# 2026 Medicaid Provider Summit

Aetna Better Health® of Illinois
**August 2026**

# Agenda

Introductions & Overview

Care Management

Pharmacy

Business Enterprise Program

Community Outreach

Marketing

Member Value-added Benefits

Quality Management

Availity Portal & Reporting

Value-based Partnerships

Health Equity

Claims Corner

Provider Escalations

Mandated Training

# Welcome from our senior leaders

**Melanie Fernando**
Chief Executive Officer

**Andrew Hyosaka**
Chief Operating Officer

**Mary Cooley**
Health Services Officer

**Garett Thomas**
Lead Director, Network Management

**Elizabeth Leonard**
Executive Director, Marketing

**Sally Szumlas**
Chief Quality Officer

**Hassan Gardezi**
Chief Compliance Officer

**Dianne Robinson**
Chief Financial Officer

**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**
Senior Manager, Provider Experience

**Latahra Smith**
Senior Manager, Provider Experience

**Steve Inzerello**
Senior Manager, Provider Experience

# Our footprint

525 W Monroe St
Chicago, IL 60661

# Our local approach

- Illinois-based staff for local member and provider servicing
- Over 850 Illinois-based employees
- Currently serving approximately 350,000 Medicaid members in the State of Illinois
- Network of more than 57,000 providers statewide
- Dedicated, local contracting and provider relations staff, with Illinois-based executive leadership



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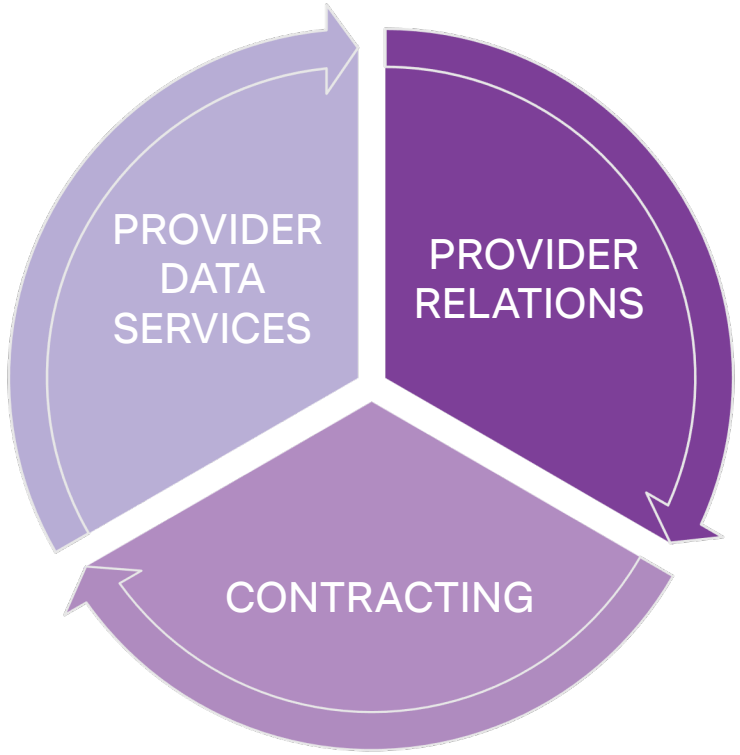
# Who we are

- 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

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# 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**

**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.

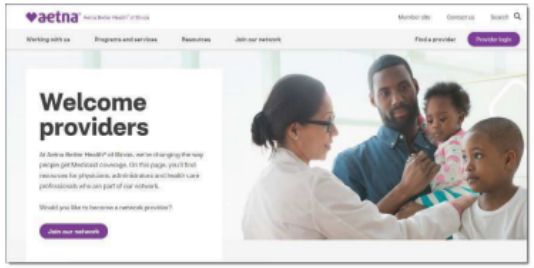
Aetna Better Health of Illinois offers a provider services line by calling **(866) 329-4701**
(Monday through Friday 7 AM-7 PM)

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 IMPACT Revalidation

## All Medicaid providers must revalidate their enrollment

**Important notes**

- All providers will be required to revalidate with IMPACT 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.

**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**.

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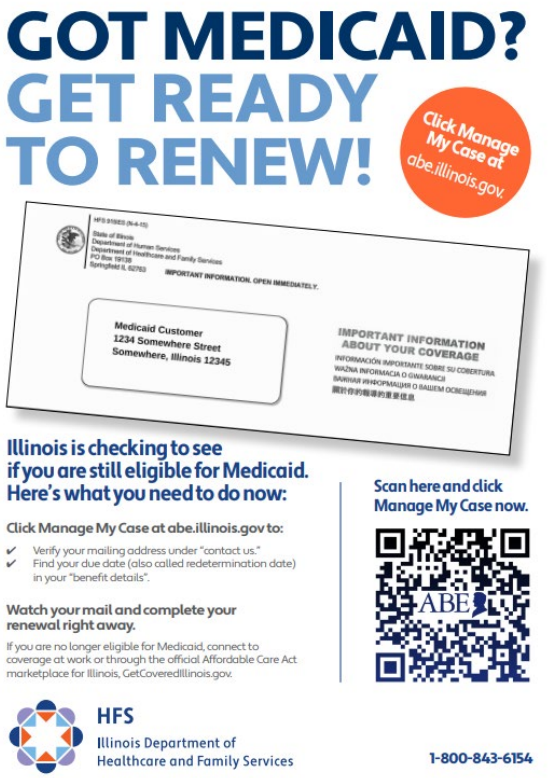
# Illinois Medicaid Redetermination

# Prepare your patients




**Visit HFS Today and access the "Ready to Renew" toolkit**

- ❑ Printable patient flyers available in different languages (post in waiting room and exam rooms)
- ❑ Social media PNG file available to use
- ❑ Palm cards available for use

**HFS Ready to Renew Toolkit**

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# How providers can help with redetermination

- ❑ **Remind Medicaid members to keep their mailing address updated with HFS.**

  Members can update mailing address with HFS via:

  - ✓ calling **1-877-805-5312 (TTY: 1-877-204-1012)**
  - ✓ visiting **www2.Illinois.gov/HFS/Address**
  - ✓ Providers should encourage members to keep contact information current to receive HFS notices

- ❑ **Let Medicaid members know that the Medical Benefits Renewal Form from HFS will be mailed 30 days prior to their redetermination date.**

  Members can confirm redetermination date or ask questions via the Application for Benefits Eligibility (ABE) hotline:

  - ✓ Call **1-800-843-6154 (TTY: 1-866-324-5553)**
  - ✓ Visit **ABE.Illinois.gov**

## Get your patients' redetermination date

Member-level Redetermination Report includes:

- Demographic information
- Redetermination date
- Form A/B distinction for all members

**Available in Availity**

## Why it's important

Helping members complete redetermination ensures that they can continue to get the care and services they need through Medicaid.

Timely renewal can help prevent claim denials due to eligibility discrepancies and keeps patient panels accurate.

**Illinois Medicaid Redetermination FAQ**



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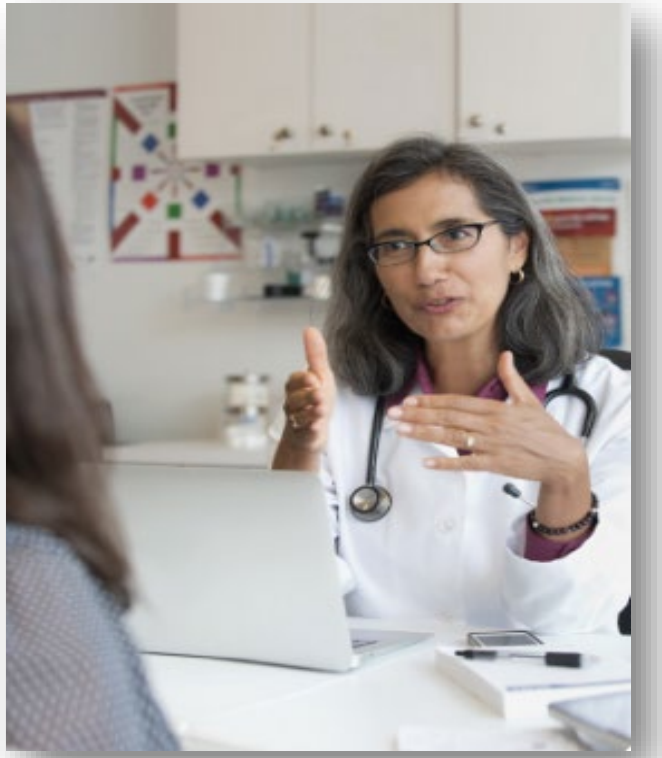
# Changes to Medicaid are Coming

- ✓ While nothing has changed yet, new Medicaid rules are coming later this year.
- ✓ Not all HealthChoice Illinois members will be impacted by upcoming changes.
- ✓ Some adult members may be required to
  - ❑ Renew Medicaid eligibility twice annually instead of once
  - ❑ Report 80 hours per month of work, education, or volunteer activities
- ✓ Work requirements may begin January 2027; certain immigration eligibility changes may begin October 2026.
- ✓ Members can continue enrolling in or renewing Medicaid coverage as usual.
- ✓ HFS will directly notify members if new requirements apply to them.



**Questions?**
Visit: GetMedicaidFacts.com



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# 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** and request a care manager or email **ABHILCOMMUNITYCMFAX@aetna.com**

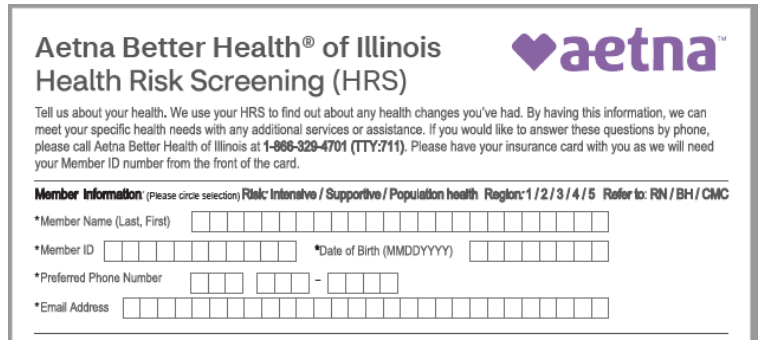
# Health Risk Screener (HRS): provider partnership

**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)

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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

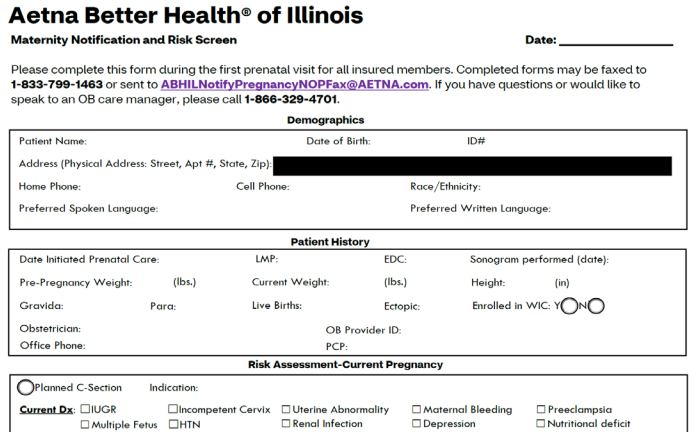
# Notification of Pregnancy (NOP): Provider partnership

**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: LMP: EDC: Sonogram performed (date):

Pre-Pregnancy Weight: (lbs.) Current Weight: (lbs.) Height: (in)

Gravida: Para: Live Births: Ectopic: Enrolled in WIC: Y ◯ N ◯

Obstetrician: OB Provider ID:

Office Phone: PCP:

**Risk Assessment-Current Pregnancy**

◯ Planned C-Section Indication:

**Current Dx**: ☐ IUGR ☐ Incompetent Cervix ☐ Uterine Abnormality ☐ Maternal Bleeding ☐ Preeclampsia

☐ Multiple Fetus ☐ HTN ☐ Renal Infection ☐ Depression ☐ Nutritional deficit

# Pharmacy

# Pharmacy resources

### Preferred drug list

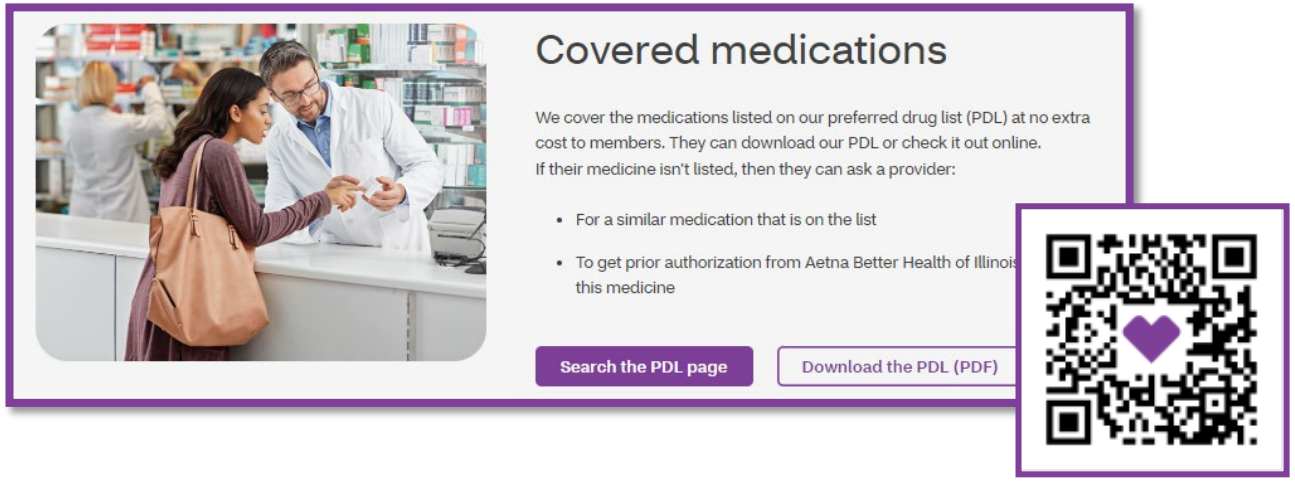
- Drug list available in PDF format as well as in the Aetna search tool.

### Medication prior authorization resources

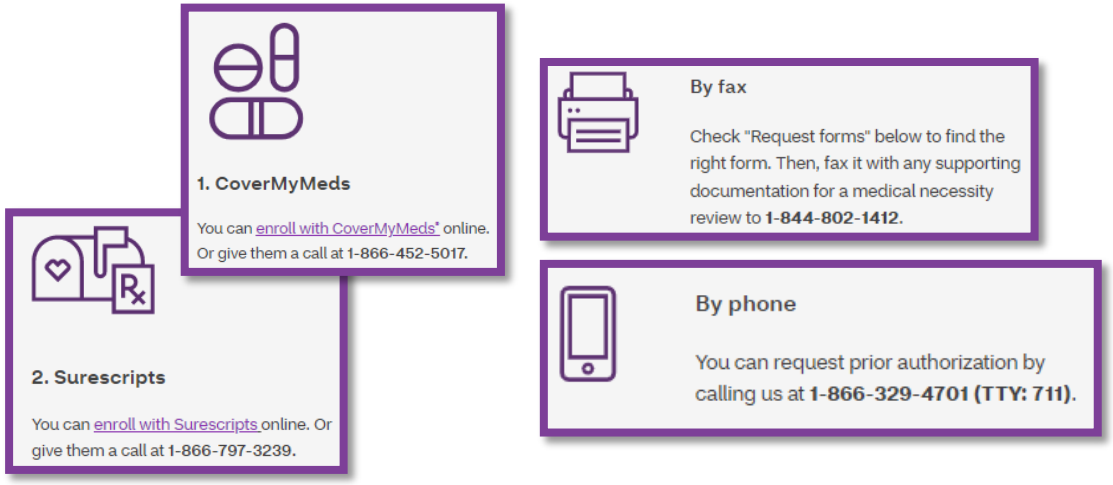
- All Rx prior authorizations reviewed within 24 hours.
- Full PA criteria are available on the provider website.
- All criteria are preloaded into CoverMyMeds in question format.

### Pharmacy PA Support Team

- Reduced PA volume, PA denials and appeals.
- 1:1 virtual session with PA ops team member.
- Customized review of all PA and appeal activity.




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



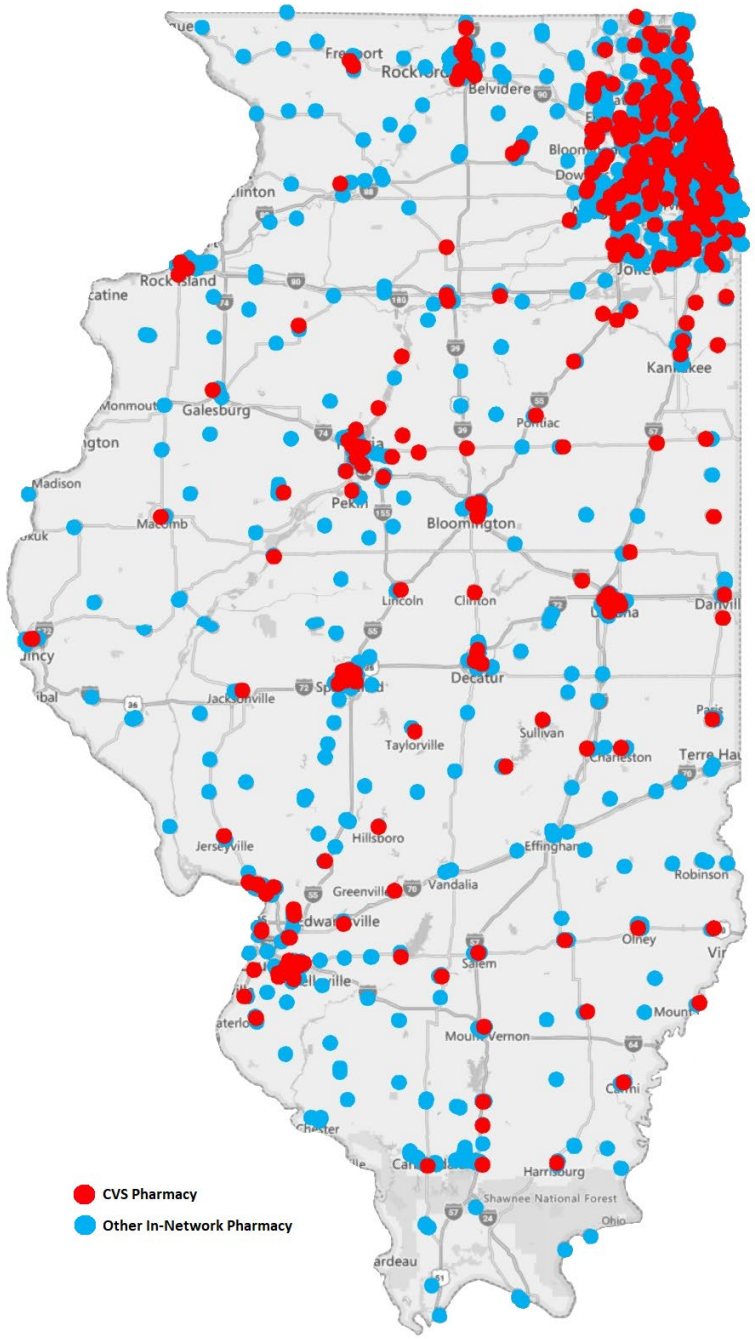
# Filling Prescriptions (Pharmacy Network)

Aetna Better Health provides members with a robust network of pharmacies to fill their prescriptions.

All participating pharmacies and prescribers must be enrolled through IMPACT at the individual NPI level.

Additional options for filling prescriptions:

| Local Same-Day Delivery | Mail Order | Dose-Pack Medication Delivery |
|---|---|---|
| • Available at all IL CVS locations<br>• Free for ABHIL members<br>• Requested at point-of-sale | • 90-day supply of maintenance medication | • Delivered through local IL pharmacies<br>• Ideal for members on complex medication regimens. |



# 2026 OTC Health Solutions


Members enjoy $25 monthly allowance on over 500 over-the-counter and food products.

| In Store | Online | By Phone |
|---|---|---|
| • Available at any CVS Pharmacy store | • Orders can be placed on cvs.com/benefits | • Orders can be placed by calling 1-888-628-2770 (TTY: 711) |

**Walkthrough Video**
Scan this QR code to watch a video on how to place orders online



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# 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**

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

# Member Retention & Communication Partnership

# What Is Changing for ACA Adults

| Jan. 1, 2027 | 80 hrs/mo | $580/mo | Every 6 mos | ~700K |
|---|---|---|---|---|
| Federal implementation date | Monthly threshold | Income alternative | Renewal cycle | Illinois ACA adults |

## ✓ Eligibility Requirement

ACA adults ages 19–64 must meet the requirement or qualify for an exemption at application and redetermination. Requirements can be met through work, income, education, community service, work-program participation, or a combination.

## ↻ Six-month Redetermination

Even members who are exempt from the work/community engagement requirement are still expected to complete eligibility redetermination every six months, increasing the need for recurring outreach and support.

## ⚕ Provider Impact

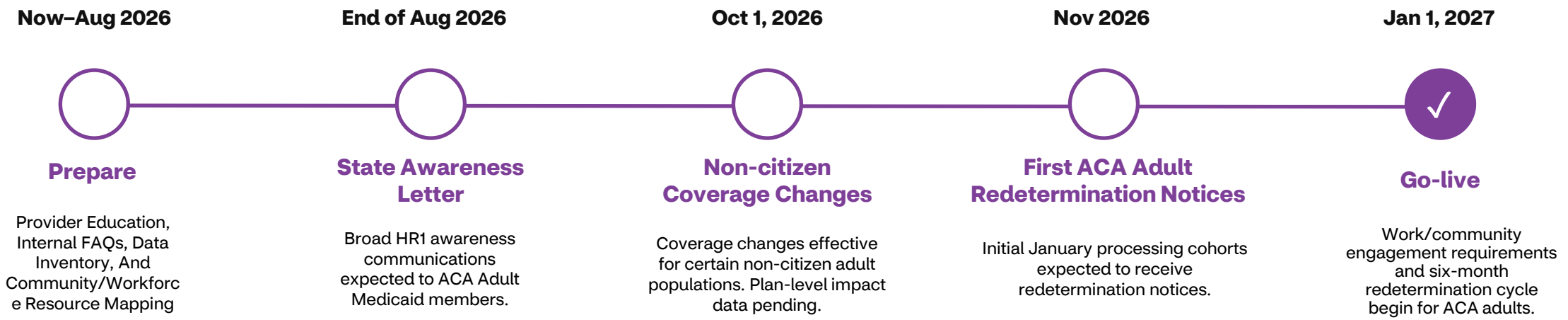
Members may bring questions to PCPs, FQHCs, behavioral health providers, care teams, and front-office staff. VBC groups may see impacts to attribution, care gaps, outreach lists, and shared performance if eligible members lose coverage.

**Key message to reinforce with members**

**Update contact information, watch for state notices, respond by required deadlines, and ask for help early if documentation or exemption support is needed.**

*Note: Exemption definitions, including medical frailty and caregiver-related criteria, are still pending state guidance.*

# Timeline and Operational Watch Points




**! Risk to manage**

Member/provider questions may begin before all FAQs, notices, and exemption details are final.

**→ Provider need**

Simple talking points, escalation contacts, and panel-level outreach priorities.

**✓ Plan focus**

Prepare early, share updates quickly, and refine based on state guidance.

*Based on current planning assumptions*

# The Member Retention Ecosystem

### State

Eligibility notices
Policy guidance
Required deadlines

### Aetna

Member outreach
Panel intelligence
Navigation resources


### Providers

Trusted messenger
Clinical context
Workflow reinforcement

### Community Partners

Workforce supports
Document navigation
Local resources

# How Aetna Will Support Provider Partners

### Panel Intelligence

At-risk cohort views by redetermination timing, outreach priority, eligibility status indicators, and escalation needs as data becomes available.

### Provider Toolkit

Concise FAQs, front-desk talking points, member handouts, sample scripts, and current links to ABE/Manage My Case and HFS resources.

### Clinical Escalation Pathway

Process to surface potential medical frailty, BH/SUD, homelessness, or caregiver-related questions once state documentation rules are finalized.

### Navigation Resources

Connection to workforce navigation, volunteer/community service resources, document support, and community-based partners.

### ↔ Feedback Loop

Standing JOC updates to review questions, member/provider barriers, data gaps, and state guidance requiring clarification.

**Goal: Minimize avoidable coverage loss while reducing administrative friction for provider partners.**

# Member Communications and Community Outreach

## Aetna's coordinated approach to reinforce messaging

### Redetermination Outreach

| Text messages | IVR | Emails | Mailer | Outbound calls |
|---|---|---|---|---|

Members begin receiving outreach 60 days prior to their redetermination due date.

1. **Remind Medicaid members to keep their mailing address updated with HFS.**

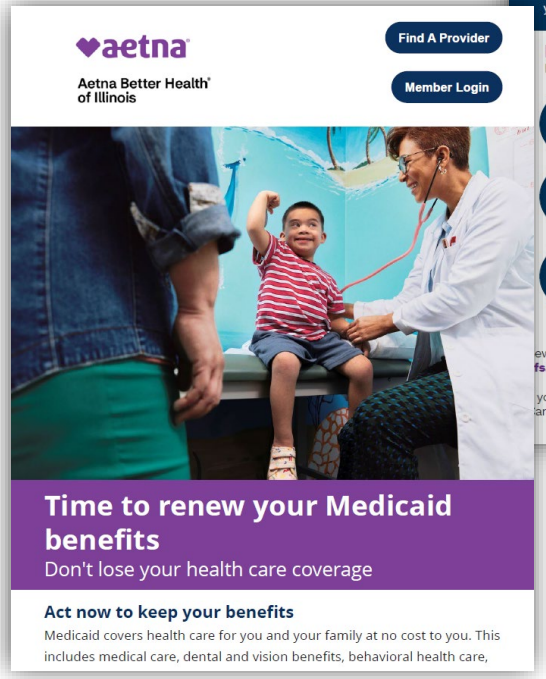
   Members can update mailing address with HFS via:

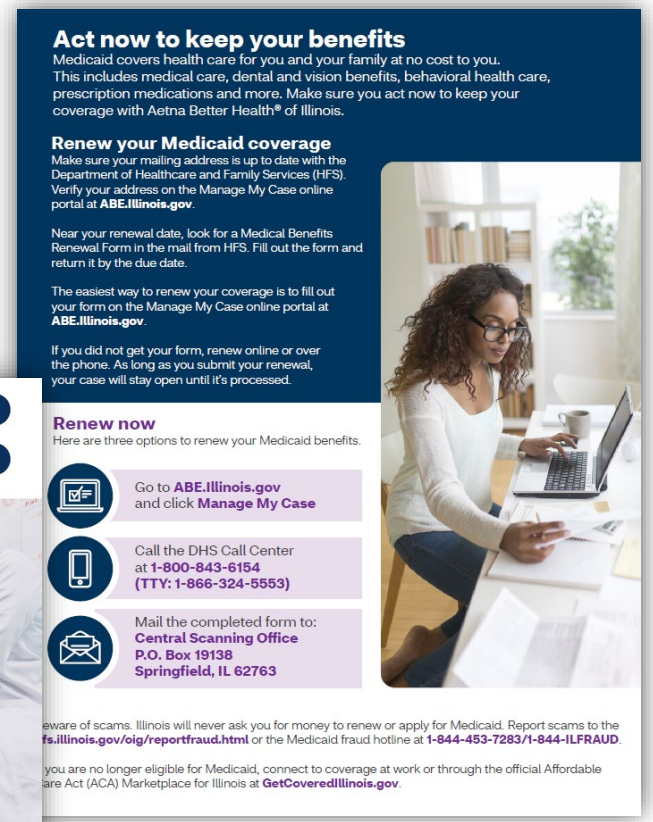
   - Call **1-877-805-5312 (TTY: 1-877-204-1012)**
   - Visit **www2.Illinois.gov/HFS/Address**

2. **Let Medicaid members know that the Medical Benefits Renewal Form from HFS will be mailed 30 days prior to their redetermination date.**

   Members can confirm redetermination date or ask questions via Application for Benefits Eligibility (ABE):

   - Call **1-800-843-6154 (TTY: 1-866-324-5553)**
   - Visit **ABE.Illinois.gov**



# Member Communications and Community Outreach
## Aetna's coordinated approach to reinforce messaging

### Community Outreach

Throughout the year, our Community Outreach team partners with trusted organizations across Illinois to support Medicaid renewals and connect members to the resources they need.

**We host Redetermination Assistance Days at community and provider sites, where partners reinforce renewal messaging and support members with:**

- On-site navigator support
- Document collection
- Aetna Medicaid 360 app education

Together, these efforts help reduce avoidable Medicaid disenrollment, increase renewal completion and member retention, improve the member and provider experience, and strengthen continuity of care.

**Each month, we also host community events throughout Illinois — including health and resource fairs, fresh produce giveaways, Laundry & Literacy events, and more.**

To see where we'll be next, check our calendar at AetnaBetterHealth.com/Illinois-Medicaid/News-Events

Interested in partnering on a Redetermination Assistance Day or hosting a community event with us? Please contact:


Ryan Yarrell

Senior Manager, Community Development

Ryan.Yarrell@aetna.com


# Member Communications and Community Outreach
## Aetna's coordinated approach to reinforce messaging

**Provider Reinforcement**

### Provider channels

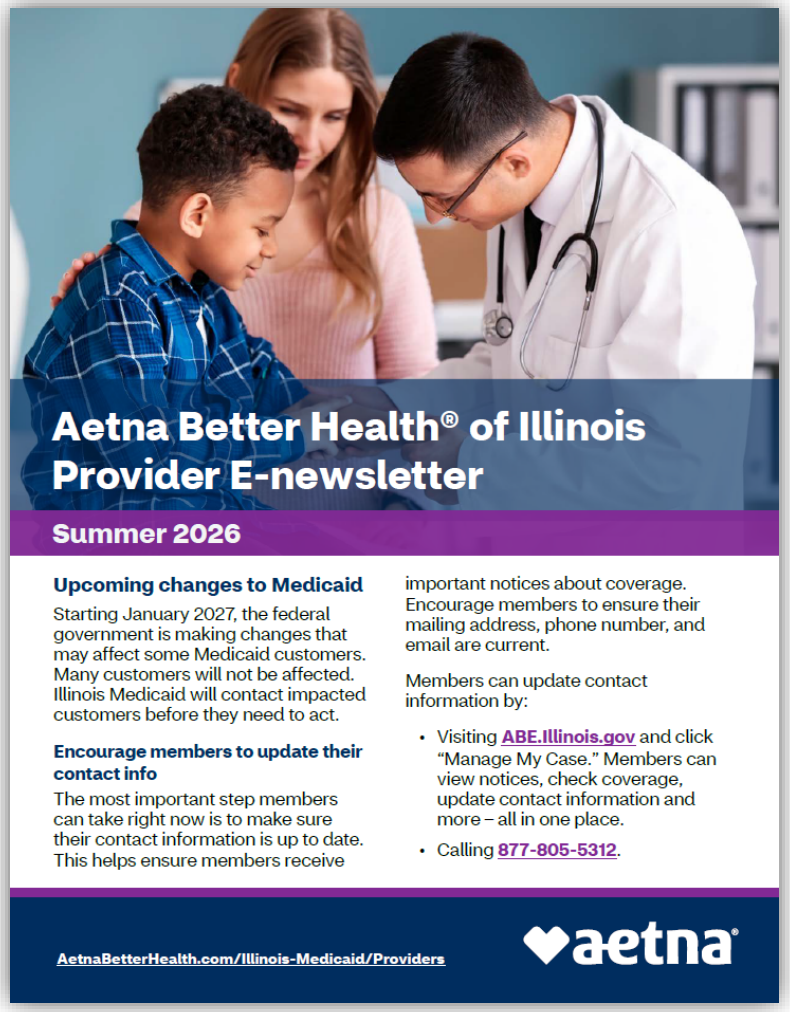
Newsletter updates, PR rep outreach, JOC cadence, and practice-facing tools.

### Provider newsletter

Our quarterly newsletter brings provider partners key updates and resources. This summer edition covers:

- Upcoming changes to Medicaid
- Availity provider portal
- Provider education opportunities
- Bill-IQ billing assistant
- Appointment and availability standards

To join the email list, share your email with your PR rep.



# Redetermination
## HR1 changes

### HR1 Communication Next Steps

**Member messaging**

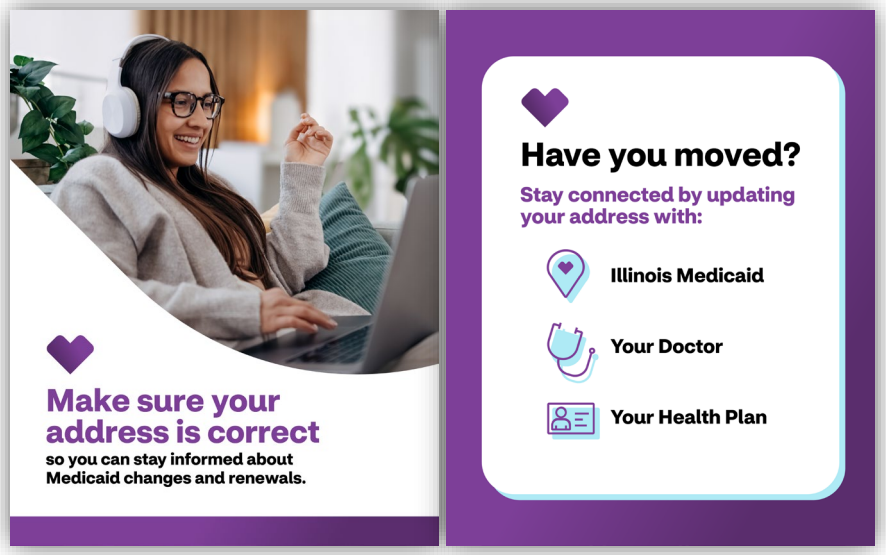
Continue encouraging members to keep contact information updated with the State, providers, and the health plan.

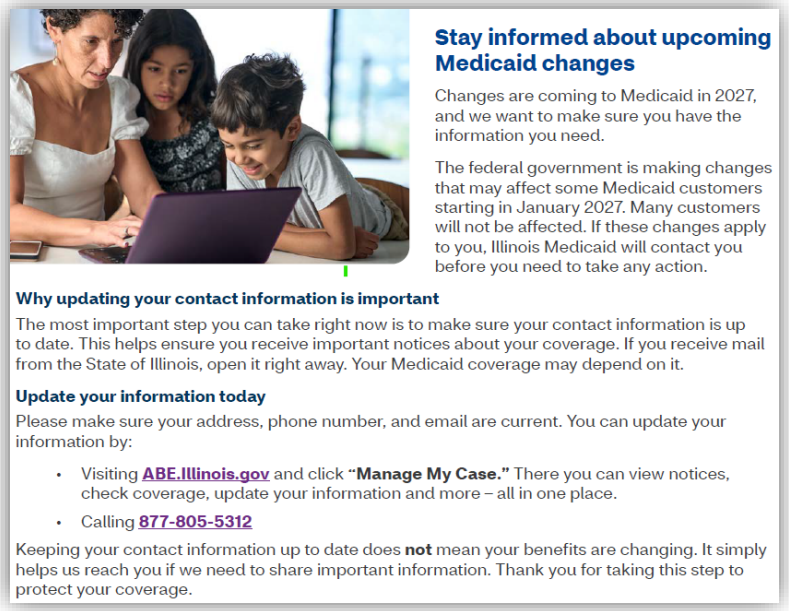
**State alignment**

Continue collaboration with the State to determine requirements and member messaging for impacted populations.

**Campaign build**

Develop a comprehensive communication campaign to inform members about required actions.



# Provider and Member Enablement Initiatives

# 2026 ABHIL Pay for Performance Program – Key Updates

- ~$4M Total Provider Earning Potential
- Three scheduled payments
  - Q3 2026 for 1H2026
  - Q1 2027 for 2H2026 (reconciled)
  - Q2 2027 for claims runout
- 19 Measures Eligible for Tiered Incentives
- 13 Specialty Measures Eligible for Flat Rate Incentives
- Program Accuracy Improvement:
  - Provider TIN Validation
  - Recent W-9 on file
  - Payment point of contact data

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# 2026 ABHIL Pay for Performance Program

## 2026 Pay for Performance measures, targets and payment tiers*

| Measure | Submeasure | Tier 1 Rate | Tier 2 Rate | Tier 3 Rate | Tier 1 | Tier 2 | Tier 3 |
|---|---|---|---|---|---|---|---|
| Adult access to primary care | AAP | 89% | - | - | $10 | - | - |
| ★ Metabolic Monitoring of Children on Psychotropic Medications | APM | 39% | 49% | 58% | $10 | $15 | $25 |
| Breast Cancer Screening (2026 MY gaps only) | BCS | 59% | 64% | 70% | $10 | $25 | $50 |
| Blood Pressure Control for Patients with Diabetes | BPD | 75% | 79% | 80% | $10 | $25 | $50 |
| Cervical Cancer Screening (2026 MY gaps only) | CCS | 56% | 62% | 69% | $10 | $15 | $25 |
| Childhood Immunization Status (Combo 10) | CIS | 26% | 31% | 38% | $25 | $50 | $75 |
| ★ Chlamydia | CHL | 58% | 68% | 73% | $10 | $15 | $25 |
| ★ Colorectal Cancer Screening | COL | 46% | 54% | 58% | $10 | $15 | $25 |
| Controlling High Blood Pressure | CBP | 72% | 74% | 78% | $10 | $25 | $50 |
| Eye Exams for Patients with Diabetes | EED | 68% | 72% | - | $20 | $30 | - |
| Glycemic Status Assessment for Patients With Diabetes (<8) | GSD | 65% | 68% | 71% | $10 | $25 | $50 |
| Immunizations for Adolescents (Combo 2) | IMA | 37% | 46% | 51% | $25 | $50 | $75 |
| ★ Oral Evaluation Dental Services (Total) | OED | 51% | 56% | - | $5 | $10 | - |
| Pharmacotherapy for Opioid Use Disorder | POD | 27% | 33% | 37% | $25 | $50 | $75 |
| Well-Child Visits 3-11 Years | WCV 3-11 | 65% | 71% | - | $15 | $20 | - |
| Well-Child Visits 12-17 Years | WCV 12-17 | 59% | 65% | - | $15 | $20 | - |
| Well-Child Visits 18-21 Years | WCV 18-21 | 34% | 42% | - | $15 | $20 | - |
| Well-Child Visits 0-14 Months | W30 | 71% | 74% | - | $15 | $20 | - |
| Well-Child Visits 15-30 Months | W30 | 82% | 84% | - | $15 | $20 | - |

## Annual flat rate per member

| Measure | Submeasure | Incentive per member |
|---|---|---|
| Follow-Up After ED Visit for Alcohol | FUA (30-Day: 18+) | $25 |
| Follow-Up After ED Visit for Alcohol | FUA (7-Day: 18+) | $70 |
| Follow-Up After ED Visit for Mental Illness | FUM (30-Day: 6-17) | $25 |
| Follow-Up After ED Visit for Mental Illness | FUM (7-Day: 6-17) | $70 |
| Follow-Up After ED Visit for Mental Illness | FUM (30-Day: 18-64) | $25 |
| Follow-Up After ED Visit for Mental Illness | FUM (7-Day: 18-64) | $70 |
| Follow-Up After Hospitalization for Mental Illness | FUH (30-Day: 18-64) | $25 |
| Follow-Up After Hospitalization for Mental Illness | FUH (7-Day: 18-64) | $70 |
| Follow-Up After Hospitalization for Mental Illness | FUH (30-Day: 6-17) | $25 |
| Follow-Up After Hospitalization for Mental Illness | FUH (7-Day: 6-17) | $70 |
| Initiation and Engagement of Substance Use Disorder Treatment | IET - I | $20 |
| Initiation and Engagement of Substance Use Disorder Treatment | IET - E | $50 |
| Prenatal Immunization Status | PRS-E | $20 |
| Timeliness of Prenatal Care | TOPC | $50 |
| Postpartum Care | PPC | $50 |

★ New measure for 2026

*program is subject to change per contract

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# Provider Incentives & Enablement Initiatives

## Provider partnership bonuses

| Measure | Detail | Provider Incentive |
|---|---|---|
| HRS Completion (w/in 60 days) | per new member HRS completed within the first 60 days | $25 |
| HRS Completion | per any HRS completed | $10 |
| SDS Data Exchange | one time bonus, per provider feed* | $1,000 |
| Z-Code (Z59.XX homelessness series) | once per member | $25 |
| Notification of Pregnancy | per notification of pregnancy | $30 |
| CPT II Code | Per compliant CBP, BPD, HBD, EED (negative only) codes on each claim billed | $25 |

*requires panel size greater than 1,000 members

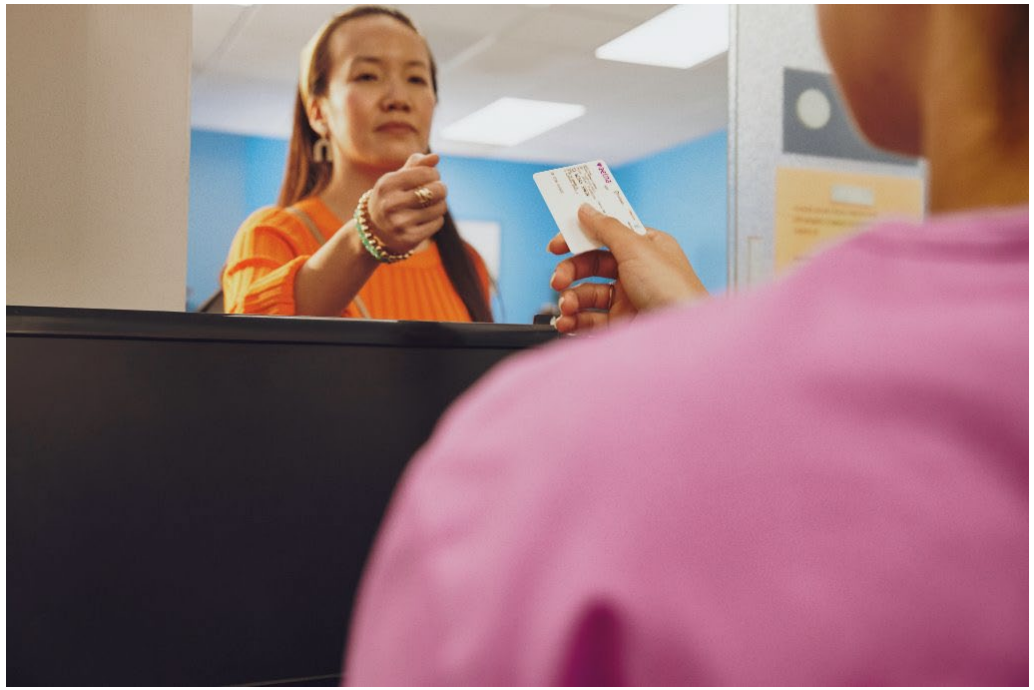
## Z-Codes for Homelessness

- Z59.0-Homelessness
- Z59.00-Unspecified
- Z59.01- Sheltered Homelessness
- Z59.02-Unsheltered Homelessness

## Member Incentives

- $50 for Breast Cancer Screening
- $50 for Cervical Cancer Screening

- Passport to Wellness – *Coming Soon*
  - $25 reward for well child visits at 0-30days, 3 months, 9 months, 24 months, and 3 Years – Total $150) – *Coming Soon*



# ABHIL 2026 P4Q reporting* - Availity

**Aetna Better Health of Illinois P4Q Report - Provider Group Performance**
Report Date : 4/25/2025 Data Refreshed On: 4/3/2025 4:14:02 PM

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| Measure Key | Submeasure Key | Measure Description | NCQA 50%ile | NCQA 75%ile | NCQA 90%ile | Provider Numerator | Provider Denominator | Provider Rate | Max Earnings | Total # Needed to Reach 50%ile | Total # Needed to Reach 75%ile | Total # Needed to Reach 90%ile |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AAP | TOTAL | Adult Access to Preventive/Ambulatory Health Services | 74% | 79% | 83% | 308 | 1,570 | 19.62% | $31,400 | 856 | 932 | 994 |
| BCSE | BCS | Breast Cancer Screening | 53% | 62% | 64% | 47 | 113 | 41.59% | $9,040 | 13 | 23 | 26 |
| BPDB | | Blood Pressure Control for Patients With Diabetes | 72% | 79% | 80% | 15 | 167 | 8.98% | $16,700 | 106 | 117 | 119 |
| CBPB | CBP | Controlling High Blood Pressure | 68% | 73% | 76% | 11 | 169 | 6.51% | $16,900 | 104 | 113 | 117 |
| CCS | | Cervical Cancer Screening | 58% | 62% | 67% | 250 | 681 | 36.71% | $40,860 | 143 | 171 | 208 |
| CIS | CO10 | Childhood Immunization Status – Combo 10 | 29% | 37% | 44% | 12 | 58 | 20.69% | $11,600 | 6 | 10 | 14 |
| EEDB | EYEEXAM | Eye Exams for Patients with Diabetes | 60% | 66% | 68% | 44 | 167 | 26.35% | $16,700 | 56 | 66 | 70 |
| GSDB | HBA1C8 | Glycemic Status Assessment for Patients With Diabetes (<8) | 60% | 64% | 66% | 22 | 167 | 13.17% | $16,700 | 79 | 85 | 89 |
| IMA | CO2 | Immunizations for Adolescents - Combination 2 | 37% | 44% | 51% | 35 | 106 | 33.02% | $14,840 | 4 | 12 | 20 |
| POD | TOTAL | Pharmacotherapy for Opioid Use Disorder | 26% | 34% | 38% | 0 | 6 | 0.00% | $840 | 2 | 3 | 3 |
| PPC | PPC | Postpartum Care | 0% | 0% | 0% | 9 | 14 | 64.29% | $0 | 0 | 0 | 0 |
| PPC | TOPC | Timeliness of Prenatal Care | 0% | 0% | 0% | 9 | 14 | 64.29% | $0 | 0 | 0 | 0 |
| PRSE | INFLUENZA | Prenatal Immunization Status | 0% | 0% | 0% | 4 | 6 | 66.67% | $0 | 0 | 0 | 0 |
| PRSE | TDAP | Prenatal Immunization Status | 0% | 0% | 0% | 5 | 6 | 83.33% | $0 | 0 | 0 | 0 |
| PRSE | COMBO | Prenatal Immunization Status | 0% | 0% | 0% | 4 | 6 | 66.67% | $0 | 0 | 0 | 0 |
| W30 | 0TO14MTH | Well-Child Visits in the First 30 Months of Life (First 14 Months) | 60% | 65% | 69% | 17 | 59 | 28.81% | $3,540 | 19 | 22 | 24 |
| W30 | 15TO30MTH | Well-Child Visits in the First 30 Months of Life (15 Months-30 Months) | 68% | 72% | 79% | 45 | 66 | 68.18% | $3,960 | 0 | 3 | 7 |
| WCV | 3TO11 | Child and Adolescent Well-Care Visits (3-11) | 59% | 65% | 71% | 5 | 867 | 0.58% | $34,680 | 510 | 562 | 611 |
| WCV | 12TO17 | Child and Adolescent Well-Care Visits (12-17) | 52% | 59% | 65% | 5 | 609 | 0.82% | $24,360 | 315 | 354 | 394 |
| WCV | 18TO21 | Child and Adolescent Well-Care Visits (18-21) | 28% | 34% | 42% | 3 | 244 | 1.23% | $9,760 | 66 | 80 | 101 |
| | | **Grand Total** | | | | **860** | **5,117** | **16.81%** | **$251,880** | | | |

*Does not include projected earnings rendering provider measures (BH, PPC, etc.)

Earnings opportunity for 90th percentile performance



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# CPT II coding to optimize your earning potential

## Opportunities

- The P4Q and Quality Care Gaps report are available in Availity and updated monthly. These empower your practice to:
  - See members with open care gaps assigned to your practice
  - **Maximize your earnings-** ABHIL incentivizes provider groups with **$25 Per compliant CBP, BPD, GSD, and EED (negative only)** codes on each claim billed

## Measures

- Controlling High Blood Pressure (CBP)
- Diabetes - Blood Pressure Control (<140-90) (BPD)
- Diabetes - Eye Exam (EED)
- Diabetes – Hemoglobin A1c Control (<8) (GSD)

**2026 HEDIS Reference Tool →**


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HEDIS REFERENCE TOOL

HRT

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).
The HEDIS Reference Tool serves educational purposes and may not encompass all details about HEDIS Measures. The content within this document is sourced from the National Committee for Quality Assurance (NCQA) Technical Specifications for HEDIS Measures. Its primary aim is to equip providers and their affiliates with a comprehensive grasp of HEDIS measures and associated information.

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3309300-01-01 (04/24)

| EYE EXAM FOR PATIENTS WITH DIABETES (EED) (negative results only) | |
|---|---|
| 2023F | Dilated retinal eye exam with interpretation by an opthalmologist or optometrist documented and reviewd: without evidence of retinopathy |
| 2025F | 7 standard field stereoscopic retinal photos with interpretation by an opthalmogist or optometrist documented and reviewed: without evidence of retinopathy |
| 2033F | Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidency of retinopathy |
| **GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)** | |
| 3044F | Hemoglobin A1c level less than 7.0% |
| 3046F | Hemoglobin A1C level greater than 9.0% |
| 3051F | Hemoglobin A1c level greater than or equal to 7.0% and less than 8.0% |
| 3052F | Hemoglobin A1c level greater than or equal to 8.0% and less than or equal to 9.0% |
| **BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD)** | |
| 3074F | Systolic blood pressure less than 130 mm Hg |
| 3075F | Systolic blood pressure 130-139 mm Hg |
| 3077F | Systolic blood pressure greater than or equal to 140 mm Hg *(out of range result, will not close care gap)* |
| 3078F | Diastolic blood pressure less than 80 mm Hg |
| 3079F | Diastolic blood pressure 80-89 mm Hg |
| 3080F | Diastolic blood pressure greater than or equal to 90 mm Hg *(out of range result, will not close care gap)* |
| **CONTROLLING BLOOD PRESSURE (CBP)** | |
| 3074F | Systolic blood pressure less than 130 mm Hg |
| 3075F | Systolic blood pressure 130-139 mm Hg |
| 3077F | Systolic blood pressure greater than or equal to 140 mm Hg *(out of range result, will not close care gap)* |
| 3078F | Diastolic blood pressure less than 80 mm Hg |
| 3079F | Diastolic blood pressure 80-89 mm Hg |
| 3080F | Diastolic blood pressure greater than or equal to 90 mm Hg *(out of range result, will not close care gap)* |

# EMR Access

## What is Remote EMR Access?

The utilization of a secure connection to EMR applications or data from a location other than the provider office. Remote EMR allows Aetna to retrieve medical record data tied to HEDIS accreditation and performance metrics, including:

- Labs & diagnostic reports
- Outpatient care, including progress and consult notes
- Immunizations
- Problem lists & histories
- Assessments & flowsheets
- Medication sheet

## Benefits

- **Reduction in office burden during quality review projects pertaining to HEDIS gap closure**
  - ❖ More time with patients
  - ❖ No phone calls or faxes tied to quality audit
  - ❖ No need to reserve space for onsite reviewers
- Reduction in costs that can be tied to copy vendors or paying additional staff to pull charts
- **Improvement in HEDIS rates**
- Identification of areas to improve in documentation or coding on claims for care rendered.
- Charts pulled from remote EMR scan close gaps tied to value-based incentives

Year-round access would still be limited to a targeted set of members based on opportunities for HEDIS rate improvement.



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# 2026 Member Enablement Strategies

*Empowering members by providing them with the tools, knowledge, and resources to actively participate in their own care*

## Member Rewards

| | |
|---|---|
| Aetna Betters Care (AAP, WCV, CIS, FUH, CCS, BCS, A1C, BPD, CBP, OED, EED, TOPC/PPC) | Value Added Benefits |

## Health Tags

| | |
|---|---|
| Prescription Message Reminders<br>BCS, CCS, WCV, CIS, EED, BPD, CBP, AIC | Pharmacy Tech Engagement |

## mPulse

| | |
|---|---|
| HEDIS Reminders (AAP, BCS, CCS, CHL, COL, FUA, IMA, OED, PPC) | Welcome, EPSDT and CAHPS |

## Next Best Action

| | |
|---|---|
| Mail, Email | Outreach |

## HEDIS Outreach Campaigns

| | |
|---|---|
| Schedule in person and telehealth appointments | In home care |

## Online Tools & App

| | |
|---|---|
| Member Portal –Open care gaps | Medicaid 360<br>TANF Population – HEDIS Reminder |

# Priority Measures 2026

## Cancer Screening & Prevention

- Breast Cancer Screening **(BCS)**
- Cervical Cancer Screening **(CCS)**
- Colorectal Cancer Screening **(COL)**

## Chronic Conditions

- Controlling High Blood Pressure **(CBP)**
- Blood Pressure Control Diabetes **(BPD)**
- Glycemic Status Assessment Diabetes **(GSD)**
- Eye Exam for Patients Diabetes **(EED)**
- Kidney Health Evaluation Diabetics **(KED)**

## Healthy Kids

- Well child visits in the first 15 months **(W30)**
- Immunizations for Adolescents **(IMA)**
- Childhood Immunization Status **(CIS)**
- Weight Assessment & Counseling **(WCC BMI)**

## Maternal Health

- Timeliness of Prenatal Care **(TOPC)**
- Postpartum Care **(PPC)**

## Behavioral Health

- Follow up After Hospitalization Mental Illness **(FUH)**
- Follow up After ED Visit for Substance Abuse **(FUA)**
- Follow Up After ED Visit Mental Illness **(FUM)**
- Initiation & Engagement of Substance Use Disorder **(IET)**

## Medication Management

- Metabolic Monitoring Children & Adolescents on Antipsychotics **(APME)**
- Pharmacotherapy Opioid Use Disorder **(POD)**
- Statin Therapy CV Disease **(SPC)**
- Statin Therapy Diabetics **(SPD)**

## Population Health/ Access to care

- Adults' Access to Preventative/ Ambulatory Health Services **(AAP)**



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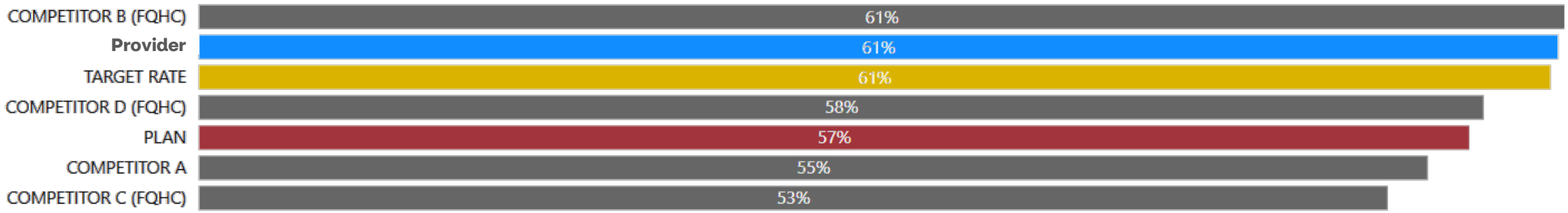
# Provider Scorecards

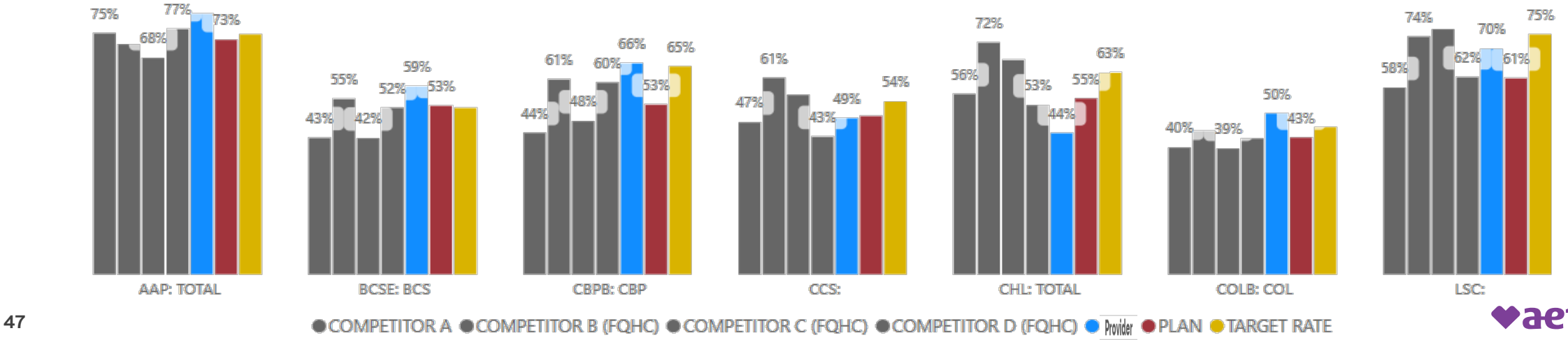
# Provider Performance Comparison Reports

## Composite Rate (All P4P Measures)

### Composite Closure Rate




### Measure Closure Rate



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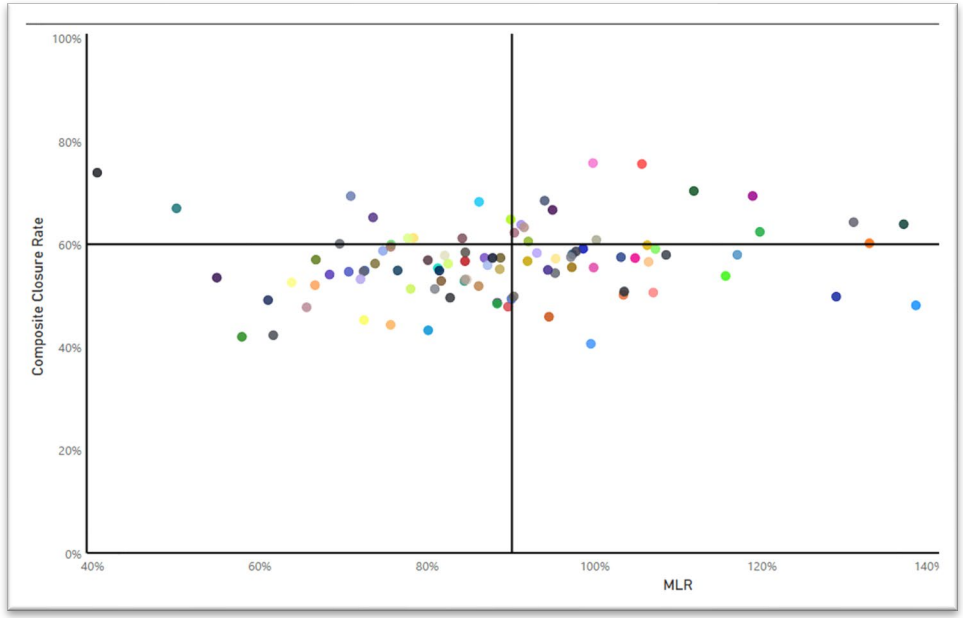
# Quality of Care vs. Cost: Four Box Analysis




- *New for 2026*
- Helps understand where care delivery falls today
- Prioritizes quality followed by cost

## Benefits

- Allows for stronger partnerships
- Provides additional opportunities for targeted support
- Keeps focus on clinical quality improvement

## Goal

Our goal is to move every provider into the top-right quadrant through collaboration and support



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# CAHPS

# Consumer Assessment of Healthcare Providers and Systems (CAHPS)

## 2025 Survey Results

## Child CAHPS results reported to NCQA – Scored

## Focus Areas:
## Rating of Personal Doctor
## Rating of Health Care
## Rating of Health Plan

## 2026 Survey Period
## Feb 10 – May 12

| Composite/Rating Area- ADULT | 2025 | 2024 | 2023 | 2022 | Variance | 2025 Projection Star Rating | 2024 Star Rating |
|---|---|---|---|---|---|---|---|
| ***Rating of Personal Doctor*** | 67.79% | 66% | 64% | 63% | 2% | 3 | 2 |
| ***Getting Care Quickly*** | 80.25% | 77% | 78% | 80% | 2% | 3 | 2 |
| ***Getting Needed Care*** | 78.3% | 76% | 81% | 79% | 2% | 2 | 2 |
| ***Rating of Health Plan*** | 52.21% | 50% | 51% | 53% | 2% | 1 | 1 |
| ***Rating of All Health Care*** | 45.65% | 51% | 48% | 51% | -5% | 1 | 2 |

| Composite/Rating Area- CHILD | 2025 | 2024 | 2023 | 2022 | Variance | 2025 Projection Star Rating | 2024 Star Rating |
|---|---|---|---|---|---|---|---|
| ***Rating of All Health Care*** | 63.3% | 67% | 68% | 66% | -4% | 2 | 3 |
| ***Rating of Health Plan*** | 60.18% | 61% | 67% | 57% | -1% | 1 | 1 |
| ***Getting Care Quickly*** | 84.79% | 85% | NA | NA | 0% | 3 | 3 |
| ***Getting Needed Care*** | 82.23% | 82% | NA | NA | 0% | 3 | 3 |
| ***Rating of Personal Doctor*** | 70.57% | 71% | 75% | 73% | -1% | 1 | 1 |

| Plan/Survey | Response Rate 2025 | Response Rate 2024 | Response Rate 2023 | Response Rate 2022 | Variance |
|---|---|---|---|---|---|
| **IL Child** | 18.9% | 20.6% | 13.2% | 15.5% | -1.7% |
| **IL Adult** | 18.7% | 17.0% | 14.3% | 13.3% | +1.7% |



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# Year Round CAHPS Process | Measuring Satisfaction

*Continuous Feedback from Members to Aetna & Providers*


## 2025 Responses

- 2617 Total Surveys Submitted (Complete)
- 40% Adult & 60% Child

## Off Cycle Surveys For all PCP/Specialist Engagement

### Getting Needed Care

- In the last 6 months, if needed, how often was it easy to get the necessary medical care, tests, and/or treatment you needed?

If ALWAYS, press 1. if USUALLY, press 2. If SOMETIMES, press 3. If NEVER, press 4. If NOT APPLICABLE, press 5.

### Getting Care Quickly

- In the last 6 months, if you needed an appointment with a specialist, how often were you able to make an appointment when it was needed?

If ALWAYS, press 1. if USUALLY, press 2. If SOMETIMES, press 3. If NEVER, press 4. If NOT APPLICABLE, press 5.

### Coordination of Care

- Picking a number from 0-5, with 0 being the worst health care received and 5 being the best health care received, how would you rate your overall health care in the past 6 months?
- Picking a number between 0-5, with 0 being the worst health plan and 5 being the best health plan, how would you rate the overall health plan?

### *Doctors' Communication

- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?

If NEVER, press 1. if SOMETIMES, press 2. USUALLY, press 3. If ALWAYS, press 4. If NOT APPLICABLE, press 5.



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# Call to Action

## 1. Ensure your practice is compliant with ABHIL's Network Access and Availability standards

- Familiarize yourself with the ABHIL Provider Manual
- Providers not in a shared risk arrangement who offer after-hours appointments and walk-in clinic availability may be eligible for a partnership bonus. Contact your Practice Transformation team member for more details.

## 2. Engage with provider resources for quality improvement monitoring and support

- Routinely access your data through Availity (e.g., P4Q reporting and gaps in care).
- Attend quality team meetings with the Practice Transformation Team to receive actionable insights and understand your strengths and opportunities for improvement.

## 3. Be aware of our ABHIL Member Resources

Our members can contact us through the **Member Services site** or at 1-866-329-4701 (TTY: 711), M-F 8:30 AM to 5:00 PM.

Members also have access to:

- The **24-hour nurse line** at 1-866-329-4701 (TTY: 711)
- **Telehealth and free life resources** (e.g., food, housing/rent, employment assistance) through Care Navigator - Aetna – MyOwnDoctor
- **Appointment transportation** through the Aetna Transportation Benefit

## 4. Educate providers on equitable care delivery across populations

As part of our commitment to health equity, we offer a clinical education hub for health care professionals. You can get on-demand, free, accredited courses to earn digital Care Champion badges for your provider profile in three clinical areas of focus:

- Culturally responsive care
- LGBTQ+ responsive care
- Culturally responsive PCP behavioral health care



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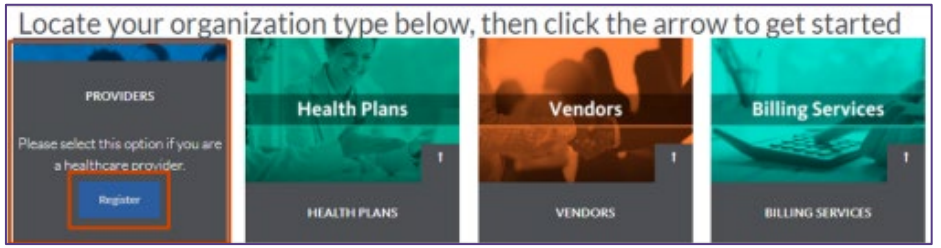
# Availity provider portal

# Availity portal registration

[Availity.com/provider-portal-registration](Availity.com/provider-portal-registration)

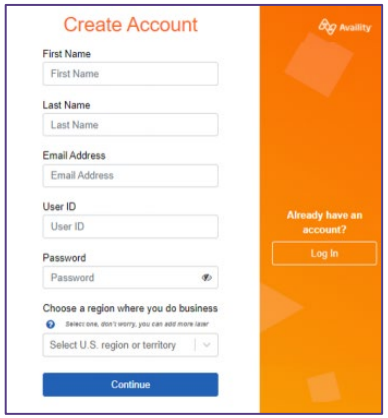
## Register your provider organization

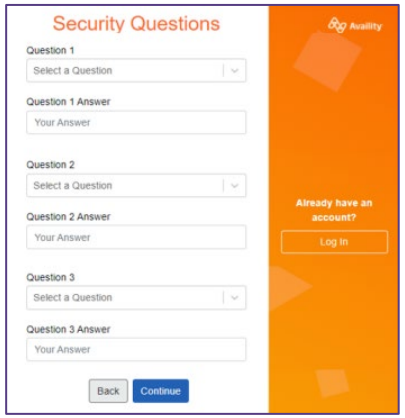
**Important**: This only applies to users who are brand new to Availity and need to register their provider organization.

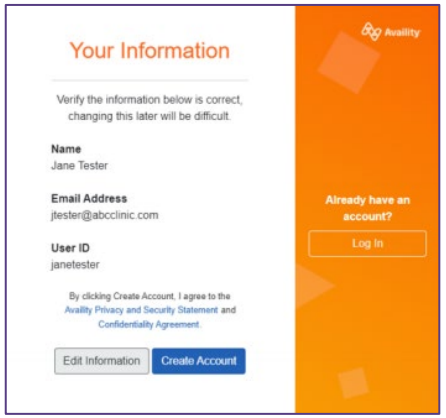



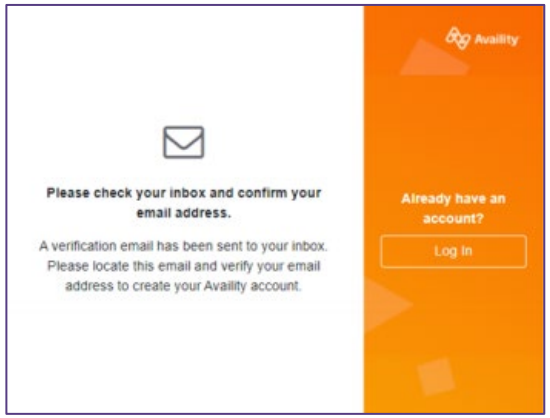

When you set up your new user account, you'll be asked to do the following tasks in the wizard:

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



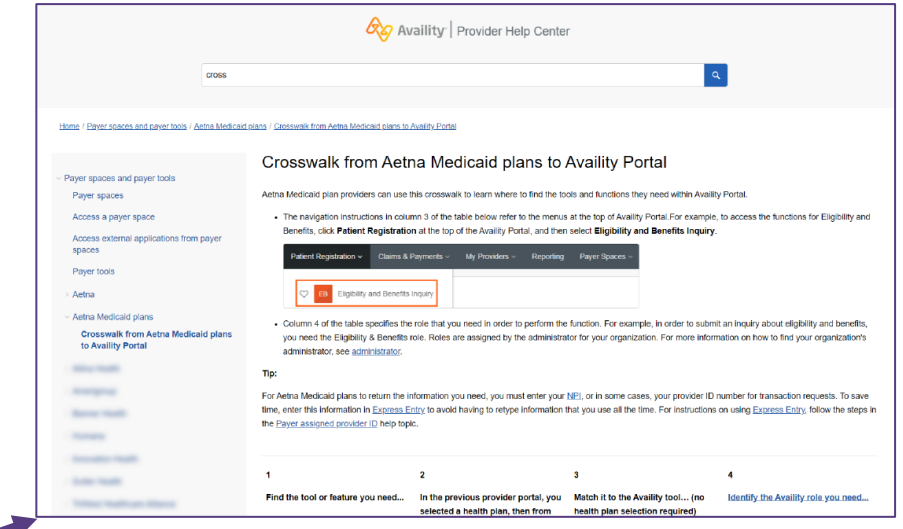



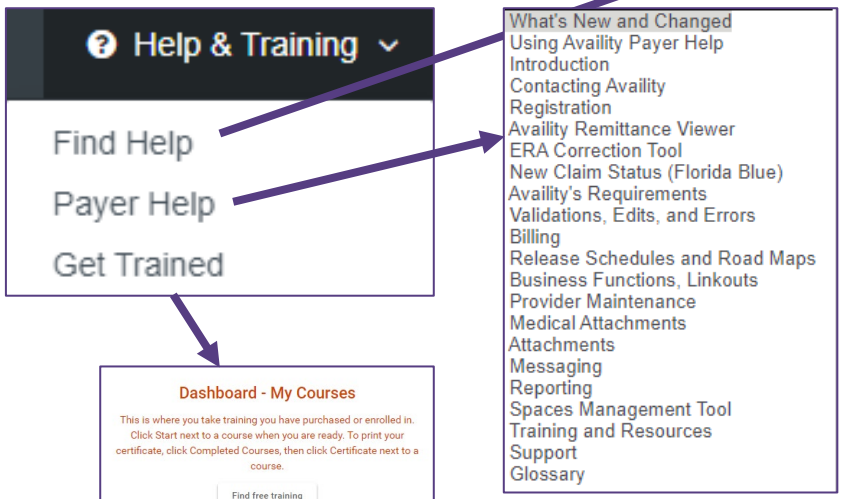



# Availity Help Center

## Crosswalk from Aetna Medicaid plans to Availity portal

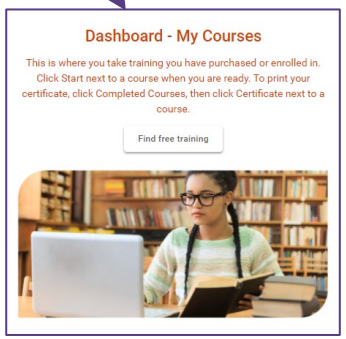
1. Select **Help & Training > Find Help**
2. Select **Payer Tools**
3. Select payer name: **Aetna Medicaid**
4. Select the topic to review in the crosswalk










# 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



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# Aetna Better Health® of Illinois Medicaid Tools and Resources

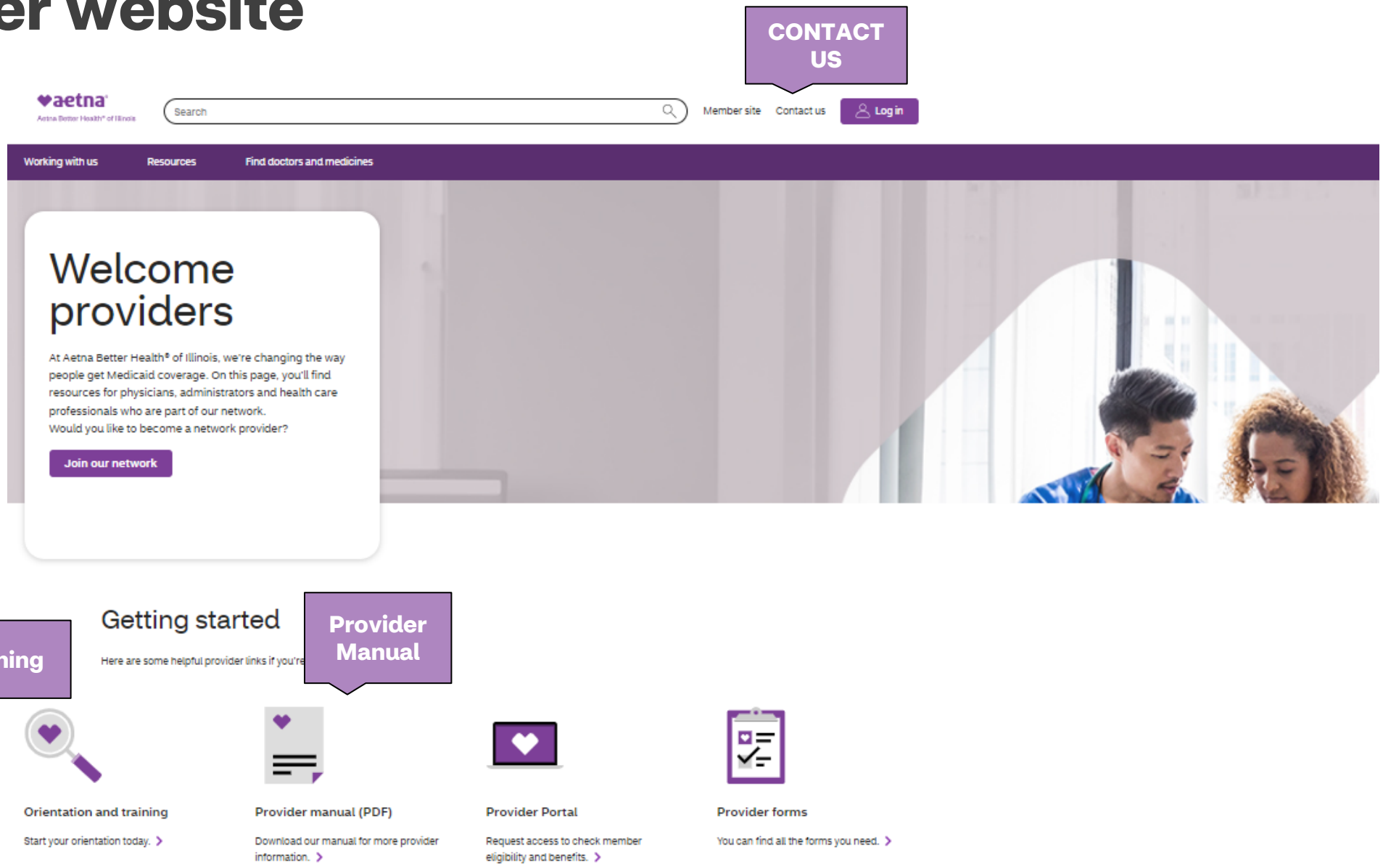
# Aetna Better Health® of Illinois Medicaid public website

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

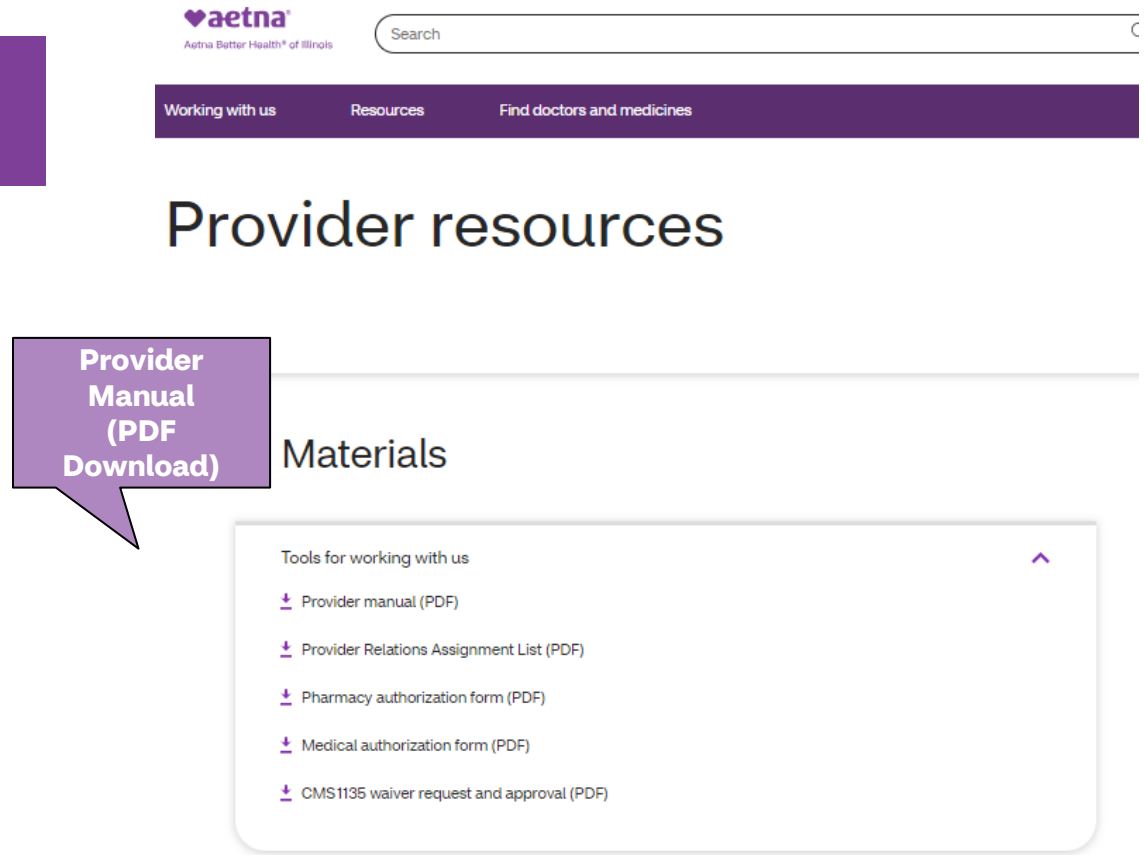


# Provider website: Provider manual

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

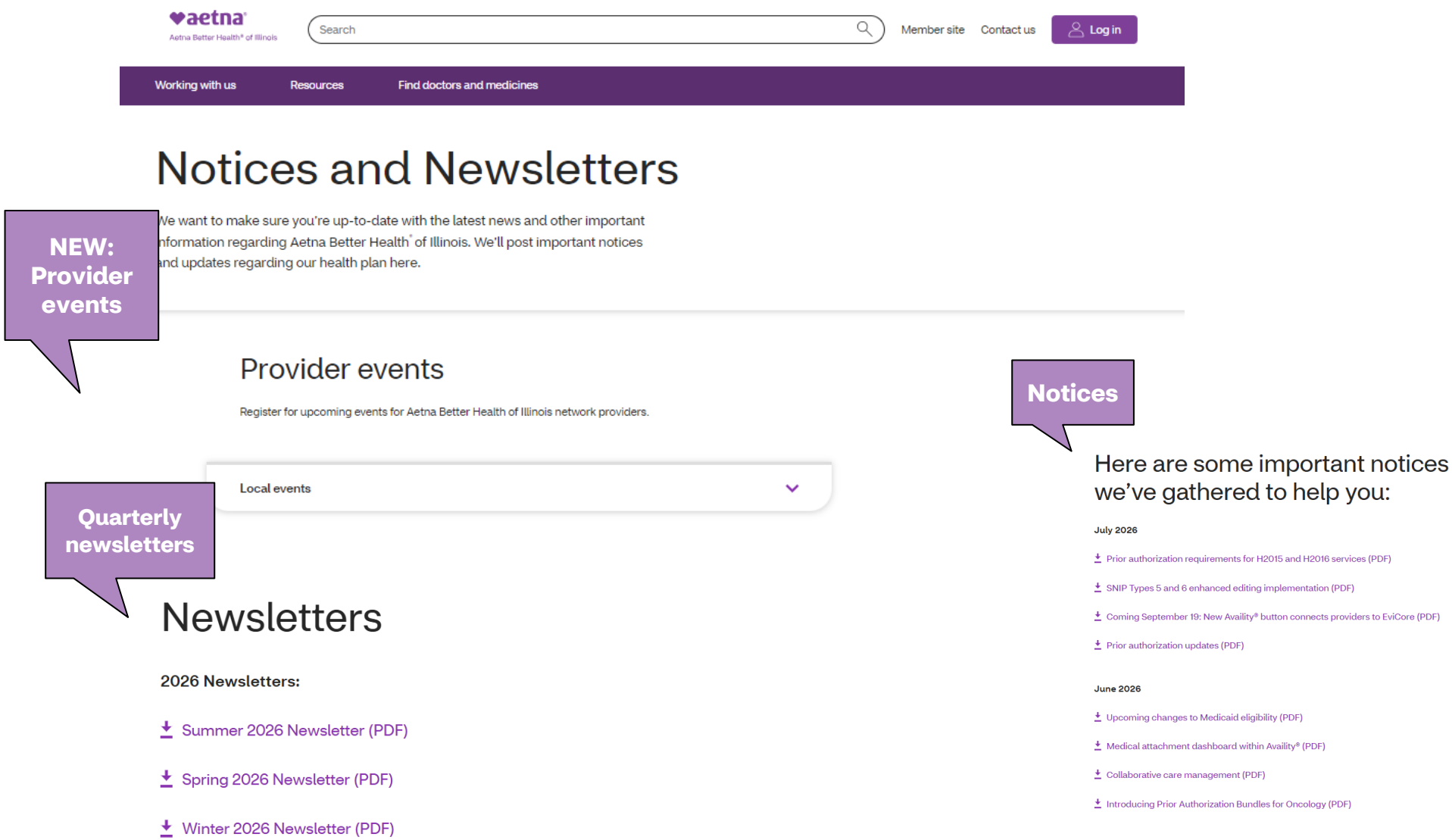
In addition to policies and procedures, this resource includes:

- 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



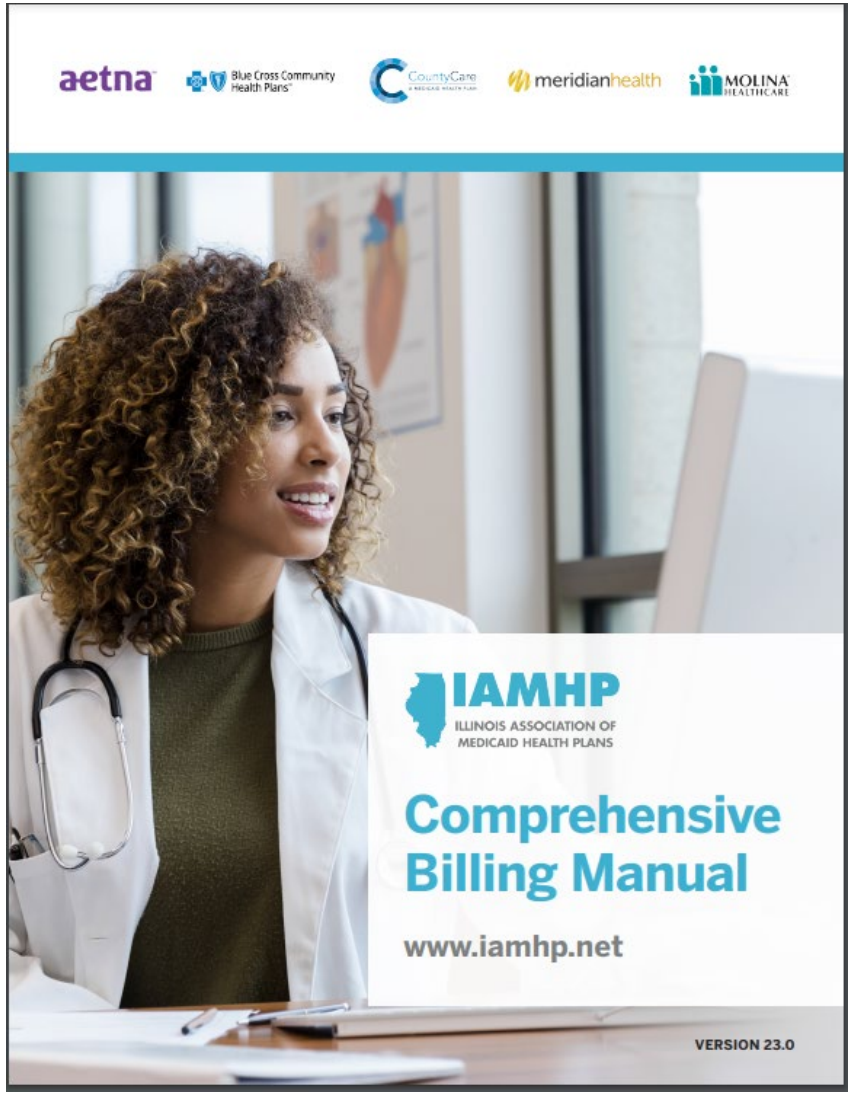
# Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters



# 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

# Bill IQ

# Bill IQ: Medicaid Billing

## Introduction

Bill IQ is a conversational AI provider support agent designed to help Medicaid providers seamlessly navigate the complex landscape of Illinois Medicaid billing guidelines.

## Here are some FAQs related to Bill IQ:

**1. What is Bill IQ?**
**Answer:** Bill IQ is a conversational AI tool developed by Everlign to help users quickly find answers to billing-related questions. Right now, it is focused on helping users understand billing rules and policies based on the **Illinois Association of Medicaid Health Plans (IAMHP) Billing Manual**.

**2. What kind of questions can I ask Bill IQ?**
**Answer:** You can ask questions related to billing guidelines that can be sourced directly from the IAMHP Billing Manual. An example question could be "are there any exceptions to this rule regarding therapeutic procedures and office visits?

**3. What kind of questions can Bill IQ not answer right now?**
**Answer:** Currently, Bill IQ cannot:

- Answer questions about specific claims (e.g., "Why was my claim denied?")
- Provide information that is not included in the IAMHP Billing Manual
- Access or interpret member or provider-specific data.

**4. Why can't Bill IQ answer my question about a rejected claim?**
**Answer:** At this stage, Bill IQ is only trained to answer questions based on the IAMHP billing manual. It does not have access to individual claims data or case-specific systems.

**5. Will Bill IQ get smarter over time?**
**Answer:** Yes! This is a soft launch. We plan to expand Bill IQ's capabilities by adding more data sources - such as provider notices, policy bulletins, and potentially FAQs from payer portals. As more content is added, Bill IQ will be able to answer a broader set of questions.

**6. How can I tell where Bill IQ is getting its answers from?**
**Answer**: Bill IQ always tells you the source of its answers. For now, all answers come from the IAMHP Billing Manual. When we add new sources, those will also be clearly cited.

**7. Is my data being stored or tracked when I use Bill IQ?**
**Answer**: ***No personal health or claims information is used or stored by Bill IQ***. It simply answers general billing questions based on public or shared resources.

**8. Who do I contact if I have issues or need support using Bill IQ?**
**Answer**: Please reach out to our claims specialist by emailing us at: *ABHILClaimSpecialist@aetna.com*.

Link: https://abhil.everlign.com/billiq

**Contact Us**

Aetna Better Health of Illinois
abhilclaimspecialist@aetna.com



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# Verifying member eligibility

# 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.

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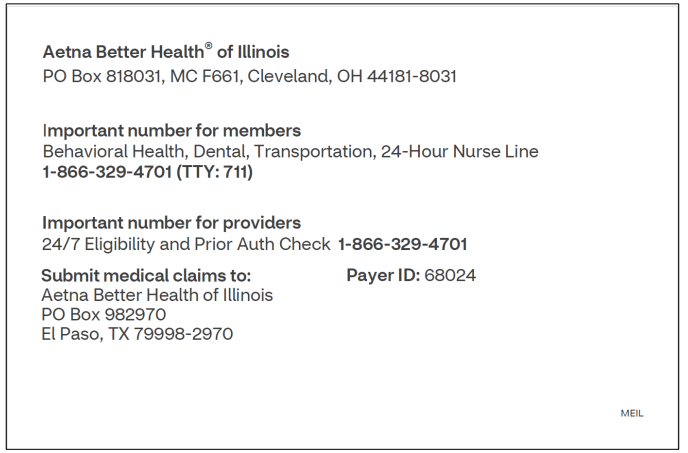
# Member ID cards

**The member ID card contains the following information:**

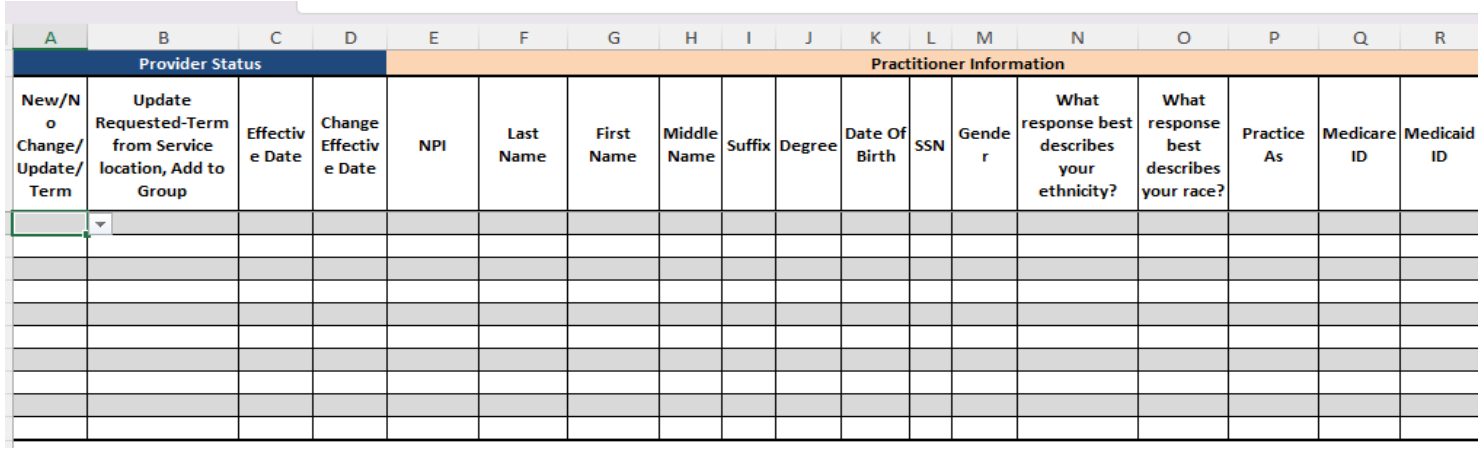
- Member name, ID, DOB & sex
- Aetna Better Health of Illinois logo / website
- PCP name and phone number
- Effective date of eligibility
- Payer ID and claims address
- Rx Bin, PCN and GRP numbers
- CVS Caremark number (for pharmacists use only)

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

# Roster/demographic submissions

## Universal IAMHP Roster Template ( Updated 5/29/2026)



| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider Status | | | | Practitioner Information | | | | | | | | | | | | | |
| New/No Change/ Update/ Term | Update Requested-Term from Service location, Add to Group | Effective Date | Change Effective Date | NPI | Last Name | First Name | Middle Name | Suffix | Degree | Date Of Birth | SSN | Gender | What response best describes your ethnicity? | What response best describes your race? | Practice As | Medicare ID | Medicaid ID |
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- 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
- Roster changes should be submitted to ABHIL on a monthly basis to ensure updates are timely
- All providers must be registered/credentialed with IMPACT

# ADA Compliance Update for Provider Data

## Mandatory ADA Information Requirement

**ADA Compliance Update**

Effective November 1, 2025, all provider data updates must include ADA information for compliance.

**Required Accessibility Details**

Submissions must include wheelchair access, interpreter services, and other disability accommodations.

**Avoiding Processing Delays**

Missing ADA data will cause submission returns and processing delays for providers.

### Questions?

Please contact your assigned **Provider Relations representative** with any questions.

# 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**
- 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**

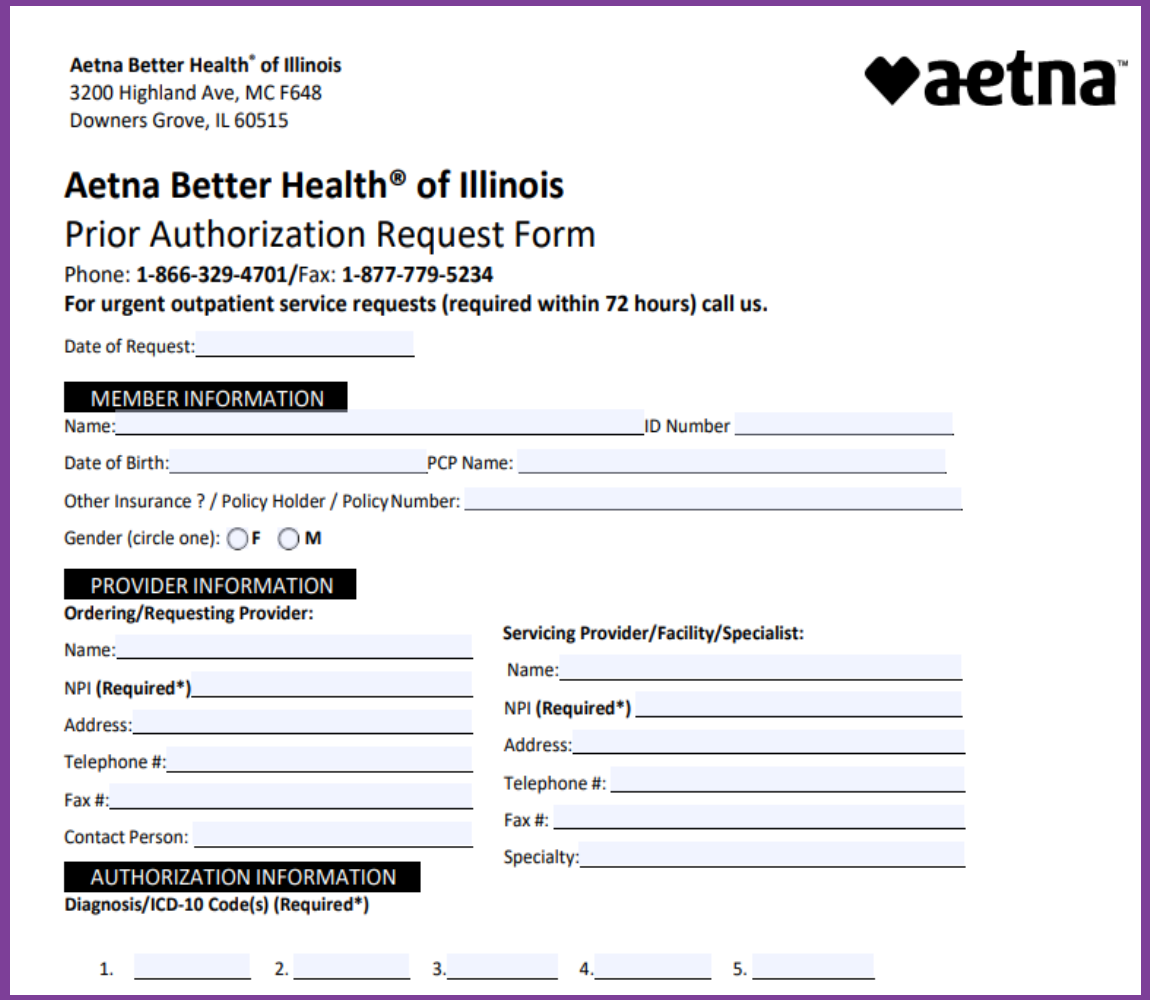
IMPORTANT ITEMS to remember:

- ✓ 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

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**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:**

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Person: _____

**Servicing Provider/Facility/Specialist:**

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

**AUTHORIZATION INFORMATION**

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

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

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# Utilization Management Legislative Update

## Utilization Management Legislative Update

Healthcare Protection Act (HPA) as amended in Public Act 104-0028 (2025): 104-0028, establishes new requirements regarding utilization management and notification of behavioral health treatment. **This provision is effective January 1, 2026, and applies to services provided to Aetna Better Health® of Illinois members. Authorization is still required for claims payment purposes.**

| Notification Requirements | |
|---|---|
| Acute Inpatient Mental Health | Providers must **notify Aetna Better Health® of Illinois within 48 hours of admission**.<br>If notification is timely: **No utilization review for the first 72 hours** of admission.<br>If notification is late: **Utilization review begins immediately upon admission**. |
| Substance Use Detox & Residential Rehab | Applies to **ASAM levels 4.0, 3.7, and 3.5**. Providers must **notify Aetna Better Health® of Illinois within 1 business day** from the start of treatment.<br>If notification is timely: **Initial authorization approved for the first day of treatment**.<br>**Utilization review begins after the 1-business-day notification period**.<br>If notification is late: Only **first day approved**, and **utilization review starts immediately**. |
| Outpatient Mental Health & SUD Services | Providers must **notify Aetna Better Health® of Illinois within 1 business day** from the start of treatment. If notification is timely: **Initial authorization approved without utilization review** for:<br>**Partial Hospitalization Program:** 5 sessions / 7-day span<br>**Intensive Outpatient Treatment:** 6 sessions / 14-day span<br>**Transcranial Magnetic Stimulation:** 36 sessions / 6-week span<br>**Electroconvulsive Therapy:** 12 sessions / 4-week span<br>**Community-Based Services:** No initial authorization required; concurrent review applies later.<br>After initial approval:<br>**Concurrent utilization review applies for additional days requested**.<br>If notification is late: Only **first day approved**, and **utilization review begins immediately**. |

**Additional changes effective January 1, 2026**

- Psychiatric and Neuropsychiatric testing will no longer require authorization.
- Assertive Community Treatment (H0039) will have no authorization required for the first 800 units per member, per provider.

**How to notify us**

Continue to submit notification of inpatient admissions for members using your current method. You can use the Provider Portal, call 1-866-329-4701 (TTY: 711), or fax the request to 1-844-528-3453 for behavioral health.

**Questions?**

Please contact your assigned Provider Relations representative if you have questions.

**Link to Notice:** Aetna Better Health of Illinois



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# Billing & Claims Payment

# 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**

❑ CHECK RUN IS DONE DAILY

**ERA:**

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



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# 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**



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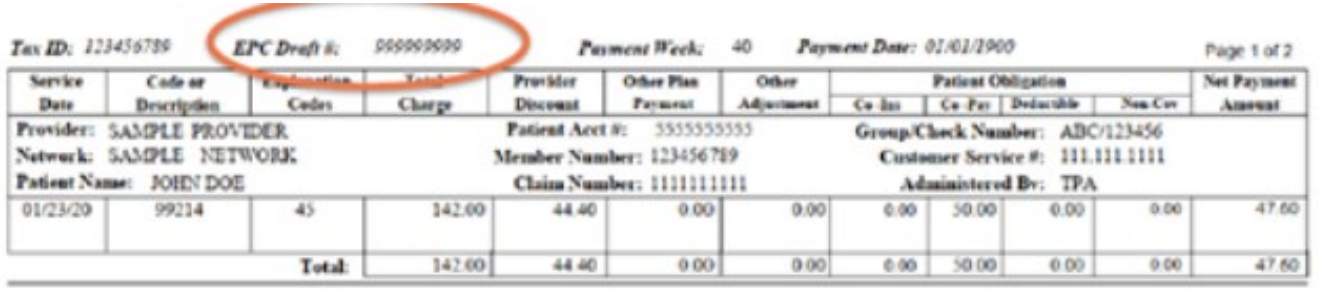
# Electronic Funds Transfer (EFT)
# Electronic Remittance Advice (ERA)

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 #: 999999999 Payment Week: 40 Payment Date: 01/01/1900 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.

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

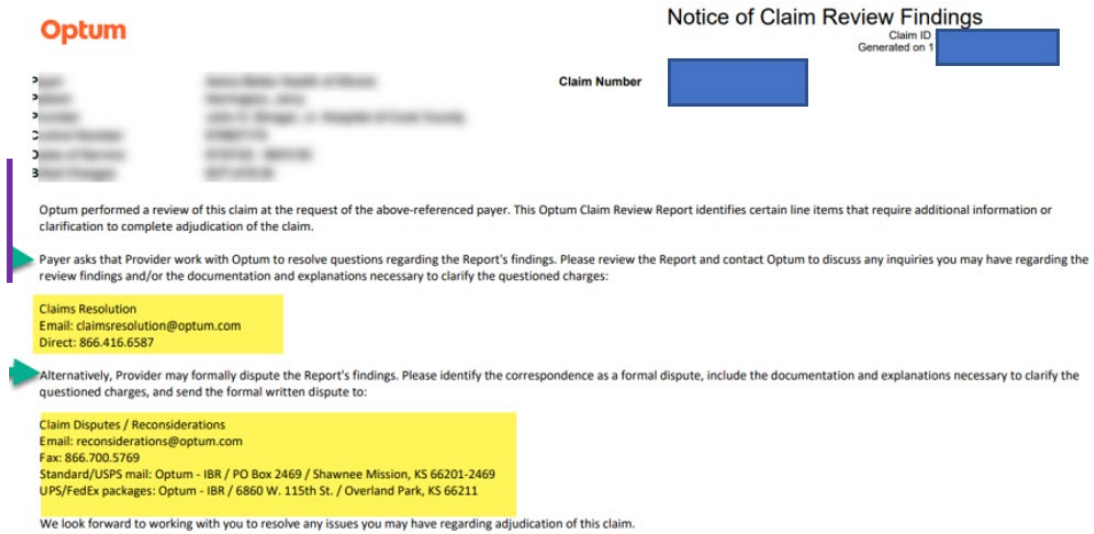
# Itemized bill process

**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 attach the Itemized Bill and **should not attach or send a copy of the claim form, as doing so will cause a duplicate claim in the system**. Instead, please reference the claim number on the reconsideration form or on your letterhead and mail the reconsideration request directly to: Aetna Better Health of Illinois
   PO Box 982970
   El Paso, TX 79998-2970

**SAMPLE OPTUM NOTICE**



Optum

Notice of Claim Review Findings

Claim ID
Generated on 1

Claim Number

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.



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# 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



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# 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 the 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



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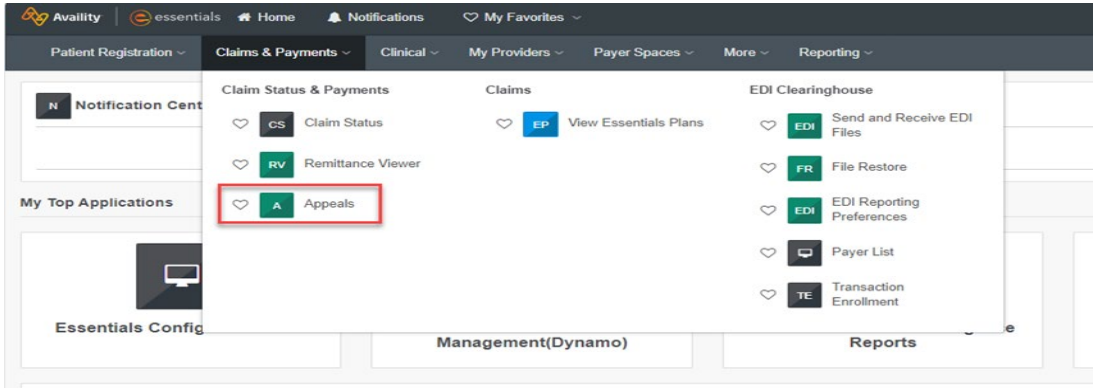
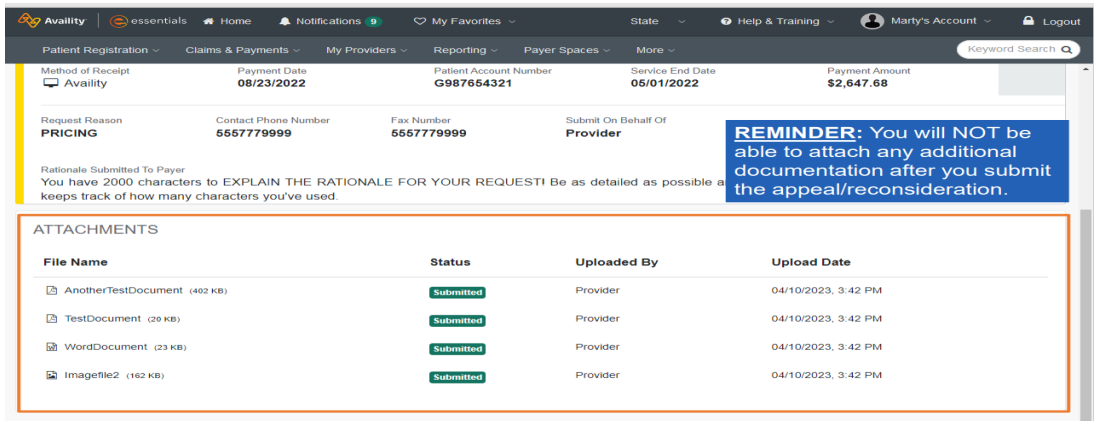
# Appeal Submission Enhancement via Availity

**Provider Appeal**

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



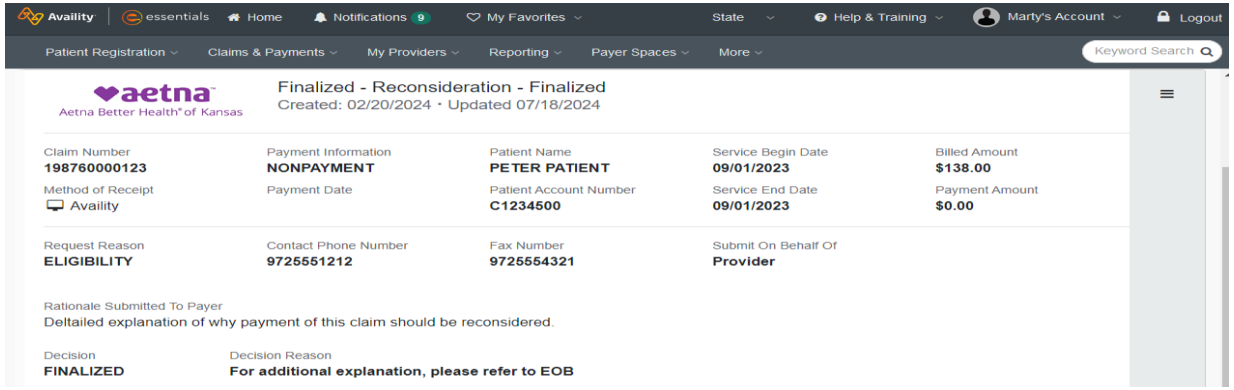




**Submission**

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

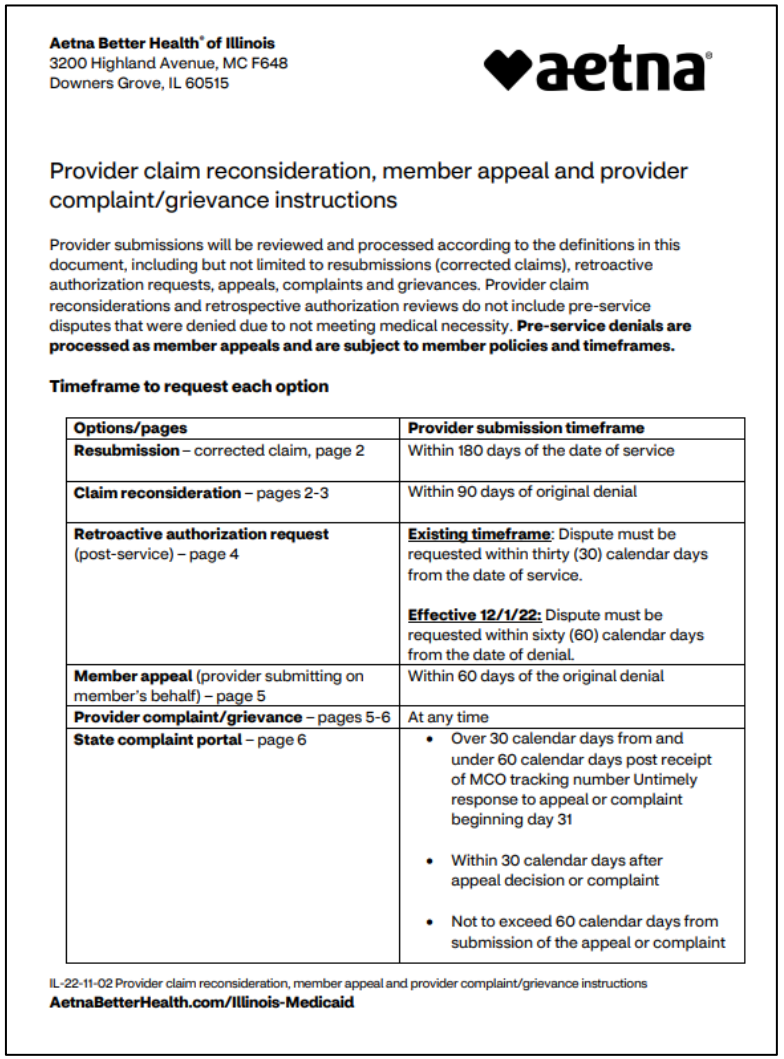
**Review Outcome**

- 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](AetnaBetterHealth.com/Illinois-Medicaid/providers/forms.html)



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

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## 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.<br><br>**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<br>• Within 30 calendar days after appeal decision or complaint<br>• 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**<br>• 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**<br>• Review request for a claim whose original reason for denial was "duplicate"<br>• 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**<br>• A review of a claim that was submitted outside the timeframe<br>• Provide good cause justification documentation for late filing; or<br>• For electronically submitted claims provide the second level of acceptance report as proof of timely filing<br>• Refer to Proof of Timely Filing Requirements in the Provider Manual |
| **Untimely decision making**<br>• A review of a decision where Aetna did not render the decision on a prior authorization timely<br>• Provide a copy of the denial showing the received date and the decision date |
| **Coordination of benefits**<br>• Attach EOB or letter from primary carrie |
| **Claim/coding edit**<br>• 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<br>• 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**<br>• 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:**<br>• Continued stay concurrent review<br>• Urgent or Emergent review<br>• Pre-Service (Prior Authorization) requests<br>  • Must have written consent to act on behalf of the member<br>• 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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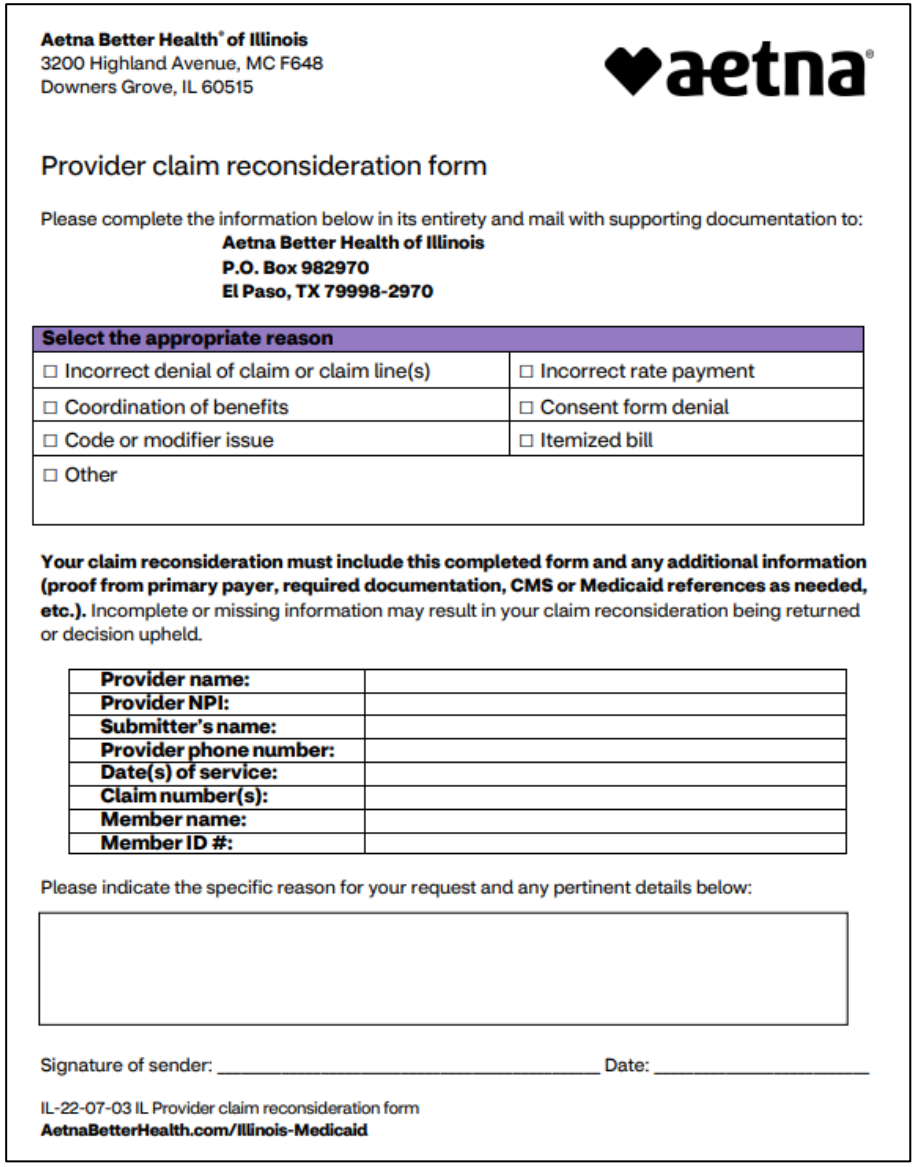
# Provider claim reconsideration form

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



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

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## 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** | |
|---|---|
| ☐ 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 claim reconsideration form
**AetnaBetterHealth.com/Illinois-Medicaid**



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# Recoupments

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

Provider notifications will include:

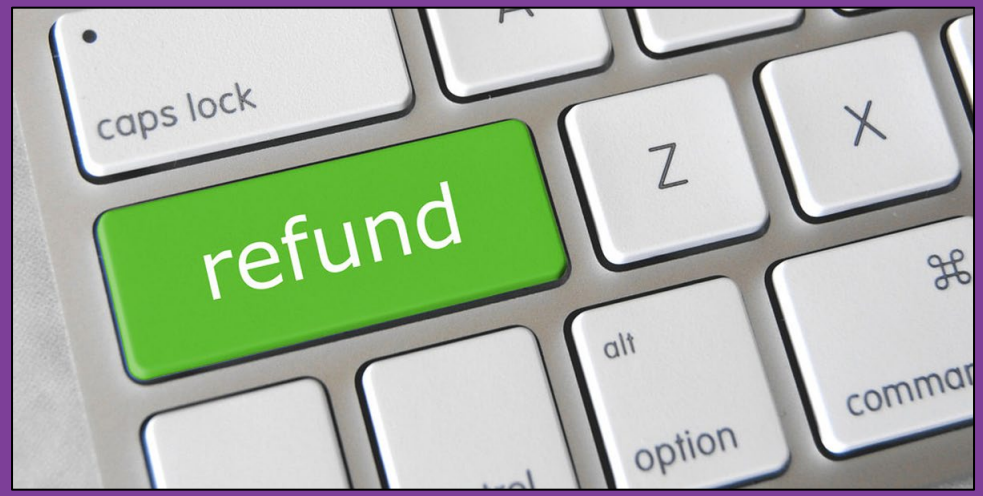
- Impacted claims
- Member's name
- Date of service

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

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# Provider Escalations

# Provider Experience escalation process




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# 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



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# 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.

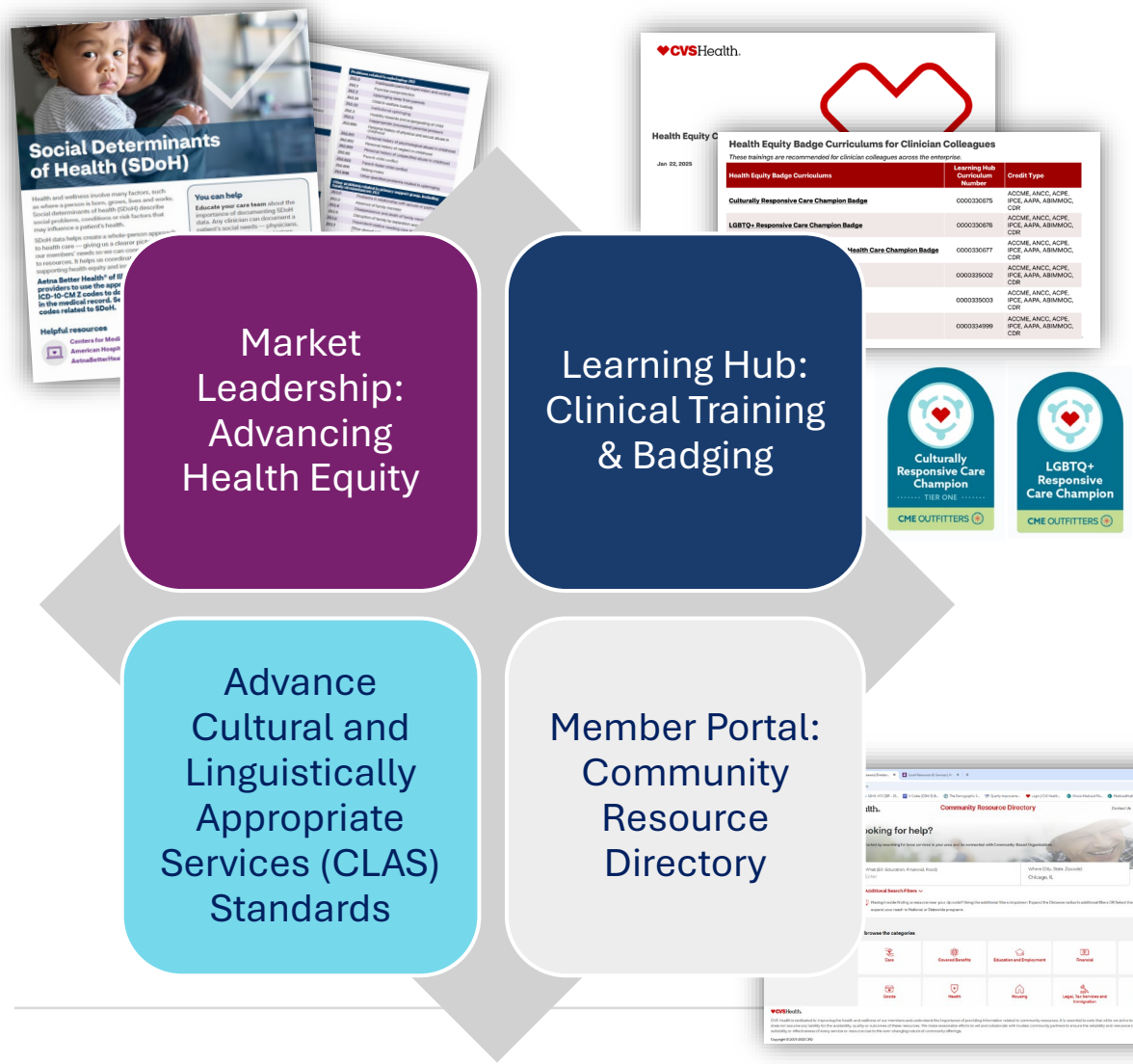
**The HFS requirements for submitting a state escalation are as follows:**

- 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.**

# Health equity

# Culture of Equity – Provider Network Resources




## Provider Empowerment

**Advancing Health Equity** — ICD-10-CM Z-Code Training Opportunities

**Clinical Training & Badging** — Clinician and colleague learning courses and Health Equity badging

**CLAS Standards** — Development and ongoing operation of the CLAS Standards that are reflective of the geographical and cultural groups served

**Community Resource Directory** — Local SDOH Support Programs & Initiatives

# NCQA Health Outcomes: Provider Network

The National CLAS Standards map directly to NCQA Health Outcomes Accreditation elements. Providers are expected to produce documentation in each area below — not just attend a training.

## Governance & Workforce Diversity

*CLAS Principal Standard — leadership accountability for equitable care*

NCQA deliverable: documented governance oversight of health equity work plan; workforce demographic data compared to the member population served.

## Language Access Services

*CLAS Standard 5 -8 — free language assistance for all encounters*

NCQA deliverable: interpreter usage logs, translated vital document inventory, and tagines on members materials in prevalent non-English languages

## Race, Ethnicity & Language (REL) Data

*CLAS Standard 9 — collect and maintain demographic data on members*

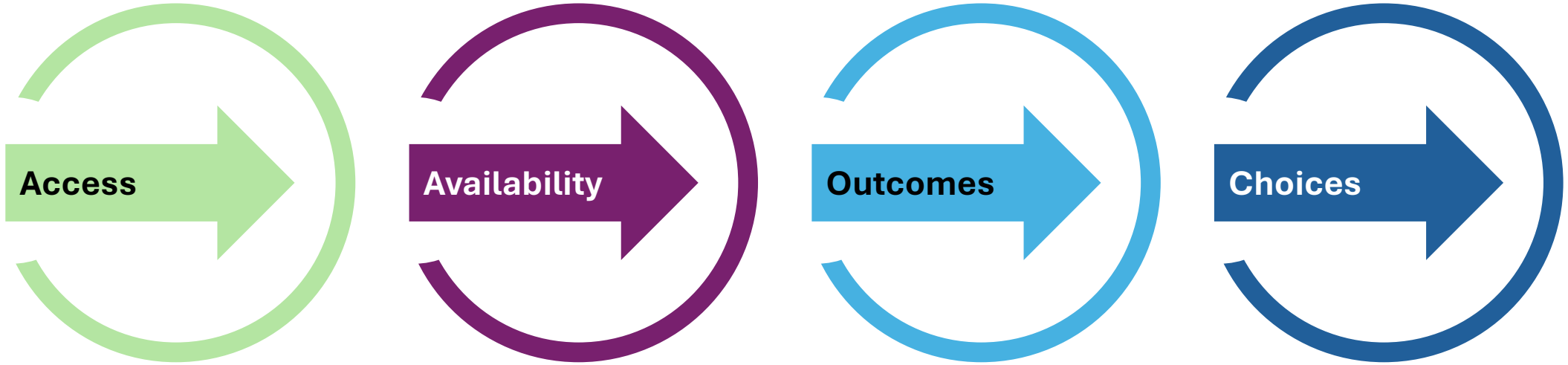
NCQA deliverable: REL (and SOGI, where applicable) data-capture completeness rates, with HEDIS measures stratified by REL to identify disparities.

## Community Engagement & CLAS Training

*CLAS Standard 12 - 14 — partnership, conflict resolution, ongoing training*

NCQA deliverable: annual CLAS/cultural-humility trainins completion rates and document community/CBO partnership activities

# Big Goals for Health Equity: Primary Prevention & Healthspan




All members have access to primary prevention services and health education — regardless of coverage status or zip code.

Prevention-focused, interprofessional care is as routine statewide as treatment for existing chronic disease.

*Healthspan** — years lived in good health — grows across every Illinois community, not just lifespan.

Stigma is removed and members are empowered to choose from the full range of evidence-based prevention programs that work for them

* *Healthspan is the number of years a person lives in good health, free from serious chronic disease and major physical or mental disability. It focuses on living well rather than just staying alive.*

Source: Kaeberlein M. (2018). How healthy is the healthspan concept?. GeroScience, 40(4), 361–364. https://doi.org/10.1007/s11357-018-0036-9

# Healthcare Transformation 1115 Waiver: Approved Services

Over the past 24 months, HFS has been engaging with a housing workgroup to develop service descriptions, service delivery, review payment rate assumptions, and gather overall program feedback.

## Current Implementation Planning

- **Health Related Social Needs (HRSN)**
  - Housing Supports
  - Medical Respite
- **Reentry Services from Carceral Settings**
  - Coverage of pre-release services 90 days prior to release

## Continuing SUD Pilots

- SUD Case Management
- SUD Treatment in Institutions of Mental Disease

## 

- Nutrition supports
- Violence Prevention & Interventions
- Supported employment
- Non-medical Transportation to and for HRSN services & supported employment

# Waiver Readiness – Before 1/1/2027

Health plans and clinical services are watching different risks. Both need to be on the same page before member volume begins.

## Health Plan Concerns

- Interim technology bridge required – the Closed-Loop referral and Billing/Claims systems will not be live at launch (2027, timing TBD)
- Reporting definitions still unclear – units of service, incomplete assessment counts, family vs. individual referrals
- Rate adequacy unconfirmed for Tier 2-3 Medical Respite acuity against DRAFT per-diem rates
- Statewide network capacity and regional coverage gaps not yet fully mapped
- NCQA Health Outcomes Accreditation timeline now overlaps directly with waiver launch prep

## Clinical Services Concerns

- Referral responsibility ambiguity – unclear whether the MCO or referring provider (hospital, FQHC, street ministry) initiates the Medical Respite referral
- Care-plan data-sharing expectations with community-based providers not yet defined
- Workforce capacity for CLAS trainings and cultural-humility requirements ahead of go-live
- CHOIS Assessment administration adds workflow burden at intake, conclusion and any plan change
- IMPACT enrollment timing uncertain for new provider types entering the network

# 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

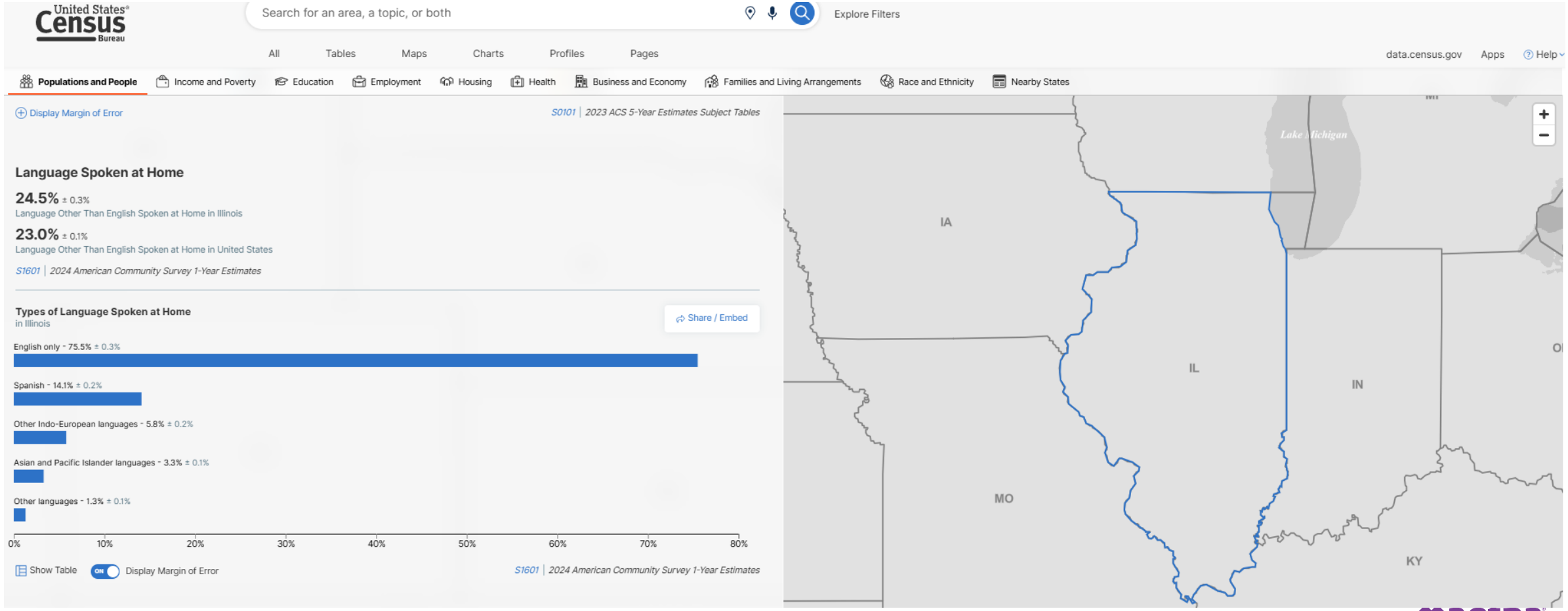


For translation services, call Member Services at 866-329-4701 or TTY: 711.

# Member Languages

**A community profile of Member languages in the state of Illinois**

# Languages Spoken in Illinois



# Using Interpreter Services

**Step 1: Identify Language Needs**

- **Asking Preferred Language**

Always ask members for their preferred language during initial contact to ensure effective communication.

- **Documenting Language Needs**

Record the member's language preference accurately in their records for future reference and compliance.

- **Sign Language & Alternative Formats**

Identify members needing sign language or alternative communication due to visual or hearing impairments.

**Step 2: Select the Appropriate Scenario**

- **Interpreter Services for Phone Calls**

Member Services facilitate interpreter-assisted conference calls using interactive voice response systems to connect members and interpreters.

- **Face-to-Face Meeting Interpretation**

Care coordinators or staff can dial in an interpreter during home visits or in-person meetings for effective communication.

- **Provider Access to Interpreter Services**

Providers without onsite interpreter access can call to connect with interpreters, ensuring communication support in various locations.

**Step 3 : Contact Member/ Provider Services**

- **Accessing Interpreter Services**

Providers should contact Member Services at 866-329-4701 or TTY 711 to arrange telephonic interpretation for members in need.

- **Alternative Communication Formats**

Member Services also provides alternative formats for visually impaired members to ensure accessibility.

- **Cost-Effective and Compliant**

Using Aetna's free telephonic interpretation service saves costs and maintains compliance for providers.

Aetna's interpretation services are **free** for members and providers.

If providers choose to use another interpretation resource, they are financially responsible for those costs.



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# 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 and availability standards

**Helping our members get the care they need — when they need it**

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

**Reminders**

- Providers are required to notify Aetna Better Health of Illinois within three calendars days if they are not able to comply with appointment wait times.
- Our Provider Relations team routinely monitors compliance and seek Corrective Action Plans (CAP) from providers that do not meet accessibility standard.

Aetna Better Health® of Illinois' appointment and availability standards are based on HFS and NCQA standards for timely access to care and services.

**Our Provider Manual defines appointment and availability standards for each type of care and specialty.**

Providers who cannot offer an appointment within the specified time frames should refer the member to our Member Services teams at **1-866-329-4701 (TTY 711).**



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# Fraud, Waste, and Abuse (FWA)

# Fraud, Waste and Abuse

| FRAUD | WASTE | ABUSE |
| --- | --- | --- |
| • 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.<br>• **Fraud** can be committed by a provider or a member | • The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.<br>• **Waste** is not generally considered to be caused by criminally negligent actions but rather by the misuse of resources. | • Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program.<br>• 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



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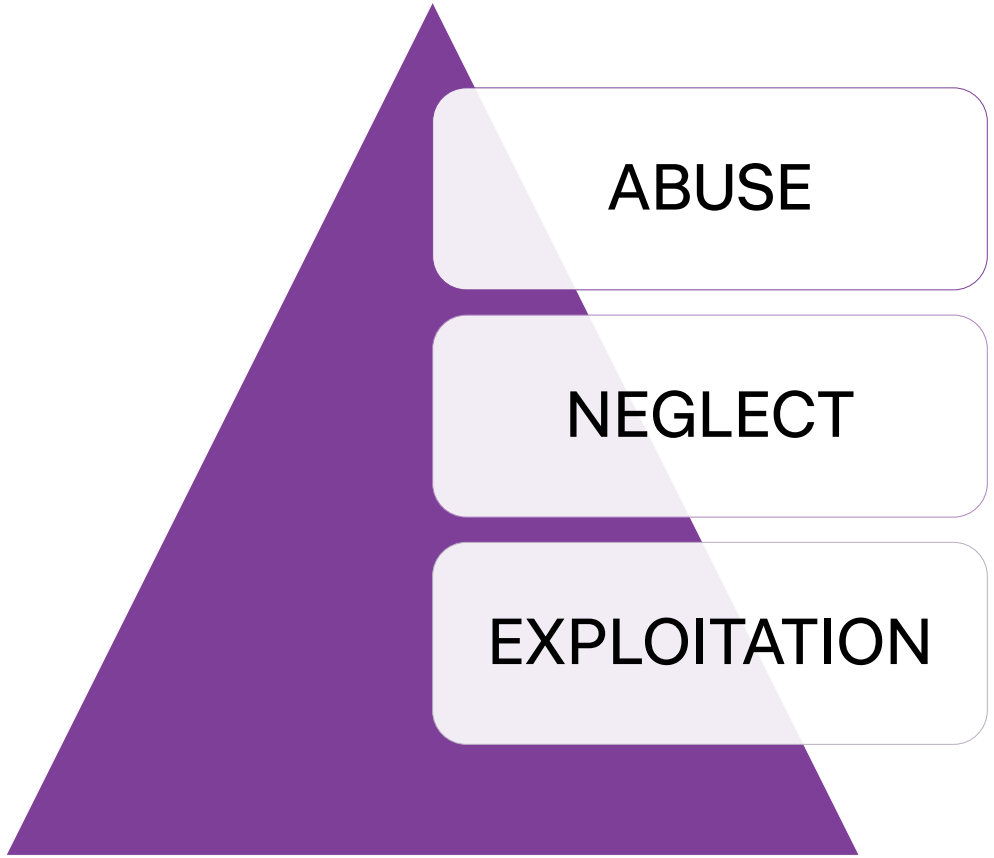
# Critical incidents | Spot the signs

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



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# 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



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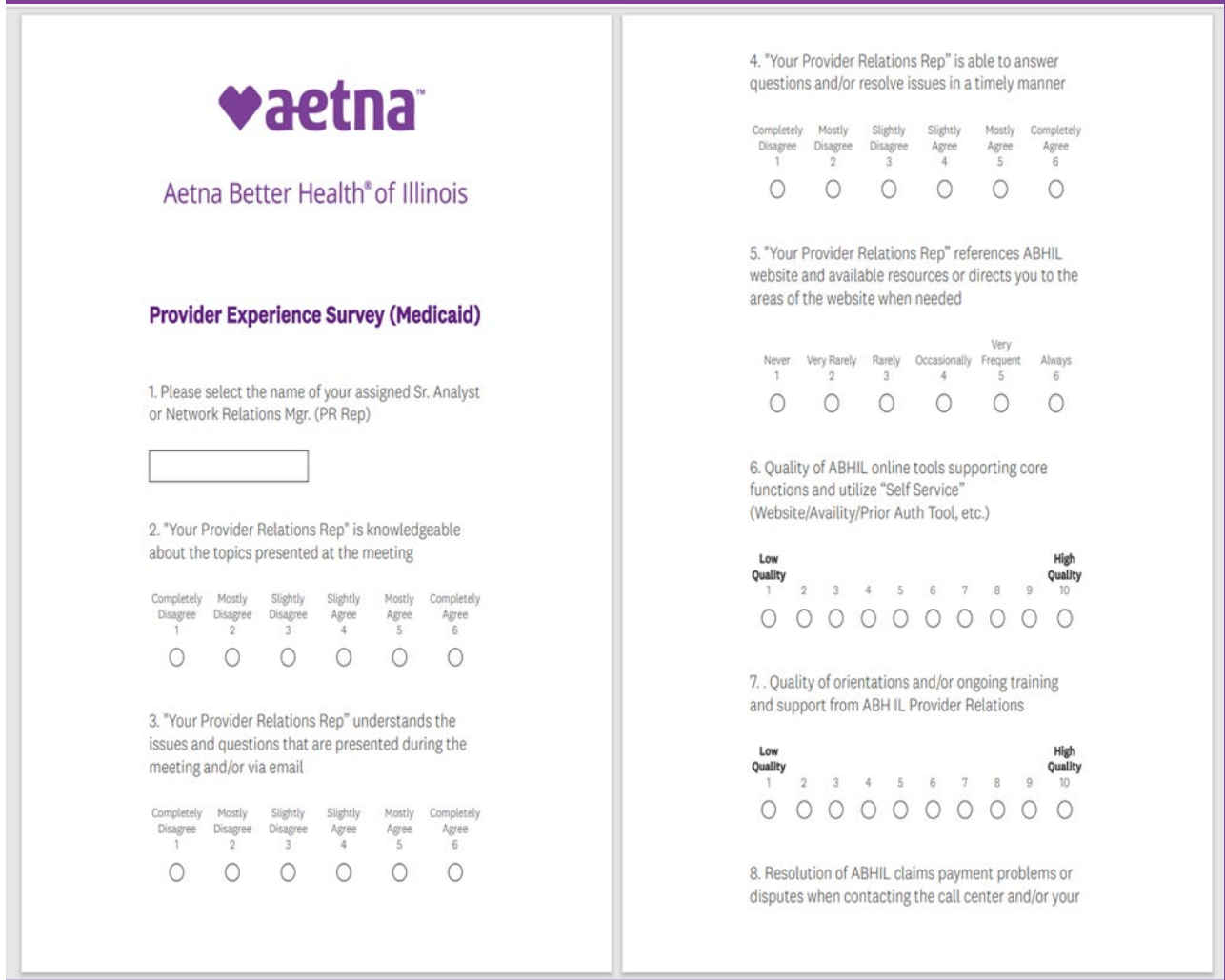
# Provider Experience Survey

# 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



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**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 1 | Mostly Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Mostly Agree 5 | Completely Agree 6 |
|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ |

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

| Completely Disagree 1 | Mostly Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Mostly Agree 5 | Completely Agree 6 |
|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ |

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

| Completely Disagree 1 | Mostly Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Mostly Agree 5 | Completely Agree 6 |
|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ |

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

| Never 1 | Very Rarely 2 | Rarely 3 | Occasionally 4 | Very Frequent 5 | Always 6 |
|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ |

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 |
|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

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

| Low Quality 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | High Quality 10 |
|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

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

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# 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
  - Phone: 1-800-508-6780
  - Website: DentaQuest.com
- **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 ages 18 and older
  - Provider Support Team is available 8 AM – 8 PM ET by phone at **888-482-8057** or via email at **ClientSupport@NantHealth.com**


Thank you!

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