New provider orientation

Aetna Better Health® of Illinois

Agenda

- **Housekeeping/introductions**
- **Plan overview**
  - Who we are
  - Provider Experience
- **Provider overview**
  - Partnerships, Member ID cards, Prior Authorization, Pharmacy, EFT/ERA remittance, billing & claims, disputes, and Availity
- **Quality management**
  - HEDIS, 2024 Provider P4P Program, Quality Improvement Program, community events, and value-added benefits
- **State-mandated training**
  - Appointment standards, cultural & linguistic competency, ADA, fraud/waste/abuse, and critical incidents
- **Q&A chat session**

Leadership

Terriana Robinson
Lead Director, Provider Relations

Christine Fox
Senior Manager, Provider Relations

Latahra, Smith,
Senior Manager, Provider Relations

Steve Inzerello
Senior Manager, Provider Relations

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Overview

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

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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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Provider Experience
Provider Relations & Contracting

Sr. Analysts or Managers, Network Relations (PR Reps) are available to assist with:

- Claims questions, inquiries and reconsiderations
- Finding a participating provider or specialist
- Change request for provider demographics
- Navigating or access requests for our secure web portal
- Scheduling trainings/site visits and meetings

Contract Negotiation Managers (Contracting Reps) are available to assist with:

- Providers interested in joining the Aetna Better Health® of Illinois network and requirements for participation
- Questions related to contractual language or terms
- Designated team members assigned by region and provider type for local assistance

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.

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Health Insurance Portability and Accountability Act(HIPAA) of 1996

HIPAA establishes national standards to protect the privacy and security of health information and to standardize electronic health care transactions. It applies to covered entities, including health care providers, health plans, and health care clearinghouses that transmit health information electronically. All providers are required to comply.

Key components include:

- ✓ Privacy and Security Rules that safeguard health information.
- ✓ Standards for electronic transactions and national identifiers to improve efficiency and consistency in health care communications.

HIPAA protects Protected Health Information (PHI), defined as individually identifiable health information in any form (electronic, paper, or oral), including medical conditions, treatment, payment information, and common identifiers such as name, address, birth date, and Social Security number. Certain records—such as employment records and FERPA-protected education records—are excluded.

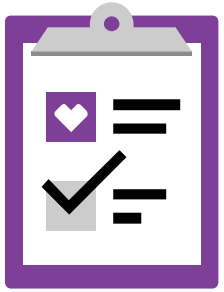
Provider responsibilities include:

- ✓ Preventing discussions of medical or financial information where others can overhear.
- ✓ Safeguarding medical records and confidential information in all formats.
- ✓ Implementing measures to prevent unauthorized disclosure.
- ✓ Releasing information to third parties only with proper authorization or as legally required.

Recommended practices to protect patient information include:

- ✓ Training staff on HIPAA requirements.
- ✓ Using discreet patient sign-in sheets.
- ✓ Keeping records and computer screens out of public view.
- ✓ Properly shredding sensitive documents.

Providers must follow HIPAA rules for required and voluntary disclosures of medical records and are encouraged to consult legal counsel to ensure full compliance with all applicable privacy laws and regulations.



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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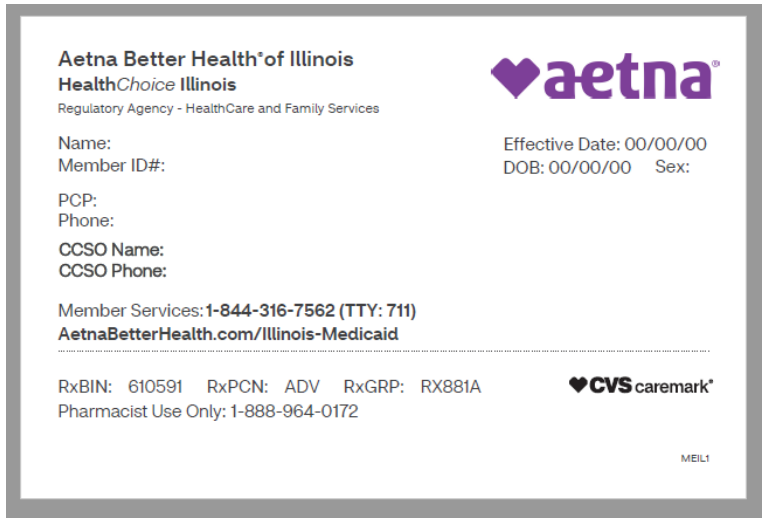
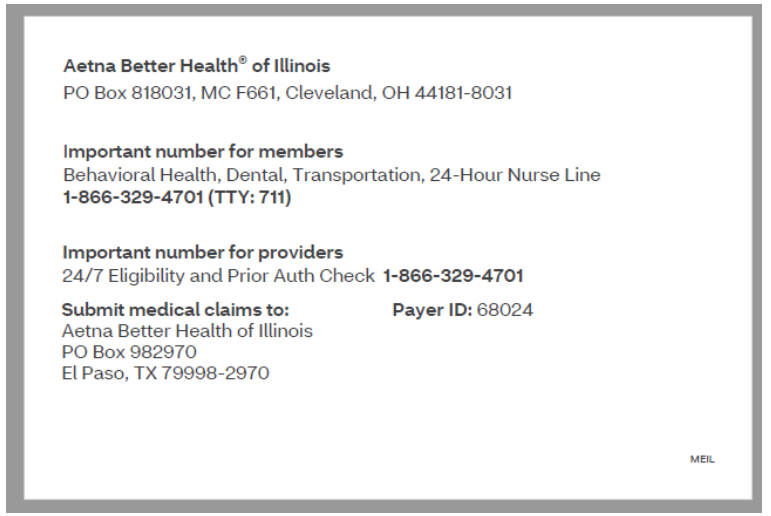
Member ID cards

The member ID card contains the following information:

- Member name, ID number, DOB
- Aetna Better Health of Illinois Logo / website
- PCP name and phone number
- Effective date of eligibility
- Payer ID and claims address
- Rx Bin Number & PCN number
- 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 2/26)

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

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

Prior authorizations

A prior authorization request may be initiated by:

- Submitting the request via the 24/7 Secure Provider Portal or Availity
- Fax the request form to **1-877-779-5234** for medical or **1-844-528-3453** for Behavioral Health
- Through our toll-free number **1-866-329-4701**

✓ Please remember that emergencies do not require prior authorization.

✓ Submit authorization requests within 7 (seven) days prior to elective procedures.

✓ Submit authorization requests within 24 hours of urgent/emergent admission.

✓ Turnaround times for processing requests are as follows:

- Standard – 4 calendar days
- Urgent – 48 hours

To check the status of a prior authorization, please log in to the provider web portal or contact our Utilization Management Department at **1-866-329-4701** Monday through Friday from 8:30 AM to 7:00 PM CST.

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

We make clinical determinations utilizing **Milliman Care Guidelines (MCG).**

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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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: Rx881A
Group: ADV

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

- A list of pharmaceuticals, including restrictions and preferences
- Customized specialty prior authorization forms, and other pharmacy documents
- Full prior authorization criteria
- How to use the pharmaceutical management procedures
- An explanation of limits or quotas
- How prescribing practitioners must provide information to support exceptions
- The organization's process for generic substitution, therapeutic interchange, and step-therapy protocols

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

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

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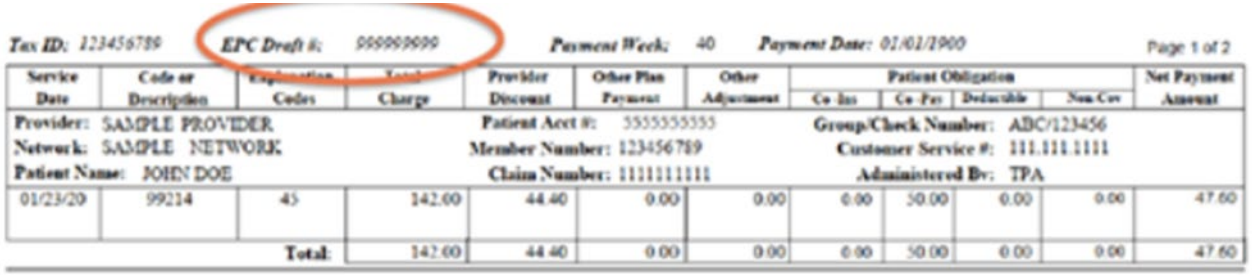
Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)

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	Charge	Provider Discount	Other Plan Payment	Other Adjustment	Patient Obligation: Co-Ins	Co-Pay	Deductible	Non-Cov	Net Payment Amount
Provider: SAMPLE PROVIDER				Patient Acct #: 5555555555			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.

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Billing & claims payment

For claim submission:
Electronic claims submission through clearinghouse:

- **Payer ID**: **68024** (Claim Submission)
  - Providers may register and submit claims directly via Connect Center .

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 835's/ERA currently come from Echo Health

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Provider disputes, resubmissions and 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, appeals, escalations 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
- Retro authorization request
- Coordination of benefits
- Proof of timely filing
- Claim coding edit

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** of the claim denial to:

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

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.

Provider appeals

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

Provider appeal

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

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

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

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

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

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

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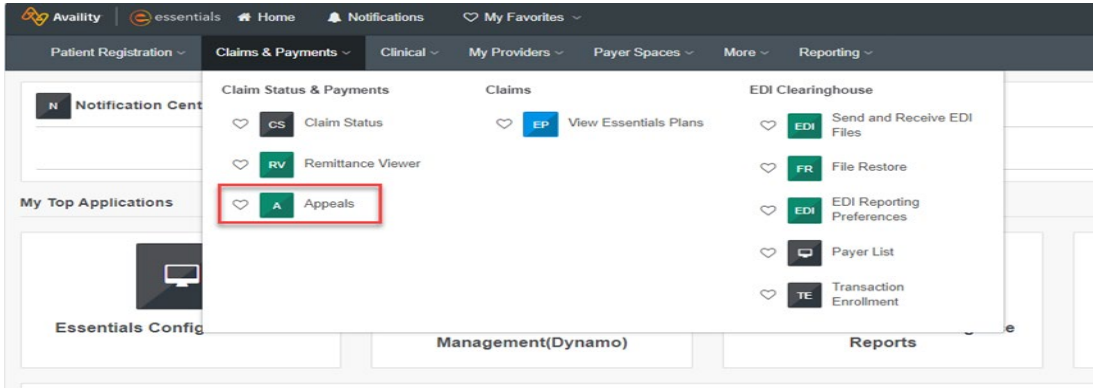
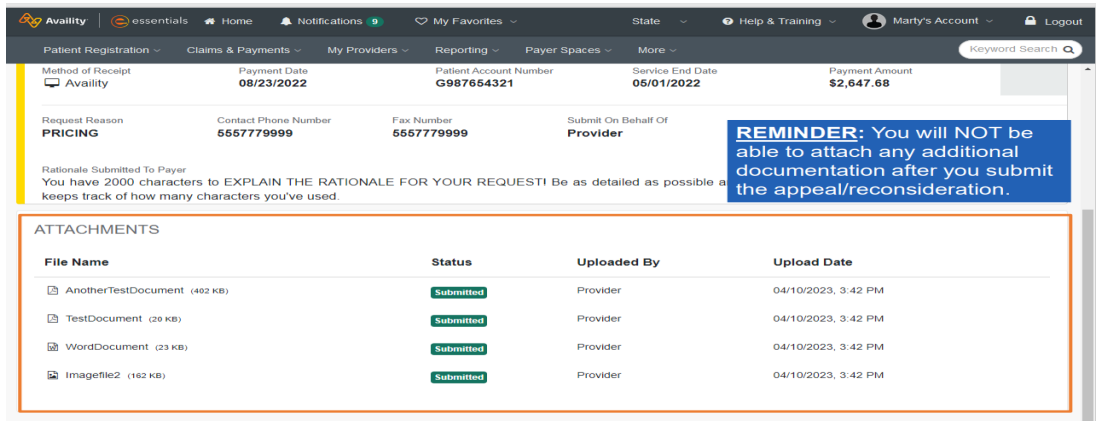
New Availity Enhancement - Enhanced Appeal Submission

Provider Appeal

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



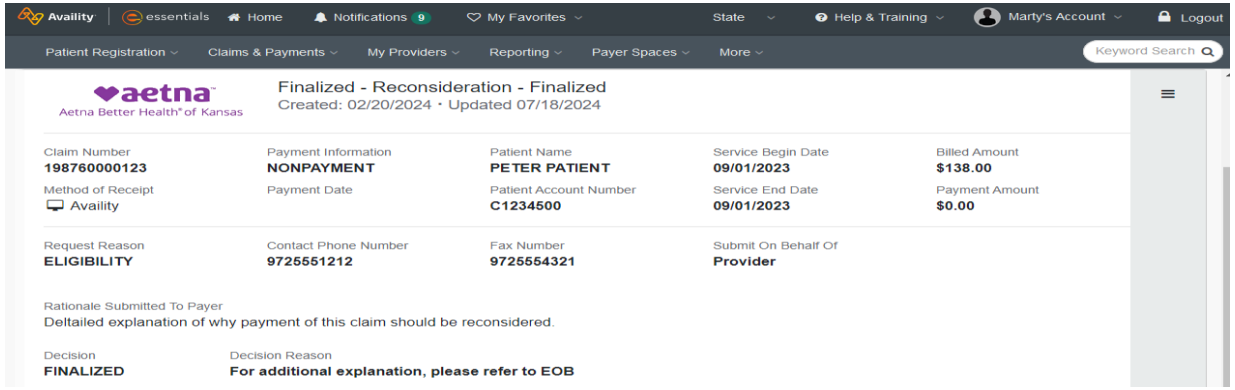


Submission

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

Review Outcome

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



Provider grievance

We have established a provider grievance process that expedites the timely and effective resolution of grievances 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 grievances about any matter other than an appeal. Possible subject of grievances include, but are not limited to, issues regarding:

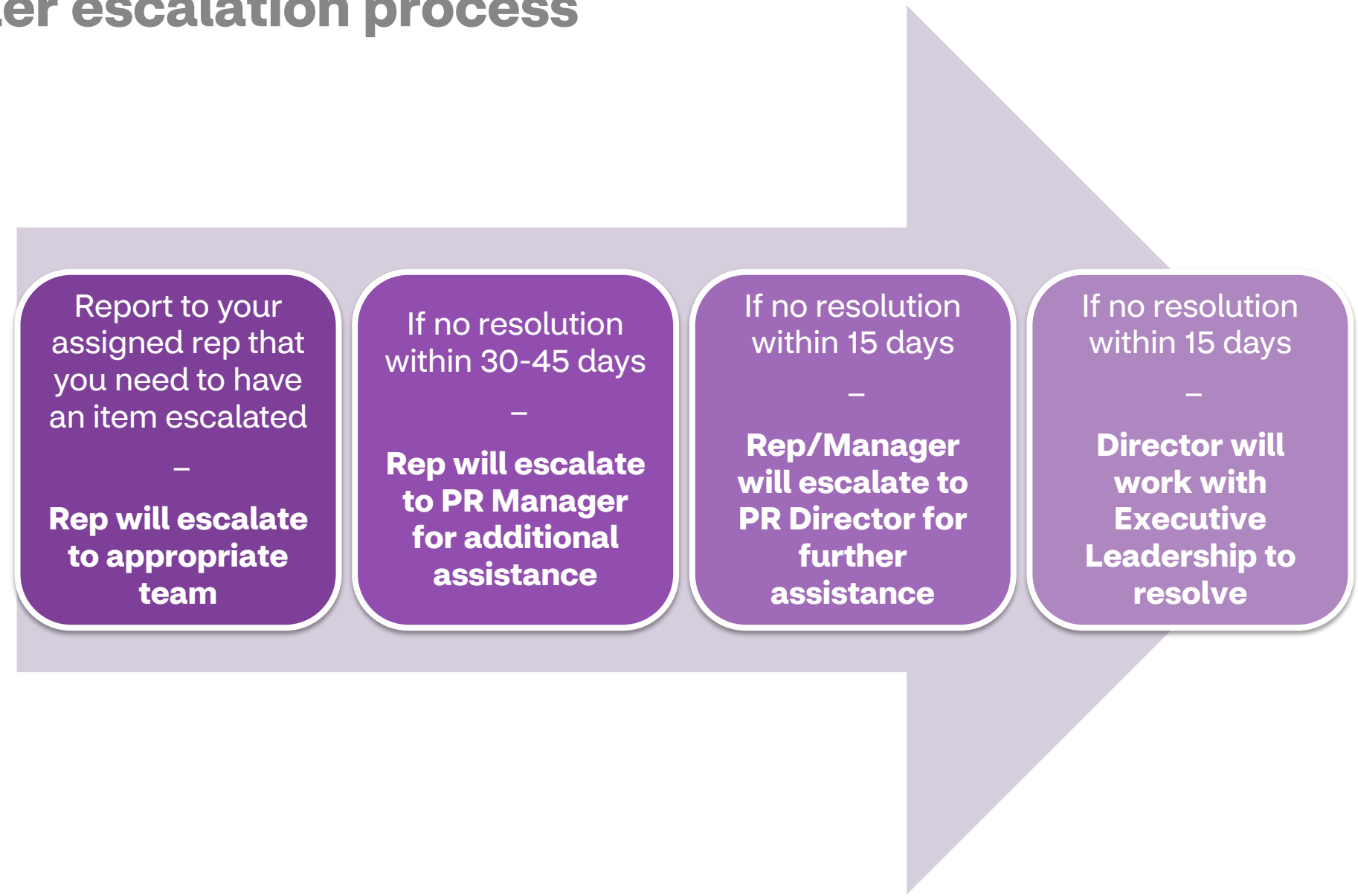
- Administrative issues
- Payment and reimbursement issues
- Dissatisfaction with the resolution of a dispute
- Aetna Better Health staff, service or behavior
- Vendor staff, service or behavior

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

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. Complaints will be reviewed and resolved within thirty (30) calendar days of receipt. The timeframe for resolution may not be extended.

Provider escalation process



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Provider state escalations

If a provider disagrees with our claims reconsideration decision, the provider can file an escalation with the Illinois Department of Healthcare and Family Services (HFS) Provider Resolution process and portal after attempting to resolve the issue with Aetna® through its process.

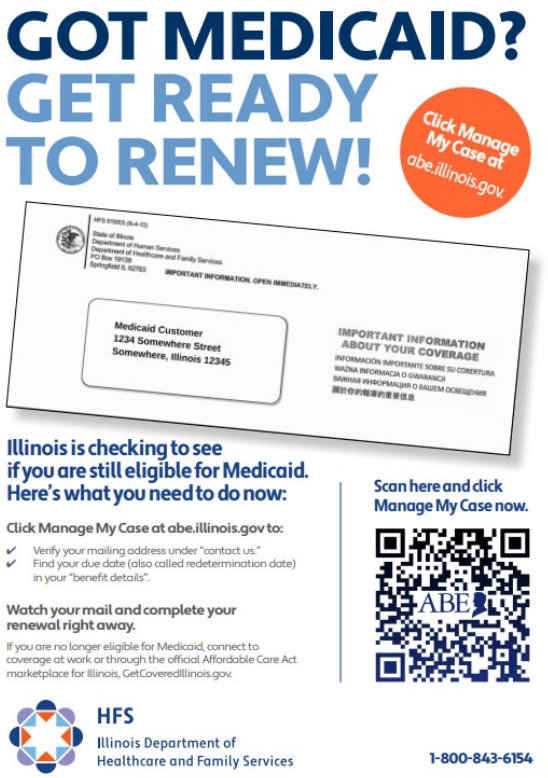
HFS requirements for submitting a state escalation

- The new provider dispute resolution process requires providers to first use the MCO internal dispute process before submitting a escalation to HFS.
- Disputes submitted to the Aetna internal dispute resolution process may be submitted to the new HFS Escalation Resolution Portal:
    1. No sooner than 30 days after submitting to the Aetna internal process, and
    2. No later than 60 days after submitting to the Aetna internal process.
        - If HFS determines an escalation was submitted sooner than 30 days or later than 60 days after submitting the dispute to the Aetna internal process, the escalation will be immediately closed.

You can find more details about Provider Resubmissions/Disputes, Appeals & Grievances in Chapter 18 of Aetna Better Health® of Illinois Provider Manual.

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 medial 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:

  - ✓ call **1-877-805-5312 (TTY: 1-877-204-1012)**
  - ✓ visit **www2.Illinois.gov/HFS/Address**

- ❑ **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.

✓ Providers should encourage members to keep contact information current to receive HFS notices

Questions?
Visit: GetMedicaidFacts.com

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Aetna Provider Summit Series

You're invited to our next Provider Summit

We're always seeking to grow and strengthen our relationships with our provider partners.

Our Provider Experience team will be hosting exciting and informative provider summits in Q3. Virtual sessions will be offered on the following dates:

Date/Time	
Thursday, August 13, 2026	10:00 AM - 12:00 PM CT
Thursday, August 27, 2026	1:00 PM - 3:00 PM CT

Scan the QR code or use the link below to register.

https://www.surveymonkey.com/r/RNCFFS9

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Quality

Quality management program

Overview

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

Medical records standards

- ABHIL's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).
- All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the ABHIL Provider Manual
- Medical Record Audits may be conducted by Aetna, HFS, or CMS to assess compliance and quality of care. Providers should refer to the ABHIL Provider Manual for detailed audit expectations and requirements.

Quality management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

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

What is our goal?

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

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

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Quality management program

Potential Quality of Care (PQoC) concerns

Aetna identifies, investigates, and resolves provider quality-of-care concerns promptly, including follow-up to ensure corrective actions are implemented and referral to peer review or external entities when appropriate. The organization also tracks and trends PQoC cases to identify repeat issues, inform credentialing decisions, and determine when broader quality improvement initiatives are needed.

Performance Improvement Projects (PIPs)

Aetna designs and implements CMS-compliant Performance Improvement Projects (PIPs) to achieve sustained, measurable improvements in care quality, selecting topics that reflect member needs, risk, and identified improvement opportunities. PIPs are approved through multidisciplinary clinical governance and continuously evaluated, with interventions refined as needed until statistically significant and sustained improvement is achieved.

Peer Review

Aetna implements CMS-compliant Performance Improvement Projects focused on measurable, sustained improvements in care quality aligned with member needs and identified gaps. These projects are governed through multidisciplinary oversight and continuously monitored, with interventions adjusted until meaningful improvement is achieved.

EQRO

External Quality Review (EQR) evaluates the quality, access, and timeliness of services provided under Medicaid managed care, and Aetna fully cooperates by supplying required data and records to the EQRO. EQR findings are shared with providers and integrated into Aetna's Quality Management and medical management programs to support continuous quality improvement. *EQR is a requirement under Title XIX of the Social Security Act.*

Provider Feedback

Aetna provides measurement and comparative feedback to providers by profiling performance across multiple quality, utilization, and evidence-based care measures and benchmarking results against peer practices. This feedback supports clinical decision-making and patient engagement by highlighting opportunities to improve outcomes, preventive services, and appropriate medication use.

For more information, please refer to the ABHIL provider manual.

Primary Care Physicians (PCPs) Roles & Responsibilities

Primary Care Providers roles & responsibilities include:

- *Primary & Preventive Care Access*: Provide or arrange 24/7 urgent and emergency services, deliver primary and preventive care, act as the member advocate, and maintain medical records.
- *Care Coordination & Referrals*: Serve as the referral agent; coordinate specialty, inpatient, behavioral health, and follow-up care; oversee medications and ensure continuity and quality of care.
- *Availability & Network Requirements*: Maintain admitting privileges or coverage arrangements, ensure access during and after office hours, and refer members to in-network specialists (prior authorization required for out-of-network care).

The PCP Role in Preventive or Screening Services:

Providers are responsible for providing appropriate preventive care to members. Examples include:

- Age-appropriate immunizations
- Disease risk assessment
- Age-appropriate physical examinations and health screenings
- Well-women visits (female members may go to an obstetrician/gynecologist for a well-woman exam once a year without a referral)
- Dental screenings and topical application of fluoride

For more information, please refer to the ABHIL provider manual.

Provider Financial Incentives & Quality Programs

Pay for Performance (P4P)

ABHIL offers financial incentives to eligible, in-network providers who meet HEDIS quality performance goals.

Eligibility: PCPs (and certain specialists) must meet panel size and quality targets; incentives are tied to individual HEDIS measure performance.

MBR Incentive & Medicaid Quality Risk Programs

Bonus Eligibility: Providers who choose to participate may earn bonuses by seeing at least 50% of assigned members for sick or well visits during the contract year and meeting target Medical Benefit Ratio (MBR) goals.

Data & Access Requirements: Providers must grant EMR access and submit complete, timely HEDIS/SDS data to support quality measurement and gap closure across designated HEDIS measures.

Quality Program Participation: Effective 1/1/24, providers must participate in P4P, submit an annual Quality Improvement Plan (QIP), and meet quality performance expectations.

Preventive & Screening Updates

Aetna Better Health of Illinois may update preventive and screening measures, targets, or bonus percentages to support State Medicaid quality programs. Providers will be notified in writing, and changes take effect on the date specified in the notice.

For more information, please refer to the ABHIL provider manual.

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

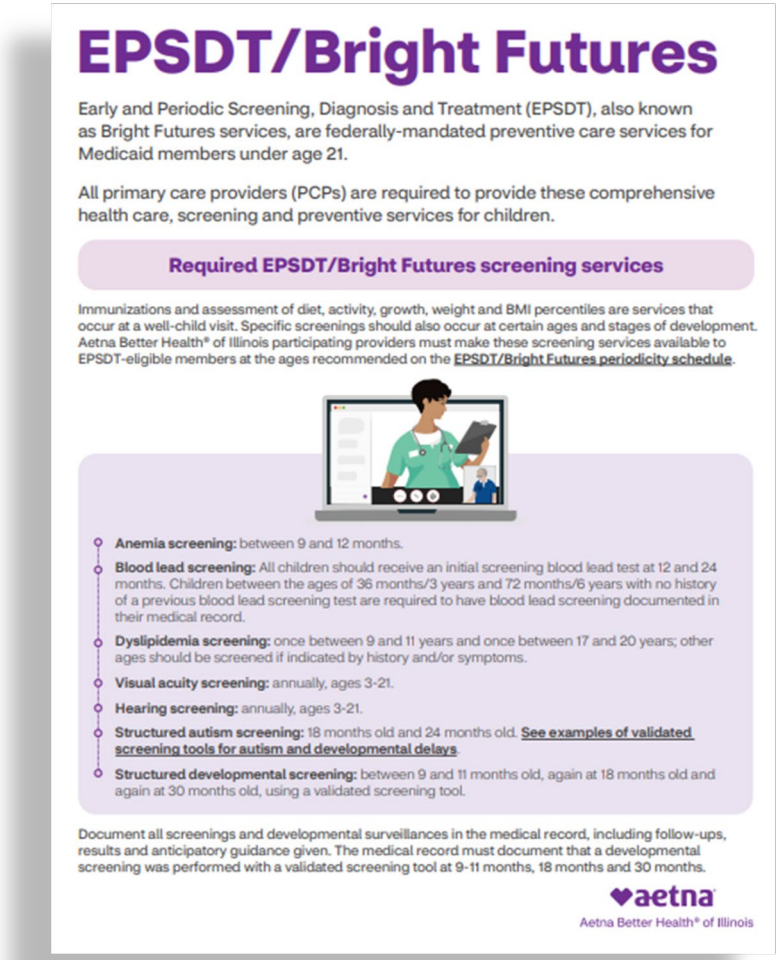
What is EPSDT?

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

Provider responsibilities:

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

Click HERE for EPSDT screening and services



EPSDT/Bright Futures

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

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

Required EPSDT/Bright Futures screening services

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

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

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

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CAHPS Annual Survey Feb – May | What does CAHPS? Measure?

In the last 6 months…

Getting Care

- When you/child needed care right away, how often did you get care as soon as needed?
- How often did you/child get an appointment for a check-up or routine care as soon as needed?
- How often was it easy to get the care, tests, or treatment you needed?

Goal

☐1 Never
☐2 Sometimes
☐3 Usually
☐4 Always

*Satisfaction with Plan Physician

- Rate Self/Child's Doctor (0-10)

Goal

0 1 2 3 4 5 6 7 8 9 10

Worst personal doctor possible — Best personal doctor possible

*Doctor Communication

- Shows respect for what the patient had to say
- Discusses your/child's healthcare
- Spends enough time
- Doctor explains things about the patient's health in a way that is easy to understand
- Doctor listened carefully to the patient
- Doctor is informed and up-to-date on self/child's care

Satisfaction w/Plan & Plan Services

- Rate yourself/child's health care (0-10)
- Rate yourself/child's Health Plan – Aetna (0-10)

Goal

0 1 2 3 4 5 6 7 8 9 10

Worst health care possible — Best health care possible

0 1 2 3 4 5 6 7 8 9 10

Worst health plan possible — Best health plan possible

*Customer Service

- Customer Service give you the information or help needed
- Customer Service treat you with courtesy and respect

Goal

☐1 Never
☐2 Sometimes
☐3 Usually
☐4 Always

*Doesn't calculate towards NCQA Star rating, may apply to state report cards

How can we work together to improve the Patient Experience?

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

- Familiarize yourself with the your ABH plan's Provider Manual
- Provide timely updates to Aetna on any changes in contact or location information, or roster or practices updates (i.e. if the practice is not accepting new patients)

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 your ABH plan's Member Resources

Our members can contact us through their state-specific **Member Services site** or phone number (M-F 8:30 AM to 5:00 PM).

Members also have access to:

- **Care Management**
- **24-hour nurse line**
- **SSDOH Resources**
- **Telehealth and free life resources**
- **Appointment transportation**

4. Engage staff in training 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

Health Risk Screening

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

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

Three (3) documented outreach attempts:

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

Questionnaire & triggers

Questionnaire include but is not limited to:

a. Demographic information for verification purposes;

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

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

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

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

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

g. Current medications; and

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

Member incentives

Aetna Better Care® Rewards

Members can earn Aetna Better Care Rewards by completing healthy activities like annual screenings, wellness exams and a health risk questionnaire.

All earned rewards are loaded onto a gift card, which members can use to shop in store or online at participating retailers.

Annual visits

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

Screenings

- **Cervical cancer screening:** $50
    - Women ages 21-64 who have a Pap smear can earn this reward once every 3 years **or** women ages 30-64 who have HPV testing or HPV/Pap smear co-testing can earn this reward once every 5 years.
- **Breast cancer screening:** $50 ages 40-74
    - Reward can be earned once every 2 years

*Controlled HbA1c: diagnosis of type 1 or type 2 diabetes with a hemoglobin A1c (HbA1c) value of less than 8.0%
**Controlled Blood Pressure: systolic blood pressure below 140 mm Hg and diastolic blood pressure below 90 mm Hg
Rewards are one per year unless otherwise stated.

Diabetes care visits

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

Assessments

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

Controlled blood pressure

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

Dental service (Child)

- **Annual child dental exam:** $20
    - Ages under 21 who have comprehensive exam with a dental provider

Behavioral health follow-up appointments

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

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Aetna Better Care® Rewards (cont'd)

Immunizations for children and adolescents

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

  HPV series counts as one reward event.

Prenatal and postpartum doctor visits

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

AetnaBetterHealth.com/Illinois-Medicaid/rewards-program.html

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Community events

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.

Value-added benefits and resources

Value-added benefits

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

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

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

Healthy kids
- Voucher for clothing for members in grades K-12 (ages 5 through 18)
- Members ages 5-21 can get an annual stipend to go towards health activities and/or programming

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

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

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

Learn more about how members can qualify at

AetnaBetterHealth.com/Illinois-Medicaid/Whats-Covered

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Pathways to Success

Pathways to Success

Pathways to Success is a program for eligible youth under age 21 with complex behavioral health needs. It offers intensive care coordination and home- and community-based services.

Providers are responsible for informing eligible members about the program, completing or referring for an IM+CANS assessment, and coordinating with health plans as needed.

Providers must follow guidance from the Joint Pathways Oversight Committee and the CCSO Provider Handbook. The Oversight Committee monitors and supports the program by developing provider networks, conducting audits and quality reviews, standardizing reporting, reviewing outcomes, implementing quality improvement strategies, and providing technical assistance to providers.

Provider website and Availity provider portal

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

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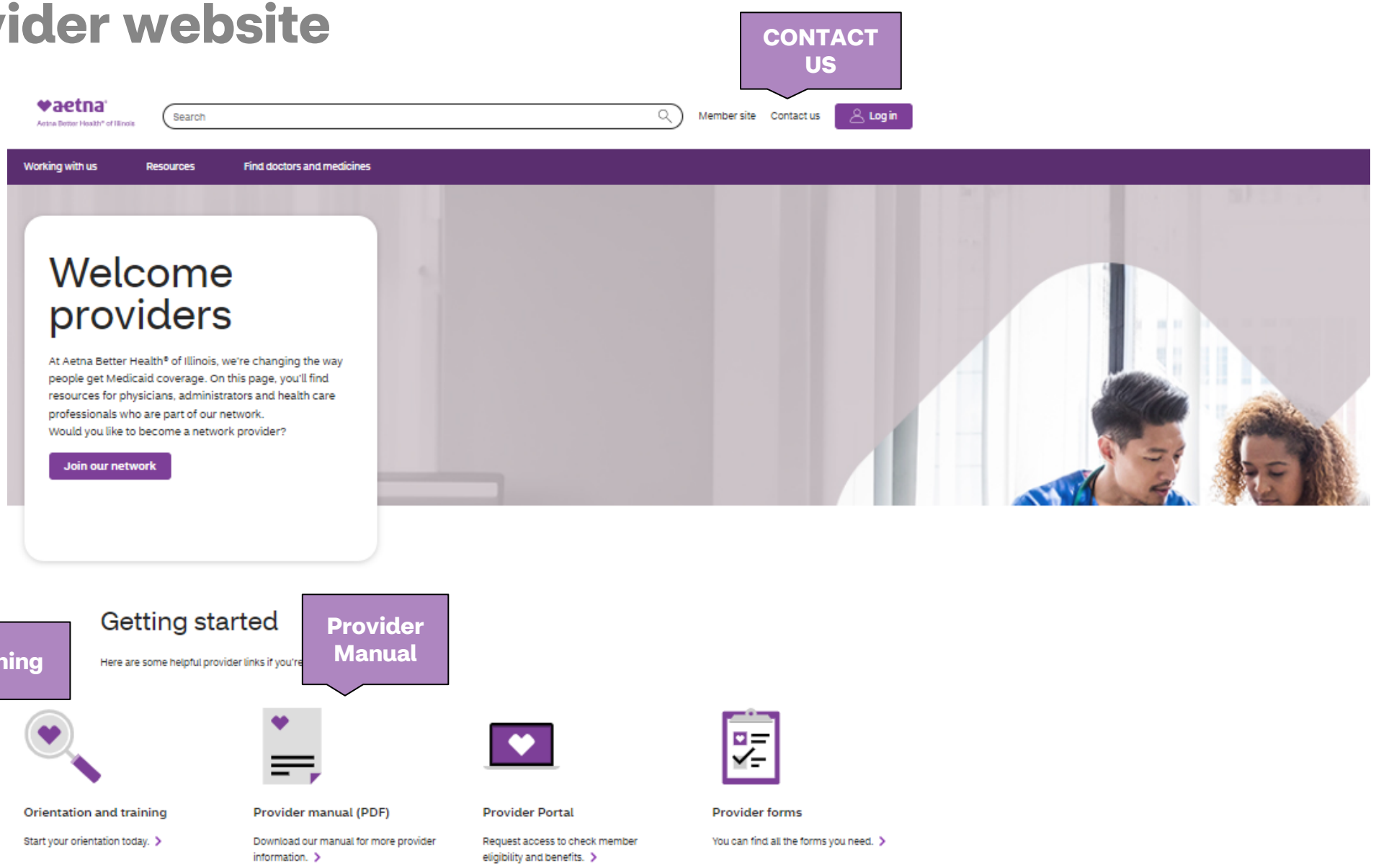
Provider website

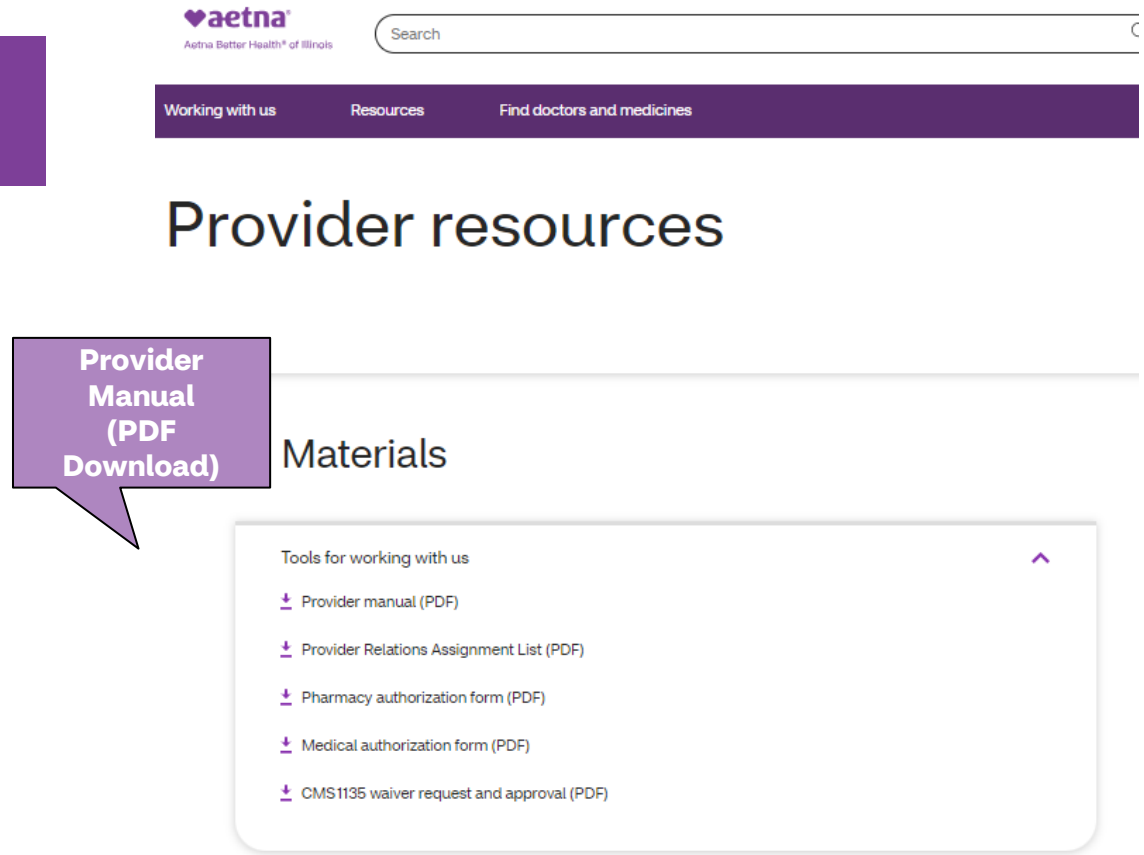


Provider website: Provider manual

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

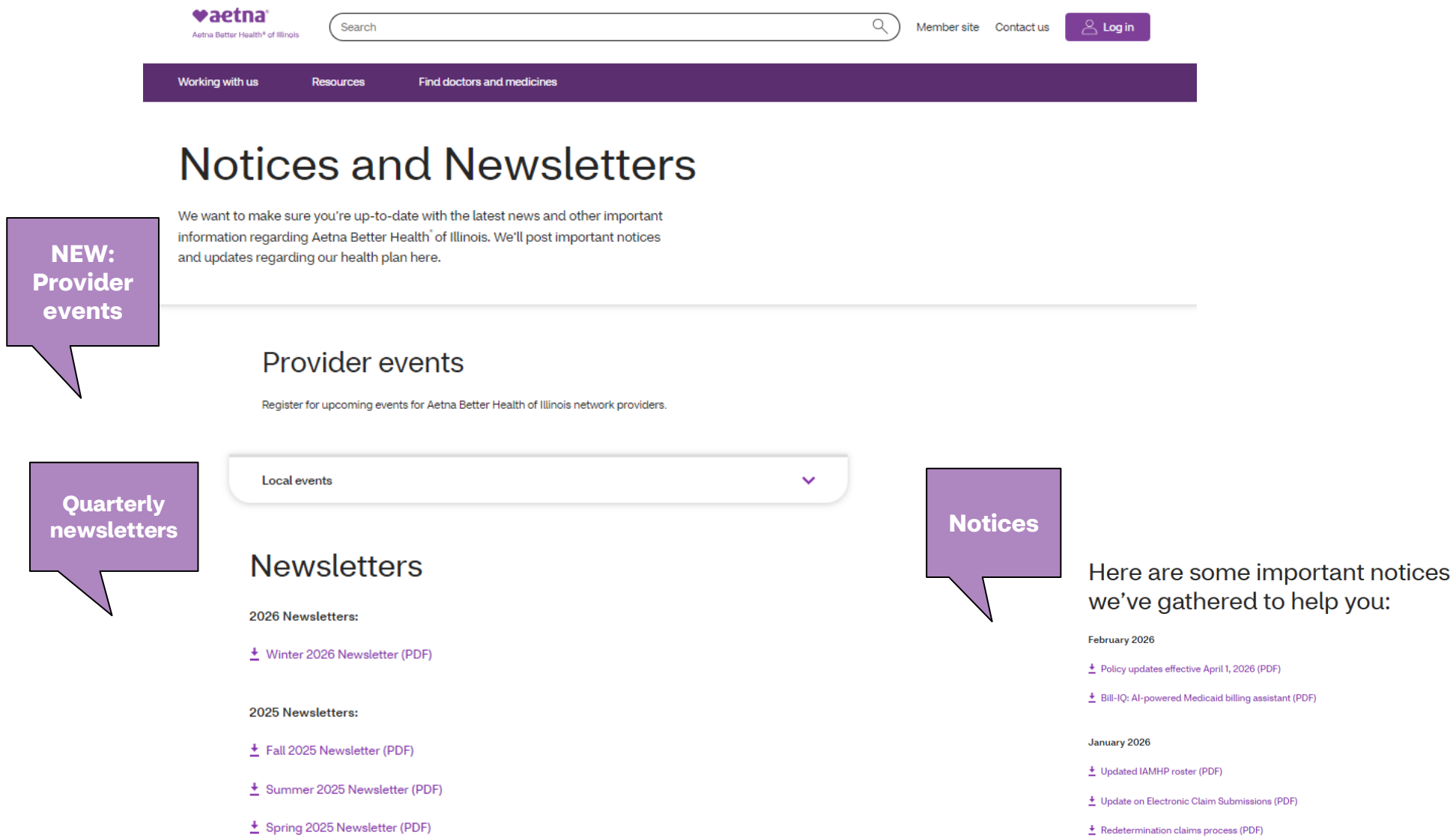
In addition to policies and procedures, this resource includes:

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



Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters

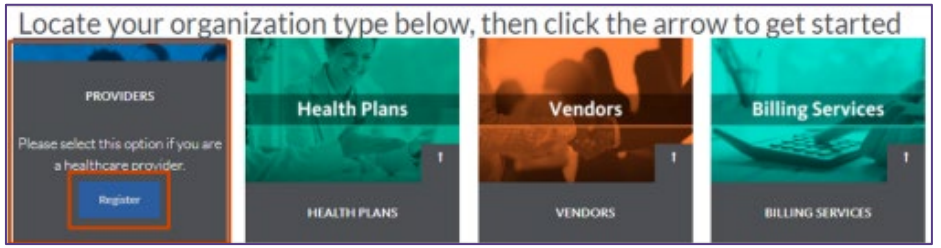


Availity portal registration

Availity.com/provider-portal-registration

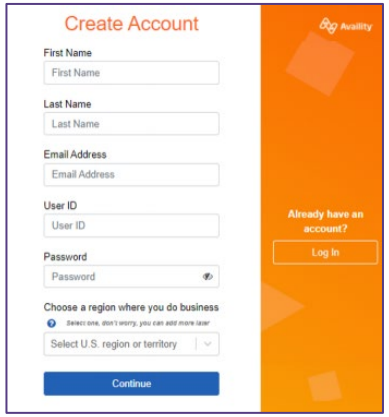
Register your provider organization

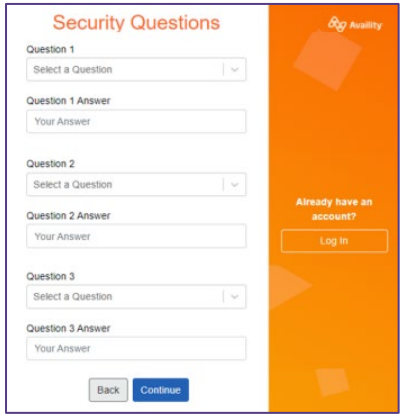
Important: This only applies to users who are brand new to Availity and need to register their provider organization.

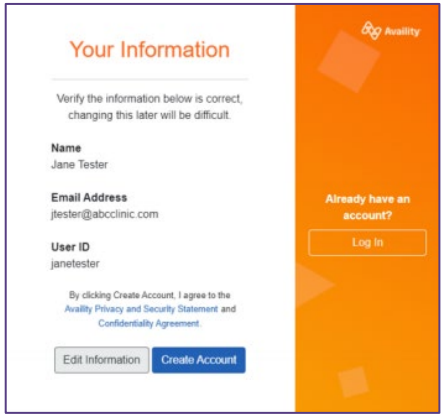


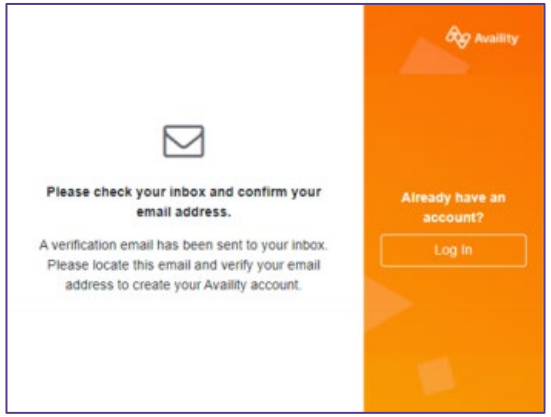
When you set up your new user account, you'll be asked to do the following tasks in the wizard:

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





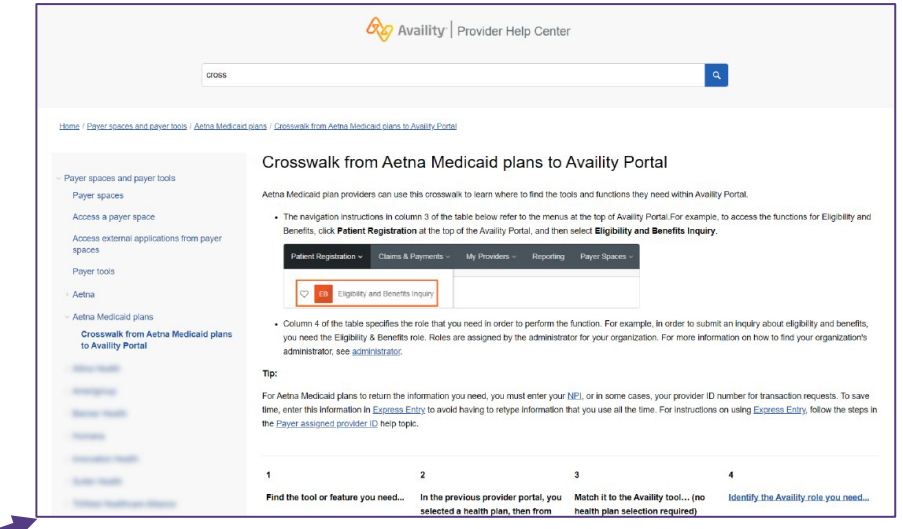


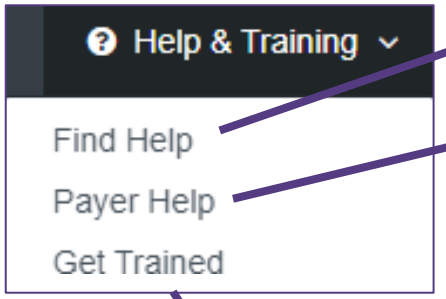


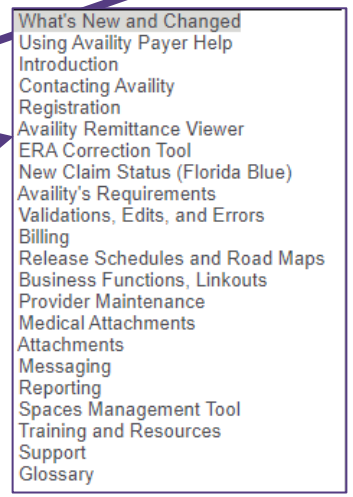
Availity Provider Help Center

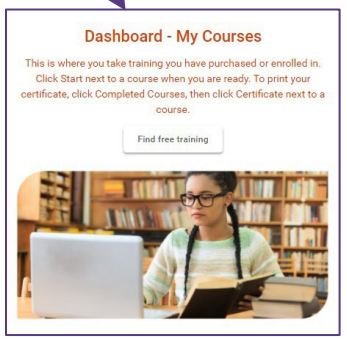
Crosswalk from Aetna Medicaid Plans to Availity Portal

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, 8 AM – 8 PM ET

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Key contacts and vendor and partners

Key contact information

- ❑ **Provider Services:** 1-866-329-4701 (TTY: 711)
- ❑ **Member Services:** 1-866-329-4701 (TTY: 711)
- ❑ **Nurse Line:** 1-866-329-4701 (TTY: 711)
- ❑ **Provider website:** AetnaBetterHealth.com/Illinois-Medicaid/providers
- ❑ List of assigned Network Relations Sr. Analysts & Managers
- ❑ Sign up here for provider training
- ❑ Aetna Better Care® Rewards

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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 Aetna Better Health of Illinois
  - Enroll contact: **MarchVisionCare.com/becomeprovider.aspx** or call toll-free at **844-456-2724**
- **Modivcare** for non-emergency medical transportation (NEMT) - **866-329-4701**
- **Availity Provider Portal** - **Availity.com/availity/web/public.elegant.login**
- **EviCore** for utilization management of advanced imaging/cardiology and interventional musculoskeletal pain management
  - Enroll at **Evicore.com** or call toll-free at **888-693-3211**
- **Eviti** is a decision support platform for oncology; it covers all medical and radiation oncology treatment plans for members ages 18 and older
  - Provider Support Team is available 8 AM – 8 PM ET or phone at **888-482-8057** or via email at **ClientSupport@NantHealth.com12111BNNB BNBNBNBNBNBNBNBNBNBNBNBNBNBNBNBNBN W QBN WDDVCSVDC VB**

State-mandated training

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

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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Cultural, linguistic & disability access requirements & services

Cultural competency

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

Linguistic competency

- **Members with limited English proficiency may experience:**
  - ❑ Less adequate access to care
  - ❑ Lower quality of care
  - ❑ Poorer health outcomes
- **Providers must ensure members have access to medical interpreters, signers, and TTY services to facilitate communication at no cost.**

- **To assist, Aetna Better Health of Illinois provides:**
  - ❑ Language Line services 24 hours a day, 7 days a week in 140 languages
  - ❑ Information in other formats including Spanish, Russian, Audio, Braille, etc., at no cost
  - ❑ TDD/TTY access
  - ❑ Translators to your office or the hospital

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

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

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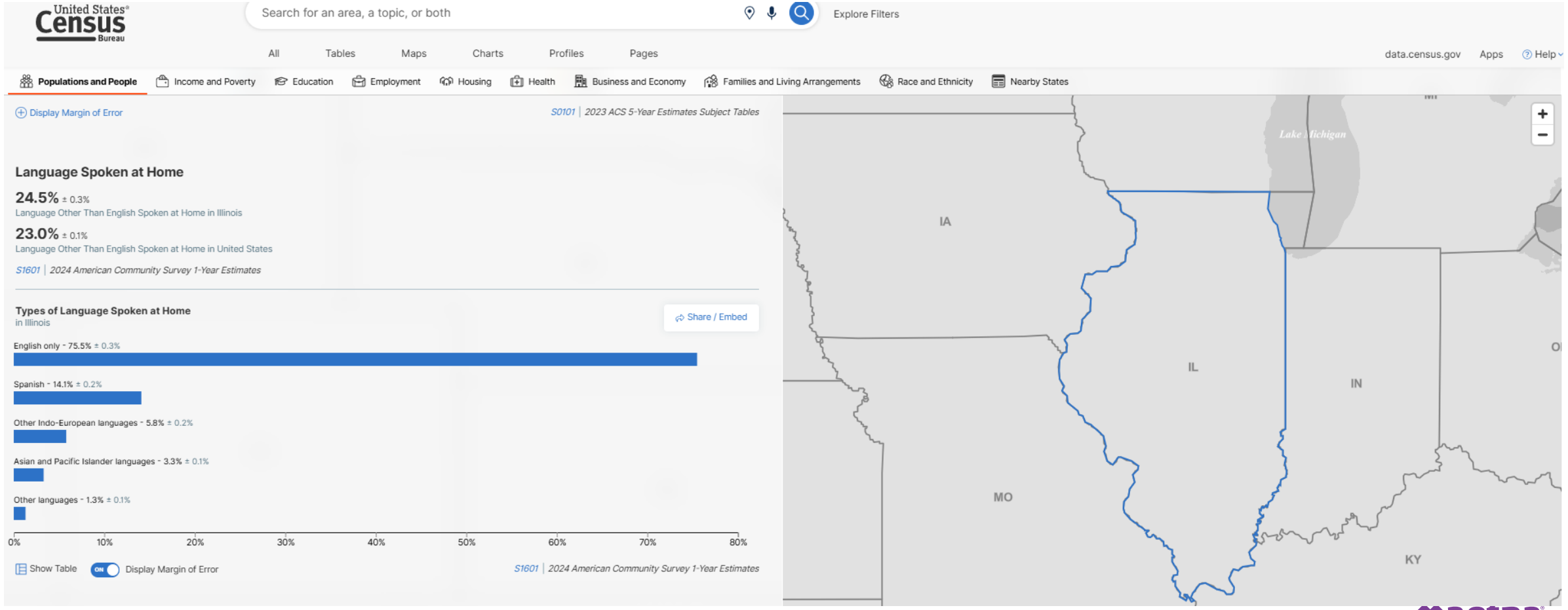
Member Languages

A community profile of Member languages in the state of Illinois

Languages Spoken in Illinois



https://data.census.gov/profile/Illinois?g=040XX00US17#populations-and-people

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
  - Complaints 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)

Fraud, Waste and Abuse (FWA)

Fraud, Waste and Abuse

Fraud

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

Waste

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

Abuse

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

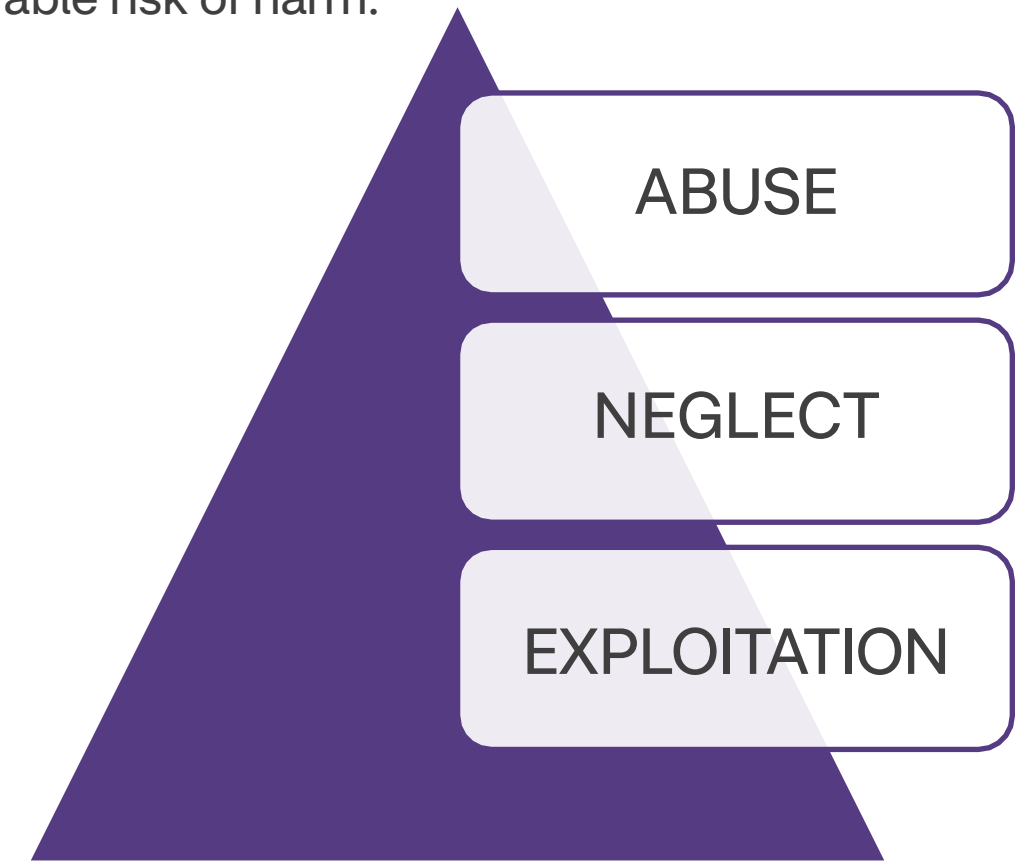
The Special Investigations Unit (SIU) proactively detects and investigates fraud, waste, and abuse across all markets using advanced technology to monitor large volumes of claims data. Staffed by about 150 investigators, analysts, and IT specialists, the SIU uses sophisticated analytics to identify suspicious provider behavior and works closely with compliance teams and law enforcement to investigate potential fraud.

Critical incidents

Abuse, neglect & exploitation

Critical incidents: Spot the signs

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



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

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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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Member Rights and Responsibilities

Member Rights and Responsibilities

We are committed to treating members with respect and dignity at all times.

- ✓ Providers must comply with member rights and responsibilities. It is our policy not to discriminate against members based on race, color, national origin, age, disability or sex, except where medically indicated, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

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

For your reference, the rights and responsibilities are:

- ❖ A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- ❖ A right to be treated with respect and recognition of their dignity and their right to privacy.
- ❖ A right to participate with practitioners in making decisions about their health care.
- ❖ A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- ❖ A right to voice complaints or appeals about the organization or the care it provides.
- ❖ A right to make recommendations regarding the organization's member rights and responsibilities policy.
- ❖ A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- ❖ A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- ❖ A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Shared decision-making aids

Shared decision-making aids

Shared decision-making aids offer healthcare providers the opportunity to leverage best practice tools tailored to their specific medical specialties. These tools serve as valuable resources, aiding physicians and other healthcare providers to engage in comprehensive discussions with their patients regarding a spectrum of treatment options. The resources offer options ranging from conservative approaches to more invasive interventions. These decision-making aids encompass detailed information on associated risks and potential outcomes, facilitating a more informed dialogue between healthcare professionals and patients.

These aids cover a diverse array of medical scenarios, providing specialized information on topics such as diabetes, cardiovascular, wellness screening, flu prevention and more. By incorporating these decision aids into your practice, healthcare providers can enhance the collaborative decision-making process, ensuring that patients are well-informed and actively involved in determining the most suitable course of action for their individual healthcare needs.

Below are evidence-based aids that provide information about treatment options, lifestyle changes and outcomes. You can access the aids under "Materials" here.

- **Diabetes**
- **Flu prevention**
- **Statin choice decision aid**
- **Depression medication choice**
- **Cardiovascular primary prevention choice.**

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Revalidation

Mandatory IMPACT Revalidation

All Medicaid providers must revalidate their enrollment

Important notes

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

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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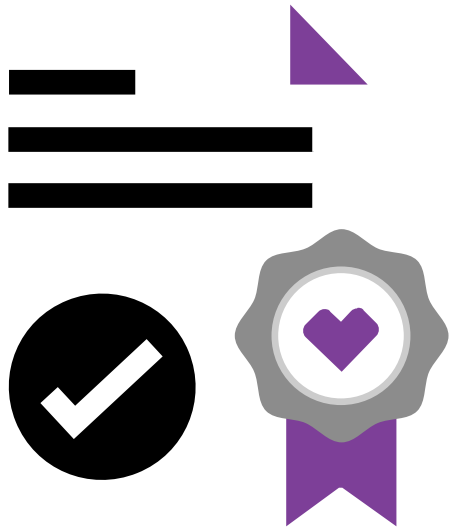
Attestation of Training Completion

As part of your contractual obligations, providers are required to complete annual training in the following areas:

- ❑ Cultural Competency
- ❑ Fraud, Waste, and Abuse (FWA)
- ❑ Critical Incident Reporting

✓ **These training requirements were covered by attending this NPO**



To support compliance, we ask that you complete and submit the attestation form using the link or QR code provided below. This will confirm your participation in the required training. Please note that this attestation is **valid for one year**. This will also be emailed.

Aetna Better Health of Illinois – Attestation of Training Completion – Aetna Better Health of Illinois- Attestation of Training Completion – Fill out form

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Q&A session

Thank you!

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