Provider orientation

Aetna Better Health® of Illinois
2024

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Our mission

Aetna Better Health® of Illinois (ABHIL) is looking forward to serving Illinoisans and partnering with health systems, providers, FQHCs and community resources to bring quality health care to the state through our experience and dedication in serving Medicaid populations.

Our Plan is led by our CEO Rushil Desai. Members of the Aetna Better of Illinois team will be based within the state to better serve the health care community and its members.

Aetna Better Health of Illinois will support our health care partners through interactive onboarding, virtual and in-person ongoing education, value based contracting opportunities, enhanced secure provider portal and claims management assistance. Additionally, we will provide useful resources and tools to help ease the administrative burden.

Together, we will collaborate on a healthier future for your patients, our members.

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Orientation agenda

- Our members, your patients
- Value-based services
- Prior authorizations
- Concurrent review
- Pharmacy
- Quality
- EPSDT
- Health Risk Screening (HRS)
- Access to care guidelines
- Telephone accessibility standards
- Abuse, neglect and exploitation
- Fraud, waste and abuse
- Claims
- Provider Preventable Conditions (PPC)
- Grievance and appeals
- Contacting Aetna Better Health of Illinois
- Availity
- Resources
- ABHIL team

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How we connect with our members

What is health equity?

Our health equity definition:
Everyone has a fair and just opportunity to be as healthy as possible.

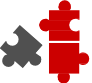
We must remember that achieving health equity means understanding the root causes of inequities.

Fair and just

Regardless of race, ethnicity, gender, sexual orientation, gender identity, preferred language, religion, geography, income or disability status.

Healthy

A complete state of physical, mental and social well-being that is impacted by clinical and non-clinical drivers of health, including access to quality health care, education, housing, transportation and jobs.



Recognition of racism and discrimination

Key drivers of health outcomes, and the importance of working with communities to remove barriers to health.

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Health equity & social determinants of health (SDOH)

Health equity is the goal

Everyone has a fair and just opportunity to be as healthy as possible.

Social determinants of health are contributing factors

The conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks.

Health equity & SDoH are closely related concepts, but they are not the same. Health equity is the goal and SDoH are factors that influence whether we achieve that goal.

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Member REACH team

The Member REACH (Real Engagement And Community Help) team is here to support Aetna Better Health of Illinois members by addressing their social care needs so they can focus on their overall health and wellbeing.

Aetna's REACH Team is dedicated to understanding and assisting member's individual needs and can connect them to local community programs that may be able to offer financial assistance, food assistance, educational services, housing assistance, legal services, employment services, support groups, baby supplies, clothing and more.

Aetna's REACH Team is dedicated to understanding and assisting with your needs. We can connect you to programs that may be able to offer:

- Financial assistance
- Food assistance
- Educational services
- Housing assistance
- Legal services
- Employment services
- Support groups
- Baby supplies
- Clothing

Call us anytime.

833-316-7010

2458552-04-01

Aetna Better Health®

Cultural competency

Aetna Better Health of Illinois Provider Manual

Cultural Competency begins on page 32 or search for “Cultural Competency”

Aetna Better Health of Illinois website

AetnaBetterHealth.com/Illinois-Medicaid/providers/training-orientation

CVS Health® You Tube Channel

ThinkCulturalHealth.hhs.gov

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Anti-Discrimination Policy and Americans with Disabilities Act (ADA)

It is our policy <u>not</u> to discriminate against members based on:

- Race
- National origin
- Creed
- Color
- Age
- Gender/gender identity
- Sexual preference
- Religion
- Health status
  - Physical/mental disability
- Other basis prohibited by law

The **ADA** gives civil rights protections to individuals with disabilities like those provided to individuals based on:

- Race
- National origin
- Creed
- Sexual preference
- Religion
- Age
- Physical/mental disability
- Color
- Gender/gender identity

Please ensure that your staff is aware of these requirements and the importance of treating members with respect and dignity.

If we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be taken.

The ADA guarantees equal opportunity for individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

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Aetna Better Care Rewards for members

The Aetna Better Care® Rewards program lets members earn rewards for living a healthy life. Rewards are placed on a gift card that can be used in stores or online.

Effective dates: January 1, 2024 - December 31, 2024

Annual visits
- Annual well care visit (PCP): $25 ages 20+
- Annual well child visit: $25 ages 3-21
- Well child visits: $10
    - Eight well child visits in the first 30 months of life (6 or more visits in the first 15 months of life, plus 2 additional visits by 30 months)

Screenings
- Cervical cancer screening: $25
    - Women ages 21-64 who have a Pap smear can earn this reward once every 3 years <u>or</u> women ages 30-64 who have HPV testing or HPV/Pap smear co-testing can earn this reward once every 5 years.
- Breast cancer screening: $25 ages 50-74
    - Reward can be earned once every 2 years

Diabetes care visits
- HbA1c control (<8.0%)*: $25 ages 18-75
- Controlled high blood pressure**: $25 ages 18-75

*Controlled HbA1c: diagnosis of type 1 or type 2 diabetes with a hemoglobin A1c (HbA1c) value of less than 8.0%
**Controlled Blood Pressure: systolic blood pressure below 140 mm Hg and diastolic blood pressure below 90 mm Hg

Immunizations for children and adolescents
- Childhood immunizations:
    - $30 for members who complete the below vaccines by their 2nd birthday:
        - Four diphtheria, tetanus and acellular pertussis (DTaP)
        - Three polio (IPV)
        - Three hepatitis B (Hep B)
        - One measles, mumps and rubella (MMR)
        - Three haemophilus influenza type B (HIB)
        - One chicken pox (VZV)
        - Four pneumococcal conjugates (PCV)
    - Additional $25 for members who complete all above vaccines, plus the vaccines shown below, by their 2nd birthday:
        - One hepatitis A (Hep A)
        - Two or three rotaviruses (RV)
        - Two influenza vaccines (Flu)
- Adolescent immunizations: $20 per vaccine (max. $60) for members who complete all required vaccines between 11-13 years of age.
    - One dose of meningococcal vaccine
    - One tetanus
    - Diphtheria toxoids and acellular pertussis (Tdap) vaccine; and
    - Two or three dose human papillomavirus (HPV) vaccine series by their 13th birthday. HPV series counts as one reward event.

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Aetna Better Care Rewards (cont'd)

Assessments
- Health Risk Screening: $20
    - Complete by paper, online or by phone within 60 days of enrollment

Controlled blood pressure
- Blood pressure < 140/90: $25 ages 18–85
    - Members must have a diagnosis of hypertension (HTN)

Dental service (Child)
- Annual child dental exam: $20
    - Ages under 21 who have comprehensive exam with a dental provider

Behavioral health follow-up appointments
- Follow up after hospitalization for mental health
    - 7-day follow up: $30 ages 18+
    - 30-day follow up (8-30 days): $20 ages 18+
- Follow up after ED visit for alcohol or drug use
    - 7-day follow up: $30 ages 18+
    - 30-day follow up (8-30 days): $20 ages 18+
- Follow up after treatment for substance use
    - 7-day follow up: $30 ages 18+
    - 30-day follow up (8-30 days): $20 ages 18+

Prenatal and postpartum doctor visits
- Postpartum visit: $50
    - 1-12 weeks after delivery
- Prenatal visit: $25
    - Within the first trimester or within 42 days of enrollment
- Notification of pregnancy: $25
    - Completed by the end of second trimester

Rewards are one per year unless otherwise stated.

AetnaBetterHealth.com/Illinois-Medicaid/rewards-program

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Value-added benefits

In 2024, our members can take advantage of these free extra benefits:

Baby essentials
Eligible pregnant members can receive a car seat or highchair or play yard, plus a diaper bag.

Eligible members can receive a voucher for up to $45 a month to spend on diapers for each child ages 2.5 years (30 months) and under.

Behavioral health wellness app
Eligible members ages 12 and up can get a voucher for digital behavioral health wellness support.

Fitness and weight management
Eligible members can get a voucher for monthly memberships at participating gyms. Ages 13 and up can receive a digital membership, ages 18 and up can receive a digital or in-person membership.

Eligible members ages 18 and up can get personalized nutrition and dietitian services and may qualify for food delivery.

Eligible members ages 18 and up can get a voucher for digital weight management support.

School clothes
Eligible members in grades K – 12 can get clothing through select online retailers.

Educational support
Eligible members ages 18 and up can receive career training, skill building and GED support.

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AetnaBetterHealth.com/Illinois-Medicaid/Whats-Covered

Member Advisory Committee

Member Advisory Committee

This group is made up of ABHIL staff, members, individuals and providers with knowledge of and experience with serving the older population and individuals with disabilities, representatives from community agencies and community advocates.

This committee discusses how to improve our policies and is responsible for:

- Providing input on cultural and linguistic needs
- Providing feedback on member materials so they are more effective and user-friendly
- Suggesting ways to contact hard to reach members
- Suggesting ways to improve telephone services
- Suggesting ways to better communicate proper ER usage and transportation services
- And more…

We encourage you to become a part of this group. Or, if you have a member who would be interested, call Member Services at **866-329-4701**

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Medical management: care management

Integrated Care Management Program (ICM)

A member-centered approach that addresses physical and behavioral health, psychosocial needs and collaboration with the members' system of care and relationships.

Specialized care markets for:

- COPD
- Asthma
- Depression
- Heart failure
- Diabetes
- Hypertension

How to refer to care management:

Phone: 1-866-329-4701 (TTY: 711)

Fax: 1-844-401-8174

Email: ABHILCommunityCMFax@Aetna.com

High

Risk

Low

Intensive care management

Supportive care management

Monitoring management ("Population Health")

General population

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How to refer to care management

Referral process:

How to refer to care management:

Phone: 1-866-329-4701 (TTY: 711)

Fax: 1-844-401-8174

Email:
ABHILCommunityCMFax@AETNA.com

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

Community Health Worker/Case Management

Provider Referral Form

Use this form to refer an Aetna Better Health member for an outreach phone call and/or in-person home visit.

Fax the completed form to 1-844-401-8174.

Date: ____________________

MEMBER INFORMATION

First Name: ____________________
Last Name: ____________________
Member ID: ____________________
Date of Birth: ____________________
Address: ____________________
City, State: ____________________
Phone: ____________________

PROVIDER INFORMATION

Provider Name: ____________________
Clinic/Agency: ____________________
Phone: ____________________ FAX: ____________________
Contact for Follow-Up: ____________________

PLEASE SELECT REASON FOR REFERRAL

- Missed Appointments (minimum of 3 missed appointments) ☐
- Medications Not Picked Up ☐
  - Date: ____________________
  - Type of Medicine: ____________________
- High Emergency Room Use ☐
- Post In-Patient Discharge Follow-Up ☐
- Other – Please Explain:

____

Forms can be found here:
AetnaBetterHealth.com/Illinois-Medicaid/providers/forms.html

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Behavioral health

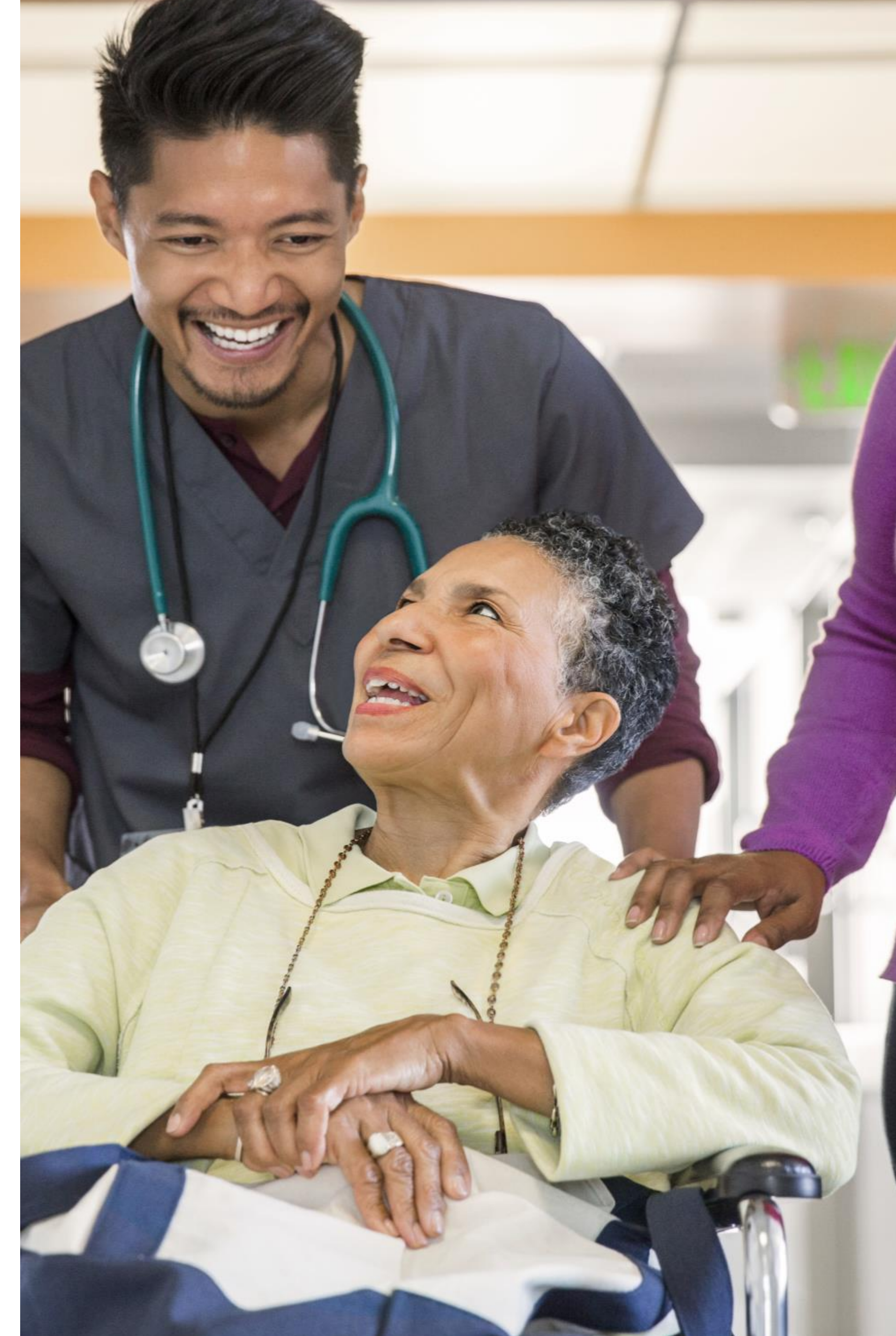
Basic behavioral health services

- Services provided for the assessment and treatment of problems related to mental health and substance use disorders.
  - Substance use disorders include abuse of alcohol and other drugs.
- Inpatient behavioral health services are reimbursed in accordance with your contract.

Primary care provider referral

ABHIL promotes early intervention and health screening for identification of behavioral health problems and patient education. To that end, our providers are expected to:

- Screen, evaluate, treat and refer (as medically appropriate), any behavioral health problem/disorder.
- Treat mental health and substance use disorders within the scope of their practice.
- Inform members how and where to obtain behavioral health services.



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Behavioral health – cont'd

Multiple access points for behavioral health services

- Mild to moderate impairment
- Moderate to severe impairment
- Substance Use Disorder

Responsibility of Aetna Better Health of Illinois, includes mild to moderate impairment:

- PCP
- Psychiatric testing
- OP counseling
- Psychiatric evaluation & Medication management
- ABA services
- Intensive Outpatient Program (IOP)

- Participating providers are required to provide treatment to pregnant enrollees who are intravenous drug users and all other pregnant substance users within twenty-four (24) hours of assessment.

- Participating providers providing inpatient psychiatric services to enrollees are required to schedule the enrollee outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven (7) calendar days from the date of discharge.

- Providers must notify ABHIL of all discharge medications **prior to** member's planned discharge from inpatient (IP) stay:
  - 1) IP Mental Health
  - 2) IP Detox
  - 3) Residential

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Behavioral health resources

Screening, Brief Interventions, & Referral to Treatment (SBIRT)

Screening: assess patient for risky substance use behaviors using standardized screening tools

Brief intervention: healthcare professional engages patient in a short conversation, providing feed back and advice

Referral to treatment: healthcare professional provides referral to brief therapy or additional treatment for patients who screening demonstrates the need for additional services

Additional resources:

SBIRT

AetnaBetterHealth.com/Illinois-Medicaid/providers

Resources and materials:

CMS Health insurance reform for consumers (MH Parity Act of 2008)

Effective December 1st, 2020, ABHIL implemented the Milliman Care Guidelines Behavioral Health Guidelines (MCG BHG) as the primary medical necessity criteria for behavioral health

- MCG BHG is nationally recognized, evidence-based clinical guidelines used for determining medical necessity, appropriate levels of care: MCG.com/content/behavioral-health-care

Depression Screening

Unhealthy drug use screening

Early and Periodic Screening, Diagnostic and Treatment info

Cognitive Health Assessment for Members 65 years of age or older

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Member ID card

The member ID card contains the following information:

- Member name, ID, DOB & gender
- 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
Health*Choice* 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**

CVS caremark®

MEIL1

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

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Member Services and enrollment

Overview

- Our Member Services Department is available to:
  - Answer questions about members health and covered services
  - Help choose primary care provider (PCP)
  - Tell member where to get needed care
  - Offer interpreter services if primary language is not English
  - Offer information in other languages/formats
  - Assist with access and questions regarding the Member Web Portal

If you need help, call Aetna Better Health of Illinois (toll free) 24 hours a day, 7 days a week at 1-866-329-4701.

You can also visit us online any time at **AetnaBetterHealth.com/Illinois-Medicaid**

How can members enroll?

The State is responsible for determining eligibility and members can contact them to enroll:

Online	Phone	In person	Mail
ABE.illinois.gov	**1-800-843-6154**	DHS Office Locator at **DHS.state.il.us** to find your nearest Family Community Resource Center	**HFS.illinois.gov/hfs/sitecollectiondocuments/il444-2378b.pdf**

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Language services

Language services can be accessed via Member Services at **1-866-329-4701 (TTY 711)**

- **Interpretation (face to face)**
  - Nationwide network of qualified interpreters offering interpretation in 15+ languages, including American Sign Language (ASL)
- **Interpretation (over the phone)**
  - Access to interpreters supporting 200+ languages via telephone

Additional resources:

Interpreter Quality Standards Guidance
NCIHC.org/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf

Office for Civil Rights
HHS.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

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Additional services provided

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 Aetna Better Health of Illinois
  - 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 Provider Portal** - **https://apps.availity.com/availity/web/public.elegant.login**

- **EviCore** for utilization management of advanced imaging/cardiology and interventional musculoskeletal pain management
  - Enroll at **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 ages 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

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How we connect with providers

Overview of Value-Based Services (VBS)

Our offer various incentive arrangements

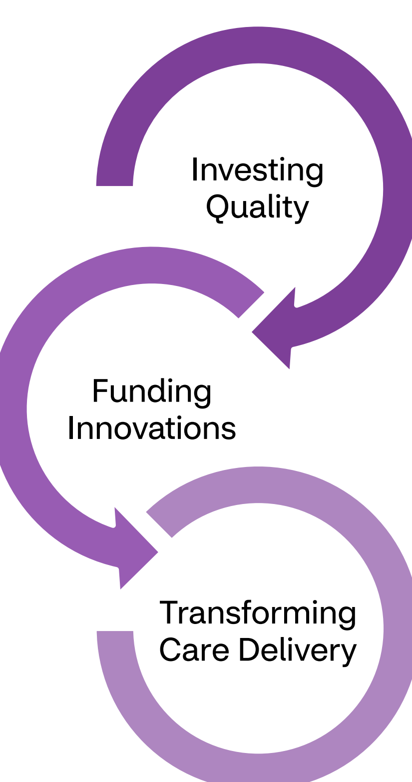
- Pay for quality with designated incentive pool
- Shared savings models
- Shared risk models
- Full risk models/capitation models

We look for participating providers in

- Primary care
- Pediatric care
- Obstetrics and Gynecology

Interested? Please contact:

- Scott Keefer – Executive Director, Strategic Provider Partnerships
- Armand Conti – Senior Manager, Strategic Provider Partnerships
- Email: **ABHILProviderPartnerships@aetna.com**



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Medical Prior Authorizations (PA)

You may submit PA requests by:

Phone
1-866-329-4701

Secure
Availity

Fax
1-877-779-5234 for medical or 1-844-528-3453 for Behavioral Health

Service Authorization Decision Timeframes	Turnaround Times
Urgent pre-service approval	48 hour from receipt of request
Standard non-urgent pre-service approval	96 hours from receipt of the request
Urgent concurrent approval	72 hours from receipt of request
Retrospective review approval	30 calendar days from receipt of the request

Additional timeframes and authorization information, is in the Provider Manual

Documentation requirements for authorization request:

- Member information
- Diagnosis code(s)
- Treatment or procedure code(s)
- Anticipated start and end dates of service(s)
- All Supporting clinical documentation to support medical necessity
- Include:
    - Office/department contact name
    - Telephone
    - Fax number

Forms can be found here:
AetnaBetterHealth.com/Illinois-Medicaid/providers/forms

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Concurrent review process

Overview

Aetna Better Health of Illinois conducts concurrent utilization review on **each** member admitted to an inpatient facility, including skilled nursing facilities (SNF) and freestanding specialty hospitals.

What does that mean?

- Admission certification
- Continued stay review
- Conducted before the expiration of the assigned length of stay
  - Providers will be notified of approval or denial of stay
- Review of the member's medical record to assess medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines
- The nurses work with the medical directors in reviewing medical record documentation for hospitalized members

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Pharmacy

Aetna Better Health of Illinois covers prescription medications and certain over-the-counter medicines when you write a prescription for a member.

We use CVS/Caremark for pharmacy benefit management services.

Online formulary search tool includes formulary status and indicates whether a drug requires step therapy (ST), has a quantity limit (QLL) or requires Prior Authorization (PA)

CVS Caremark Mail Order Pharmacy

Pharmacy PA:

- Prior authorizations may be submitted electronically via CoverMyMeds and SureScripts, or via fax 844-802-1412 or phone 866-329-4701.
- Through a direct link on our website, you can view:
  - PA criteria
  - PA forms

Visit our provider page for more information at:

AetnaBetterHealth.com/Illinois-Medicaid/providers/pharmacy

Electronic PA:

Use Surescripts or Covermymeds® to:

- Submit prior authorization (PA)
- Check member eligibility and coverage status
- Check medication history, and formulary information

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Quality management program

Overview

- QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. The process enables us to:
  - Assess current practices in both clinical and non-clinical areas
  - Identify opportunities for improvement
  - Select the most effective interventions
  - Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

Medical records standards

- ABHIL's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).
- All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the ABHIL Provider Manual

Quality management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

- Two ways data is collected for HEDIS measures.
  - Administrative- measures use claims/encounters for hospitalizations, medical office visits and procedures or pharmacy data only.
  - Hybrid- measures use data obtained directly from the member's medical record in addition to administrative data.

What is our ultimate goal

- For providers to submit claims/encounters with coding that administratively captures all required HEDIS data via claims. This decreases or removes the need for medical record (hybrid) review.

Please see HEDIS Tips for PCPs located on our website at **AetnaBetterHealth.com/Illinois-Medicaid/providers**

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Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

What is EPSDT?

- ➢ It is a federally defined health program for children under age 21 who are enrolled in Medicaid.
- ➢ The EPSDT benefit is more robust than the ABHIL benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.
- ➢ The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

Provider responsibilities:

- ✓ Complete the required screenings according to the current American Academy of Pediatrics "Bright Futures" periodicity schedule and guidelines
- ✓ Fully document all elements of EPSDT assessments, including anticipatory guidance and follow-up activities
- ✓ Report EPSDT visits by submitting the applicable CPT codes on claim submission

Click HERE for EPSDT screening and services

EPSDT/Bright Futures

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), also known as Bright Futures services, are federally-mandated preventive care services for Medicaid members under age 21.

All primary care providers (PCPs) are required to provide these comprehensive health care, screening and preventive services for children.

Required EPSDT/Bright Futures screening services

Immunizations and assessment of diet, activity, growth, weight and BMI percentiles are services that occur at a well-child visit. Specific screenings should also occur at certain ages and stages of development. Aetna Better Health® of Illinois participating providers must make these screening services available to EPSDT-eligible members at the ages recommended on the EPSDT/Bright Futures periodicity schedule.

- **Anemia screening:** between 9 and 12 months.
- **Blood lead screening:** All children should receive an initial screening blood lead test at 12 and 24 months. Children between the ages of 36 months/3 years and 72 months/6 years with no history of a previous blood lead screening test are required to have blood lead screening documented in their medical record.
- **Dyslipidemia screening:** once between 9 and 11 years and once between 17 and 20 years; other ages should be screened if indicated by history and/or symptoms.
- **Visual acuity screening:** annually, ages 3-21.
- **Hearing screening:** annually, ages 3-21.
- **Structured autism screening:** 18 months old and 24 months old. See examples of validated screening tools for autism and developmental delays.
- **Structured developmental screening:** between 9 and 11 months old, again at 18 months old and again at 30 months old, using a validated screening tool.

Document all screenings and developmental surveillances in the medical record, including follow-ups, results and anticipatory guidance given. The medical record must document that a developmental screening was performed with a validated screening tool at 9-11 months, 18 months and 30 months.

Aetna Better Health® of Illinois

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Health Risk Screening

As an Aetna Better Health provider, it is expected that you perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has an OCS eligible medical condition. We rely on you, our network providers, to complete the Initial Health Risk Screening within thirty (30) days of the members enrollment to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care.

The Health Risk Questionnaire for will assist us in identifying enrollees with special health care needs. If identified, we will follow-up with a Comprehensive Assessment (CA) as a part of the Risk Stratification Level Framework. This information must be included in the patient's medical records and supplied to Aetna Better Health of Illinois or its regulators upon request.

Three (3) documented outreach attempts:

- Enrollee to complete the questionnaire in-person, by phone, electronically via ABHIL member portal, or by mail

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Health Risk Screening questionnaire & triggers

Questionnaire include but is not limited to:

a. Demographic information for verification purposes;

b. Current and past physical health and behavioral health conditions;

c. Identifying enrollees with special health care needs and specialized treatment or equipment;

d. Services or treatment the enrollee is currently receiving, including from out-of-state providers;

e. Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another plan;

f. Most recent ER visit, hospitalization, physical exam and medical appointments;

g. Current medications; and

h. Questions to address Social Determinants of Health, including food, shelter, transportation, utilities and personal safety.

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Comprehensive assessment

a. Demographic intake;
b. Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content and memory;
c. Functional or adaptive deficits/needs (e.g., ADLs, IADLs);
d. Behavioral health, including previous psychiatric, addictions and/or substance abuse history, and a behavioral health, depression, and substance abuse screen;
e. Medical conditions, complications, and disease management needs;
f. Trauma, abuse, neglect, violence and/or sexual assault history of self and/or others, including Department of Human Services involvement;
g. Disability history;
h. Educational attainment, skills training, certificates, difficulties, and history;
i. Family/caregiver and social history;
j. Medication history and current medications, including name, strength, dosage, and length of time on medication;
k. Social profile, community, and social supports (e.g., transportation, employment, living arrangements, financial, community resources) and support system, including peer and other recovery supports;
l. Advance directives;
m. Present living arrangements;
n. Enrollee strengths, needs and abilities;
o. Home environment; and
p. Enrollee cultural and religious preferences.

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How we remain compliant

Access to care guidelines

Appointment availability standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Provider Relations will routinely monitor compliance and seek Corrective Action markets (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the Illinois Department of Healthcare and Family Services (HFS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

Appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), and high-volume Participating Specialist Providers (PSPs).

**Please note that follow-up to ED visits must be in accordance with ED attending provider discharge instructions.*

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Access to care guidelines – cont'd

Specialty care appointment time frames (list all high volume and high impact specialists)

Provider type	Emergency services	Urgent care	Preventative and routine care	Wait time in office standard	After hours (voicemail not acceptable)
PCP	Same day	Within one business day	Within 72 hours	Within three weeks	No more than 45 minutes
Specialty referral (includes high-volume specialty care)	Same day	Within one business day	Within 72 hours	Within three weeks	No more than 45 minutes

Oncology and high-impact specialty appointment timeframes

Provider type	Emergency services	Urgent care	Non-urgent	Preventative and routine care	Wait time in office standard	After hours (voicemail not acceptable)
Oncologist and other high- impact specialist	Same day	Within one business day	Within 72 hours	Within three weeks	No more than 45 minutes	24/7

Maternity appointment timeframes

Aetna contractually requires its providers to comply with the following prenatal care appointment access standards:

Provider type	First trimester	Second trimester	Third trimester	High-risk condition	Emergency condition
Maternity	As soon as possible after identification. For members without expressed problems appointments will be made available within two (2) weeks after the request.	Within seven (7) calendar days of identification for members without expressed problems	Within three (3) calendar days of identification for members without expressed problems	Within one (1) calendar days of identification	Immediately upon identification

- First trimester: within two (2) weeks after a request
- Second trimester: within seven (7) calendar days of request
- Third trimester: within three (3) days of request

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Access to care guidelines – cont'd

Provider type	Emergency services	Non-life-threatening urgent care	Urgent (no immediate danger)	Preventative and routine care	Wait time in office standard
Behavioral Health	Immediately	Within 6 hours	Within 48 hours	Initial visit: Within 10 business days of original request	No more than 45 minutes

- Non-life-threatening urgent: There is no immediate danger to self or others and/or if the situation is not addressed within six hours, it may escalate resulting in a risk to self or others:
  - Extreme anxiety
  - Parent child issues
  - Passive suicidal ideation
  - Excess drug or alcohol usage
- Urgent (no immediate danger): There is no immediate danger to self or others and/or if the situation is not addressed within forty-eight (48) hours, it may escalate resulting in a risk to self or others:
  - Follow-up to a crisis stabilization
  - Escalating depression
  - Escalating anxiety
  - Escalating drug/alcohol usage
  - Escalating behavioral issues in children

Additionally, behavioral health providers are contractually required to offer:

Provider type	Follow-up BH medication mgt.	Follow-up BH therapy	Next follow-up BH therapy
Behavioral health	Within 3 months of first appointment	Within 10 business days of first appointment	Within 30 business days of first appointment

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Telephone accessibility standards

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all the following situations:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

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Telephone accessibility standards – cont'd

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable:	Unacceptable:
• Telephone is answered by provider, office staff, answering service, or voice mail. • The answering service either: ○ Connects the caller directly to the provider ○ Contacts the provider on behalf of the caller and the provider returns the call ○ Provides a telephone number where the provider/covering provider can be reached • The provider's answering machine message provides a telephone number to contact the provider/covering provider.	• The answering service: ○ Leaves a message for the provider on the PCP's/covering provider's answering machine ○ Responds in an unprofessional manner • The provider's answering machine message: ○ Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. ○ Instructs the caller to leave a message for the provider. • No answer • Listed number no longer in service • Provider no longer participating in the contractor's network • Answering service refuses to provide information for after-hours survey • Telephone lines persistently busy despite multiple attempts to contact the provider

**Providers must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.*

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Abuse, neglect and exploitation

As mandated by State of Illinois, all providers who work or have any contact with an Aetna Better Health of Illinois members, are required as “mandated reporters” to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency.

Children

If you suspect that a child has been harmed or is at risk of being harmed by abuse or neglect, report it online at https://childabuse.illinois.gov. In an emergency, call the 24-hour Child Abuse Hotline at 800-25-ABUSE (800-252-2873). If you believe a child is in immediate danger of harm, call 911 first. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following State agencies:

•The Illinois Domestic Violence Hotline at **1-877-863-6339**

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Fraud, waste and abuse

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste

Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse

Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Providers can report suspected fraud, waste or abuse in the following ways:

- By phone to the confidential Aetna Better Health of Aetna Better Health of Illinois Provider Services: **866-329-4701**
- By phone to our confidential Special Investigation Unit (SIU) at **866-536-0542**

You can also report provider fraud to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477**).

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Claims and claims submission

Clearinghouse & clean claims
We accept both paper and electronic claims via Change Healthcare and is the preferred clearing house for electronic claims

- **Payer ID: 68024**

EDI claims received directly from Change Healthcare & processed through pre-import edits to:

- Evaluate Data Validity
- Ensure HIPAA Compliance
- Validate Member Enrollment
- Facilitate Daily Upload to ABHOK System

Claims submissions
We require clean claims submissions for processing. To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure code

New claim submissions

- Submitted within 180 calendar days from the date the service unless there is a contractual exception.
- For hospitals inpatient claims (date of service means the entire length of stay for the member).
- For FQHC and RHC providers, please list the rendering provider on your claims.

Claim resubmission
Corrected claims must be submitted within 180 days from the date of service.

- Providers may resubmit a claim that was originally denied because of:
  - Missing documentation
  - Incorrect coding
  - Incorrectly paid or denied because of processing errors

How to submit a claim:

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

Online via Change Healthcare's ConnectCenter for Physicians claim submission portal
Portal Registration (Use vendor code 214568 to allow submission to ABHIL)
Home/Portal Login

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Provider dispute resolution processing timeframe

<table>
<tr><th colspan="2">DESCRIPTION</th><th>TURNAROUND TIME FRAME</th></tr>
<tr><td rowspan="2">DEADLINE FOR MARKET RECEIPT OF PROVIDER DISPUTES</td><td>Dispute related to an individual claim, billing dispute, or contractual dispute;

OR

Dispute related to a demonstrable and unfair payment pattern by the market</td><td>Deadline: Within 90 days of original denial</td></tr>
<tr><td>Dispute regarding a market notice of overpayment</td><td>Deadline: Within 60 working days of receipt of the market notice of overpayment of a claim</td></tr>
</table>

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Provider dispute resolution processing timeframe (cont'd)

DESCRIPTION		TURNAROUND TIME FRAME
TIME PERIOD FOR ACKNOWLEDGEMENT	Electronic Provider Dispute (directly into the system)	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.
	Paper Provider Dispute (mail, fax, e-mail, physical delivery)	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.
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Aetna Better Health will review reconsideration requests and provide a written response within 30 calendar days of receipt.
PAST DUE PAYMENTS AND INTEREST AND PENALTIES	Resolution of a dispute involving a claim, which is determined in whole or part in favor of the provider, shall include the payment of any outstanding monies determined to be due and all interest due.	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.

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Provider Preventable Conditions (PPCs)

The Patient Protection and Affordable Care Act-Section 2702, requires that state Medicaid programs implement non-payment policies for Provider Preventable Conditions (PPCs), including Health Care-Acquired Conditions (HCACs) (in an acute inpatient setting) and Other Provider-Preventable Conditions (OPPCs) (in any health care setting).

We use a claims business application system that is designed to stop automatic processing of PPC claims identified for clinical review. We use this process to pend processing of claims received with PPC related diagnosis codes.

Pended claims are referred to a concurrent review nurse to initiate the investigation process. In addition, associates involved with the concurrent review process may identify potential PPCs during the course of utilization management evaluation.

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Provider Preventable Conditions (PPCs) – cont'd

We will not reduce payment for a PPC to a provider when the condition (defined as a PPC for a particular patient) existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- The identified PPCs would otherwise result in an increase in payment.
- The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPCs.

Payment will not be available for any State expenditure for PPC conditions.

We will ensure that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

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Claim submission resources

Claim submission assistance/links

Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

How to fill out a CMS 1500 Form:

CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

Sample CMS 1500 Form:

https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1500.pdf

How to fill out a CMS UB-04/1450 Form:

CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

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Provider appeal and grievance system

Provider appeal: A request for a review of a post-service, authorization-related claim denial for potential reprocessing when it is:

- Attributed to authorization not kept current due to extenuating circumstances, or
- Authorizations denied due to services not being medically necessary
- **NOTE:** All pre-service denials must go through the Member Appeal process, in which an Authorized Representative Form must be completed and signed by the member
- Provider Appeals must be requested within 60 days from date of denial
- Provider Appeals are acknowledged within 5 business days of receipt and decisions are made no more than 30 business days of receipt.

Provider grievance: An expression of dissatisfaction to ABHIL regarding our policies, procedures or any aspect of our administrative functions.

- Provider grievances can be requested at any time.
- Provider grievances are acknowledged within 5 business days of receipt and resolution is made no more than 30 business days of receipt.

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Provider appeal and grievance system

How to file an appeal or grievance:

Phone: **866-329-4701**

Fax: **844-951-2143**

Online: **Availity** & member portal

Email: **ILAppealandGrievance@Aetna.com**

Mail:

Aetna Better Health of Illinois
Attn: Appeal and Grievances
PO Box 81040
Cleveland, OH 44181

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

https://www.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	• 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 • 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 • 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 • 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 • 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 • Attach EOB or letter from primary carrier
Claim/coding edit • We use two (2) claims edit applications: Claim Check and Cotiviti. Please 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 • 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 • When filing on behalf of a member the request is processed as a **Member Grievance** andis subject to the member grievance policies and timeframes

Examples of appeals: (Step 2 if applicable)
On behalf of a member: • Continued stay concurrent review • Urgent or Emergent review • Pre-Service (Prior Authorization) requests   • 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

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Reconsideration form

https://www.aetnabetterhealth.com/illinois-medicaid/providers/forms.html

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

Provider dispute and 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	
☐ Incorrect denial of claim or claim line(s)	☐ Incorrect rate payment
☐ Coordination of benefits	☐ Consent form denial
☐ Code or modifier issue	☐ Itemized bill
☐ 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 dispute and claim reconsideration form
AetnaBetterHealth.com/Illinois-Medicaid

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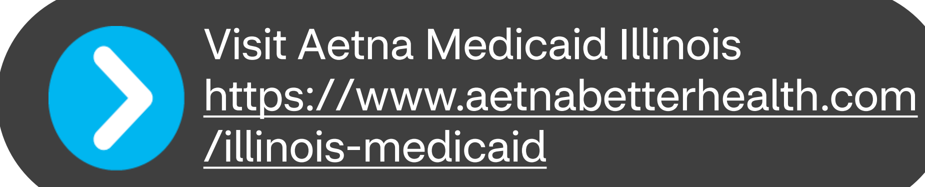
Additional information & resources

Contacting Aetna Better Health of Illinois



Provider/Member Services Line:

1-866-329-4701 (TTY: 711)

- 24/7 Medical/Behavioral Advice Line
- Care Coordination
- Claims
- Eligibility

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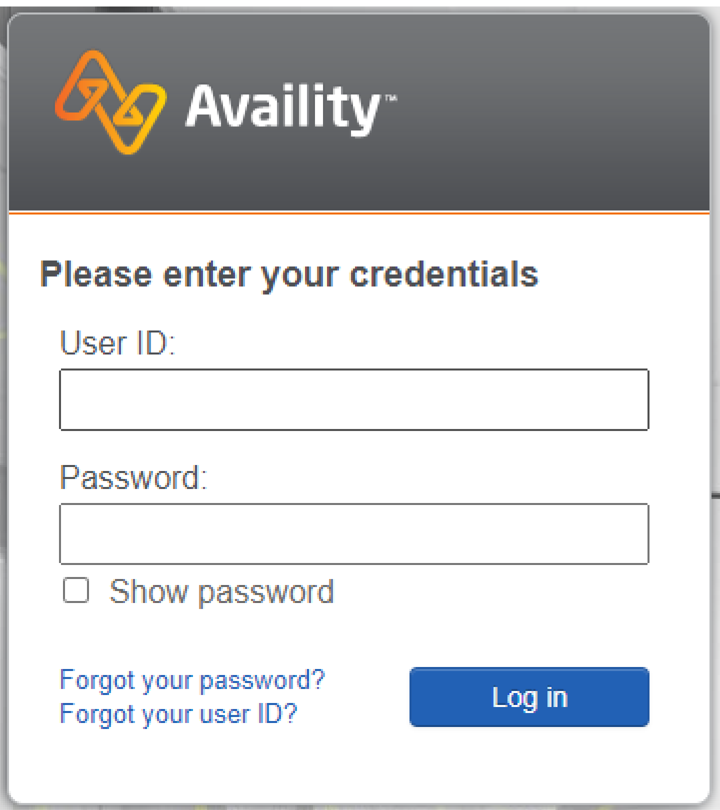
Availity: provider secure web portal

Aetna Better Health of Illinois uses Availity for our provider portal. We're excited to support you as you provide services to our members. Our communications will be via email. Keeping our providers informed is our priority.

Some highlights of increased functionality include:

- Claims look up
- Online claim submission
- Prior authorization submission and look up
- Grievance and appeals submission
- Panel searches
- A new robust prior authorization tool
- Review of grievance and appeals cases
- Eligibility and member look up



Availity

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Our website

Tools

List of participating providers

Pharmacy search tool

Provider manual

24/7 secure provider portal

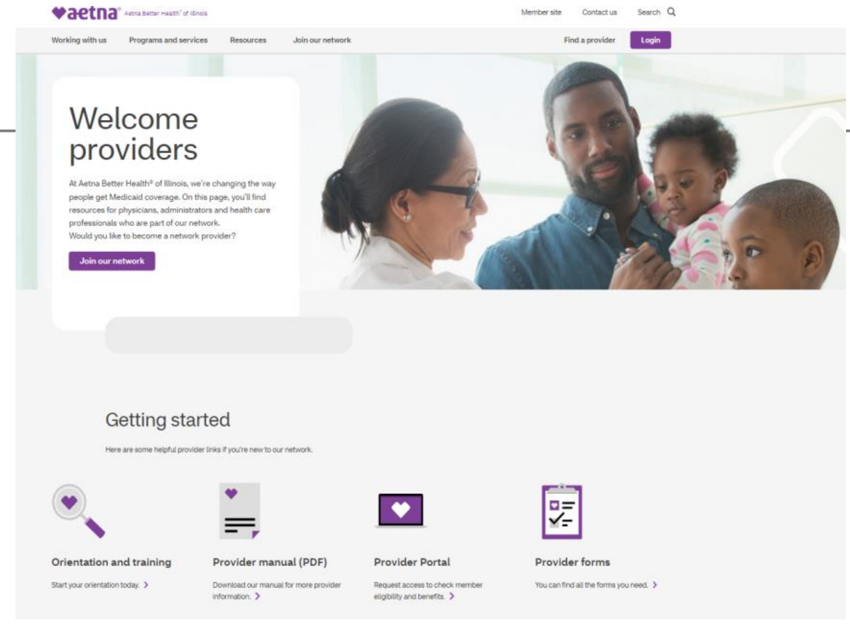
Clinical guidelines forms

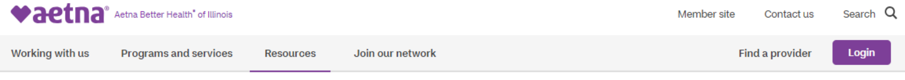
Provider education

BH screeners

Screening, Brief Interventions, & Referral to Treatment (SBIRT) Information & Training **SBIRT Training Link**

Website: **AetnaBetterHealth.com/Illinois-Medicaid**





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.

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

January 2024

- Register for our 2024 Provider Summits (PDF)
- Redetermination claims process (PDF)
- Clinical, payment and coding policy changes (PDF)

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Available resources

- Claims Inquiry & Research (CICR) team
- Provider Enrollment team
- **Online provider manual**
- **Secure web portal**
- Dedicated network relations manager
- Quick reference guide

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Your Aetna Better Health of Illinois team

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 can be sent to: ABHILProviderRelations@aetna.com

Terriana Robinson	Christine Fox-Zapata	Steve Inzerello
Lead Director Provider Experience	Senior Director Provider Experience	Senior Director Provider Experience
(224) 430-5989	(312) 547-3589	(773) 687-5475
RobinsonT6@aetna.com	FoxC@aetna.com	InzerelloS@aetna.com

Provider Relations assignment list

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Thank you!
aetna