2024 Medicaid Provider Summit

Aetna Better Health® of Illinois

December 2024

Agenda

Introductions & Overview

Care Management

Pharmacy

Business Enterprise Program

Community Outreach

Marketing

2024 Member Value-added Benefits

Quality Management

Availity Portal & Reporting

Value-based Partnerships

Tools & Resources

Claims Corner

Provider Escalations

Mandated Training

Welcome from our senior leaders

Rushil Desai
Chief Executive Officer

Melanie Fernando
Chief Operating Officer

Dr. Lakshmi Emory
Chief Medical Officer

Dianne Robinson
Chief Financial Officer

Mary Cooley
Health Services Officer

Elizabeth Leonard
Executive Director, Marketing

Sally Szumlas
Chief Quality Officer

Hassan Gardezi
Chief Compliance Officer

Andrew Hyosaka
Lead Director, Service Operations

Steve Sproat
Principal Clinical Leader, Pharmacy

Terriana Robinson
Lead Director, Provider Relations

Denise Gaines
Lead Director, Government Affairs

Shaan Trotter
Health Equity Officer

Introduction to our Provider Relations leadership

Terriana Robinson
Lead Director, Provider Relations

Christine Fox-Zapata
Senior Director, Provider Experience

Steve Inzerello
Senior Director, Provider Experience

Our footprint

3200 Highland Avenue
Downers Grove, IL 60515

333 W. Wacker Drive
Chicago, IL 60606

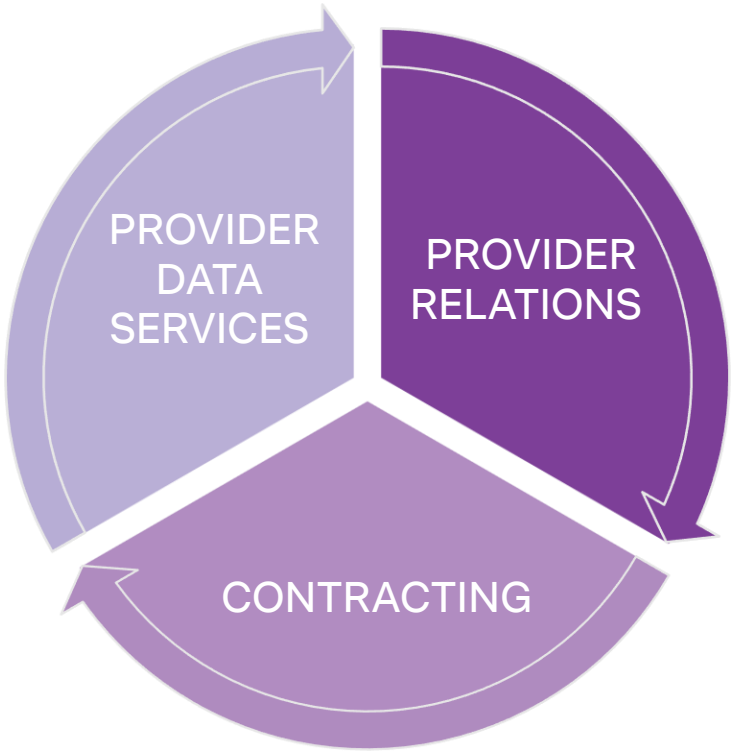
Our local approach

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

Who we are

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

Provider network overview



Sr. Analyst, Network Relations (PR Rep):
Training & servicing for our provider network

Network Management Rep (Contracting Rep):
Contracting activities, SCA & settlement for our provider network

Top 10 reasons to connect with a provider network team member

1. For claims questions, inquiries and reconsiderations

2. To find a participating provider or specialist for referral or member inquiry

3. To request a change for provider demographics

4. To request assistance navigating or accessing our secure web portal

5. To schedule trainings, site visits and other provider meetings

6. For inquiries about joining the Aetna Better Health of Illinois network and requirements for participation

7. For questions related to contractual language or terms

8. For clarification or updates on bulletins or policies

9. To escalate concerns related to claims, demographics or authorizations

10. To request a copy of your Provider Data Setup and/or Participating Provider Agreement

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Locating your network relations representative

Outreach to Provider Relations via email
ABHILProviderRelations@aetna.com

Locate your assigned rep via our online assignment listing:
AetnaBetterHealth.com/Illinois-Medicaid/providers/provider-resources.html

Outreach to Provider Services via phone
1.866.329.4701

Network Relations contact information and coverage areas

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

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

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

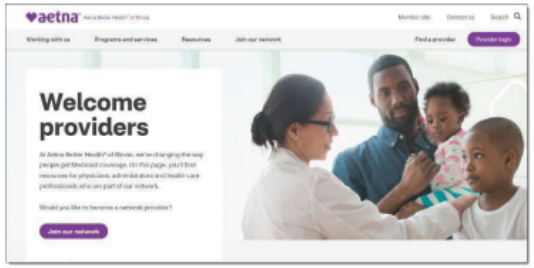
Aetna Better Health of Illinois offers a provider services line by calling **(866) 329-4701**
(Monday through Friday 7 AM-7 PM)

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

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

Save time by accessing our online resources

Be sure to check out our convenient web tools, available 24/7.



Health plan website

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

Availity

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

Mandatory IMPACT Revalidation

Mandatory IMPACT Revalidation

All Medicaid providers must revalidate their enrollment

Important notes

- 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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Care management

Care management

Role of care management:

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

How to refer to care management

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

To refer for Care Management, please call **1-866-329-4701** and request a care manager or email **ABHILCOMMUNITYCMFAX@aetna.com**

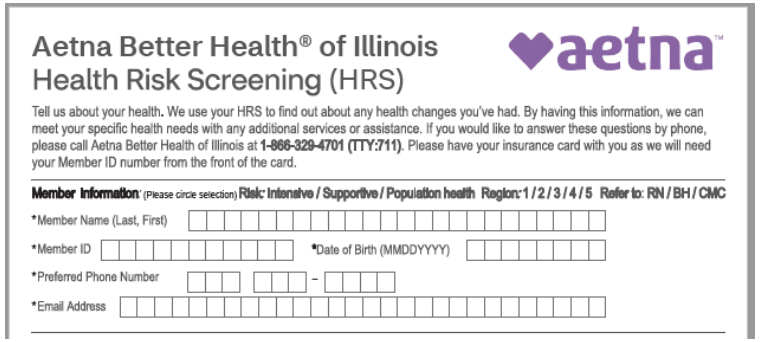
Health Risk Screener (HRS): provider partnership

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

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

Partnership benefits:

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



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

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

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

*Member Name (Last, First)

*Member ID *Date of Birth (MMDDYYYY)

*Preferred Phone Number -

*Email Address

Provider playbook:

Provider Playbook

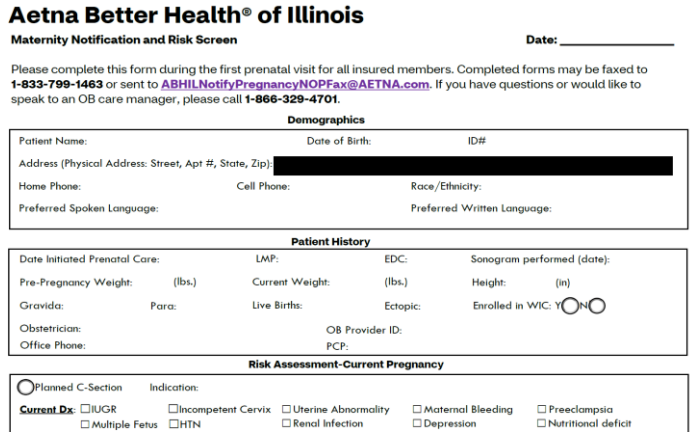
Notification of Pregnancy (NOP): Provider partnership

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

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

Partnership benefits:

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



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Maternity Notification and Risk Screen **Date:** _____

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

Demographics

Patient Name: Date of Birth: ID#

Address (Physical Address: Street, Apt #, State, Zip): [redacted]

Home Phone: Cell Phone: Race/Ethnicity:

Preferred Spoken Language: Preferred Written Language:

Patient History

Date Initiated Prenatal Care: LMP: EDC: Sonogram performed (date):

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

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

Obstetrician: OB Provider ID:

Office Phone: PCP:

Risk Assessment-Current Pregnancy

Planned C-Section Indication:

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

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

Pharmacy

Pharmacy resources

Preferred drug list

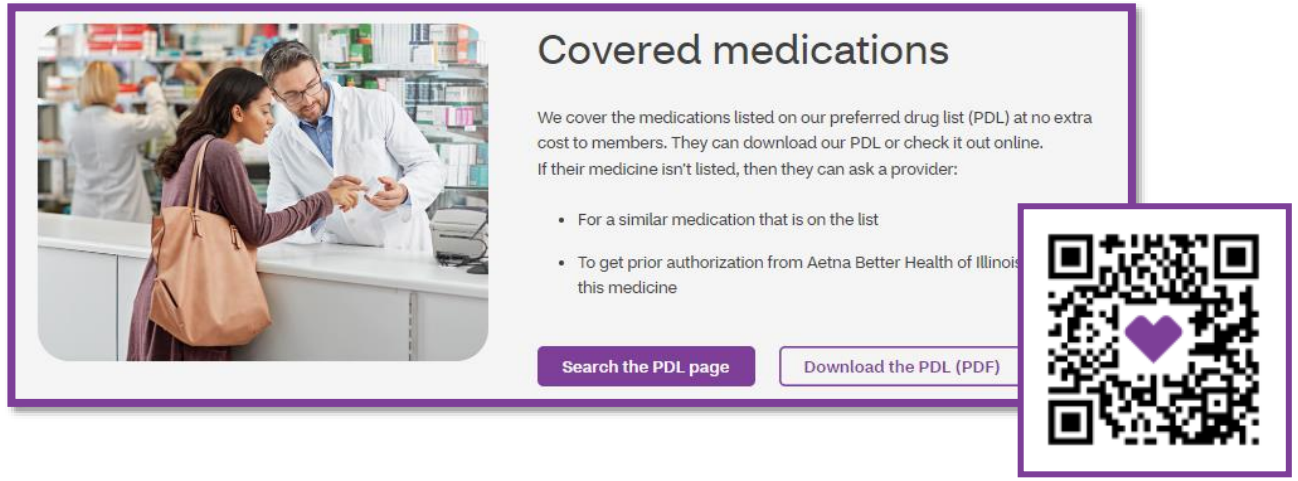
- Drug list available in PDF format as well as in the Aetna search tool.

Medication prior authorization resources

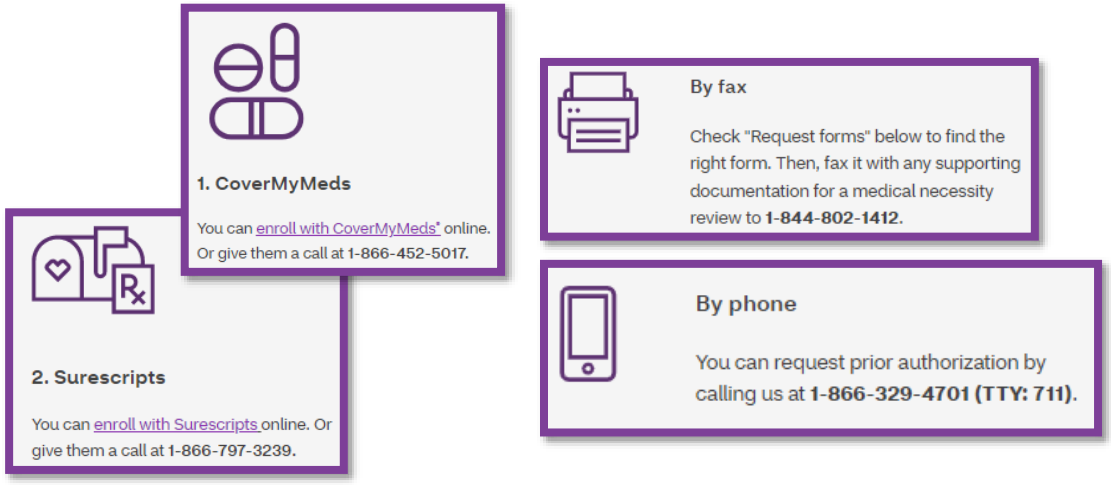
- All Rx prior authorizations reviewed within 24 hours.
- Full PA criteria are available on the provider website.
- All criteria are preloaded into CoverMyMeds in question format.

Pharmacy PA Support Team

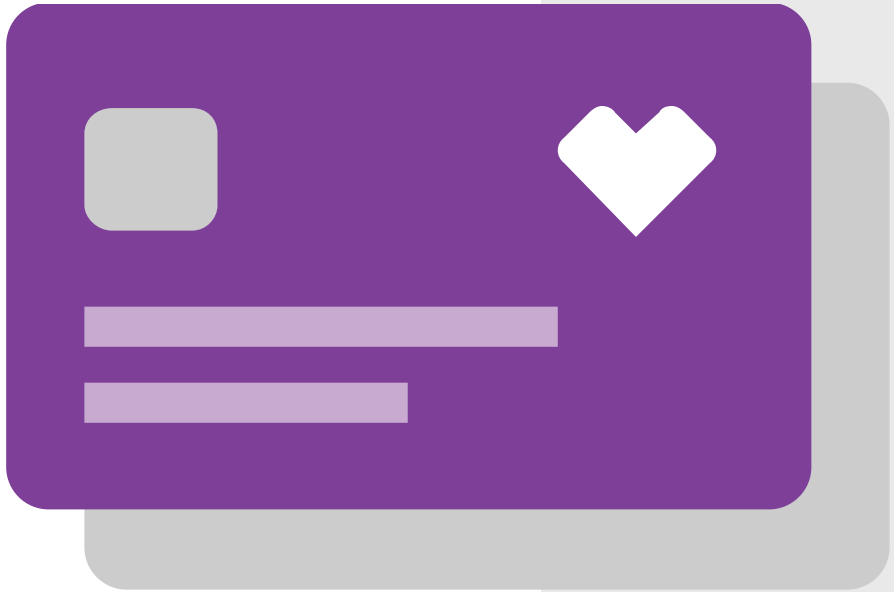
- Reduced PA volume, PA denials and appeals.
- 1:1 virtual session with PA ops team member.
- Customized review of all PA and appeal activity.



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



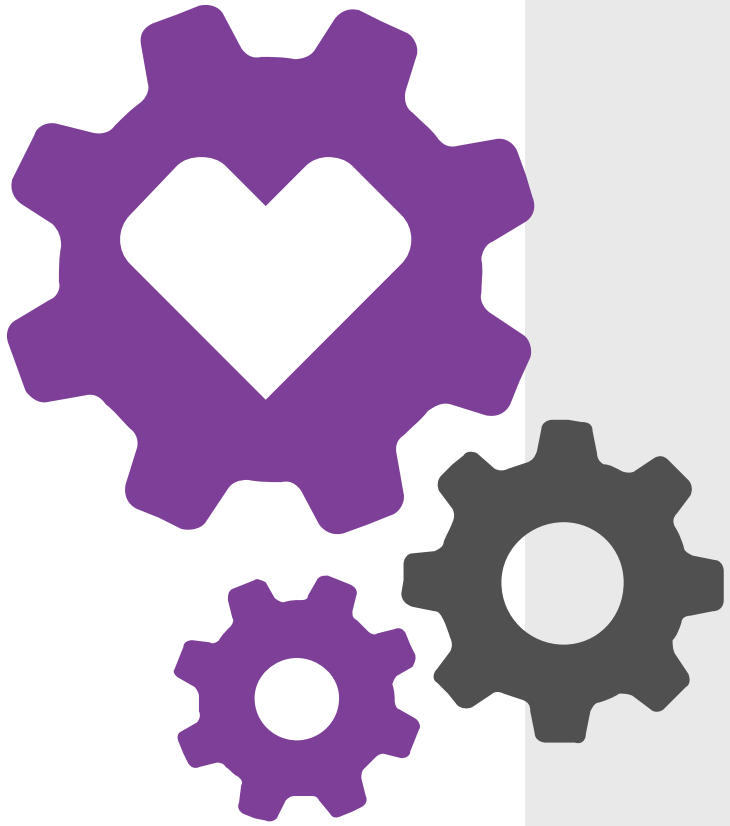
Free local Rx delivery



The Aetna Better Health® of Illinois and CVS Health® free prescription delivery program will help members receive their prescriptions in a fast and convenient way. The delivery program will provide members with additional ways to receive their prescriptions.

- Deliveries will be offered for our members free of charge.
- Prescriptions will be filled by a member's local, Illinois-based CVS Pharmacy location and delivered to the member.
- Deliveries will be made to members same day. If same-day delivery is not available due to a member's particular address, 1-2 day delivery will be offered using a national delivery service.
- Certain drugs, like controlled substances and items requiring refrigeration, will not be eligible for delivery and will need to be picked up in the pharmacy.

Illinois Advance Academic Detailing



Provide evidence-based, non-commercial education programs for Medicaid prescribers and pharmacists.

Illinois ADVANCE is composed of clinical pharmacists from the University of Illinois Chicago (UIC).

Live in-person, virtual and web-based CME and CPE available

Wide variety of topics offered in the following categories:

- Pain Management and Opioid Safety
- Chronic Disease States
- Infectious Disease

CME Visits and Programs can be scheduled by visiting:

[Schedule an Academic Detailing Visit | Illinois ADVANCE | University of Illinois Chicago (uic.edu)]

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Business Enterprise Program (BEP)

Business Enterprise Program (BEP) overview

What is BEP?

Business Enterprise Program (BEP) was established in 1989 to serve the State of Illinois's interest in promoting open access in the awarding of State contracts to disadvantaged small business enterprises.

The Business Enterprise Program for businesses owned by minorities, women, and persons with disabilities is committed to fostering an inclusive and competitive business environment that will help business enterprises increase their capacity, grow revenue, and enhance credentials.

Who can become certified?

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

What are the benefits?

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

Community outreach

Community events

Each month our team hosts events across Illinois including:

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

Get each month's schedule at **AetnaBetterHealth.com/IL-Medicaid**

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

Winter Wellness Health & Resource Fairs

December Signature Community Events

Winter Wellness Health and Resource Fairs are designed to encourage healthy living as well as provide health education, health screenings, community resources, family-friendly activities and the distribution of cold weather gear.

Date & Time	Event Name	Venue	Location
Tuesday, 12/3 3 PM – 5 PM	Winter Wellness	Aurora Public Library	101 S River St. Aurora, IL 60506
Friday, 12/13 9 AM – 12 PM	Winter Wellness	Empowerment Opportunity Center	360 East Marietta St. Decatur, IL 62521
Friday, 12/13 4 PM – 6 PM	Winter Wellness	La Casa Norte	3533 W. North Ave. Chicago, IL 60647
Saturday, 12/14 12 PM – 3 PM	Winter Wellness	Kershaw Elementary	6450 S Lowe Ave, Chicago, IL 60621
Wednesday, 12/18 1 PM – 3 PM	Winter Wellness	Rockford Ridge Apartments Community Room	3552 Elm St. Rockford, IL 61102

Value-added benefits

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

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Quality and practice performance

Our quality mission

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

Provider enablement strategies

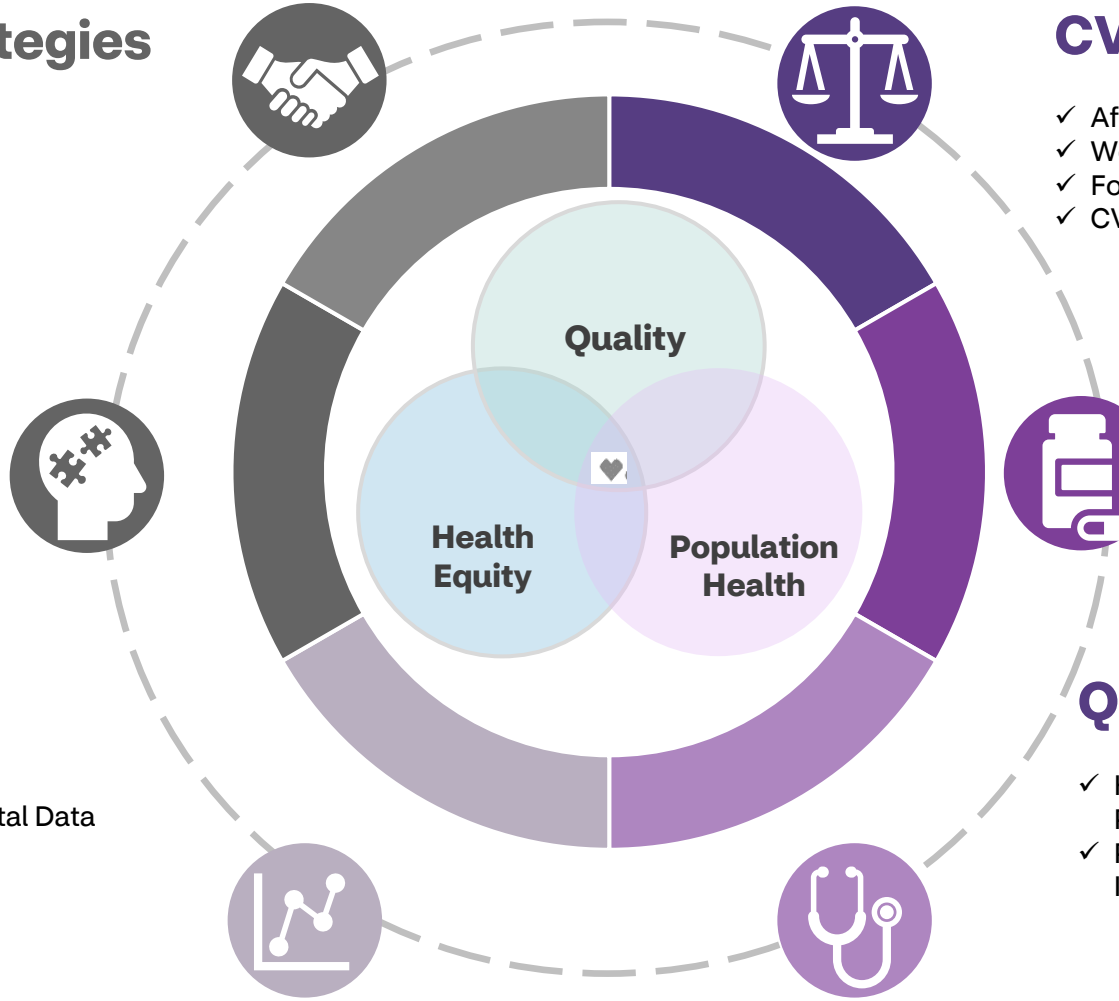
- ✓ Value-Based Contracting
- ✓ P4P Program

Clinical solutions

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

Data & technology

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



CVS community solutions

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

Pharmacy

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

Quality management

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

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Bringing the quality strategy to life

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

Healthcare Effectiveness Data and Information Set

Measuring health plan quality

HEDIS® - Healthcare Effectiveness Information Data Set

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

CAHPS® - Consumer Assessment of Health Care Providers and Systems

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

NCQA health plan ratings and summary score

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

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HEDIS® reporting cycle

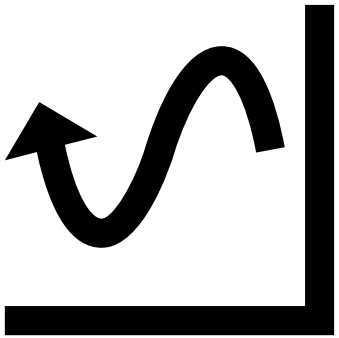
Measurement year

The year in which the HEDIS® services are completed

2024 measurement year

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

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



Reporting year

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

2025 reporting year

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

- This is what most providers and health plans recognize as "**HEDIS® Hybrid season**"

- HEDIS® hits may be captured using **hybrid data** a combination of administrative data and medical record review
- Year Round **EMR** access and Year-Round chart retrieval

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2024 P4P
Pay for Performance overview

2024 Pay for Performance Program

Pending updates for 2025 to be communicated in December

Eligibility

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

P4P targets and benchmarks

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

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

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

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

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Partnership bonuses

Health Risk Survey (HRS) completion

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

Adult Link to Form
Child Link to Form

Notification of Pregnancy

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

Link to Form

Data exchange

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

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

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

Link to Form

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

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Aetna Better of Illinois Provider & Member Incentives: 2024 4Q Push Metrics

Measure	Measure Description	Provider Incentive			Member Incentive
		Tier 1 Incentive for NCQA 33rd-50th%ile	Tier 2 Incentive for NCQA 50th-75th %ile	Tier 3 Incentive for NCQA 75th + %ile	
AAP	Adult Access to Preventive/Ambulatory Health Services	$10 Threshold 69.59%	$20 Threshold 72.91%	$40 For > 78.08%	$25
BCSE	Breast Cancer Screening	$25 48.06%	$50 52.20%	$100 58.35%	$25 Double Incentive through 12/31/24 = $50 VIA ONSITE GIFT CARD FOR EVENTS
BPDA	Blood Pressure Control for Patients With Diabetes	$25 59.85%	$50 63.99%	$100 70.07%	$25
CBPB	Controlling High Blood Pressure	$25 57.66%	$50 61.31%	$100	$25
*CCS	*Cervical Cancer Screening	$25 53.37%	$50 57.11%	$100 61.80%	$25 Double Incentive through 12/31/24 $50
CDCB	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	$25 49.39%	$50 52.31%	$100 57.18%	$25
POD	Pharmacotherapy for Opioid Use Disorder	$25 23.38%	$50 28.49%	$100 33.85%	$25 per Notification of Pregnancy Form
*PPC	*Timeliness of Prenatal Care	$25 81.75%	$50 84.23%	$100 88.33%	$25
*PPC	*Postpartum Care	$25 75.18%	$50 78.10%	$100 82.00%	$50
W30	Well-Child Visits in the First 30 Months of Life (First 15 Months)	$15 55.21%	$30 58.38%	$60 63.34%	$10
W30	Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	$15 63.73%	$30 66.76%	$60 71.35%	$20
WCV	Child and Adolescent Well-Care Visits (18-21)	$10 21.72%	$20 24.02%	$40 29.23%	
WCV	Child and Adolescent Well-Care Visits (3-11)	$10 52.40%	$20 55.66%	$40 62.89%	
WCV	Child and Adolescent Well-Care Visits (12-17)	$10 45.57%	$20 49.20%	$40 56.32%	

* Rendering provider only

EMR access

What is remote EMR access?

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

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

Benefits

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

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

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CPT II coding to optimize your earning potential

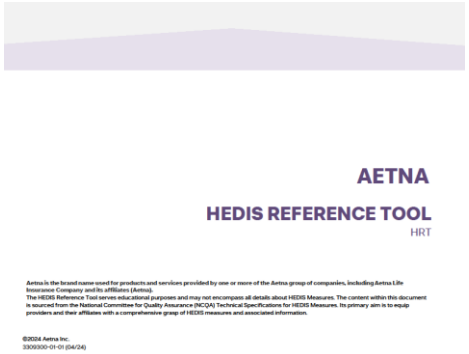
Opportunities

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

Measures

- Diabetes - Blood Pressure Control (<140-90) (BPD)
- Diabetes – Hemoglobin A1c Control (<8) (HBD)
- Blood Pressure (CBP)

2024 HEDIS Reference Tool →



Numerator codes for CDC

There is a large list of approved NCQA codes used to identify services included in the CDC measure. Below are a few of the approved codes. For a complete list, see NCQA.org.

Diabetes diagnosis

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

HbA1c tests

CPT	83036; 83037	HbA1c tests

HbA1c levels: the most recent results

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

Example HEDIS Tip Sheets
Link to HEDIS Tip Sheets

Numerator codes for CBP

There is a large list of approved NCQA codes used to identify services included in the CBP measure. Below are a few of the approved codes. For a complete list, see NCQA.org.

Identifying Patients with Hypertension

ICD-10	I10	Essential primary hypertension

Identifying Representative Blood Pressure

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

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Supplemental Data Exchange (SDS)

Supplemental Data Exchange (SDS)

Questions?

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

ABHILQUALITYOUTREACH@AETNA.com

New 2024 Program

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

SDS -Supplemental data exchange

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

Goal

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

Set-up guide

- The guide can be emailed to you upon request

Data sharing requirements

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

Availity reporting

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Quality

Availity P4P provider reporting

Aetna Better Health of Illinois P4Q Report - Provider Group Performance
Report Date : 11/20/2024 Data Refreshed On: 11/20/2024 6:40:15 AM

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Full Availity report includes member and PCP level detail

Measure Key	Submeasure Key	Measure Description	NCQA 33%ile	NCQA 50%ile	NCQA 75%ile	Provider Numerator	Provider Denominator	Provider Rate	Plan Rate	Provider Tier	Tier 1 33rd-50th	Tier 2 50th-75th	Tier 3 75th+	Current Earnings	Max Earnings	Total # Needed to Reach 33%ile	Total # Needed to Reach 50%ile	Total # Needed to Reach 75%ile	Achieved Tier 1	Achieved Tier 2	Achieved Tier 3
AAP	TOTAL	Adult Access to Preventive/Ambulatory Health Services	69.59%	72.91%	78.08%	1,349	1,835	73.51%	66.07%	50th-75th	$10	$20	$40	$26,980	$73,400	0	0	84	Y	Y	
BCSE	BCS	Breast Cancer Screening	48.06%	52.20%	58.35%	76	162	46.91%	44.38%		$25	$50	$100	$0	$16,200	2	9	19			
BPDA		Blood Pressure Control for Patients With Diabetes	59.85%	63.99%	70.07%	36	212	16.98%	32.86%		$25	$50	$100	$0	$21,200	91	100	113			
CBPB	CBP	Controlling High Blood Pressure	57.66%	61.31%	67.27%	44	284	15.49%	32.88%		$25	$50	$100	$0	$28,400	120	131	148			
CCS		Cervical Cancer Screening	53.37%	57.11%	61.80%	313	793	39.47%	43.31%		$0	$0	$0	$0	$0	111	140	178			
CDCB	HBA1C8	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	49.39%	52.31%	57.18%	13	212	6.13%	24.69%		$25	$50	$100	$0	$21,200	92	98	109			
CIS	CO10	Childhood Immunization Status – Combo 10	26.76%	30.90%	37.64%	7	61	11.48%	13.77%		$50	$100	$200	$0	$12,200	10	12	16			
FUA	A18D30	Follow-Up After ED Visit for Alcohol – 30 day (18yrs +)	31.27%	36.67%	42.55%	9	18	50.00%	35.13%	75th+	$0	$0	$0	$0	$0	0	0	0	Y	Y	Y
FUA	A18D7	Follow-Up After ED Visit for Alcohol 7 day (18yrs +)	20.04%	24.62%	30.26%	5	18	27.78%	24.56%	50th-75th	$0	$0	$0	$0	$0	0	0	1	Y	Y	
FUH	1864_30DAY	Follow-Up After Hospitalization for Mental Illness - 30 day ages 18 – 64 yrs	45.49%	50.89%	61.31%	16	33	48.48%	47.29%	33rd-49th	$0	$0	$0	$0	$0	0	1	5	Y		
FUH	617_30DAY	Follow-Up After Hospitalization for Mental Illness – 30 day ages 6 – 17 yrs	65.96%	71.93%	77.47%	8	17	47.06%	74.41%		$0	$0	$0	$0	$0	4	5	6			
FUH	1864_7DAY	Follow-Up After Hospitalization for Mental Illness - 7 day ages 18 – 64 yrs	26.22%	29.48%	39.46%	9	33	27.27%	29.17%	33rd-49th	$0	$0	$0	$0	$0	0	1	5	Y		
FUH	617_7DAY	Follow-Up After Hospitalization for Mental Illness - 7 day ages 6 – 17 yrs	41.28%	46.27%	54.04%	5	17	29.41%	44.99%		$0	$0	$0	$0	$0	3	3	5			
FUM	6TO17D30	Follow-Up After ED Visit for Mental Illness – 30 day ages 6 – 17 yrs	61.20%	69.57%	77.41%	7	7	100.00%	72.58%	75th+	$0	$0	$0	$0	$0	0	0	0	Y	Y	Y
FUM	6TO17D7	Follow-Up After ED Visit for Mental Illness – 7 day ages 6 – 17 yrs	43.27%	51.39%	62.96%	7	7	100.00%	67.56%	75th+	$0	$0	$0	$0	$0	0	0	0	Y	Y	Y
IMA	CO2	Immunizations for Adolescents - Combination 2	30.66%	34.31%	40.88%	23	115	20.00%	27.95%		$35	$70	$140	$0	$16,100	13	17	25			
LSC		Lead Screening in Children (Informational Only – Not a P4Q Measure)	54.26%	62.79%	70.07%	29	62	46.77%	57.45%		$0	$0	$0	$0	$0	5	10	15			
POD	TOTAL	Pharmacotherapy for Opioid Use Disorder	23.38%	28.49%	33.85%	4	18	22.22%	17.10%		$25	$50	$100	$0	$1,800	1	2	3			
PPC	PPC	Postpartum Care	75.18%	78.10%	82.00%	52	71	73.24%	69.99%		$0	$0	$0	$0	$0	2	4	7			
PPC	TOPC	Timeliness of Prenatal Care	81.75%	84.23%	88.33%	57	71	80.28%	81.57%		$0	$0	$0	$0	$0	2	3	6			
W30	15TO30MTH	Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	63.73%	66.76%	71.35%	58	75	77.33%	67.01%	75th+	$15	$30	$60	$3,480	$4,500	0	0	0	Y	Y	Y
W30	0TO14MTH	Well-Child Visits in the First 30 Months of Life (First 15 Months)	55.21%	58.38%	63.34%	48	64	75.00%	61.82%	75th+	$15	$30	$60	$2,880	$3,840	0	0	0	Y	Y	Y
WCV	12TO17	Child and Adolescent Well-Care Visits (12-17)	45.57%	49.20%	56.32%	233	674	34.57%	39.10%		$10	$20	$40	$0	$26,960	75	99	147			
WCV	18TO21	Child and Adolescent Well-Care Visits (18-21)	21.72%	24.02%	29.23%	38	246	15.45%	20.21%		$10	$20	$40	$0	$9,840	16	22	34			
WCV	3TO11	Child and Adolescent Well-Care Visits (3-11)	52.40%	55.66%	62.89%	376	900	41.78%	41.89%		$10	$20	$40	$0	$36,000	96	125	191			
						2,822	**6,005**	**46.99%**						**$33,340**	**$271,640**						

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Member experience

—

Quality

Voice of the Customer Program

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

Program Overview

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

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

Listening Channels

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

New Strategies

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

VoC Feedback Mosaic & Dashboard

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

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

Closing the feedback loop

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

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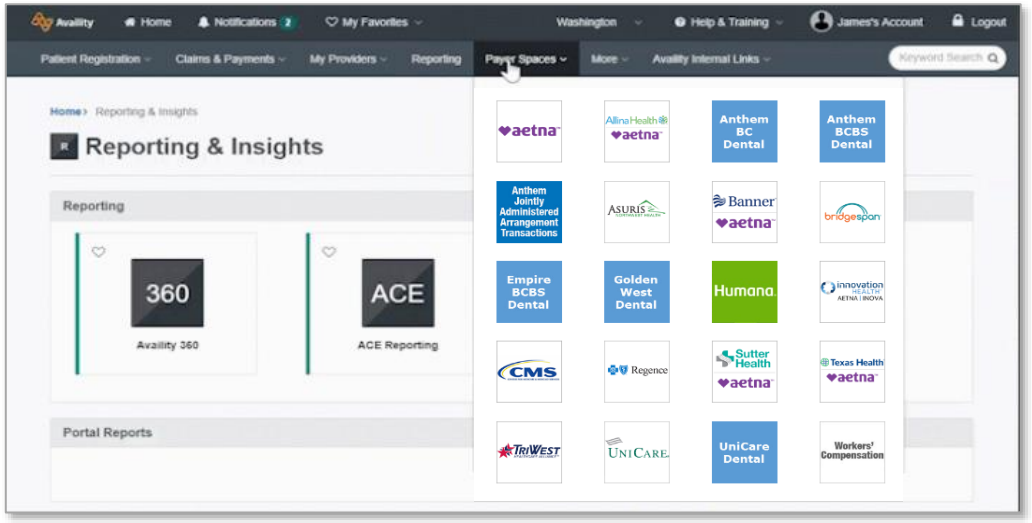
Availity reporting

Availity reporting

Capabilities active now

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



Upcoming capabilities

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

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Provider Analytics Reporting Suite (PARS)

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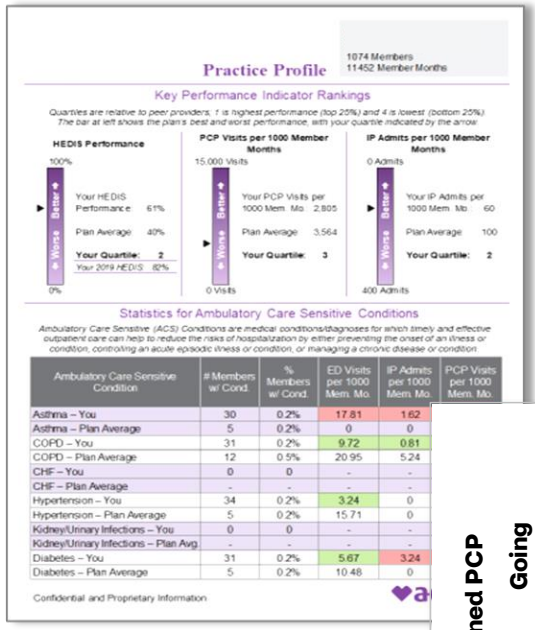
Practice Profile

1074 Members
11452 Member Months

Key Performance Indicator Rankings

Quartiles are relative to peer providers, 1 is highest performance (top 25%) and 4 is lowest (bottom 25%)
The bar at left shows the plan's best and worst performance, with your quartile indicated by the arrow.

HEDIS Performance
100%
Better
Worse
Your HEDIS Performance: 61%
Plan Average: 40%
Your Quartile: 2
Your 2019 HEDIS: 82%
0%

PCP Visits per 1000 Member Months
15,000 Visits
Better
Worse
Your PCP Visits per 1000 Mem Mo: 2,805
Plan Average: 3,564
Your Quartile: 3
0 Visits

IP Admits per 1000 Member Months
0 Admits
Better
Worse
Your IP Admits per 1000 Mem Mo: 60
Plan Average: 100
Your Quartile: 2
400 Admits

Statistics for Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive (ACS) Conditions are medical conditions/diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease or condition

Ambulatory Care Sensitive Condition	# Members w/ Cond.	% Members w/ Cond.	ED Visits per 1000 Mem. Mo.	IP Admits per 1000 Mem. Mo.	PCP Visits per 1000 Mem. Mo.
Asthma – You	30	0.2%	17.81	1.62	
Asthma – Plan Average	5	0.2%	0	0	
COPD – You	31	0.2%	9.72	0.81	
COPD – Plan Average	12	0.5%	20.95	5.24	
CHF – You	0	0	-	-	
CHF – Plan Average	-	-	-	-	
Hypertension – You	34	0.2%	3.24	0	
Hypertension – Plan Average	5	0.2%	15.71	0	
Kidney/Urinary Infections – You	0	0	-	-	
Kidney/Urinary Infections – Plan Avg	-	-	-	-	
Diabetes – You	31	0.2%	5.67	3.24	
Diabetes – Plan Average	5	0.2%	10.48	0	

Confidential and Proprietary Information

Provider and Practitioner Handbooks

Member Attribution Grid

Assigned PCP

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

Total Membership: 6,682

Members not seeing any PCP had 391 IP/ED visits with spend of **$331,543**

Prioritized Member List

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

Daily Census

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

P4Q Performance

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

Cost and Utilization Dashboard

Provider Group	PCP Status	Member Count	Member Months	MBR Pct	PMPM
ALL OTHER ABHIL		**569,450**	**2,375,981**	**83.7 %**	**$332**
	ALL OTHER ABHIL	569,450	2,375,981	83.7 %	$332
Sample Provider		**7,523**	**31,171**	**71.8 %**	**$259**
	Exclusively Seeing Assigned PCP	2,684	12,573	75.0 %	$261
	No Longer Assigned to PCP	1,587	2,982	67.7 %	$238
	Not Seeing Any PCP	1,591	7,722	17.5 %	$64
	Not Seeing Assigned PCP	593	2,790	98.6 %	$345
	Seeing Multiple PCPs	1,068	5,104	130.9 %	$512
Grand Total		**576,973**	**2,407,152**	**83.6 %**	**$331**

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Availity reporting capabilities

Refresh cadence

Monthly | Weekly | Daily

Prioritized Member List	High-risk, high-acuity member list including all relevant outreach and intervention metrics – IP/ED utilization, total expense, MBR, Rx non-adherence, quality gaps, risk gaps
Inpatient ADT Census	Inpatient census report populated using state Admit, Discharge, and Transfer (ADT) data; shows members currently admitted at a hospital or other inpatient facility; updated four times per day
Inpatient Authorization Census	Inpatient census report populated using authorization data; shows members currently admitted at a hospital or other inpatient facility and estimates discharge date
Group-Level P4Q Performance	Quality gap report including YTD performance against targets by provider group and PCP, incentive earnings for all measures, and member-level gap data; includes all of provider's TINs in a single report
Assigned Member Panel	Group-level roster rather than individual TIN or practitioner
Claims Remits	Group-level remit report
Provider Roster Echo Back	Report that confirms provider roster submissions; report layout is the same as the IAMHP template providers use to submit roster updates to ABHIL
Negative Balance	Group-level negative balance report
Rx Adherence	Uses Rx claims data to identify members taking maintenance medications who have missed expected prescription fill dates. Includes member and prescription detail.

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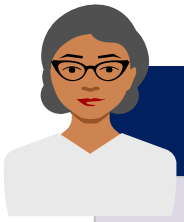
Value-based partnerships

Value-based care benefits

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



Patient Benefits

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

Healthier patients, lower costs

Provider Benefits

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

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

39%
Fewer ED visits

77%
Fewer IP admissions

$24PMPM
Less in ED spend

$55PMPM
Less in IP spend

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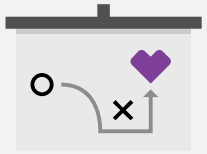
Tools for success in value-based care

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

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



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

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

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

Interested in learning more? Contact **ABHILProviderPartnerships@aetna.com**

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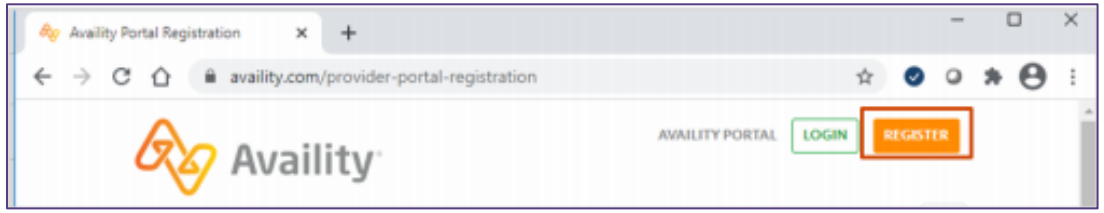
Availity provider portal

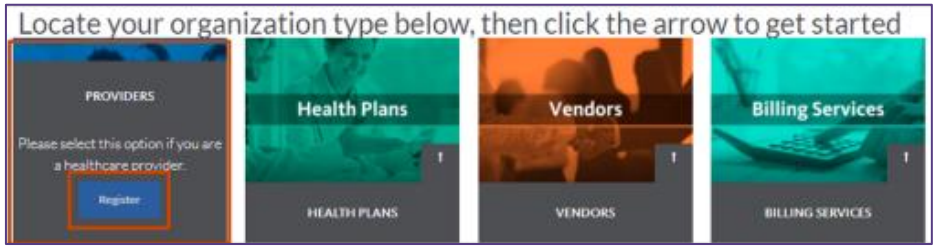
Availity portal registration

Availity.com/provider-portal-registration

Register your provider organization

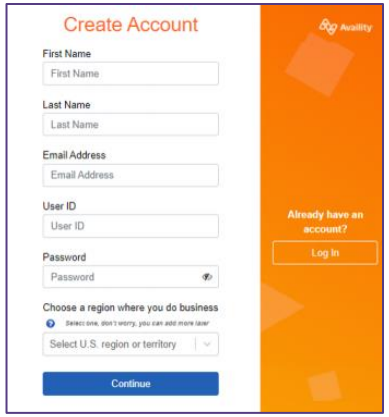
Important: This only applies to users who are brand new to Availity and need to register their provider organization.

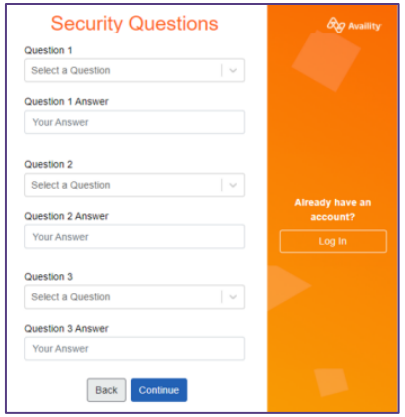


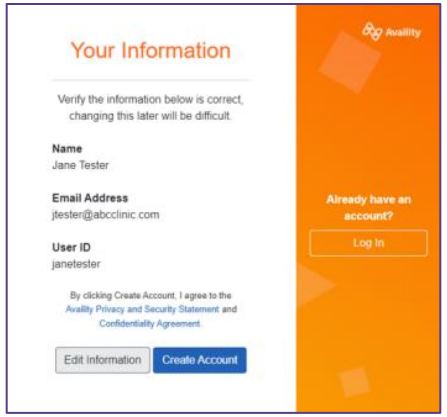


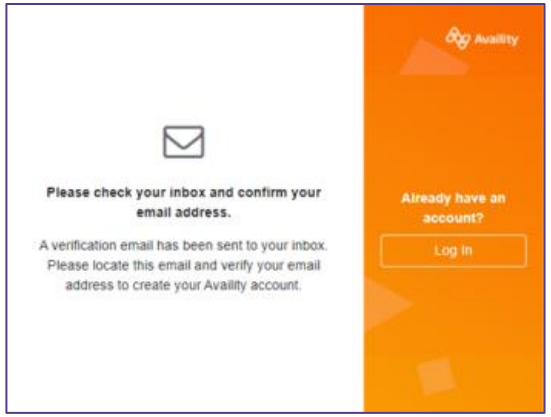
When you set up your new user account, you'll be asked to do the following tasks in the wizard:

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





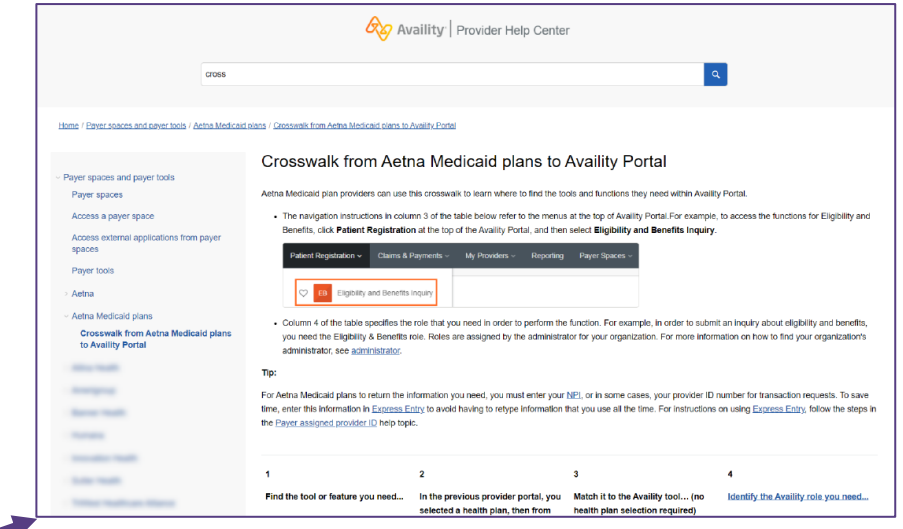


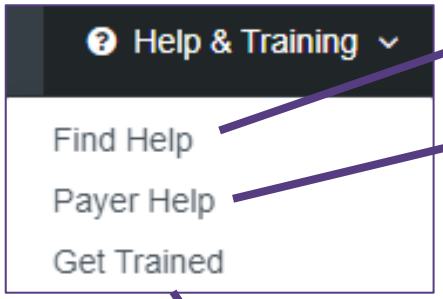


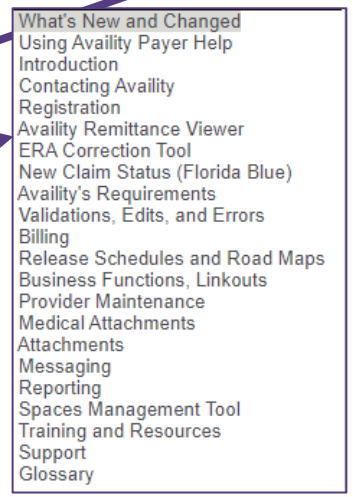
Availity Help Center

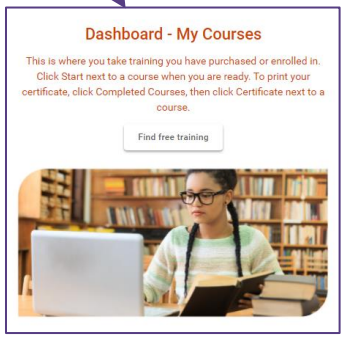
Crosswalk from Aetna Medicaid plans to Availity portal

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









Availity support

Support tools

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

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Aetna Better Health® of Illinois Medicaid tools and resources

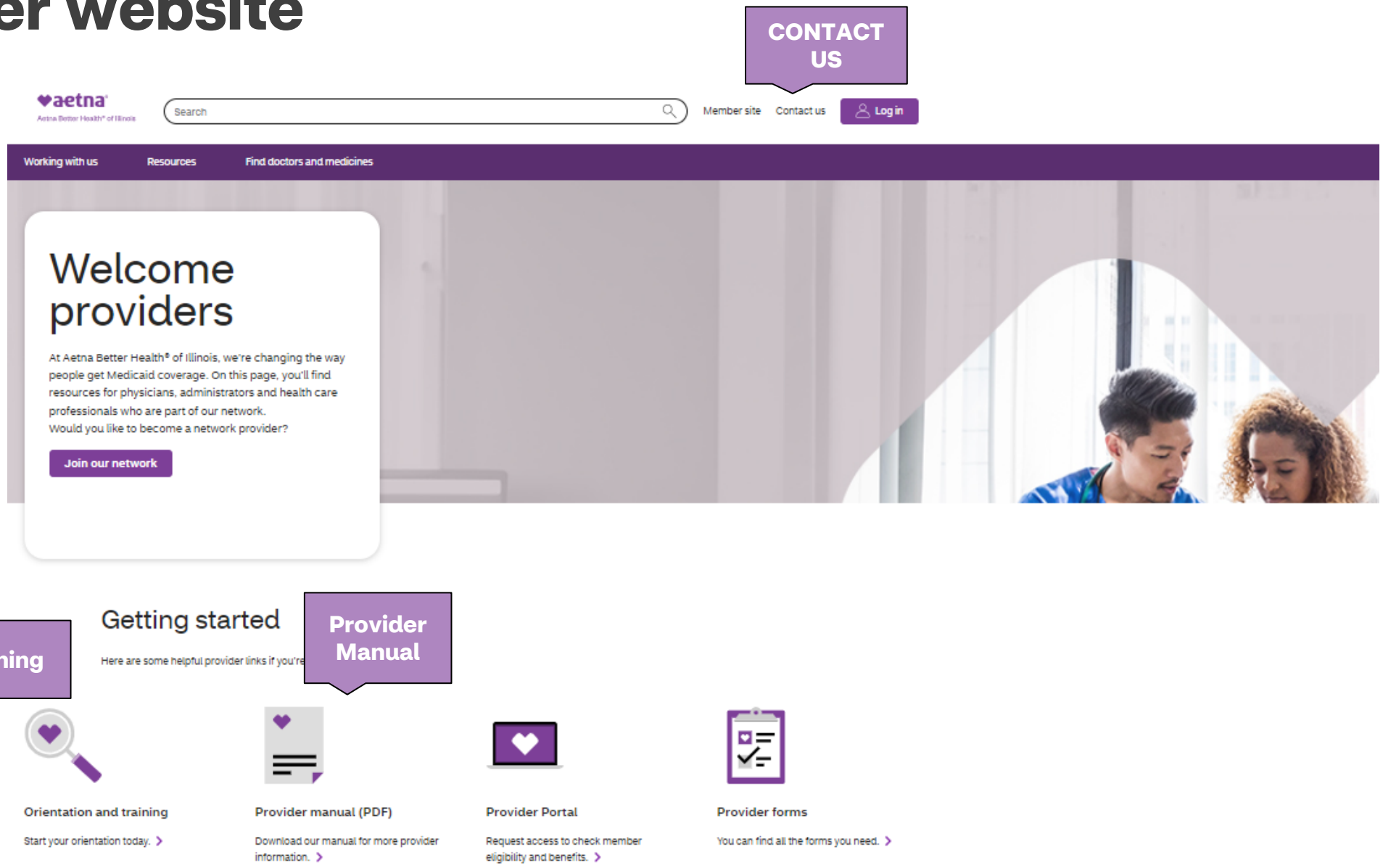
Aetna Better Health® of Illinois Medicaid public website

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

Providers will be able to access:

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

Provider website

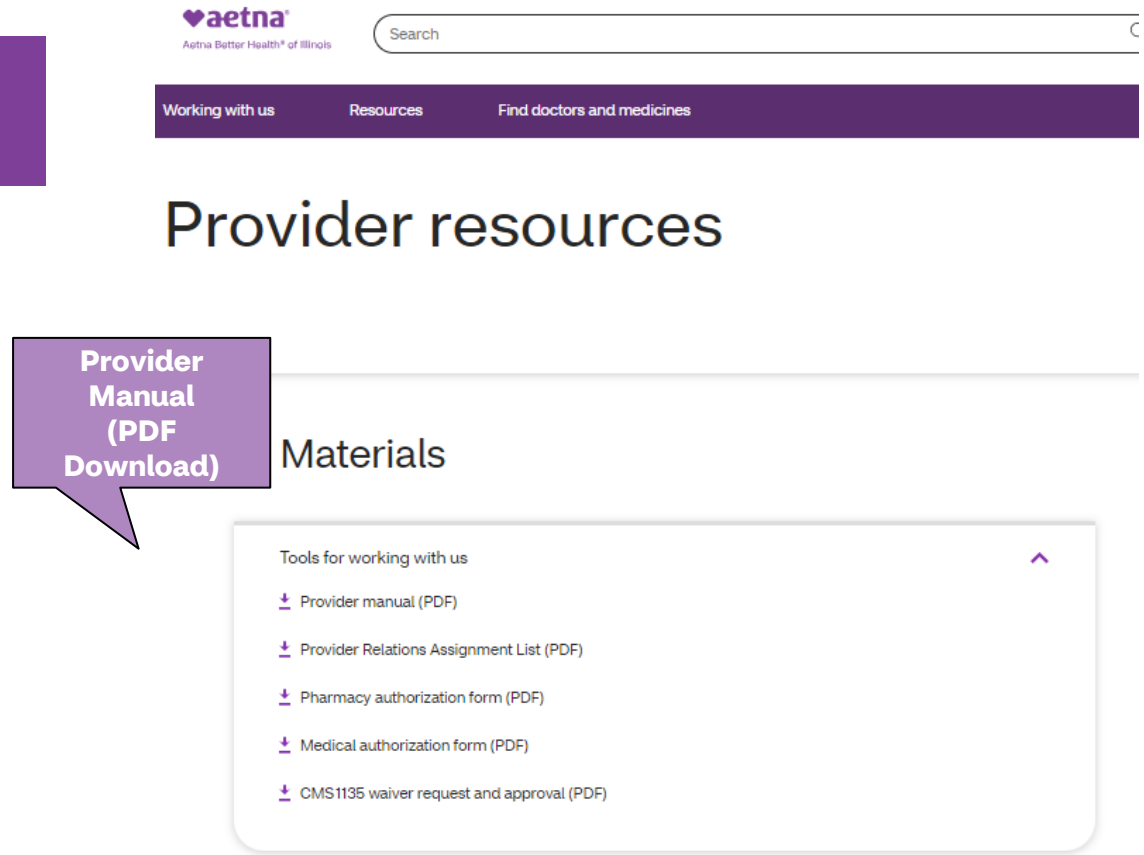


Provider website: Provider manual

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

In addition to policies and procedures, this resource includes:

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



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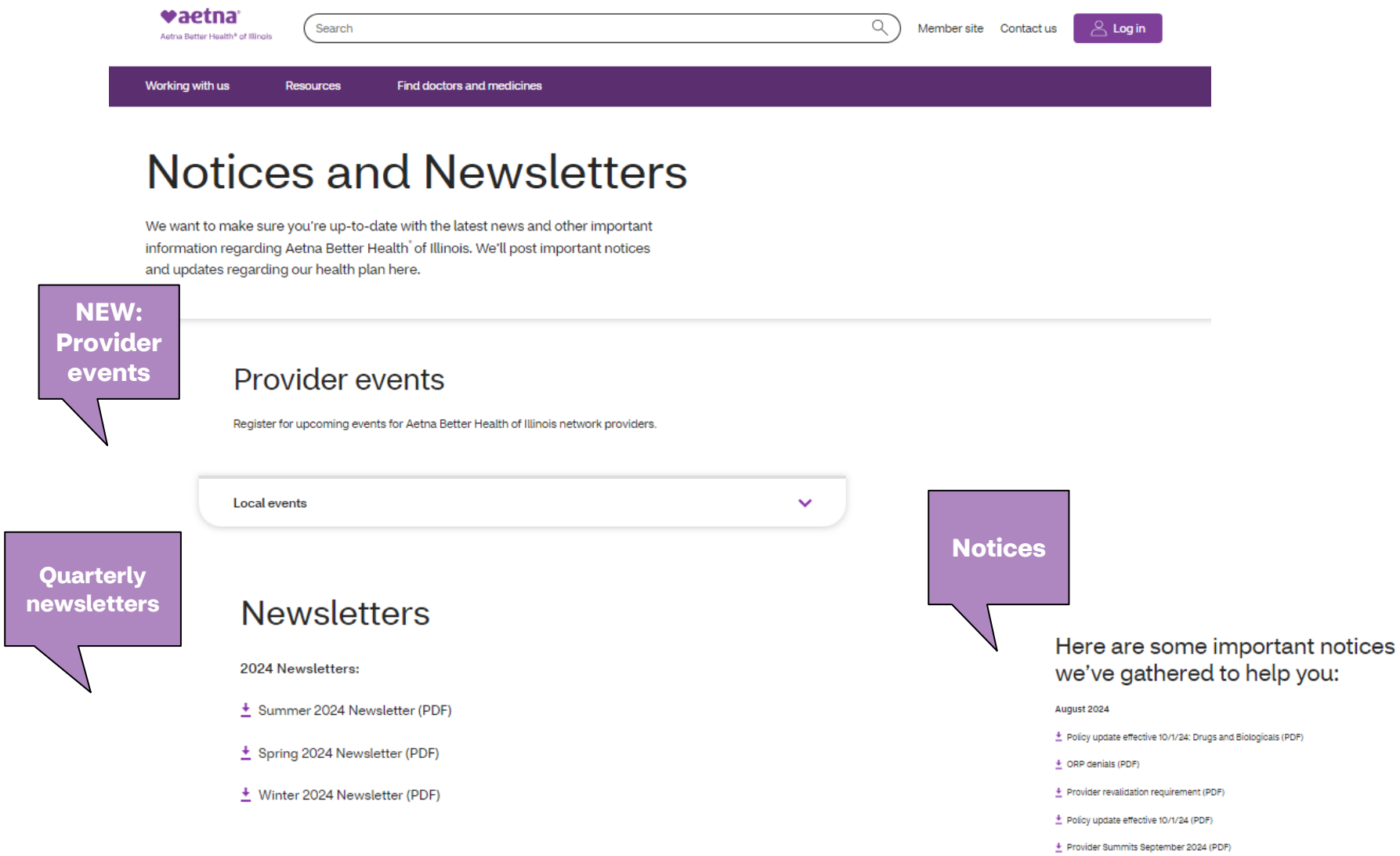
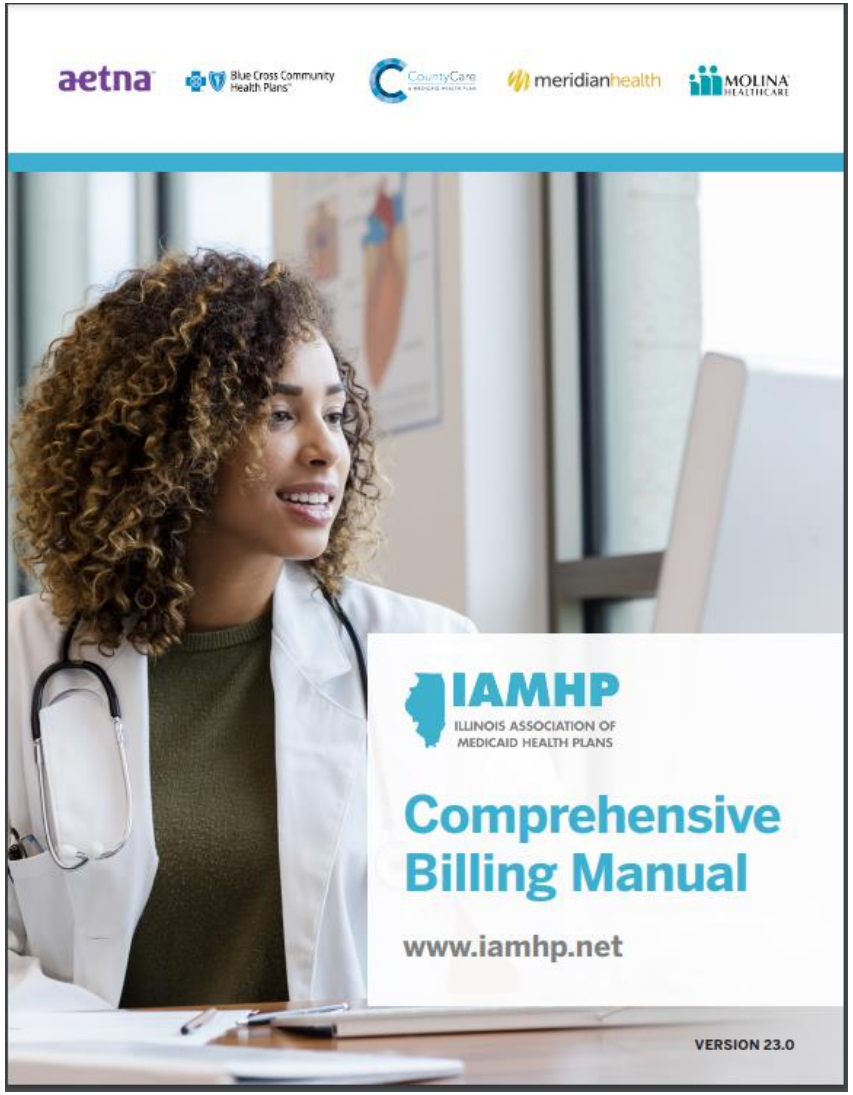
Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters



Claims Corner

IAMHP billing manual



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

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

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

Verifying member eligibility

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

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

- HFS' secure MEDI website provides Medicaid beneficiary eligibility information to providers.

- Secure website portal: Providers can verify up to five members at a time for eligibility verification.
- Availity portal: Providers can verify members eligibility through Availity Essentials portal.

- Telephone verification: Call our Member Services Department to verify eligibility at 1-866-329-4701. 8:30AM to 5:00 PM CT Monday through Friday to speak with a live agent or 24/7 via our automated system.

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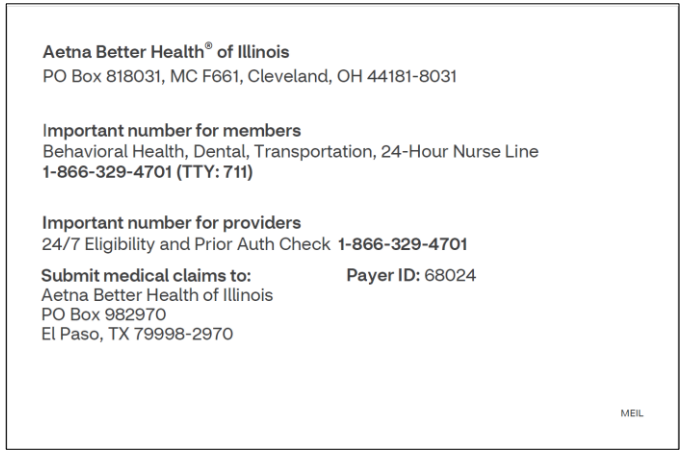
Member ID cards

The member ID card contains the following information:

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

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



Roster/demographic submissions

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

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

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

Prior authorizations

A prior authorization request may be initiated by:

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

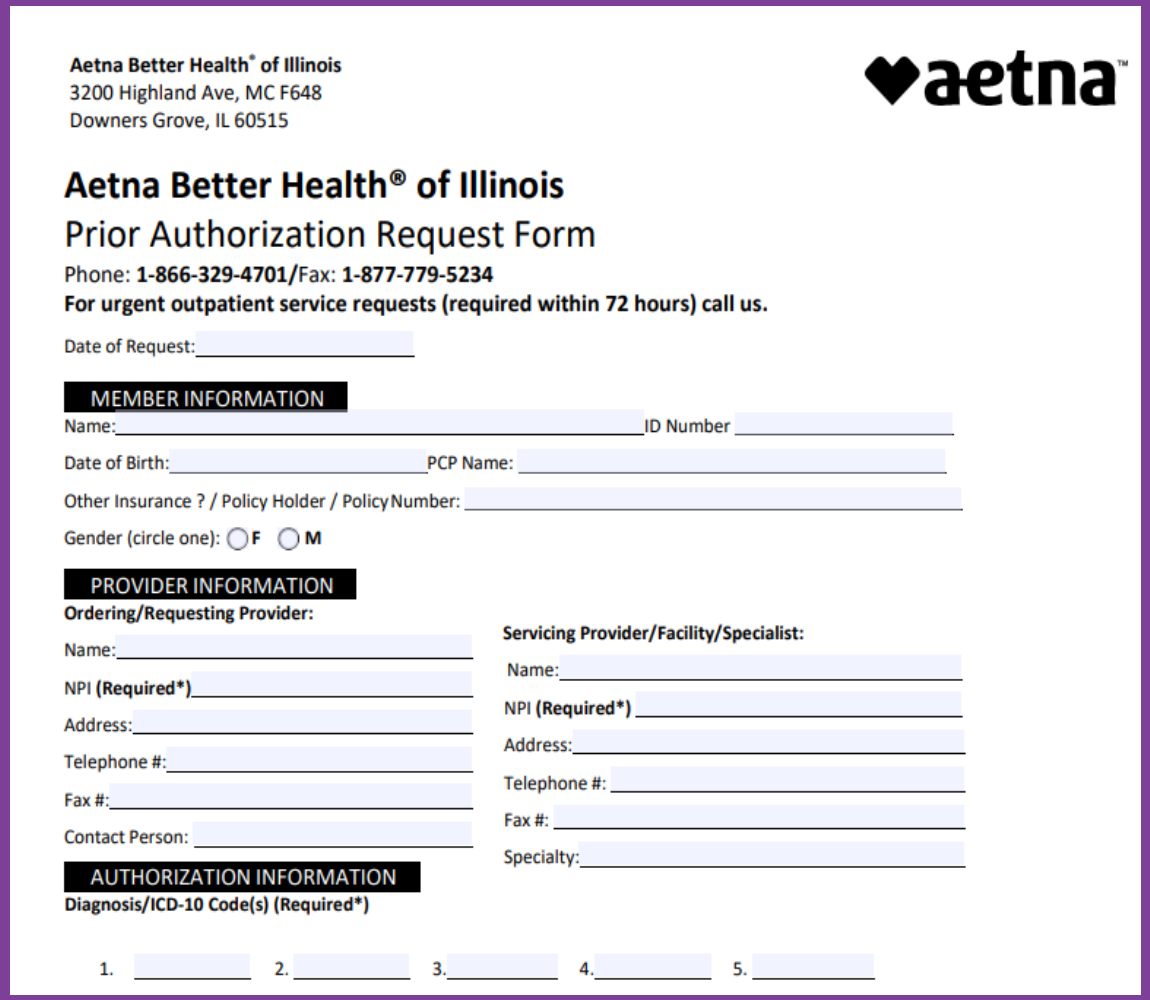
IMPORTANT ITEMS to remember:

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

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

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

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



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

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Aetna Better Health® of Illinois

Prior Authorization Request Form

Phone: **1-866-329-4701**/Fax: **1-877-779-5234**

For urgent outpatient service requests (required within 72 hours) call us.

Date of Request: _____

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____ PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): ◯ F ◯ M

PROVIDER INFORMATION

Ordering/Requesting Provider:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Person: _____

Servicing Provider/Facility/Specialist:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

AUTHORIZATION INFORMATION

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

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

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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 1st check run, with a Tuesday paid date
- ❑ Wednesday will be the 2nd check run, with a Thursday paid date
- ❑ Friday will be the 3rd 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 835s and ERAs come from ECHO Health Electronic Payment System

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Pharmacy claims

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

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

BIN: 610591
PCN: ADV
Group: Rx881A

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

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

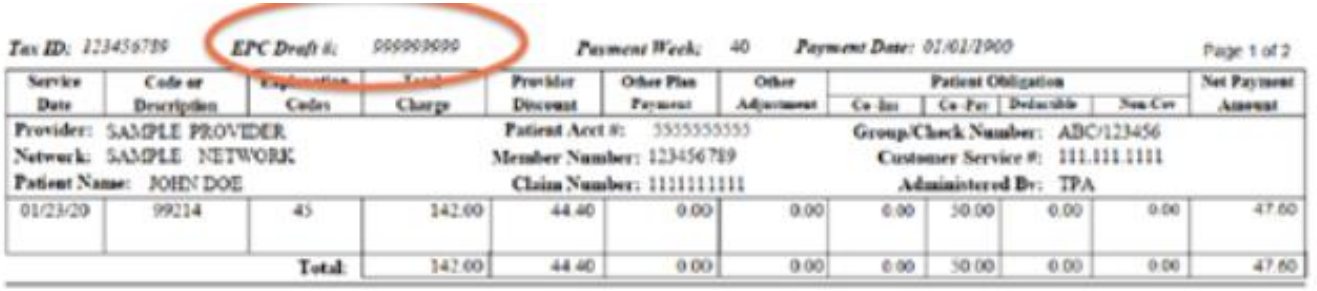
Prior authorizations may be submitted electronically via CoverMyMeds and SureScripts, or via fax **844-802-1412** or phone **1-866-329-4701.**

For a full list of in-network Aetna Better Health of Illinois pharmacies please visit: **https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/ABHIL%20Pharmacy%20Network.pdf**

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 #: 000003000 Payment Week: 40 Payment Date: 01/01/1900 Page 1 of 2

Service Date	Code or Description	Explanation Codes	Total Charge	Provider Discount	Other Plan Payment	Other Adjustment	Patient Obligation				Net Payment Amount
							Co-Ins	Co-Pay	Deductible	Non-Cov	
Provider: SAMPLE PROVIDER				Patient Acct #: 5555555555			Group/Check Number: ABC123456				
Network: SAMPLE NETWORK				Member Number: 123456789			Customer Service #: 111.111.1111				
Patient Name: JOHN DOE				Claim Number: 1111111111			Administered By: TPA				
01/23/20	99214	45	142.00	44.40	0.00	0.00	0.00	50.00	0.00	0.00	47.60
		Total:	142.00	44.40	0.00	0.00	0.00	50.00	0.00	0.00	47.60

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

Itemized bill process

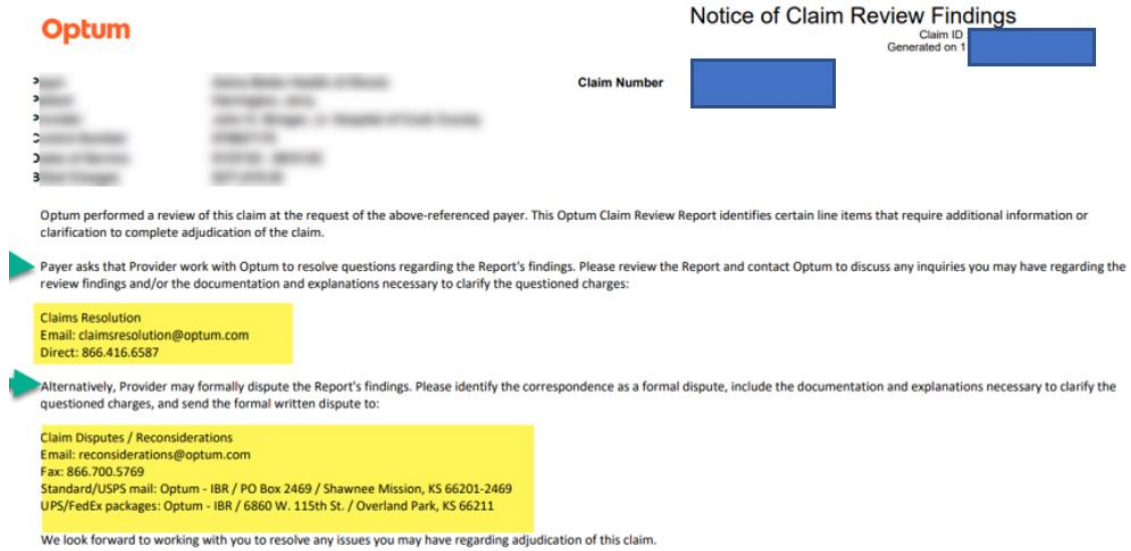
High-dollar inpatient DRG claims at or exceeding an expected reimbursement of $25K require an itemized bill.

There are three ways to submit an itemized bill:

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

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

SAMPLE OPTUM NOTICE



Optum

Notice of Claim Review Findings

Claim ID
Generated on 1

Claim Number

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

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

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

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

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

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

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Provider disputes (resubmissions/reconsiderations)

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

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

Corrected claims

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

Reconsiderations

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

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

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

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

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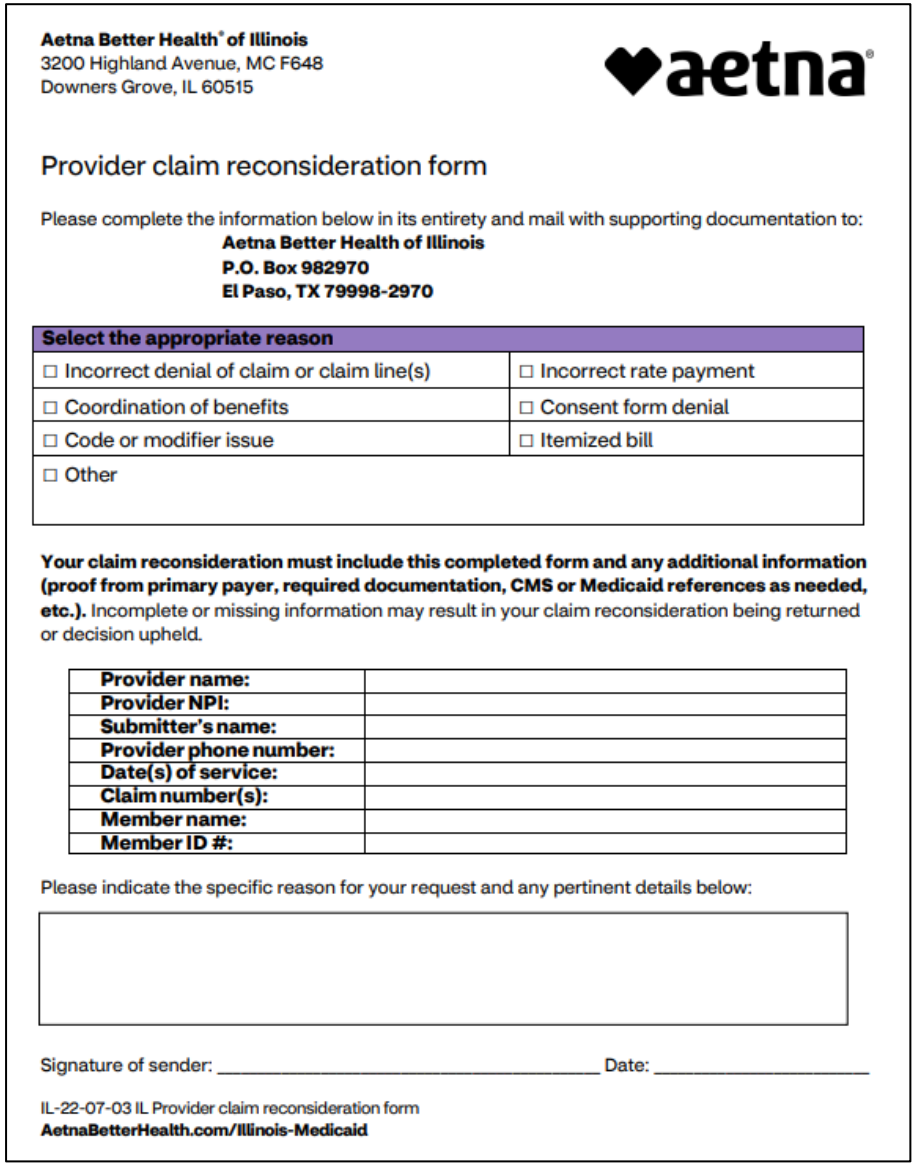
Provider claim reconsideration form

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



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

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Provider claim reconsideration form

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

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

Select the appropriate reason	
☐ Incorrect denial of claim or claim line(s)	☐ Incorrect rate payment
☐ Coordination of benefits	☐ Consent form denial
☐ Code or modifier issue	☐ Itemized bill
☐ Other	

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

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

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

Signature of sender: _____ Date: _____

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

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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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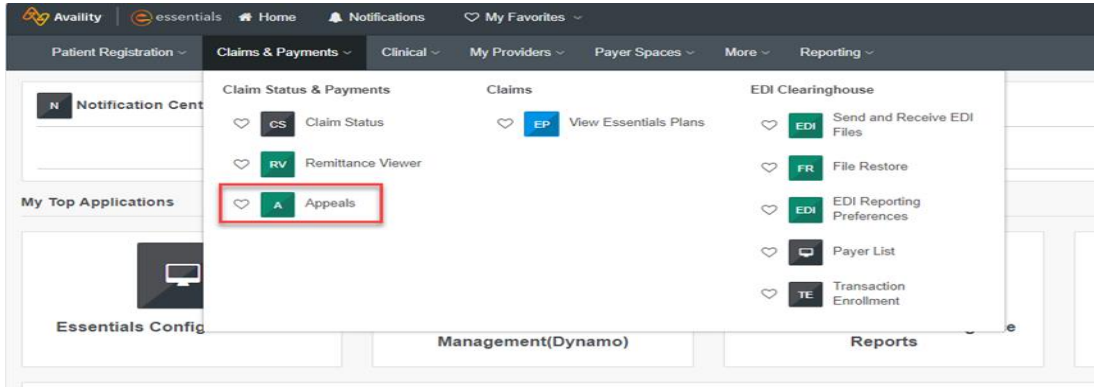
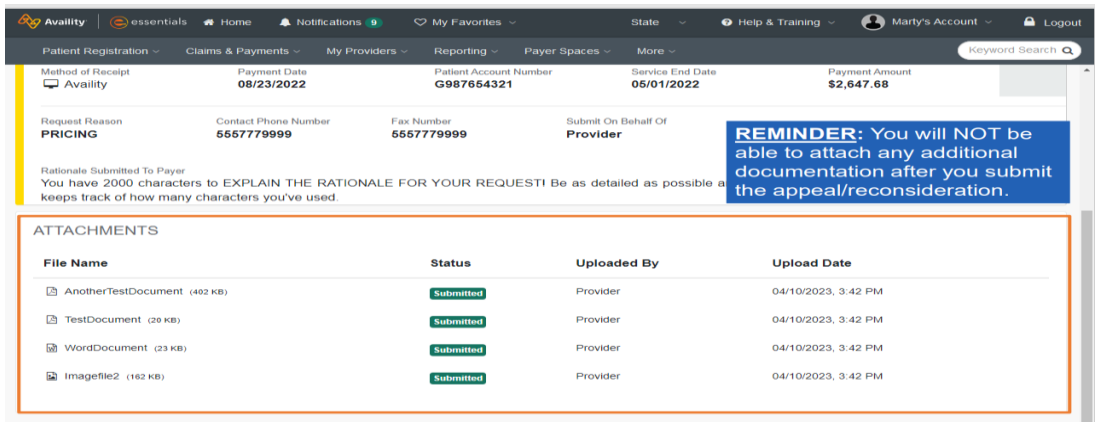
New Availity Enhancement - Enhanced Appeal Submission

Provider Appeal

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



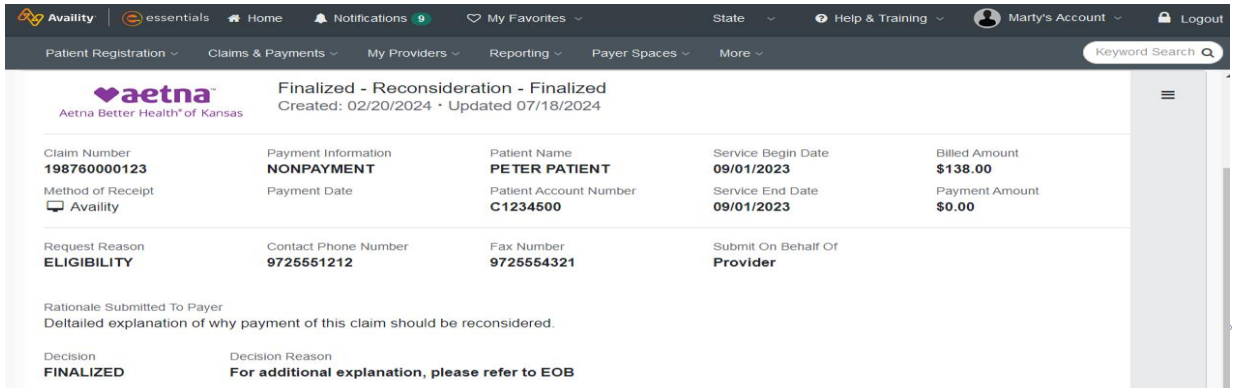


Submission

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

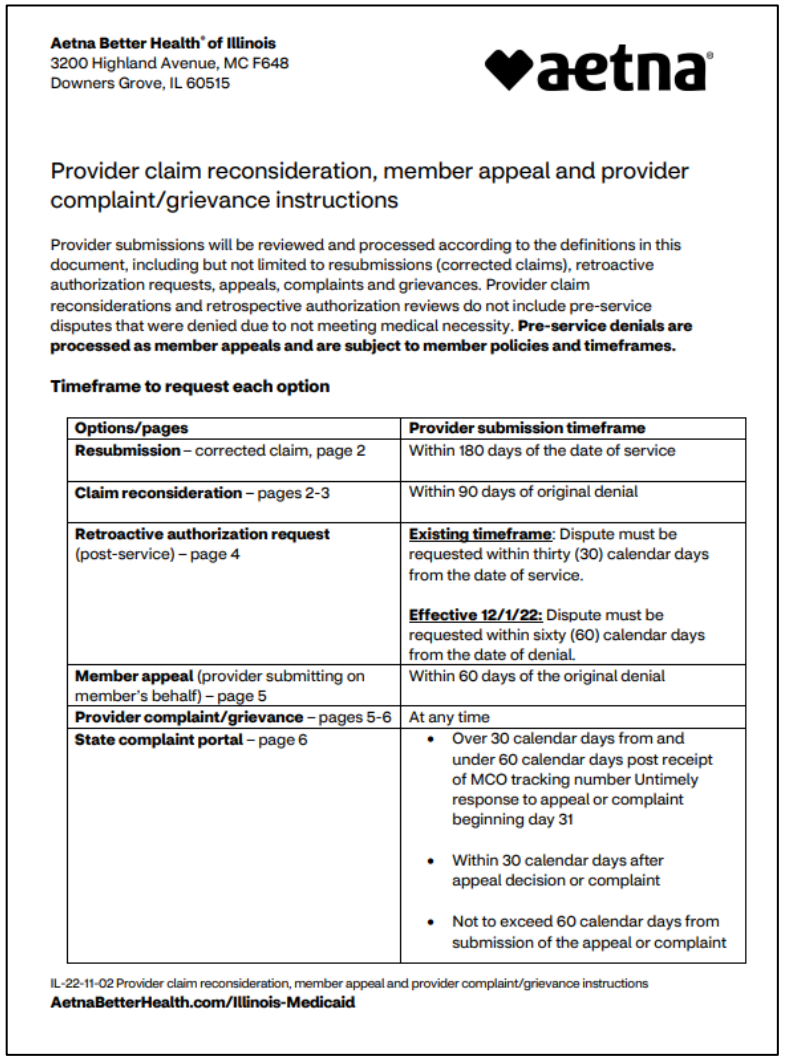
Review Outcome

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



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

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



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Downers Grove, IL 60515

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

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

Timeframe to request each option

Options/pages	Provider submission timeframe
Resubmission – corrected claim, page 2	Within 180 days of the date of service
Claim reconsideration – pages 2-3	Within 90 days of original denial
Retroactive authorization request (post-service) – page 4	**Existing timeframe**: Dispute must be requested within thirty (30) calendar days from the date of service. **Effective 12/1/22:** Dispute must be requested within sixty (60) calendar days from the date of denial.
Member appeal (provider submitting on member's behalf) – page 5	Within 60 days of the original denial
Provider complaint/grievance – pages 5-6	At any time
State complaint portal – page 6	• Over 30 calendar days from and under 60 calendar days post receipt of MCO tracking number Untimely response to appeal or complaint beginning day 31 • Within 30 calendar days after appeal decision or complaint • Not to exceed 60 calendar days from submission of the appeal or complaint

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

Examples of reconsiderations: (Step 1, if applicable)
Itemized bill • An itemized bill must be broken out per Rev Code to verify charges billed on the UB match the charges billed on the itemized bill. (Please attach I-Bill that is broken out by rev code with sub-totals.)
Duplicate claim • Review request for a claim whose original reason for denial was "duplicate" • Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed
Untimely filing of the claim • A review of a claim that was submitted outside the timeframe • Provide good cause justification documentation for late filing; or • For electronically submitted claims provide the second level of acceptance report as proof of timely filing • Refer to Proof of Timely Filing Requirements in the Provider Manual
Untimely decision making • A review of a decision where Aetna did not render the decision on a prior authorization timely • Provide a copy of the denial showing the received date and the decision date
Coordination of benefits • Attach EOB or letter from primary carrie
Claim/coding edit • We use two (2) claims edit applications: refer to the Provider Manual for details.

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

Examples of retrospective authorization disputes: (Step 2, if applicable)
Requests by provider for review of claims for medical necessity
Dispute of denied days during concurrent review
Request for review of additional services not authorized
Retro authorization request • Claims that were denied due to no authorization on file. Medical records must be included with the resubmission.

Examples of complaints/grievances: (Step 1, if applicable)
Dissatisfaction with administrative functions or policies
Vendor staff service or behavior
Aetna staff behavior
On behalf of a member • When filing on behalf of a member the request is processed as a **Member Grievance** andis subject to the member grievance policies and timeframes

Examples of appeals: (Step 2 if applicable)
On behalf of a member: • Continued stay concurrent review • Urgent or Emergent review • Pre-Service (Prior Authorization) requests   • Must have written consent to act on behalf of the member • When filing on behalf of a member the request is processed as a **Member Appeal** and is subject to the member appeal policies and timeframes

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Recoupments

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

Provider notification will include:

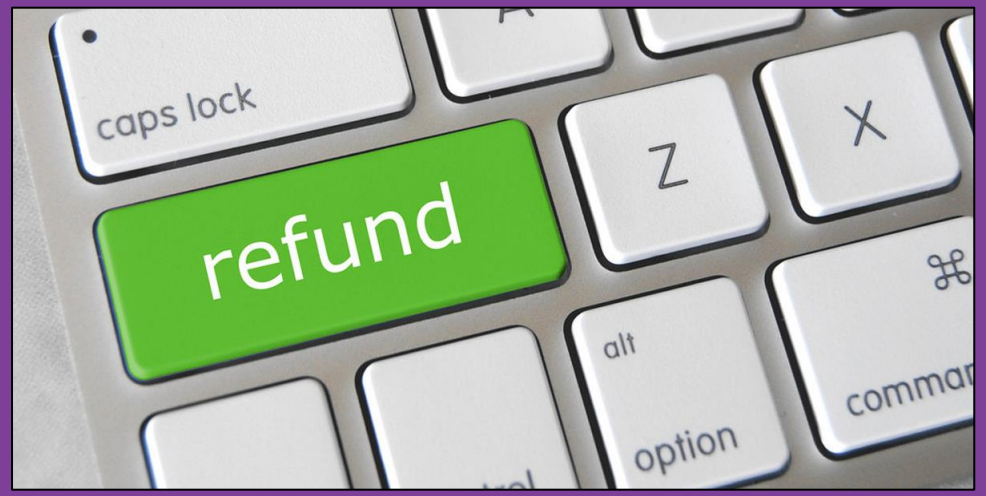
- Impacted claims
- Member's name
- Date of service

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

Aetna Better Health of Illinois
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

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

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



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Provider escalations

Provider Experience escalation process

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Provider grievances

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

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

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

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

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

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

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Provider state escalations

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

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

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

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

Health equity

CVS Health® definition of health equity

Fair and just

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

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

Healthy

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

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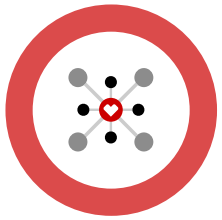
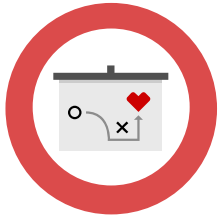
Measuring business unit health equity impact is critical to realizing CVS Health® health equity strategy

Health Equity Pillars



Empower our people

Measure what matters



Take bold actions

How the BUA enables the pillars

- ✓ Establishes common **health equity language** across business units
- ✓ Standardizes **health equity training and resources** across business units
- ✓ Inspires a **growth mindset** by encouraging and rewarding continuous innovation
- ✓ Enables understanding of **business unit** health equity impact
- ✓ Creates **centralized and standardized data repository** to track health equity progress
- ✓ Embeds health equity in the **goals and objectives** of all teams
- ✓ Builds **internal assets and frameworks** to drive health equity actions across business units
- ✓ Establishes **community partnership** standards

Intended BUA outcomes

1. **Embed health equity into business unit goals**
2. **Understand enterprise health equity needs and build corresponding assets**
3. **Implement a scalable annual process**

Successful deployment of the BUA will enable CVSH to:

- Bring leaders and teams along on the journey to gain health equity **buy-in**
- Create a straightforward and frictionless health equity assessment **experience**
- Demonstrate health equity **value** and drive **accountability** across business units

The BUA was designed to meet industry standards and operationalize health equity in five key areas

KEY CONSIDERATIONS

- ✓ Aligns to **external health equity standards and guidelines** (CDC, CMS, IHI, NCQA, NCLAS)* to drive improvements in care quality and consumer experiences
- ✓ Establishes an **annual process** for teams to assess and identify current and future actions based on where they are in their health equity journey
- ✓ Embeds the BUA into **existing strategic planning and budgeting** processes to realize health equity impact
- ✓ Supported by **executive leadership** for use **across the enterprise**

FIVE EMPHASES

Goal 1: Establish health equity as a strategic priority

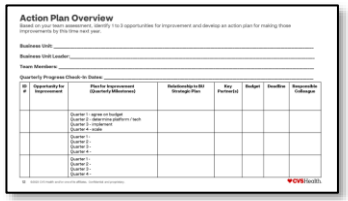
Goal 2: Measure, monitor and review health equity performance

Goal 3: Empower team members to advance health equity

Goal 4: Take thoughtful actions to prevent the creation of inequities

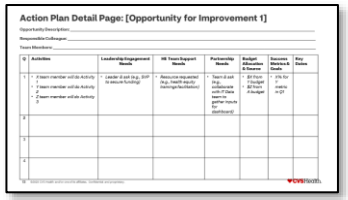
Goal 5: Meaningfully engage underserved communities as partners and leaders to improve health equity

OUTPUTS & RESOURCES

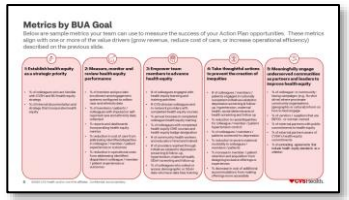


Action Plan Overview

Action Plan Best Practices



Action Plan Detail



Action Plan Metrics

**CDC "A Practitioner's Guide for Advancing Health Equity", CMS "Framework for Health Equity", Institute for Healthcare Improvement (IHI) "Improving Health Equity Guide", National Committee for Quality Accreditation (NCQA) Health Equity standards, U.S. Department of Health and Human Services National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards*

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The BUA is an annual process that ensures teams continually track their progress and remain accountable to their health equity actions

	STEP 1: Assessment Overview	STEP 2: Conduct Assessment	STEP 3: Develop Action Plan	STEP 4: Leadership Incorporates into BU Strategy	STEP 5: Quarterly Check-Ins	STEP 6: Celebrate Accomplishments
Summary	**TEAM** schedules time with a health equity business consultant to review the assessment tool and intended outputs.	**TEAM** fills out the assessment anonymously.	**CONSULTANT** develops a summary report of the results and reviews results with **TEAM** to develop a One-Year Action Plan.	**TEAM** leaders ensure that the Action Plan is incorporated into the BU strategic plan and goals.	**CONSULTANT** schedules quarterly check-ins with the team to track progress and provide assistance as needed.	**HEALTH EQUITY TEAM** shares wins across the enterprise through internal communications channels.
Intended Outcomes	• *Readiness to complete the assessment* • *Health equity-minded strategic planning*	• *Awareness of health equity components* • *Understanding of how health equity could manifest in their work*	• *Alignment on priority opportunities* • *Assigned responsibilities for carrying out related actions* • *Key metrics to measure success*	• *Incorporation of Action Plan into overall strategy* • *Accountability and alignment to strategic plan* • *Alignment on budget needs and sources*	• *Accountability to Action Plan steps* • *Health Equity Team insight into progress, activities, and challenges*	• *Motivation to continue with the BUA process and drive towards continuous improvement* • *Inspiration for other teams*

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Our roadmap to advancing health equity

Vision	We are dedicated to shaping a future where all our members thrive in communities built on shared prosperity, unity, and a commitment to equitable access and outcomes - regardless of race, place, or identity
Current state	While our state has been experiencing unprecedented economic stability, disparities in health, social, and economic outcomes are simultaneously increasing. In Illinois, 7,500 years of life were lost to deaths of people under age 75, per 100,000 people compared to US average of 8,000.[1] Inequities disproportionately impact isolated and medically underserved communities based on group identity and geography, due to systemic barriers
Goals	To achieve this vision, our ABH®IL requires sustaining an **Empowered Members & Community**, **Focusing on Results**, and **Unleashing Innovation** enacted by a sense of urgency to facilitate access, influence, and voice for members in support of a thriving region

	Equity outcomes	Strategies		Alignment	Indicators	
	We aim to achieve...	*We will invest in...*		*We will align with...* *(illustrative examples)*		*We will measure...* *(illustrative examples)*
Empowered Members & Community	Fully engaged members and communities with our network of providers through transparency and quality information for the best decision making, particularly those most impacted by inequities	**Integrative Tactics** Leadership Development Community Organizing Capacity Building Power & Coalition Building Policy & Advocacy Public Narrative	• Community Stability Methods • Community-Based Partnerships • Case Management	• Healthcare Transformation Collaboratives (HTC) • Community Health Councils (CHC) • Community-Based Organizations • Advocacy Groups & Associations	**Integrative Indicators** Expanded community leadership Increased capacity Strengthened connections Shared commitment Adoption & implement-tation of equitable policies	Health Equity Screening rates # of collaborations and joint initiatives % of members that contacted by CBOs to address SDOH
Focusing on Results	Ensuring the entire enterprise is accountable by insisting on high quality outcomes for members and providers while also exercising responsible stewardship of state dollars		• Health Equity Screeners & Quality Outcomes • Performance Indicators • Summative Evaluation	• SDOH Resources • Housing Support Services • FoodRX • WITC		Total capital investments in housing developments % of total jobs that pay a member sustainable wage YOY change in food access and nutrient uptake
Unleashing Innovation	First-class MCO plan by unleashing innovation in technology and removing the barriers to innovation and competition through which providers and vendors compete to deliver better care		• Innovative Tech • Data & Analytics • Targeted interventions • HIEs/Surveillance Tools	• Pyx Health • Mae & Maven • CCBHC • Community Resource Directory		MoM change in total high IP/ED utilization Reduced administrative burden # of proactive CM referrals for the following ambulatory sensitive conditions

[1]*Data and resources. County Health Rankings & Roadmaps. (n.d.). https://www.countyhealthrankings.org/explore-health-rankings/illinois/data-and-resources*

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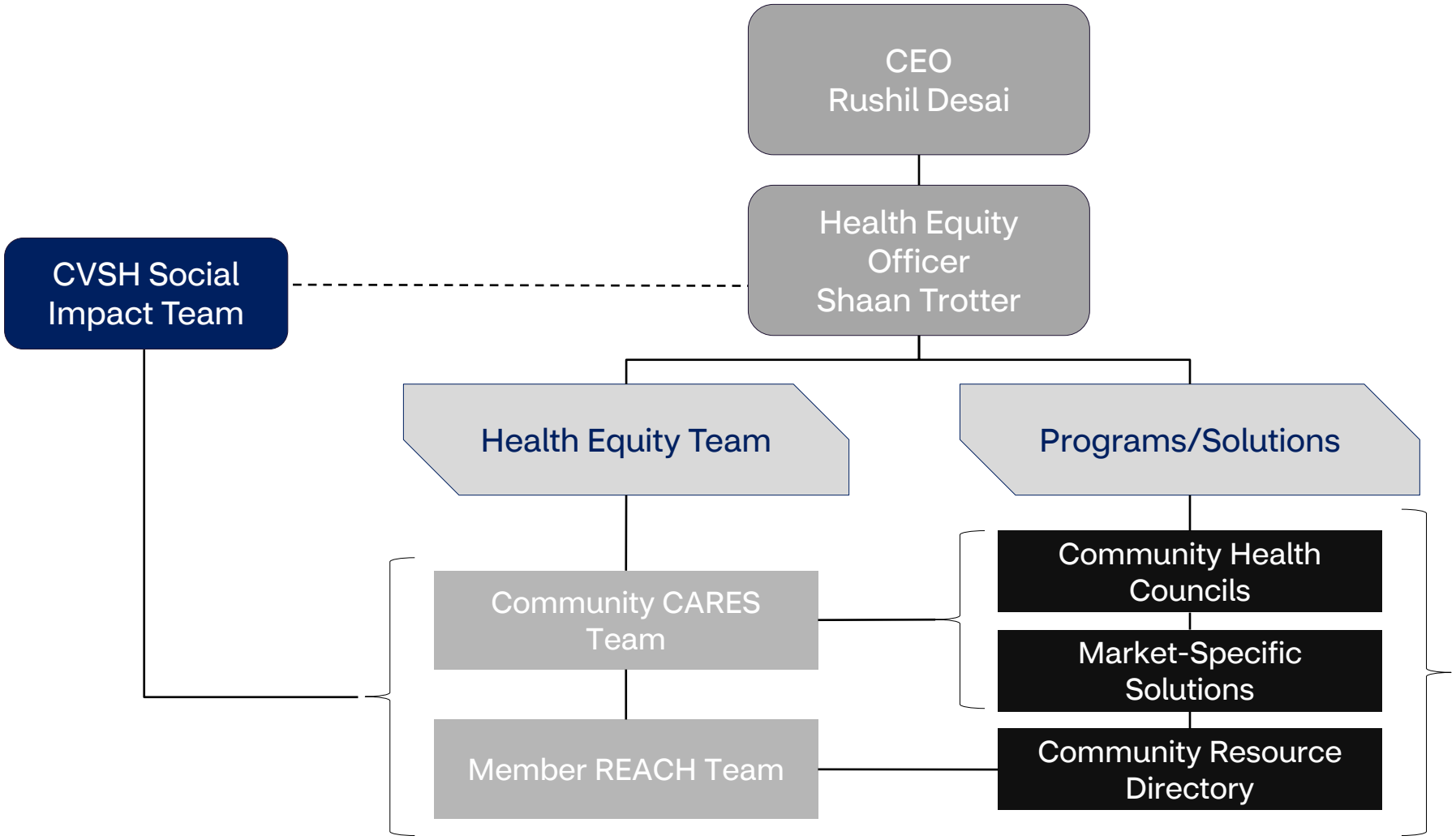
Aetna Health Equity Operational Model



Health Related Social Needs

- Healthcare
- Housing
- Food Security
- Workforce Assistance
- Community Reintegration
- Violence Prevention
- Transportation
- Substance Use Disorder Supports
- Maternal Health
- Education

Health Equity Team structure processes

Continuous Quality Improvement

Analyze	Social Impact Project Team	Provide project management to improve accuracy and simplicity, while supporting evaluation for internal and external solutions
Strategize	Growth & Innovation Team	Monitor SDoH trends/contract requirements to drive strategy creation through improved data resources for all stages of RFP submissions
	Health Equity Team	Ensure a consistent Medicaid approach through improved standardization, centralized reporting, and culturally responsive programs
Implement	*community-facing solution* Community CARES Team	Establish partnerships to support sustainability of the social safety net with community-based organizations through SDoH and health equity initiatives built through analysis and strategy planning
	member-facing solution Member REACH Team	Call center focused on screening non-care managed members for SDoH needs to connect them to national and local resources, closing the loop, then addressing care gaps

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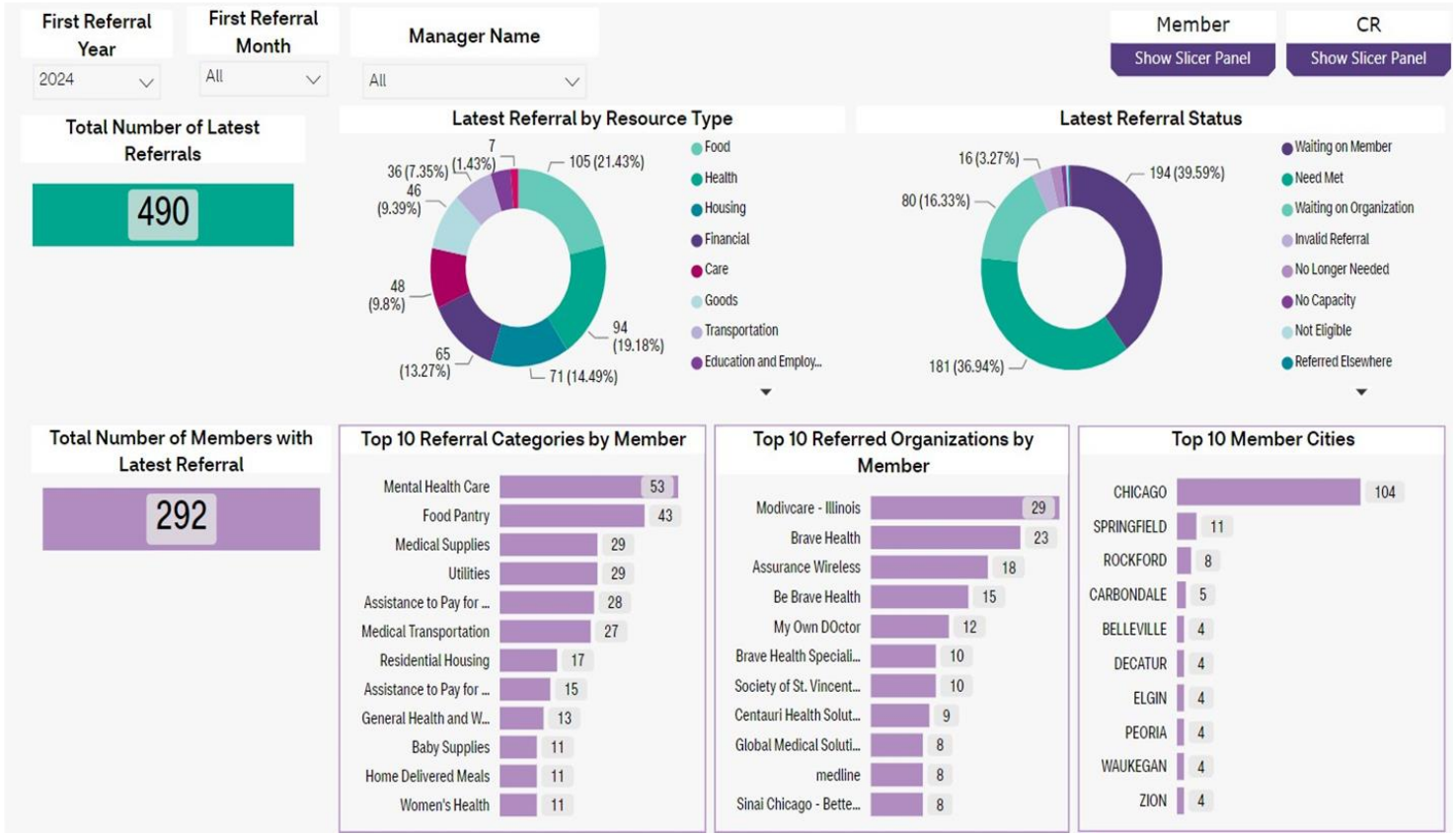
Better Together: Community Resource Directory (CRD)

Nationwide, Directory of CBOs & Agency Services

Member HRSN/HE assessment completed → **Plan Risk Stratification** → **Member contact by CM or REACH Team** → **HRSN assessment and referrals** → **Member completes referral**

Illinois (2024)



Key Points

- Allows access to a wide range of community resources aimed to reduce HRSN.
- Demonstrated impact to health outcomes when HRSN needs are met.
- Ability to track and report member resource utilization.
- Integrated with internal systems, allowing consistency at any touchpoint with the member.
- CRD allows an automated closed-loop functionality with bidirectional feedback.
- Members are informed through CVS/Aetna's REACH Team outreach and health promotion activities (i.e., member portal, direct mail / text messaging, case management, etc.)

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Member health equity journey

Alignment of Social Support Services Focusing on Comprehensive Person-Centered Care

Inbound claims and digital data streams

Members Identified

- *Through monthly claims data, health risk assessments, referrals and surveillance*

Member Stratified to High or Moderate Risk

- *Member queued for Care Management outreach and program offerings including CBO or social service resources.*

Member Stratified to HRSN or SDOH Risk

- *Member queued for REACH team outreach and CBO or social services .*

CM Engagement

Comprehensive nursing and health equity assessments of clinical and social needs and health equity.

- ***Referrals to CRD and social services as needed based on health equity screener.***

REACH Team Engagement

- *REACH team engages member and conducts health equity assessment.*
- ***Makes referrals to CRD and social services as needed based on health equity screener results.***

Integrated Whole Person Care

- *The Integrated Care team focuses on all aspects of physical health, BH, pharmacy and social services to ensure all member needs are assessed and addressed through the lens of health equity.*
- *Referrals for CBOs and social support services augment care, reduce HRSN and contribute to recovery and secondary prevention.*

Social Services and Community Partner Supports

- *Referrals to CBOs and social support services augment care, reduce HRSN and contribute to recovery and secondary prevention.*

Transition

- *Member may stay engaged with CBO for individualized needs.*
- *CRD remains available for member community resource requests.*

Transition

- *Member may remain in CM or re-engage for support any time in the future.*
- *CRD remains available for member community resource requests.*

Aetna programs support an individualized, patient centered approach planned and executed through the lens of health equity.

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Compliance and mandated training

Cultural, Linguistic & Disability Access Requirements & Services

Cultural competency

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

Linguistic competency

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

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

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

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
    - Concerns related to the Health Plan and/ or Provider's failure to offer reasonable accommodations to patients with a disability

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

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

Appointment standards

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

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

Fraud, Waste, and Abuse (FWA)

Fraud, Waste and Abuse

FRAUD	WASTE	ABUSE
• Intentionally or knowingly submitting false information to the Government or a Government contractor to get money or a benefit to which you are not entitled. • **Fraud** can be committed by a provider or a member	• The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. • **Waste** is not generally considered to be caused by criminally negligent actions but rather by the misuse of resources.	• Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. • Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment

Critical incidents

Abuse, Neglect & Exploitation

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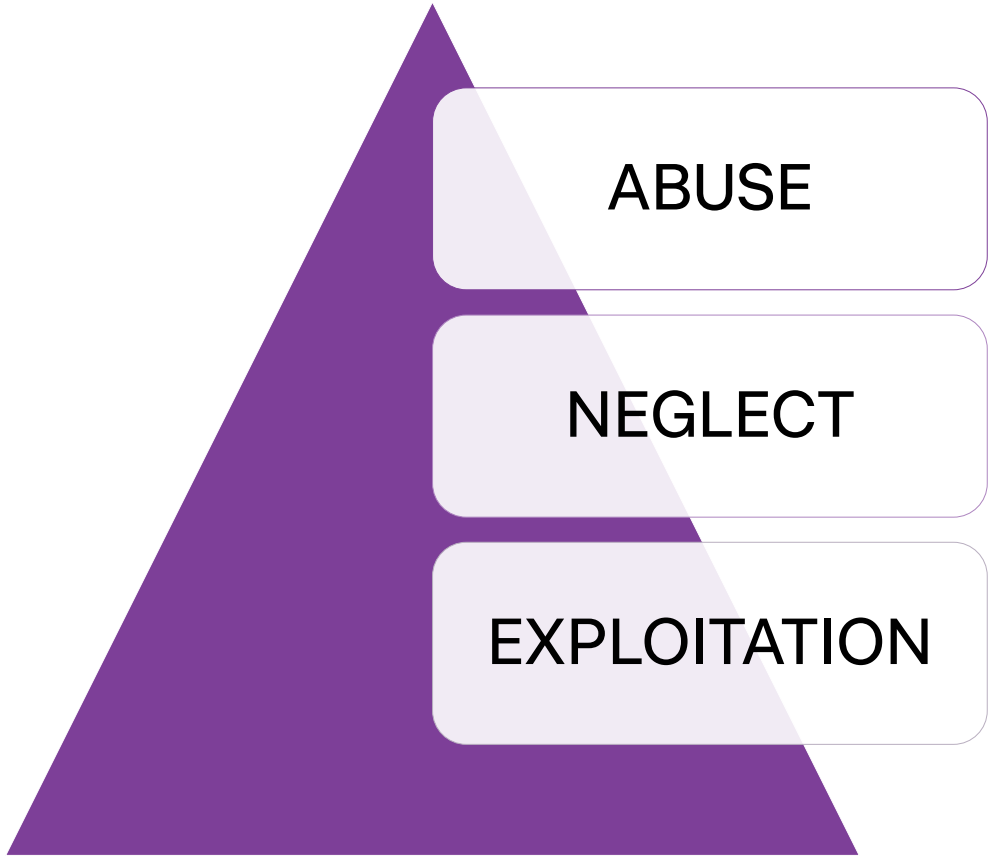
Critical incidents | Spot the signs

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



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

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Reporting critical incidents

Office of Inspector General (OIG):

800-368-1463

Aetna Better Health of Illinois Provider Services:

866-329-4701

IL Department on Aging (IDoA):

866-800-1409

Senior Help Line:

800-252-8966

IL Department of Public Health (IDPH):

800-252-4343

Critical Incident Reporting and Analysis System (CIRAS):

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

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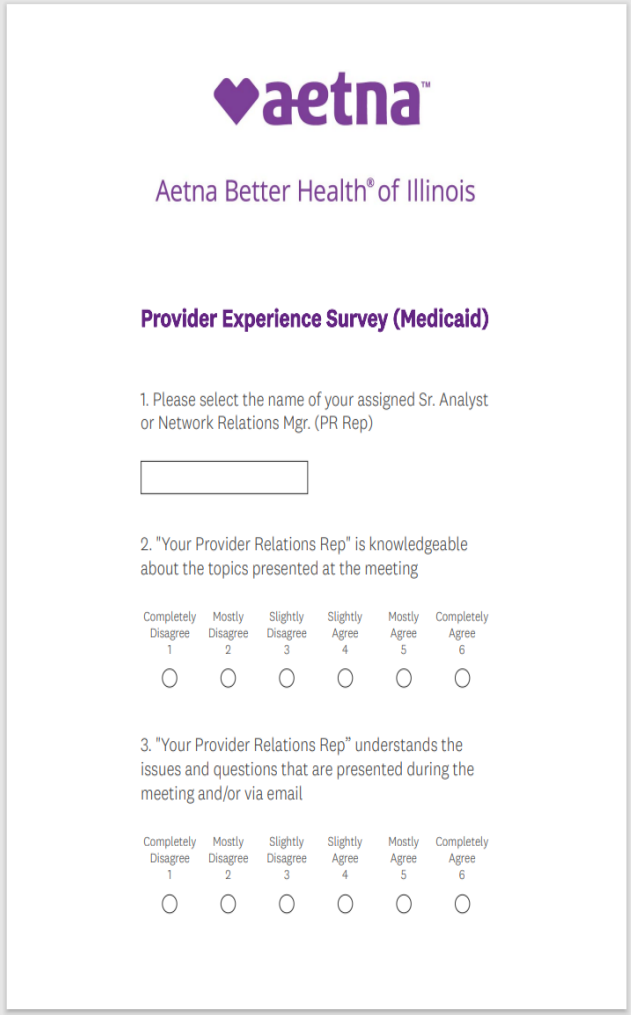
Provider Experience survey

New Provider Experience survey

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

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

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



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Provider Experience Survey (Medicaid)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Key contacts

Key contact information

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

Vendors and Partners

Vendors and partners

Aetna Better Health® of Illinois subcontracts the following services:

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

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

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

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

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

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

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Thank you!

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


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