



# New provider orientation

Aetna Better Health® of Illinois



# CAHPS 2025 Timeline | Adult & Child Survey Administration

Data collection closes May 10th | 2025 NCQA Goal Child Survey ★ ★ ★

## Week of February 10<sup>th</sup>



CAHPS Texting Campaign

## Early February



POST FIRST CLASS  
U.S. POSTAGE  
PAID  
BALTIMORE, MD  
PERMIT 5745

CSS Processing  
PO Box 3416  
Hopkins, MN 55343  
Scan here to take the survey online!

AET11\_U\_P

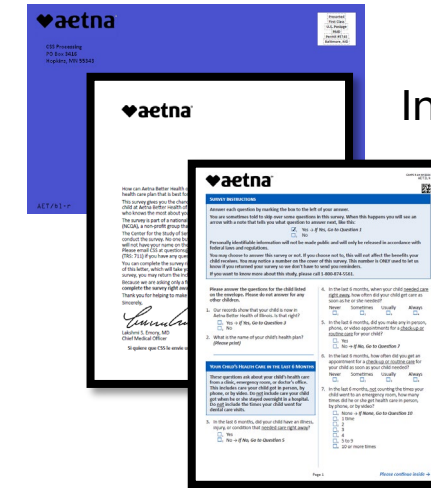
Aetna Better Health of Illinois is conducting a survey to find out about the services that it provides to children. Your child's name was selected at random to tell us what you think. In a few days, you will receive a survey in the mail (with log on information to complete the survey online) from the Center for the Study of Services (CSS), an independent research firm.

You can complete the survey online, right now, by scanning the QR code on the front of this postcard with your smart phone.

Would you please help us by completing the survey?  
Thank you!

Postcard Prenotification

## February 7-14<sup>th</sup>

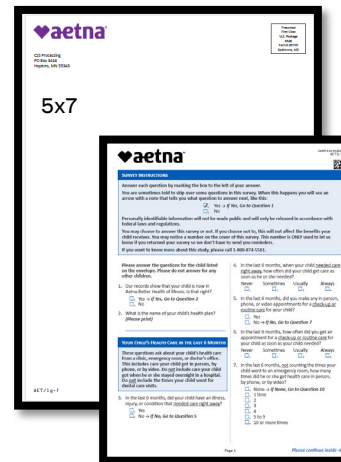


Initial Mailing

Survey Closes May 12th

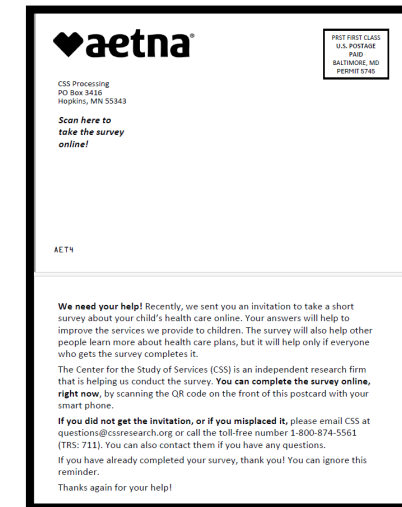
## March 14<sup>th</sup> Response Rate Tracking

## March 14-21<sup>st</sup>



Final Reminder Mailing

## March 14-27<sup>th</sup>



Postcard Reminder

CSS HOME ABOUT SERVICES CLIENTS CONTACT MY ACCOUNT

My Projects lacroix@aetna.com | Logout

- HEDIS/CAHPS
- Response Rates
- eReports
- Schedule
- xTabs Adult Medicaid
- xTabs Child Medicaid

My Resources

- Account Information
- FAQ
- FileXchange
- Portal Features

**HEDIS/CAHPS**

**WHAT'S NEW**

- HEDIS data collection has begun for all plans

**OVERVIEW OF FIELDING SCHEDULE**

- Data collection begins February 2024
- Response rate tracking available online in March 2024
- Data collection closes May 10, 2024
- Data submission to NCQA on May 13, 2024

**QUESTIONS**

If you have any questions during the fielding process, please contact your account representative or reach us at [questions@cssresearch.org](mailto:questions@cssresearch.org). For more information about the HEDIS/CAHPS program, please visit <http://www.ncqa.org>.

**ABOUT**

CENTER FOR THE STUDY OF SERVICES (CSS) is a nonprofit, 501(c)(3) founded in 1974. Our organization has decades of experience in healthcare surveys, research, analysis, and reporting. We work with research organizations, federal agencies, health plans, healthcare providers, and state insurance exchanges to measure, report, and improve the experiences of healthcare consumers and patients.



# What does CAHPS Measure?

In the last 6 months...

## Getting Care



- Child get care as soon as needed
- Get appointment for a check-up or routine care as soon as needed
- Easy to get the care, tests, or treatment your child needed

Never  
 1

Sometimes  
 2

Usually  
 3

Always  
 4

## Satisfaction with Plan Physician



- Doctor explain things about child's health in a way easy to understand
- Doctor listened carefully to you
- Show respect for what you had to say
- Talk about child's healthcare
- Spend enough time
- Doctor informed, up-to-date on child's care
- Rate Child's Doctor (0-10)
- Rate Specialist your child talked to the most (0-10)

## Satisfaction w/Plan & Plan Services



- Rate your child's health care (0-10)
- Rate your Child's Health Plan – Aetna (0-10)

## \*Customer Service



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

\*Results are not part of overall NCQA Rating, included on HFS scorecard

# 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-Zapata**

Senior Director, Provider Relations

### **Steve Inzerello**

Senior Director, Provider Relations

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# Overview

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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

## Our footprint



3200 Highland Avenue  
Downers Grove, IL 60515

333 W. Wacker Drive  
Chicago, IL 60606

## Our local approach

- Illinois-based staff for local member and provider servicing
- Over 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

# 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.

# 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.**



**Aetna Better Health<sup>®</sup> of Illinois**  
**HealthChoice Illinois**  
Regulatory Agency - HealthCare and Family Services

**aetna<sup>®</sup>**

Name:  
Member ID#:

Effective Date: 00/00/00  
DOB: 00/00/00 Sex:

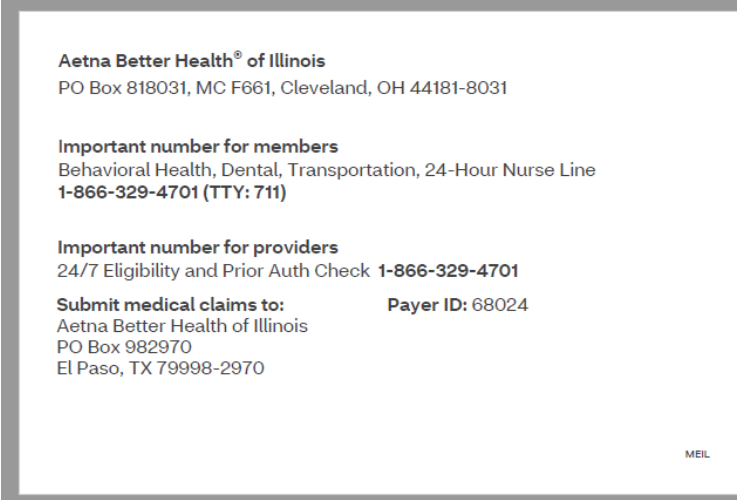
PCP:  
Phone:

CCSO Name:  
CCSO Phone:

Member Services: 1-844-316-7562 (TTY: 711)  
[AetnaBetterHealth.com/Illinois-Medicaid](http://AetnaBetterHealth.com/Illinois-Medicaid)

RxBIN: 610591 RxCN: ADV RxGRP: RX881A **CVS caremark<sup>®</sup>**  
Pharmacist Use Only: 1-888-964-0172

MEIL1



**Aetna Better Health<sup>®</sup> of Illinois**  
PO Box 818031, MC F661, Cleveland, OH 44181-8031

**Important number for members**  
Behavioral Health, Dental, Transportation, 24-Hour Nurse Line  
**1-866-329-4701 (TTY: 711)**

**Important number for providers**  
24/7 Eligibility and Prior Auth Check **1-866-329-4701**

**Submit medical claims to:** Payer ID: 68024  
Aetna Better Health of Illinois  
PO Box 982970  
El Paso, TX 79998-2970

MEIL

# 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



## 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. \_\_\_\_\_

# 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>

# 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: 01/01/2000 Page 1 of 2

Service Date	Code or Description	Explanation Codes	Total Charge	Provider Discount	Other Plan Payment	Other Adjustment	Patient Obligation				Net Payment Amount
							Co-Ins	Co-Pay	Defensible	Non-Cov	
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
<b>Total:</b>			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](mailto:allpayer@echohealthinc.com) or 888.834.3511.

# 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 IS THREE TIMES A WEEK

- Monday will be the 1<sup>st</sup> check run, with a Tuesday paid date
- Wednesday will be the 2<sup>nd</sup> check run, with a Thursday paid date
- Friday will be the 3<sup>rd</sup> check run, with a Monday paid date.
- Paper remits and checks will generally be mailed on Mondays and Wednesdays.

## ERA:

- Remittance advices are available within the Availity provider portal.
- Electronic 835's/ERA currently come from Echo Health

# 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:

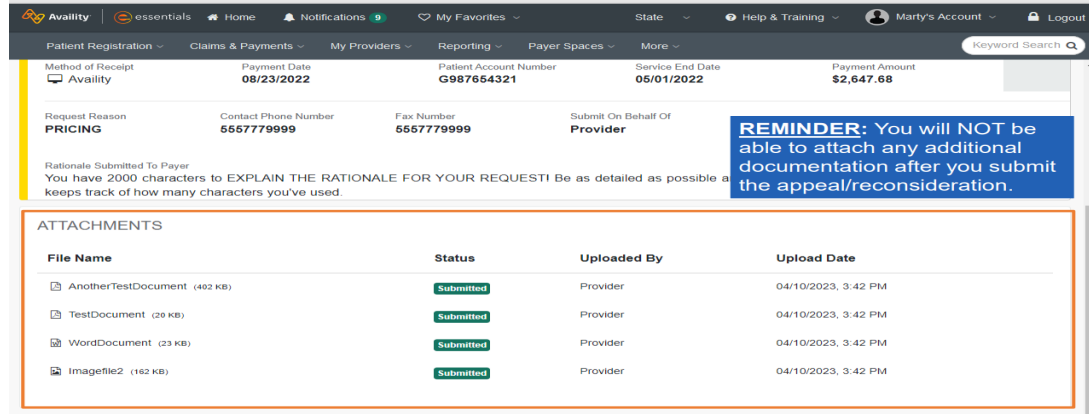
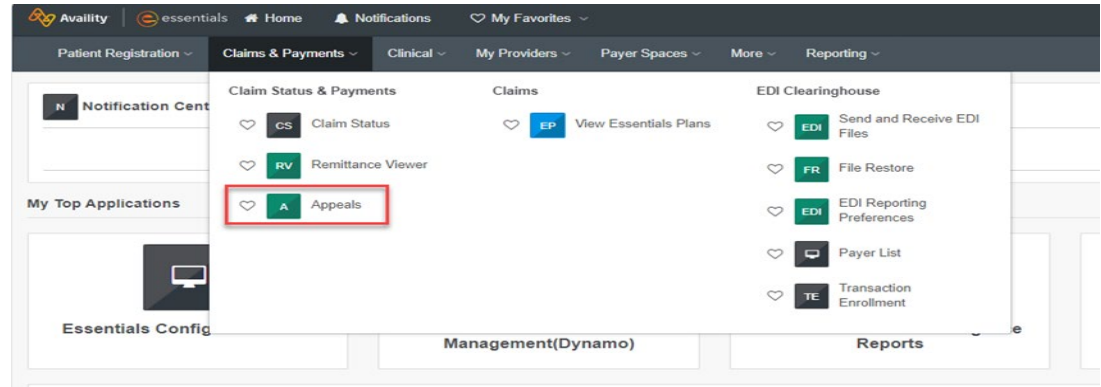
**Aetna Better Health of Illinois**  
**Attn: Appeals & Grievances**  
**PO Box 81040**  
**5801 Postal Rd**  
**Cleveland, OH 44181**



# 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

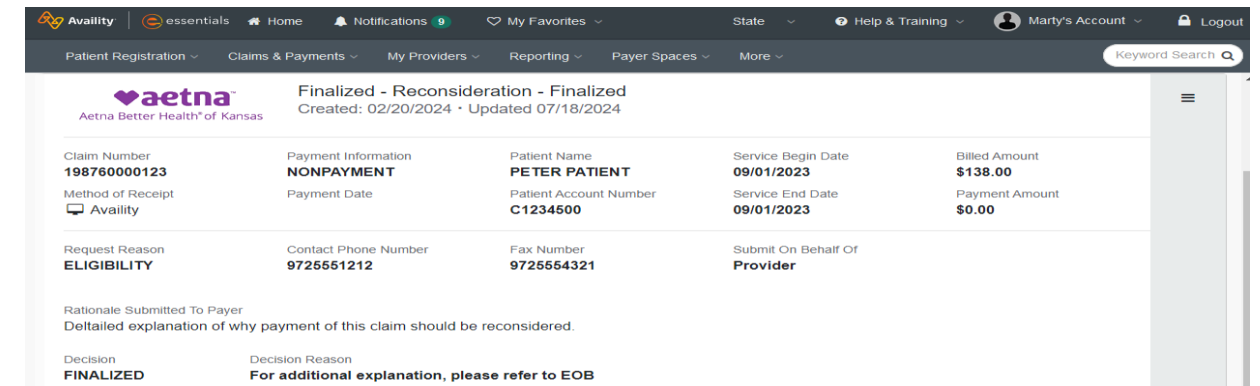


## Submission

- 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 the 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:

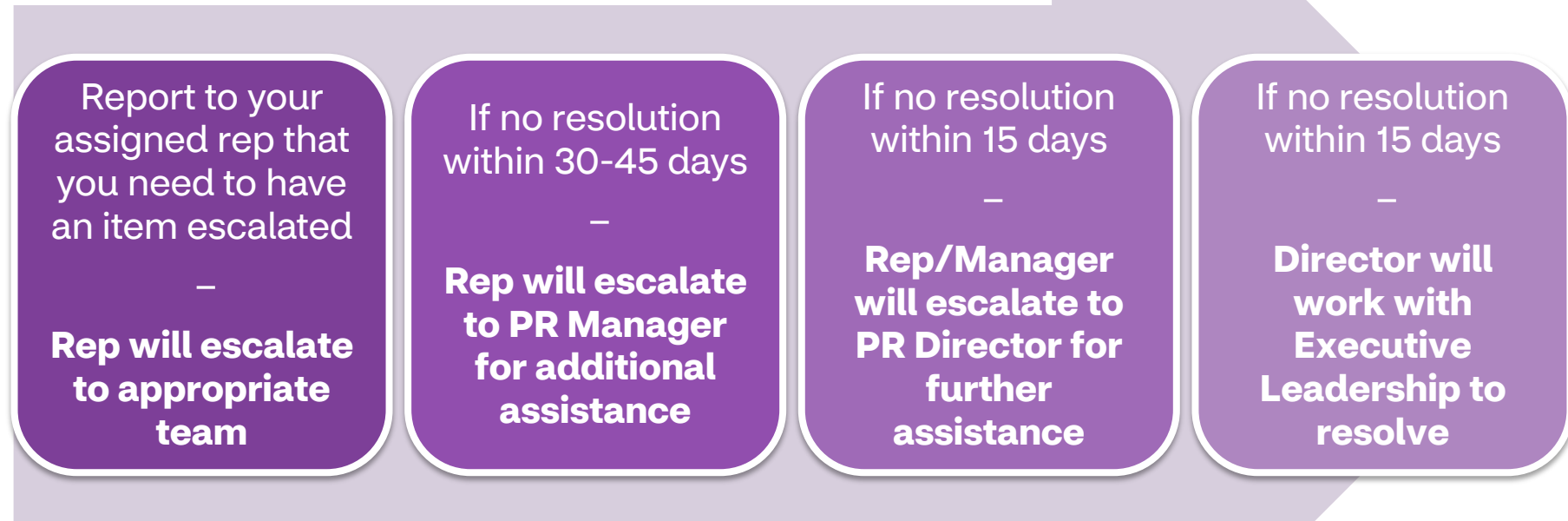
- Administrative issues
- Payment and reimbursement issues
- Dissatisfaction with the resolution of a dispute
- Aetna Better Health staff, service or behavior
- Vendor staff, service or behavior

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



# 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.**



# **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 an exciting and informative provider summit in Q3. A virtual session will be offered on the following dates:

Date/Time
Thursday, August 7, 2025 at 10 AM-12 PM CT
Thursday, August 21, 2025 at 1 PM-3 PM CT

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

[2025 Aetna Better Health of Illinois Medicaid Provider Summits Survey \(surveymonkey.com\)](https://www.surveymonkey.com)



**Quality**

# Quality management program

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## 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

## Quality management - HEDIS

### Healthcare Effectiveness Data and Information Set (HEDIS)

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

### What is our ultimate goal?

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

Please see HEDIS Tips for PCPs located on our website at [AetnaBetterHealth.com/Illinois-Medicaid/providers](https://www.aetna.com/betterhealth/illinois-medicaid/providers)



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

## What is EPSDT?

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

## Provider responsibilities:

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

Click [HERE](#) for EPSDT screening and services

## EPSDT/Bright Futures

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

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

### Required EPSDT/Bright Futures screening services

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



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

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

  
Aetna Better Health® of Illinois

# Health Risk Screening

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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<sup>®</sup> Rewards

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

In 2025, 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: \$25
  - 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: \$25 ages 50-74
  - 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+

# Aetna Better Care<sup>®</sup> 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](https://www.aetna.com/illinois-medicaid/rewards-program.html)

# 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](https://www.aetna.com/better-health/illinois)

Interested in hosting an event? Send an email to [ABHILCommunity@aetna.com](mailto:ABHILCommunity@aetna.com).



# **2025 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
- **NEW in 2025** Voucher for monthly subscription fees for grocery delivery services

## Healthy kids

- Voucher for clothing for members in grades K-12 (ages 5 through 18)
- **NEW in 2025** 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](https://www.aetna.com/better-health/illinois-medicaid/whats-covered)

# **Provider website and Avality provider portal**

# Aetna Better Health<sup>®</sup> of Illinois Medicaid public website

Members and providers can access the Aetna Better Health<sup>®</sup> of Illinois website at [AetnaBetterHealth.com/Illinois-Medicaid](https://AetnaBetterHealth.com/Illinois-Medicaid)

## Providers will be able to access:

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



# Provider website

CONTACT US

The screenshot shows the top navigation bar with the Aetna logo (Aetna Better Health of Illinois), a search bar, and links for Member site, Contact us, and Log in. Below the navigation is a purple header with links for Working with us, Resources, and Find doctors and medicines. The main content area features a large white box with the heading "Welcome providers" and a "Join our network" button. The background of the main content area is a photograph of two healthcare professionals, a man and a woman, looking at a screen together.

Training

## Getting started

Provider Manual

Here are some helpful provider links if you're



### Orientation and training

Start your orientation today. >



### Provider manual (PDF)

Download our manual for more provider information. >



### Provider Portal

Request access to check member eligibility and benefits. >



### Provider forms

You can find all the forms you need. >

# Provider website: Provider manual

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

In addition to policies and procedures, this resource includes:

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



Search

Working with us

Resources

Find doctors and medicines

## Provider resources

Provider Manual  
(PDF Download)


### Materials

Tools for working with us

- ↓ [Provider manual \(PDF\)](#)
- ↓ [Provider Relations Assignment List \(PDF\)](#)
- ↓ [Pharmacy authorization form \(PDF\)](#)
- ↓ [Medical authorization form \(PDF\)](#)
- ↓ [CMS1135 waiver request and approval \(PDF\)](#)

# Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters

  [Member site](#) [Contact us](#) [Log in](#)

[Working with us](#) [Resources](#) [Find doctors and medicines](#)

## Notices and Newsletters

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

**NEW:**  
Provider events

### Provider events

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

Local events 

**Quarterly newsletters**

### Newsletters

**2025 Newsletters:**

- [Spring 2025 Newsletter \(PDF\)](#)
- [Winter 2025 Newsletter \(PDF\)](#)

**2024 Newsletters:**

- [Fall 2024 Newsletter \(PDF\)](#)

**Notices**

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

**May 2025**

- [Appointment and availability standards \(PDF\)](#)
- [New review process for DRG claims \(PDF\)](#)
- [2025 Provider Satisfaction Survey \(PDF\)](#)

**April 2025**

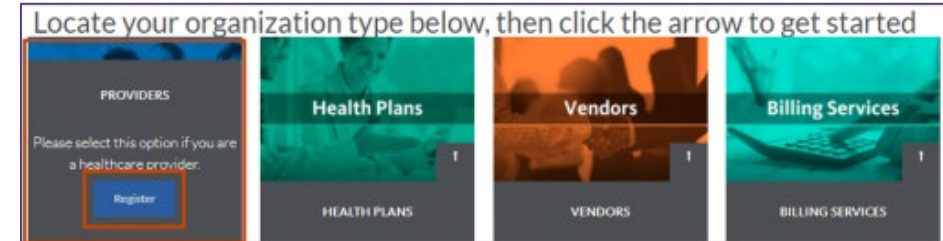
- [Provider Summits May 2025 \(PDF\)](#)

# Availity portal registration

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

## Register your provider organization

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



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

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

# Availity 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

The image shows a navigation menu for 'Help & Training' with three options: 'Find Help', 'Payer Help', and 'Get Trained'. Arrows point from 'Find Help' and 'Payer Help' to a list of topics. An arrow also points from 'Get Trained' to a 'Dashboard - My Courses' section which includes a 'Find free training' button and an image of a woman at a computer.

**What's New and Changed**

- Using Availity Payer Help
- Introduction
- Contacting Availity
- Registration
- Availity Remittance Viewer
- ERA Correction Tool
- New Claim Status (Florida Blue)
- Availity's Requirements
- Validations, Edits, and Errors
- Billing
- Release Schedules and Road Maps
- Business Functions, Linkouts
- Provider Maintenance
- Medical Attachments
- Attachments
- Messaging
- Reporting
- Spaces Management Tool
- Training and Resources
- Support
- Glossary

**Dashboard - My Courses**

This is where you take training you have purchased or enrolled in. Click Start next to a course when you are ready. To print your certificate, click Completed Courses, then click Certificate next to a course.

Find free training

The screenshot shows the 'Availity | Provider Help Center' page. It features a search bar at the top and a navigation menu on the left. The main content area is titled 'Crosswalk from Aetna Medicaid plans to Availity Portal'. It includes instructions for Aetna Medicaid plan providers and a table with four columns: 'Find the tool or feature you need...', 'In the previous provider portal, you selected a health plan, then from', 'Match it to the Availity tool... (no health plan selection required)', and 'Identify the Availity role you need...'. A table row is visible with 'Eligibility and Benefits Inquiry' in the first column.

## 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



**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)**
- ❑ **Provider website: [AetnaBetterHealth.com/Illinois-Medicaid/providers](https://www.aetna.com/illinois-medicaid/providers)**
- ❑ **[List of assigned Network Relations Sr. Analysts & Managers](#)**
- ❑ **[Sign up here for provider training](#)**
- ❑ **[Aetna Better Care® Rewards](#)**

# Vendors and partners

Aetna Better Health® of Illinois subcontracts the following services:

- ❑ **DentaQuest** for Dental
  - DentaQuest contacts:
    - [Krista.Smothers@dentaquest.com](mailto:Krista.Smothers@dentaquest.com) (Central and Southern Illinois)
    - [LaDessa.Cobb@dentaquest.com](mailto:LaDessa.Cobb@dentaquest.com) (Northern Chicago)
    - [Michelle.ONail@dentaquest.com](mailto:Michelle.ONail@dentaquest.com) (Southern Greater Chicago)
  
- ❑ **March Vision** for Vision
  - Optometry claims go to March Vision
  - Ophthalmology claims go to Aetna Better Health of Illinois
  - Enroll contact: [MarchVisionCare.com/becomeprovider.aspx](https://www.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](https://www.availity.com/availity/web/public.elegant.login)
  
- ❑ **EviCore** for utilization management of advanced imaging/cardiology and interventional musculoskeletal pain management
  - Enroll at [Evicore.com](https://www.evicore.com) or call toll-free at **888-693-3211**
  
- ❑ **Eviti** is a decision support platform for oncology; it covers all medical and radiation oncology treatment plans for members ages 18 and older
  - Provider Support Team is available 8 AM – 8 PM ET or phone at **888-482-8057** or via email at [ClientSupport@NantHealth.com](mailto:ClientSupport@NantHealth.com)

# **State-mandated training**

# Appointment and availability standards



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

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

# **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.

# 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.

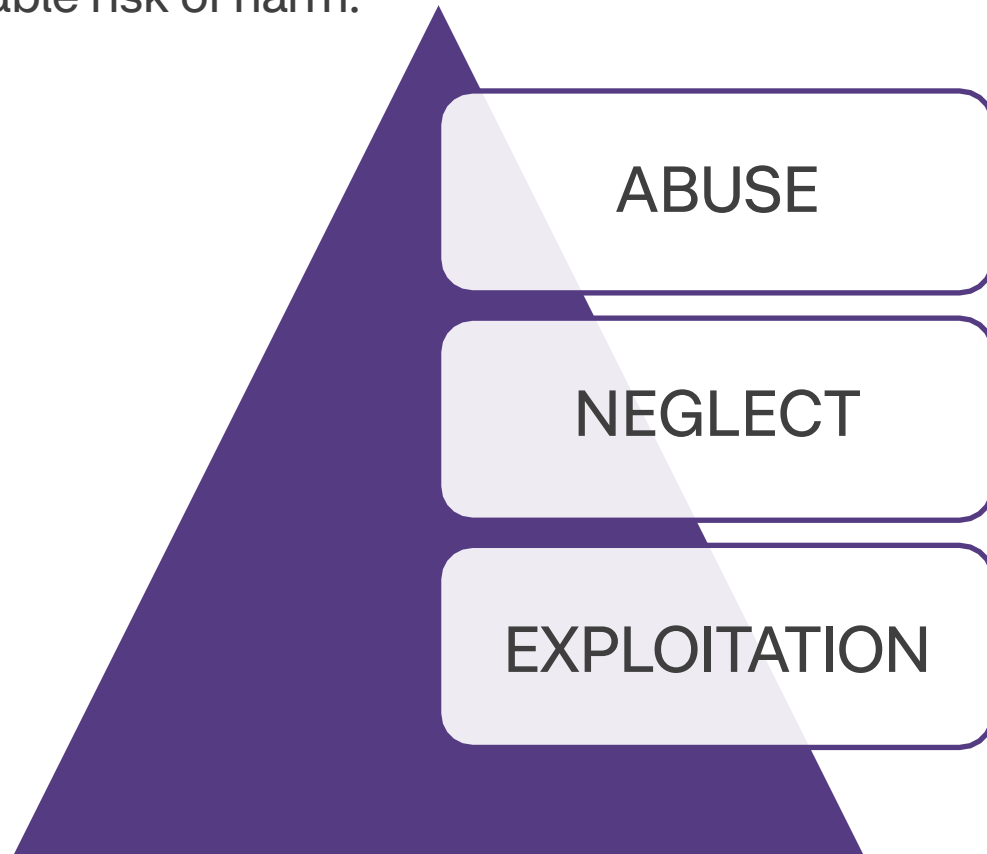
## Abuse

- 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.

**Critical incidents**  
Abuse, neglect & exploitation

# Critical incidents: Spot the signs

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



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

# Reporting critical incidents

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

**800-368-1463**

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

**866-329-4701**

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

**866-800-1409**

**Senior Help Line:**

**800-252-8966**

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

**800-252-4343**

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

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

# **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.**



# Revalidation

# Mandatory Revalidation

## All Medicaid providers must revalidate their enrollment

### Important notes

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

### Need more info?

More information about revalidation — including a list of Frequently Asked Questions — is available from HFS at [HFS.Illinois.gov/Impact](https://HFS.Illinois.gov/Impact).

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

**Q&A session**

**Thank you!**

