38.39%		\$75	\$75	\$150	\$0.00	\$750	1	1	1			
Follow-Up After ED Visit for Mental Illness – 30 day ages 6 – 17 yrs	3	6	50.00%	58.10%		\$40	\$40	\$80	\$0.00	\$480	1	2	2			
Follow-Up After ED Visit for Mental Illness – 7 day ages 6 – 17 yrs	3	6	50.00%	52.38%	33rd-49th	\$75	\$75	\$150	\$225.00	\$900	0	1	1	Y		
Immunizations for Adolescents - Combination 2	129	429	30.07%	22.37%		\$35	\$35	\$70	\$0.00	\$30,030	3	19	47			
Lead Screening in Children (Informational Only – Not a P4Q Measure)	126	204	61.76%	52.92%	33rd-49th	\$0	\$0	\$0	\$0.00	\$0	0	3	17	Y		
Pharmacotherapy for Opioid Use Disorder	3	51	5.88%	7.67%		\$25	\$25	\$50	\$0.00	\$2,550	9	12	15			
Timeliness of Prenatal Care	76	90	84.44%	82.02%	50th-75th	\$25	\$25	\$50	\$1,900.00	\$4,500	0	0	4	Y	Y	
Postpartum Care	57	90	63.33%	59.60%		\$25	\$25	\$50	\$0.00	\$4,500	11	14	17			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	48	167	28.74%	33.20%		\$15	\$15	\$30	\$0.00	\$5,010	45	50	58			
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	128	234	54.70%	56.73%		\$15	\$15	\$30	\$0.00	\$7,020	22	29	39			
Child and Adolescent Well-Care Visits (3-11)	325	3,121	10.41%	8.29%		\$10	\$10	\$20	\$0.00	\$62,420	1,311	1,413	1,638			
Child and Adolescent Well-Care Visits (12-17)	204	2,764	7.38%	5.34%		\$10	\$10	\$20	\$0.00	\$55,280	1,056	1,156	1,353			
Child and Adolescent Well-Care Visits (18-21)	75	1,179	6.36%	4.38%		\$10	\$10	\$20	\$0.00	\$23,580	182	209	270			

\$3,005.00 **\$689,500.00**

Member Experience



Quality

Voice of the Customer Program

Feedback informs engagement approach, plan overall strategy, interventions, innovation and improvement

Program Overview

Research process that collects and analyzes multi-channel member and provider feedback

Uncover insights behind member and provider decisions, perceptions, and requirements to drive innovation for improved experiences and new programs, incentives, processes, engagement approaches, materials, resources, and benefits

ABHIL

Voice of the Customer
Program Description

Building Blocks for Enhanced Member & Provider Satisfaction



Listening Channels

Real-time insights into customers' experiences. From this feedback, Aetna can identify trends and opportunities to improve customer experience across the member and provider journey, meet their needs, and build better engagements and relationships.

New Strategies

- Off cycle surveys
- Suggestion box
- Feedback Polling during member facing committee, JOC and QPL engagements
- Rack Card Feedback (gathering pulse)
- Healthy Habit Focus groups
- CAHPS Outreach Interventions
- KIOSK – Satisfaction Question
- 1/1s & Family Interviews
- CAHPS Provider Summit

VoC Feedback Mosaic & Dashboard

Capture and analyze critical components of customer feedback data for both structured and unstructured inputs.

Track key insights, ensuring a nuanced understanding of customer sentiments and need across diverse feedback channels

Closing the feedback loop

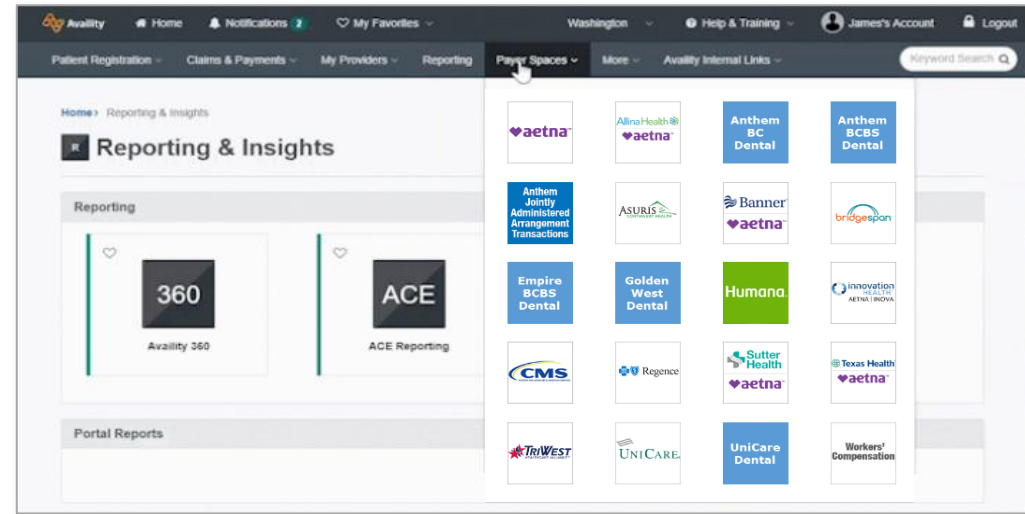
- Classify feedback – neutral, positive, negative
- Determine impact of feedback
- Aetna action

Availity Reporting

Availity reporting

Capabilities active now

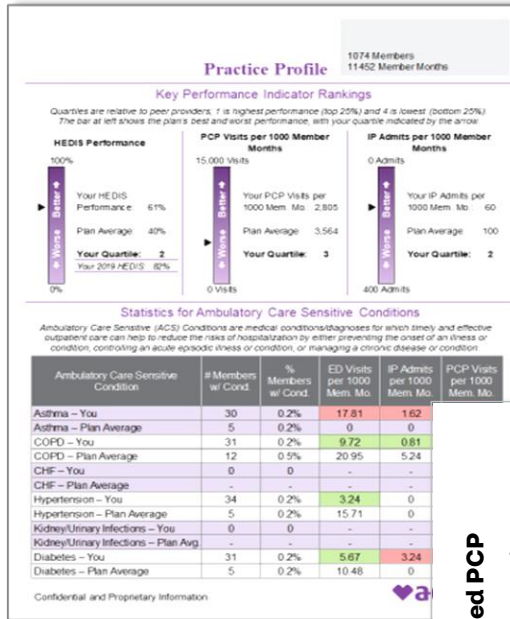
- **Payer-agnostic platform**; single user login allows access to multiple payers' tools
- **Ambient Reporting** – customized ABHIL reporting available for providers to address operational and performance needs
- Payer Spaces: news, policy and process updates, and payer-specific collaboration tools
- Claim Submission Link
- “Contact Us” Messaging
- Claim Status Inquiry
- Appeals and Grievances Submission and Status
- Prior Authorizations Submission/Status
- ProReports / Provider Deliverables Manager (PDM)



Upcoming capabilities

- New Ambient reports and enhancements to existing reports continuously in development
- Eligibility and benefits
- Remit PDF

Provider Analytics Reporting Suite (PARS)



Provider and Practitioner Handbooks

Prioritized Member List

Group	# of Members	# of Risk Gaps	# of Rx Non-Adherence Gaps	# of Open Quality Gaps	IP Admits	IP Acute Spend	ER Visits	ER Spend	MBR	MBR Margin	Total Expense
All	386	81	70	263	179	\$1,021,154	956	\$442,990	246%	\$4,010,786	\$6,754,270
Priority 1	70	34	21	87	86	\$434,524	316	\$154,789	386%	\$1,474,258	\$1,988,904
Priority 2	117	22	20	107	76	\$534,694	371	\$180,235	280%	\$1,761,624	\$2,740,588
Priority 3	102	16	20	60	17	\$51,936	180	\$79,082	180%	\$545,381	\$1,224,107
Priority 4	97	9	9	9	0	\$0	89	\$28,883	140%	\$229,523	\$800,670

Daily Census

Name	Product Group	Phone	DOB	Gender	Assigned PCP	Assigned PCP Name	Assigned TIN	Admitted Facility TIN	Admitted Facility Name
Member 1	Medicaid Expansion			M	1255536215	RICHARDS, DAVID	363317058	362340313	NORTHWEST COMMUNITY
Member 2	TANF			F	1447321898	WESTSIDE FAMILY HEALTH	363317058	800865012	CHICAGO BEHAVIORAL HOSPITAL
Member 3	TANF			M	1629156807	AUBURN GRESHAM FAMILY	363317058	363488183	THE UNIVERSITY OF CHICAGO
Member 4	SSI Non-Dual			M	1629156807	AUBURN GRESHAM FAMILY	363317058	370813229	OSF LITTLE COMPANY OF MARY
Member 5	Medicaid Expansion			M	1982783692	THE GENESIS CENTER,	363317058	362169147	ADVOCATE LUTHERAN GENERAL
Member 6	Medicaid Expansion			F	1629151352	BOLER, LEO	363317058	350868133	METHODIST HOSPITAL NORTH
Member 7	LTC Non-Dual			F	1972674315	ACCESS COMMUNITY HEALTH	363317058	353465388	PRESENCE SAINTS MARY AND
Member 8	SSI Non-Dual			M	1295829646	WOODARD EDMOND, DANEEN	363317058	376000511	UNIVERSITY OF ILLINOIS HOSPITAL
Member 9	Medicaid Expansion			M	1164505467	MANALO, ALBERTO	363317058	362167060	NORTHSHORE UNIVERSITY
Member 10	SSI Non-Dual			M	1366514887	ACCESS COMMUNITY HEALTH	363317058	621678690	FRANCISCAN HEALTH OLYMPIA

	Assigned PCP	
	Going	Not Going
Going	566 (8.5%)	486 (7.3%)
Non-Assigned PCP	143% MBR	148% MBR
Not Going	2,889 (43.2%)	2,741 (41%)
	76% MBR	20% MBR

P4Q Performance

Measure Description	NCOA 50%ile	NCOA 75%ile	TIN Num	TIN Denom	TIN Rate	TIN TIER	Plan Rate	<50th	50th-75th	75th+	Current Earnings
Adults Access Prev/Amb: All members (AAP)	78.26	81.97	1,549	2,339	66.22	<50th	64.63	\$0.25	\$0.50	\$1.00	\$387.25
Breast Cancer Screening Non M/Care (BCS)	53.93	58.7	107	212	50.47	<50th	42.59	\$15.00	\$20.00	\$25.00	\$1,605.00
Controlling High Blood Pressure (CBP)	55.47	62.53	173	375	46.13	<50th	16.67	\$30.00	\$40.00	\$50.00	\$5,190.00
Comp Diabetes: HbA1c Adequate Control (<8) (CDC)	46.83	51.34	74	226	32.74	<50th	15.71	\$30.00	\$40.00	\$50.00	\$2,220.00
Children who turned 30 months old during the measurement year: Two or more w el-child visits (W30)	70.72	76.15	46	100	46	<50th	59.11	\$10.00	\$20.00	\$30.00	\$460.00
Cervical Cancer Screen (CCS)	59.12	63.93	552	1,118	49.37	<50th	42.99				
Childhood Immunization Status Combo 3 (CISR)	67.98	72.75	47	106	44.34	<50th	52.93				
Follow-Up after ED AOD 30 Day: Age 18+ (FUA)	21.64	26.74	28	71	39.44	75th	21.4				
Follow-Up after ED AOD 7 Day: Age 18+ (FUA)	13.64	18.28	23	71	32.39	75th	14.76				
Follow-Up after Hospitalization for Mental Illness: Age 18 to 64 within 30 days (FUH)	54.26	63.4	4	28	14.29	<50th	40.26				

Member Attribution Grid

Cost and Utilization Dashboard

Provider Group	PCP Status	Member Count	Member Months	MBR Pct	PMPM
ALL OTHER ABHIL		569,450	2,375,981	83.7 %	\$332
	ALL OTHER ABHIL	569,450	2,375,981	83.7 %	\$332
Sample Provider	Exclusively Seeing Assigned PCP	7,523	31,171	71.8 %	\$259
	No Longer Assigned to PCP	2,684	12,573	75.0 %	\$261
	Not Seeing Any PCP	1,587	2,982	67.7 %	\$238
	Not Seeing Assigned PCP	1,591	7,722	17.5 %	\$64
	Seeing Multiple PCPs	593	2,790	98.6 %	\$345
Grand Total		576,973	2,407,152	83.6 %	\$331

Total Membership: 6,682
Members not seeing any PCP had 391 IP/ED visits with spend of **\$331,543**



Availity reporting capabilities

Refresh cadence

Monthly

Weekly

Daily

Prioritized Member List

High-risk, high-acuity member list including all relevant outreach and intervention metrics – IP/ED utilization, total expense, MBR, Rx non-adherence, quality gaps, risk gaps

Inpatient ADT Census

Inpatient census report populated using state Admit, Discharge, and Transfer (ADT) data; shows members currently admitted at a hospital or other inpatient facility; updated four times per day

Inpatient Authorization Census

Inpatient census report populated using authorization data; shows members currently admitted at a hospital or other inpatient facility and estimates discharge date

Group-Level P4Q Performance

Quality gap report including YTD performance against targets by provider group and PCP, incentive earnings for all measures, and member-level gap data; includes all of provider's TINs in a single report

Assigned Member Panel

Group-level roster rather than individual TIN or practitioner

Claims Remits

Group-level remit report

Provider Roster Echo Back

Report that confirms provider roster submissions; report layout is the same as the IAMHP template providers use to submit roster updates to ABHIL

Negative Balance

Group-level negative balance report

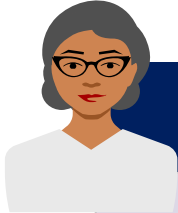
Rx Adherence

Uses Rx claims data to identify members taking maintenance medications who have missed expected prescription fill dates. Includes member and prescription detail.

Value-based partnerships

Value-based care benefits

Value-based care (VBC) aligns goals by rewarding providers for activities that keep patients healthy.



Patient Benefits

- **Patients are at the center** of the health care experience
- **Care is proactive**, both preventative and to treat chronic conditions, and emphasizes reducing hospitalizations
- **Providers are more well-informed** and are accountable for high-quality outcomes
- **Treatment is customized** at the patient level

**Healthier patients,
lower costs**

Provider Benefits



- Financial **bonus potential greater** than traditional Pay-for-Quality (P4Q) structure
- **Increased data sharing** between payor and provider helps identify risks and improve care coordination
- **Pay based on quality care** and improving patient outcomes
- Best practices and infrastructure creates foundation for **long-term success**
- **Simplifies performance targets** for bonus payout

When comparing to historical utilization, VBC provider group cohorts had on average:

39%

Fewer ED visits

77%

Fewer IP admissions

\$24PMPM

Less in ED spend

\$55PMPM

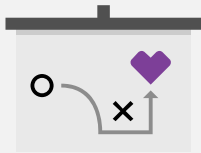
Less in IP spend

Tools for success in value-based care

We're equipped with resources to support successful provider partnerships.



Provider Analytics Reporting Suite (PARS), offers timely and actionable data ensure sure patients receive the care they need. Data is reviewed regularly, and insights are outlined for providers.



Financial and quality targets based on provider-specific population create a fair baseline for meaningful quality improvement and cost reduction



Cross-functional work groups including regular meetings with medical management, quality, pharmacy and network to collaborate and share best practices



Dedicated partnership team including clinical and business resources, intended to remove barriers and strategize on improving in quality and efficiency

Interested in learning more? Contact ABHILProviderPartnerships@aetna.com

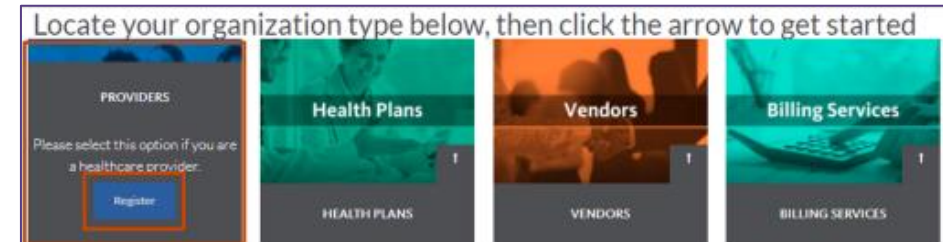
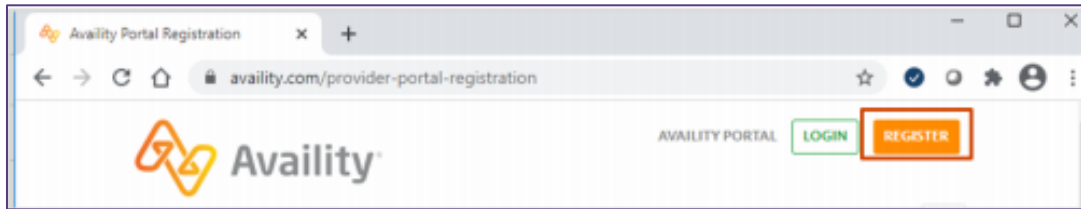
Availity provider portal

Availity portal registration

[Availity.com/provider-portal-registration](https://www.availity.com/provider-portal-registration)

Register your provider organization

Important: This only applies to users who are brand new to Availity and need to register their provider organization.



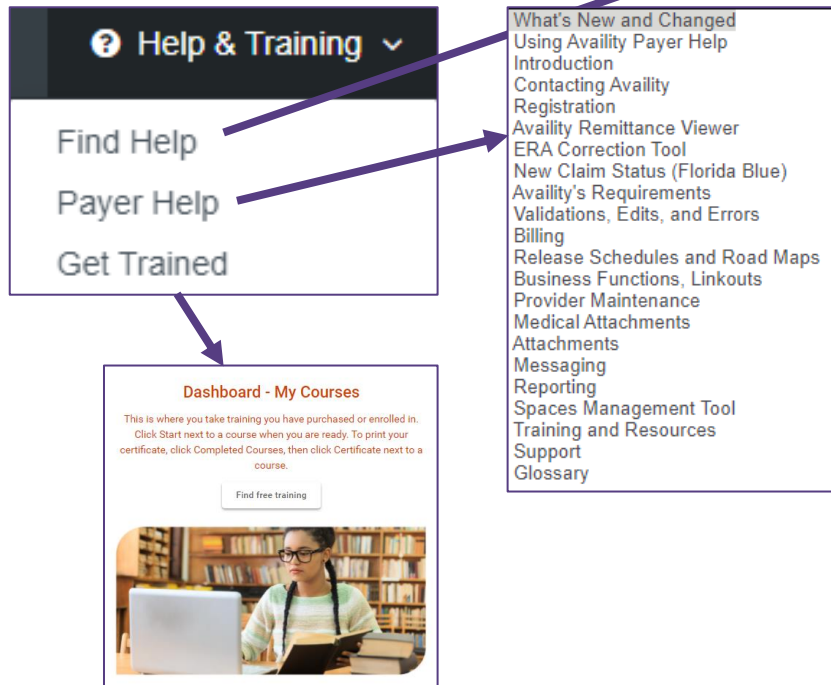
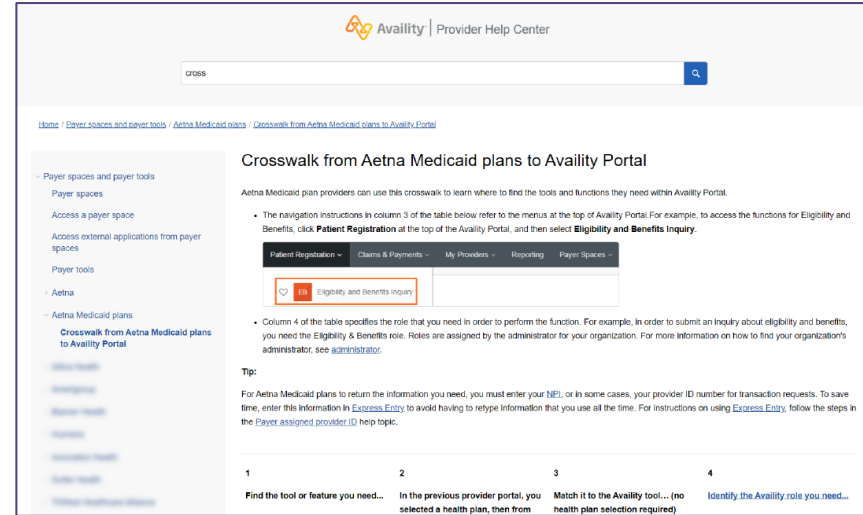
When you set up your new user account, you'll be asked to do the following tasks in the wizard:

- Add information about yourself
- Set up security questions
- Verify your information
- Confirm your email address

Availity Help Center

Crosswalk from Aetna Medicaid plans to Availity portal

1. Select **Help & Training > Find Help**
2. Select **Payer Tools**
3. Select payer name: **Aetna Medicaid**
4. Select the topic to review in the crosswalk



Availity support

Support tools

- Help & Training – Find Help
 - Question mark icons next to some fields that provide additional information
- Help & Training – Get Trained
 - Links on pages to view demos
- Help & Training – My Support Tickets
 - Link on My Account page
 - Availity Client Services
 - Call toll free 1.800.AVAILITY (282.4548)
 - Monday – Friday
 - 8am – 8pm ET

For additional Availity training please reach out to Market Development Specialist, Jackie Knox.

Jackie Knox

Market Development Specialist, Client Engagement Services

Jackie.Knox@availity.com



Aetna Better Health[®] of Illinois
Medicaid tools and resources

Aetna Better Health[®] of Illinois Medicaid public website

Members and providers can access the Aetna Better Health[®] of Illinois website at AetnaBetterHealth.com/Illinois-Medicaid

Providers will be able to access:

- Our provider manual, communications, bulletins, newsletters and trainings
- Important forms
- Clinical practice guidelines
- Member & provider materials
- Fraud & abuse information and reporting
- Information on reconsideration and provider appeals



Provider website

CONTACT US

The screenshot shows the top section of the Aetna provider website. At the top left is the Aetna logo with the tagline "Aetna Better Health® of Illinois". To the right is a search bar and navigation links for "Member site", "Contact us", and "Log in". Below this is a dark purple navigation bar with links for "Working with us", "Resources", and "Find doctors and medicines". The main content area features a large white box on the left with the heading "Welcome providers" and a sub-heading "Join our network". To the right is a large image of two healthcare professionals, a man and a woman, looking at a screen together.

Training

Getting started

Here are some helpful provider links if you're

Provider Manual



Orientation and training

Start your orientation today. >



Provider manual (PDF)

Download our manual for more provider information. >



Provider Portal

Request access to check member eligibility and benefits. >



Provider forms

You can find all the forms you need. >

Provider website: Provider manual

Resources > Tools and materials > General provider resources > Tools for working with us

In addition to policies and procedures, this resource includes:

- Important contact information
- Provider rights and responsibilities
- Member eligibility and enrollment
- Billing and claims
- Reconsiderations, appeals and grievances
- Utilization management program and requirements
- Quality improvement program
- Covered services



Search

Working with us

Resources

Find doctors and medicines

Provider resources

Provider Manual (PDF Download)

Materials

Tools for working with us

Provider manual (PDF)

Provider Relations Assignment List (PDF)

Pharmacy authorization form (PDF)

Medical authorization form (PDF)

CMS1135 waiver request and approval (PDF)

Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters

 **Aetna**
Aetna Better Health® of Illinois

Search

Member site Contact us  Log in

Working with us Resources Find doctors and medicines

Notices and Newsletters

We want to make sure you're up-to-date with the latest news and other important information regarding Aetna Better Health® of Illinois. We'll post important notices and updates regarding our health plan here.

NEW:
Provider events

Provider events

Register for upcoming events for Aetna Better Health of Illinois network providers.

Local events 

Quarterly newsletters






Newsletters

2024 Newsletters:

-  [Summer 2024 Newsletter \(PDF\)](#)
-  [Spring 2024 Newsletter \(PDF\)](#)
-  [Winter 2024 Newsletter \(PDF\)](#)

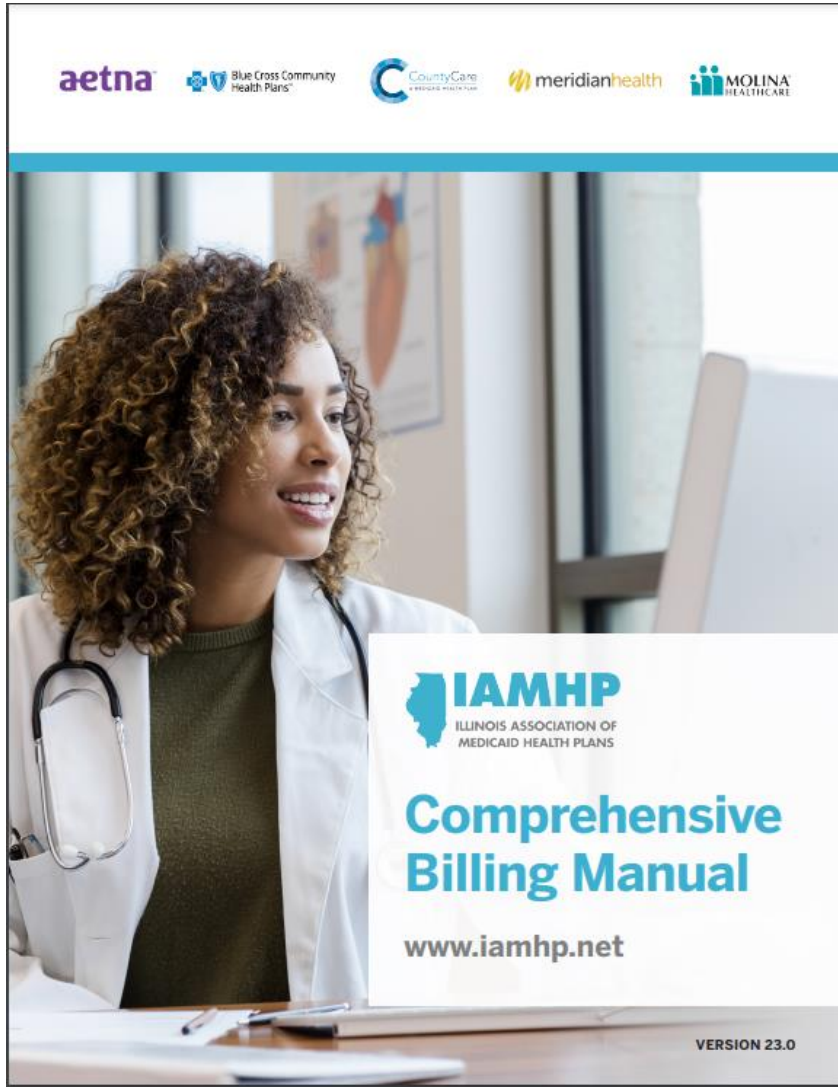
Notices

Here are some important notices we've gathered to help you:

- August 2024
-  [Policy update effective 10/1/24: Drugs and Biologicals \(PDF\)](#)
 -  [ORP denials \(PDF\)](#)
 -  [Provider revalidation requirement \(PDF\)](#)
 -  [Policy update effective 10/1/24 \(PDF\)](#)
 -  [Provider Summits September 2024 \(PDF\)](#)

Claims Corner

IAMHP Billing Manual



The IAMHP Comprehensive Billing Manual is designed to provide support and guidance to contracted Medicaid managed Care providers on billing services rendered to Medicaid members.

This manual gives providers a one-stop document for billing and claim procedures, without having to look up each health plan and/or provider specific process separately.

The IAMHP billing manual can be found at www.IAMHP.net

Verifying member eligibility

- All providers must verify a member's enrollment status prior to the delivery of nonemergent, covered services.
- Providers must verify a member's assigned provider prior to rendering primary care services.
- We do not reimburse services rendered to ineligible members who lost eligibility or who were not assigned to the PCP's panel.



You can verify member eligibility through one of the following ways:

- HFS' secure MEDI website provides Medicaid beneficiary eligibility information to providers.
- Secure website portal: Providers can verify up to five members at a time for eligibility verification.
- Availity portal: Providers can verify members eligibility through Availity Essentials portal.
- Telephone verification: Call our Member Services Department to verify eligibility at 1-866-329-4701. 8:30AM to 5:00 PM CT Monday through Friday to speak with a live agent or 24/7 via our automated system.



Member ID cards

The member ID card contains the following information:

- Member name, ID, DOB & sex
- Aetna Better Health of Illinois logo / website
- PCP name and phone number
- Effective date of eligibility
- Payer ID and claims address
- Rx Bin, PCN and GRP numbers
- CVS Caremark number (for pharmacists use only)

Presentation of an Aetna Better Health of Illinois ID card is not a guarantee of eligibility or reimbursement.

Aetna Better Health® of Illinois HealthChoice Illinois Regulatory Agency - HealthCare and Family Services	
Name: Member ID#:	Effective Date: 00/00/00 DOB: 00/00/00 Sex:
PCP: Phone:	
CCSO Name: CCSO Phone:	
Member Services: 1-844-316-7562 (TTY: 711) AetnaBetterHealth.com/Illinois-Medicaid	
RxBIN: 610591 RxPCN: ADV RxGRP: RX881A Pharmacist Use Only: 1-888-964-0172	
MEIL3	

Aetna Better Health® of Illinois PO Box 818031, MC F661, Cleveland, OH 44181-8031	
Important number for members Behavioral Health, Dental, Transportation, 24-Hour Nurse Line 1-866-329-4701 (TTY: 711)	
Important number for providers 24/7 Eligibility and Prior Auth Check 1-866-329-4701	
Submit medical claims to: Aetna Better Health of Illinois PO Box 982970 El Paso, TX 79998-2970	Payer ID: 68024
MEIL	

Roster/demographic submissions

Universal IAMHP Roster Template (Updated 9/18/23)

Provider Status			Practitioner Information									
New/No Change/ Update/ Term	Provide detail on what is being updated or termed if "Update" or "Term" is selected (i.e. - terming service location or termed from the group)	Effective Date	NPI	Last Name	First Name	Middle Name	Suffix	Degree	Date Of Birth (MM/DD/YYYY)	SSN # (No Dashes)	Gender (M/F)	Practice As (P

- ❖ Roster template can be found on the IAMHP website at <https://iamhp.net/providers>
- ❖ Rosters can be submitted directly to ABHILProviderUpdateRequests@aetna.com
 - ❖ Upon submission, you will receive an email with a case number for tracking purposes
 - ❖ NOTE: Any questions or concerns regarding your roster submission should be directed to your Provider Representative with reference to your case number
- ❖ Rosters changes should be submitted to ABHIL on a monthly basis to ensure updates are timely
- ❖ All providers must be registered/credentialed with IMPACT

Prior authorizations

A prior authorization request may be initiated by:

- Submitting the request 24/7 via the Secure Provider Web Portal [AetnaBetterHealth.com/Illinois-Medicaid](https://www.aetna.com/illinois-medicaid)
- Faxing the request form to 877-779-5234 for Physical Health or 844-528-3453 for Behavioral Health
- Through our toll-free number **866-329-4701**

IMPORTANT ITEMS to remember:


- ✓ Emergency Services do not require prior authorization
- ✓ Authorization requests must be submitted within 7 (seven) days prior to elective procedures
- ✓ Submit Authorization requests within one business day of urgent/emergent admission
- ✓ Turnaround times for processing requests are as follows:
 - Standard – 96 hours
 - Urgent – 48 hours
 - Urgent Concurrent – 3 calendar days

To check the status of a prior authorization, please log in to the Provider Web Portal or contact our Utilization Management Department at **866-329-4701** Monday through Friday from 8:30 AM to 7:00 PM CST.

To determine which services require prior authorization, please review the ProPat Auth Lookup Tool on our provider website.

Clinical determinations are made utilizing **Milliman Care Guidelines (MCG)**, while Behavioral Health will continue to use ASAM criteria for Substance Abuse admissions.

Aetna Better Health® of Illinois
3200 Highland Ave, MC F648
Downers Grove, IL 60515



Aetna Better Health® of Illinois Prior Authorization Request Form

Phone: 1-866-329-4701/Fax: 1-877-779-5234
For urgent outpatient service requests (required within 72 hours) call us.

Date of Request: _____

MEMBER INFORMATION

Name: _____ ID Number: _____

Date of Birth: _____ PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): F M

PROVIDER INFORMATION

Ordering/Requesting Provider:	Servicing Provider/Facility/Specialist:
Name: _____	Name: _____
NPI (Required*) _____	NPI (Required*) _____
Address: _____	Address: _____
Telephone #: _____	Telephone #: _____
Fax #: _____	Fax #: _____
Contact Person: _____	Specialty: _____

AUTHORIZATION INFORMATION

Diagnosis/ICD-10 Code(s) (Required*)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Billing & claims payment

For claim submission:

Electronic claims submission through clearinghouse:

- **Payer ID: 68024** (Claim Submission)

Submit paper claims to:

Aetna Better Health of Illinois
P.O. Box 982970
El Paso, TX 79998-2970



Check run twice a week

- Wednesday will be 1ST check run, with a Saturday paid date
- Friday will be a 2ND check run, with a Tuesday paid date.
- Paper remits and checks will generally be mailed on Mondays and Wednesdays.

ERA:

- Remittance advices are available within the Availity provider portal.
- Electronic 835s and ERAs come from ECHO Health Electronic Payment System

Pharmacy claims

Aetna Better Health® works with CVS/Caremark® to administer the pharmacy benefit.

Pharmacy claims may be submitted to CVS/Caremark via the latest NCPDP D.0 communication standards

**BIN: 610591
PCN: ADV
Group: Rx881A**

Helpful resources can be found by visiting our provider website, including:

- Access to the most up to date ABH-IL Formulary
- Customized specialty prior authorization forms
- Full Prior Authorization criteria
- Important forms, and other pharmacy documents

Prior authorizations may be submitted electronically via CoverMyMeds and SureScripts, or via fax **844-802-1412** or phone **1-866-329-4701**.

For a full list of in-network Aetna Better Health of Illinois pharmacies please visit:

<https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/ABHIL%20Pharmacy%20Network.pdf>

Electronic Funds Transfer (EFT) Electronic Remittance Advice (ERA)

Providers that want to update their payment/Electronic Remittance Advice (ERA) distribution preferences for Aetna Medicaid claims payment on the dedicated [Aetna Better Health/ECHO portal](#). No fees apply when using this dedicated portal, which is identified by the “Aetna Better Health” name in the top left of the page.

To sign up for electronic funds transfer, providers will need to provide an ECHO payment draft number and payment amount for security reasons as part of the enrollment authentication. The ECHO draft number can be found on all provider Explanation of Provider Payments (EPP), typically above your first claim on the EPP. If you have not received a payment from ECHO previously, you will receive a paper check with a draft number you can use to register after receiving your first payment.

Tax ID: 123456789 **EPC Draft #: 000000000** Payment Week: 40 Payment Date: 01/01/2000 Page 1 of 2

Service Date	Code or Description	Explanation Codes	Total Charge	Provider Discount	Other Plan Payment	Other Adjustment	Patient Obligation				Net Payment Amount
							Co-Ins	Co-Pay	Deductible	Non-Cov	
Provider: SAMPLE PROVIDER				Patient Acct #: 555555555			Group/Check Number: ABC/123456				
Network: SAMPLE NETWORK				Member Number: 123456789			Customer Service #: 111.111.1111				
Patient Name: JOHN DOE				Claim Number: 1111111111			Administered By: TPA				
01/23/20	99214	45	142.00	44.40	0.00	0.00	0.00	50.00	0.00	0.00	47.60
Total:			142.00	44.40	0.00	0.00	0.00	50.00	0.00	0.00	47.60

Please note that initially after go-live, there could be a 48-hour delay between the time a payment is received, and an ERA is available. Providers that choose to enroll in ECHO’s ACH all payer program will be charged fees, so be sure to use the Aetna ECHO portal for no-fee processing.

Itemized bill process

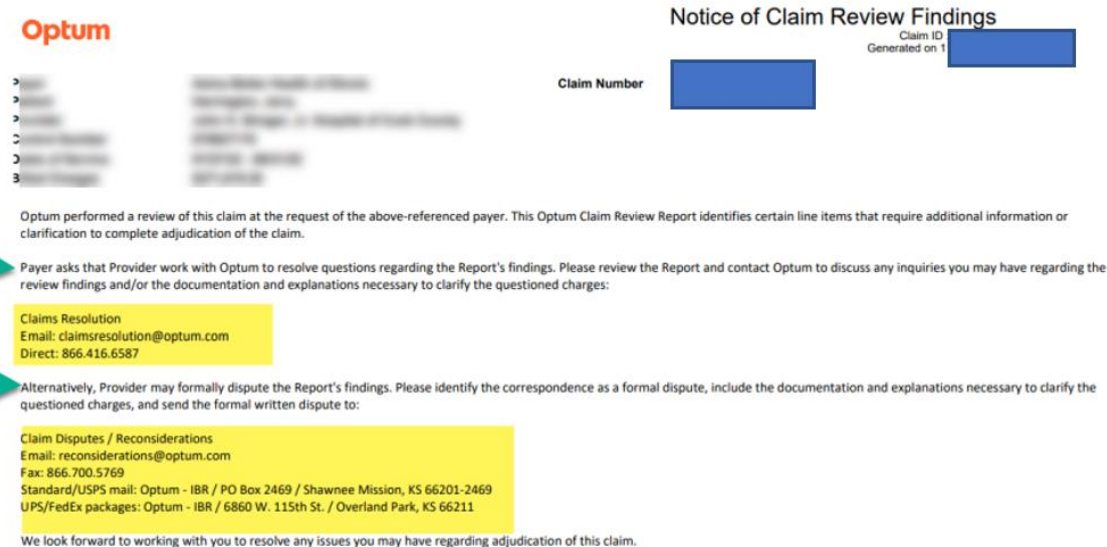
High-dollar inpatient DRG claims at or exceeding an expected reimbursement of \$25K require an itemized bill.

There are three ways to submit an itemized bill:

1. If a provider's clearinghouse is able to submit a 275 transaction to Aetna, the provider may submit an itemized bill along side their first-time claim submission.
2. Following electronic claims submission, the provider may upload the Itemized Bill via the Availity portal.
3. When mailing the itemized bill via claim reconsideration, the provider should include a copy of the claim form, attach the Itemized Bill, and mail directly to Aetna Better Health of Illinois PO Box 982970, El Paso, TX 79998-2970

PLEASE NOTE: The claim form should only be attached when submitting an Itemized Bill with your reconsideration request. Claim forms should **NOT** be attached with any other reconsiderations.

SAMPLE OPTUM NOTICE



The image shows a sample document titled "Optum Notice of Claim Review Findings". The document includes the Optum logo, a blurred list of items, and a "Claim Number" field. The main body of the document contains the following text:

Optum performed a review of this claim at the request of the above-referenced payer. This Optum Claim Review Report identifies certain line items that require additional information or clarification to complete adjudication of the claim.

Payer asks that Provider work with Optum to resolve questions regarding the Report's findings. Please review the Report and contact Optum to discuss any inquiries you may have regarding the review findings and/or the documentation and explanations necessary to clarify the questioned charges:

Claims Resolution
Email: claimsresolution@optum.com
Direct: 866.416.6587

Alternatively, Provider may formally dispute the Report's findings. Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute to:

Claim Disputes / Reconsiderations
Email: reconsiderations@optum.com
Fax: 866.700.5769
Standard/USPS mail: Optum - IBR / PO Box 2469 / Shawnee Mission, KS 66201-2469
UPS/FedEx packages: Optum - IBR / 6860 W. 115th St. / Overland Park, KS 66211

We look forward to working with you to resolve any issues you may have regarding adjudication of this claim.

Provider disputes (resubmissions/reconsiderations)

A **Dispute** is defined as an expression of dissatisfaction with any administrative function including policies and decisions based on contractual provisions inclusive of claim disputes. Disputes can include resubmissions, reconsiderations, appeal and grievances.

A **Provider Resubmission** is a request for review of a claim denial or payment amount on a claim originally denied because of incorrect coding or missing information that prevents Aetna Better Health from processing the claim and can include:

Corrected claims

- Any change to the original claim
- Code changes
- Newly added modifier

Reconsiderations

- Itemized bills
- Duplicate claims
- Coordination of benefits
- Proof of timely filing
- Claim coding edit

We acknowledge provider reconsiderations in writing within 10 calendar days of receipt. Aetna Better Health will review reconsideration requests and provide a written response within 30 calendar days of receipt.

A provider may request a claim resubmissions/reconsiderations using the Provider Dispute & Resubmission form if they would like us to review the claim decision. Claim reconsideration is available to providers prior to submitting an appeal. **Resubmissions** must be submitted within **180 days of the date of service**. Reconsideration requests must be submitted within **90 calendar days from the date of the notice (EOP)** of the claim denial to:

Aetna Better Health of Illinois
PO BOX 982970
El Paso, TX 79998-2970

Provider claim reconsideration form

AetnaBetterHealth.com/Illinois-Medicaid/providers/forms.html

Aetna Better Health[®] of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515



Provider claim reconsideration form

Please complete the information below in its entirety and mail with supporting documentation to:

Aetna Better Health of Illinois
P.O. Box 982970
El Paso, TX 79998-2970

Select the appropriate reason	
<input type="checkbox"/> Incorrect denial of claim or claim line(s)	<input type="checkbox"/> Incorrect rate payment
<input type="checkbox"/> Coordination of benefits	<input type="checkbox"/> Consent form denial
<input type="checkbox"/> Code or modifier issue	<input type="checkbox"/> Itemized bill
<input type="checkbox"/> Other	

Your claim reconsideration must include this completed form and any additional information (proof from primary payer, required documentation, CMS or Medicaid references as needed, etc.). Incomplete or missing information may result in your claim reconsideration being returned or decision upheld.

Provider name:	
Provider NPI:	
Submitter's name:	
Provider phone number:	
Date(s) of service:	
Claim number(s):	
Member name:	
Member ID #:	

Please indicate the specific reason for your request and any pertinent details below:

Signature of sender: _____ Date: _____

IL-22-07-03 IL Provider claim reconsideration form
AetnaBetterHealth.com/Illinois-Medicaid



Provider appeals

Aetna Better Health® has established a provider appeal process that provides for the prompt and effective resolution of appeals between the health plan and providers. This system is specific to providers and does not replace the member appeal and grievance system which allows a provider to submit an appeal on behalf of a member. When a provider submits an appeal on behalf of a member, the requirements of member appeal and grievance system will apply.

Provider appeal

A provider appeal is a request by a provider to appeal actions of the health plan when the provider:

- Has a claim for reimbursement, or request for authorization of service delivery, denied or not acknowledged with reasonable promptness

Requests to appeal post-service items are always on behalf of the provider. They are NOT eligible for expedited processing.

Requests to appeal pre-service items on behalf of the member are considered member appeals and subject to the member appeal timeframes and policies.

A provider may file an appeal within 60 calendar days of the date of the notice of adverse benefit determination. Provider Appeals can be submitted to:

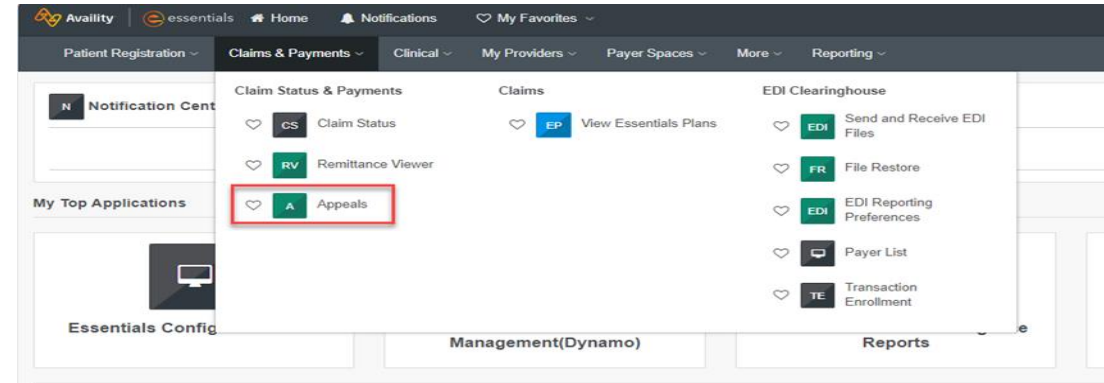
Aetna Better Health of Illinois
Attn: Appeals & Grievances
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

New Availity enhancement - Enhanced appeal submission

Availity is a self-service platform used by Aetna to support Medicaid providers. Availity allows providers to have access to a wide range of performance data through a suite of reports. Providers also have access to services such as authorization search, claim status, view remittances, access panel rosters, search in network providers, facilitate case management, submit Appeals and much more.

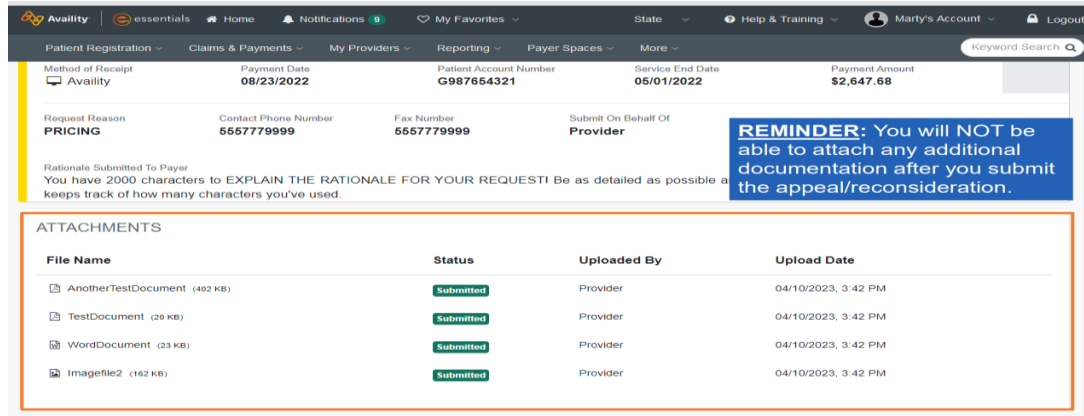
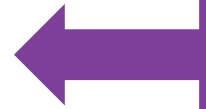
Provider Appeal

- Begins when a provider is dissatisfied with Aetna decision on a claim
- Provider request for the claim to be reconsidered by Aetna



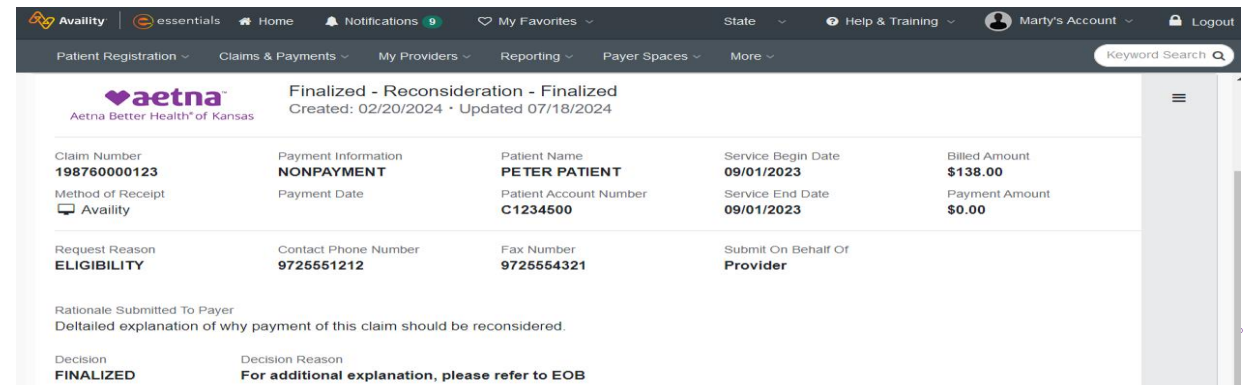
Submission

- Locate the disputed claim
- Submit request and supporting documentation
- Case number assigned within 48-72 hours



Review Outcome

- Review process can take up to 30 to 60 days to complete
- Reconsideration decision will be outlined under the claim/s that was disputed
- Details are outlined on EOB & Determination Letter



Instructions for claim reconsideration, member appeal and provider escalations/grievance

AetnaBetterHealth.com/Illinois-Medicaid/providers/forms.html

Aetna Better Health* of Illinois
 3200 Highland Avenue, MC F648
 Downers Grove, IL 60515



Provider claim reconsideration, member appeal and provider complaint/grievance instructions

Provider submissions will be reviewed and processed according to the definitions in this document, including but not limited to resubmissions (corrected claims), retroactive authorization requests, appeals, complaints and grievances. Provider claim reconsiderations and retrospective authorization reviews do not include pre-service disputes that were denied due to not meeting medical necessity. **Pre-service denials are processed as member appeals and are subject to member policies and timeframes.**

Timeframe to request each option

Options/pages	Provider submission timeframe
Resubmission – corrected claim, page 2	Within 180 days of the date of service
Claim reconsideration – pages 2-3	Within 90 days of original denial
Retroactive authorization request (post-service) – page 4	Existing timeframe: Dispute must be requested within thirty (30) calendar days from the date of service. Effective 12/1/22: Dispute must be requested within sixty (60) calendar days from the date of denial.
Member appeal (provider submitting on member's behalf) – page 5	Within 60 days of the original denial
Provider complaint/grievance – pages 5-6	At any time
State complaint portal – page 6	<ul style="list-style-type: none"> Over 30 calendar days from and under 60 calendar days post receipt of MCO tracking number Untimely response to appeal or complaint beginning day 31 Within 30 calendar days after appeal decision or complaint Not to exceed 60 calendar days from submission of the appeal or complaint

IL-22-11-02 Provider claim reconsideration, member appeal and provider complaint/grievance instructions
AetnaBetterHealth.com/Illinois-Medicaid

Examples of reconsiderations: (Step 1, if applicable)
Itemized bill <ul style="list-style-type: none"> An itemized bill must be broken out per Rev Code to verify charges billed on the UB match the charges billed on the itemized bill. (Please attach I-Bill that is broken out by rev code with sub-totals.)
Duplicate claim <ul style="list-style-type: none"> Review request for a claim whose original reason for denial was "duplicate" Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed
Untimely filing of the claim <ul style="list-style-type: none"> A review of a claim that was submitted outside the timeframe Provide good cause justification documentation for late filing; or For electronically submitted claims provide the second level of acceptance report as proof of timely filing Refer to Proof of Timely Filing Requirements in the Provider Manual
Untimely decision making <ul style="list-style-type: none"> A review of a decision where Aetna did not render the decision on a prior authorization timely Provide a copy of the denial showing the received date and the decision date
Coordination of benefits <ul style="list-style-type: none"> Attach EOB or letter from primary carrier
Claim/coding edit <ul style="list-style-type: none"> We use two (2) claims edit applications: refer to the Provider Manual for details.

Examples of a corrected claim: (Step 1 if applicable)
Newly added modifier
Code changes
Any change to the original claim

Examples of retrospective authorization disputes: (Step 2, if applicable)
Requests by provider for review of claims for medical necessity
Dispute of denied days during concurrent review
Request for review of additional services not authorized
Retro authorization request <ul style="list-style-type: none"> Claims that were denied due to no authorization on file. Medical records must be included with the resubmission.

Examples of complaints/grievances: (Step 1, if applicable)
Dissatisfaction with administrative functions or policies
Vendor staff service or behavior
Aetna staff behavior
On behalf of a member <ul style="list-style-type: none"> When filing on behalf of a member the request is processed as a Member Grievance and is subject to the member grievance policies and timeframes

Examples of appeals: (Step 2 if applicable)
On behalf of a member: <ul style="list-style-type: none"> Continued stay concurrent review Urgent or Emergent review Pre-Service (Prior Authorization) requests <ul style="list-style-type: none"> Must have written consent to act on behalf of the member When filing on behalf of a member the request is processed as a Member Appeal and is subject to the member appeal policies and timeframes



Recoupments

In the event of an overpayment, providers will receive written notification within 12 months

Provider notification will include:

- ❖ Impacted claims
- ❖ Member's name
- ❖ Date of service

If a provider has concerns about the overpayment notice, the provider may contact us in writing to contest the overpayment, within 60 business days of the date of the notice, to:

Aetna Better Health of Illinois

PO Box 81040
5801 Postal Road
Cleveland, OH 44181

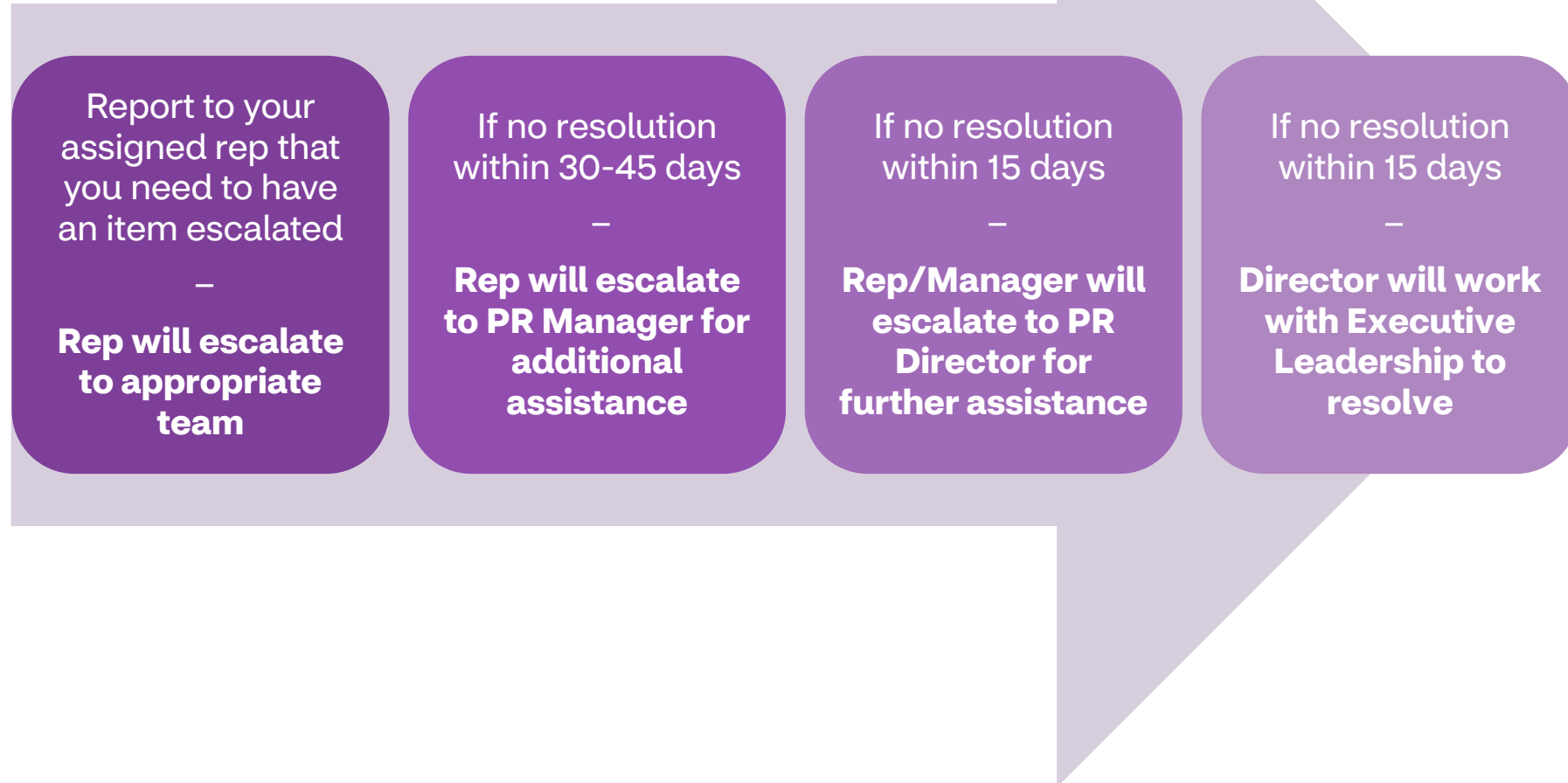
After the recoupment process is complete, the health care provider shall be provided a remittance advice, which will include an explanation. At a minimum, the recoupment explanation will include:

- ❖ Name of the patient
- ❖ Date of service
- ❖ Service code and/or description
- ❖ Recoupment amount
- ❖ Reason for the recoupment or offset



Provider escalations

Provider Experience escalation process



Provider grievances

Aetna Better Health has established a provider escalation process that expedites the timely and effective resolution of escalations between the health plan and providers. This system is specific to providers and does not replace the member grievance system which allows a provider to submit a grievance on behalf of a member. **If a provider submits a grievance on behalf of a member, the requirements of the member grievance system will apply.**

A provider grievance is any written or verbal expression of dissatisfaction by a provider against Aetna Better Health policies, procedures or any aspect of Aetna Better Health's administrative functions including escalations about any matter other than an appeal. Possible subject of escalations include, but are not limited to, issues regarding:

- Administrative issues
- Payment and reimbursement issues
- Dissatisfaction with the resolution of a dispute
- Aetna Better Health staff, service or behavior
- Vendor staff, service or behavior

Aetna Better Health will acknowledge all verbal requests verbally at the time of receipt and will acknowledge written requests either verbally or in writing within five (5) business days. Grievances will be reviewed and resolved within thirty (30) calendar days of receipt. The timeframe for resolution may not be extended.

Both network and non-network providers may submit a grievance either verbally or in writing at any time to:

Aetna Better Health of Illinois
Attn: Appeals & Grievances
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

Provider state escalations

If a provider disagrees with an Aetna Better Health's claim reconsideration decision, the provider can file a escalation through the Illinois Department of Healthcare and Family Services' (HFS) Provider Resolution process, after attempting to resolve the issue with Aetna through its process.

The HFS requirements for submitting a state escalation are as follows:

- Providers must first use the MCO internal dispute process before submitting an escalation to HFS.
- Disputes submitted through the MCO internal dispute process may be submitted through the HFS Resolution Portal:
 1. No sooner than 30 days after submitting to the MCO's internal process and
 2. No later than 60 days after submitting to the MCO's internal process.
 - If HFS determines an escalation was submitted sooner than 30 days or later than 60 days after submitting the dispute to the MCO's internal process, the escalation will be immediately closed.
 3. Claim numbers should be used as a tracking number
 - Any changes will be updated by the MCO

For additional details around Provider Resubmissions/Disputes, Appeals & Grievances, please see Chapter 18 of Aetna Better Health of Illinois Provider Manual.

Compliance and mandated training



Cultural, linguistic & disability access requirements & services

Cultural competency

A set of interpersonal skills (including, awareness, attitude, behaviors, skills, and policies) that allow individuals to increase their understanding, acceptance, and respect for all cultures, races, and religious and ethnic backgrounds.

Linguistic competency

- **Members with limited English proficiency may experience:**

- Less adequate access to care
- Lower quality of care
- Poorer health outcomes

- **Providers must ensure members have access to medical interpreters, signers, and TTY services to facilitate communication at no cost.**

- **To assist, Aetna Better Health of Illinois provides:**

- Language Line services 24 hours a day, 7 days a week in 140 languages
- Information in other formats including Spanish, Russian, Audio, Braille, etc., at no cost
- TDD/TTY access
- Translators to your office or the hospital

- **To complete your yearly state mandated Cultural Competency training, please visit: Cultural competency training (PDF)**
- To complete your attestation please click here.
- **By completing the attestation, you certify that your organization is committed to ensuring compliance with all applicable federal, state and CMS regulations.**

Accommodating people with disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as:

- ❑ A person who has a physical or mental impairment that substantially limits one or more major life activity, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability

- ❑ The Health Plan ensures equal access in partnership with participating providers by maintaining an ADA Plan. The ADA Plan monitors the following:
 - Physical accessibility of provider offices
 - Quality of the Health Plan's free transportation services
 - Concerns related to the Health Plan and/or provider's failure to offer reasonable accommodations to patients with a disability

Accommodations for people with disabilities include, but are not limited to:

- Physical accessibility
- Accessible medical equipment (e.g. examination tables and scales)
- Policy modification (e.g. use of service animals)
- Effective communication (e.g., minimize distractions and stimuli for members with intellectual and developmental disabilities)

Appointment standards

Emergency Care	Immediately
Urgent Care	Within 24 hours
Routine Preventive Care	Within five (5) weeks For infants under six (6) months: Within two (2) weeks
Pregnant Woman Visits	1st Trimester: 2 week 2nd Trimester: 1 week 3rd Trimester: 3 days
Post-Discharge Follow-Up	Within 7 days
Office Wait Times	Not to exceed 60 minutes
After Hours	24/7 coverage (voicemail only not acceptable)
Behavioral Health	Non-Life Threatening within six (6) hours Urgent within 48 hours Routine Care within ten (10) business days

PLEASE NOTE: If you cannot offer an appointment within these timeframes, please refer the member, to Member Services so they may be rescheduled with an alternative provider who can meet the access standards and member needs.



Fraud, Waste, and Abuse (FWA)

Fraud, Waste and Abuse

FRAUD

- Intentionally or knowingly submitting false information to the Government or a Government contractor to get money or a benefit to which you are not entitled.
- **Fraud** can be committed by a provider or a member

WASTE

- The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.
- **Waste** is not generally considered to be caused by criminally negligent actions but rather by the misuse of resources.

ABUSE

- Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program.
- Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment

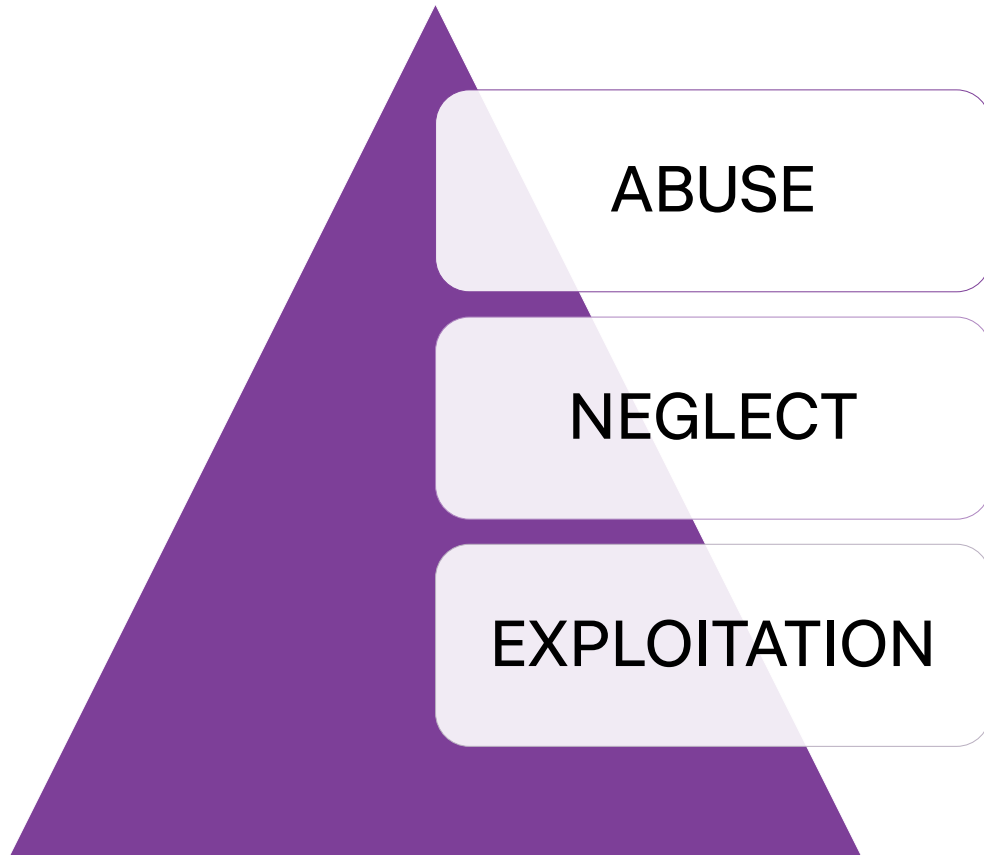


Critical incidents

Abuse, Neglect & Exploitation

Critical incidents | Spot the signs

Critical incidents are the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm.



- History of substance abuse, mental illness, or violence
- Lack of affection
- Prevents member from speaking or seeing others
- Unexplained withdrawal of money
- Unpaid bills despite having enough money
- Adding additional names on bank account
- Anger, indifference or aggressiveness towards members
- Conflicting accounts of incidents

Reporting critical incidents

**Office of Inspector
General (OIG):**

800-368-1463

**Aetna Better Health of
Illinois Provider
Services:**

866-329-4701

**IL Department on
Aging (IDoA):**

866-800-1409

Senior Help Line:

800-252-8966

**IL Department of
Public Health (IDPH):**

800-252-4343

**Critical Incident
Reporting and Analysis
System (CIRAS):**

<https://www.dhs.state.il.us/page.aspx?item=97101>

Provider Experience survey

New Provider Experience survey

- Allows providers to provide their feedback as it relates to their experience with assigned PE Rep as well as the Health plan
- PE Rep will email survey and remind providers to complete after every meeting (onsite or virtual)
- Allow for the PE Team to address any issues and/or concerns the providers may have in real time to avoid escalations

Please use the following link or QR Code to complete the survey

<https://www.surveymonkey.com/r/R5LPPZ2>



Aetna Better Health® of Illinois

Provider Experience Survey (Medicaid)

1. Please select the name of your assigned Sr. Analyst or Network Relations Mgr. (PR Rep)

2. "Your Provider Relations Rep" is knowledgeable about the topics presented at the meeting

Completely Disagree	Mostly Disagree	Slightly Disagree	Slightly Agree	Mostly Agree	Completely Agree
1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. "Your Provider Relations Rep" understands the issues and questions that are presented during the meeting and/or via email

Completely Disagree	Mostly Disagree	Slightly Disagree	Slightly Agree	Mostly Agree	Completely Agree
1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. "Your Provider Relations Rep" is able to answer questions and/or resolve issues in a timely manner

Completely Disagree	Mostly Disagree	Slightly Disagree	Slightly Agree	Mostly Agree	Completely Agree
1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. "Your Provider Relations Rep" references ABHIL website and available resources or directs you to the areas of the website when needed

Never	Very Rarely	Rarely	Occasionally	Very Frequent	Always
1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Quality of ABHIL online tools supporting core functions and utilize "Self Service" (Website/Availity/Prior Auth Tool, etc.)

Low Quality	1	2	3	4	5	6	7	8	9	High Quality	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Quality of orientations and/or ongoing training and support from ABHIL Provider Relations

Low Quality	1	2	3	4	5	6	7	8	9	High Quality	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Resolution of ABHIL claims payment problems or disputes when contacting the call center and/or your

Key contacts

Key contact information

- ❑ **Provider Services phone: 1-866-329-4701 (TTY: 711)**
- ❑ **Provider website: www.AetnaBetterHealth.com/Illinois-Medicaid/providers/index.html**
- ❑ **Access listing of assigned Network Relations Sr. Analysts & Managers:
<https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/Provider%20Relations%20Territory%20Assignment%20List%202020.pdf>**
- ❑ **Sign up for provider training here: <https://www.aetnabetterhealth.com/illinois-medicaid/providers/training-orientation.html>**
- ❑ **Member Services phone: 1-866-329-4701 (TTY: 711)**

Vendors and partners

Vendors and partners

Aetna Better Health® of Illinois subcontracts the following services:

- ❑ **DentaQuest** for Dental
 - DentaQuest contacts:
 - Krista.Smothers@dentaquest.com (Central and Southern Illinois)
 - LaDessa.Cobb@dentaquest.com (Northern Chicago)
 - Michelle.ONail@dentaquest.com (Southern Greater Chicago)

- ❑ **March Vision** for Vision
 - Optometry claims go to March Vision
 - Ophthalmology claims go to ABHIL
 - Enroll contact: <https://marchvisioncare.com/becomeprovider.aspx> or call toll-free at **844-456-2724**

- ❑ **Modivcare** for Non-emergency Medical Transportation (NEMT) - **866-329-4701**

- ❑ **Availity** for ABHIL Provider Portal - <https://apps.availity.com/availity/web/public.elegant.login>

- ❑ **EviCore** for utilization management of advanced imaging/cardiology and interventional musculoskeletal pain management
 - *To Enroll contact:* www.evicore.com or call toll-free at **888-693-3211**

- ❑ **Eviti** is a decision support platform for oncology; it covers all medical and radiation oncology treatment plans for members age 18 and older
 - Provider Support Team is available 8 AM – 8 PM ET or phone at **888-482-8057** or via email at ClientSupport@NantHealth.com

A high-angle, top-down photograph of a diverse group of people standing in a circle on a wooden floor. Their arms are extended towards the center, and their hands are stacked on top of each other in a gesture of unity and teamwork. The individuals are wearing various casual and business-casual clothing, including jeans, blouses, and button-down shirts. The lighting is bright and even, highlighting the textures of the clothing and the wood of the floor. The overall mood is positive and collaborative.

Thank you!

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

