Aetna Better Health® of Illinois

2025 Provider Manual

Provider Services: **1-866-329-4701**

AetnaBetterHealth.com/Illinois-Medicaid

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

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CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH OF ILLINOIS

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Welcome

Welcome to Aetna Better Health® of Illinois. We rely on our provider network to provide excellent service to our members. By joining our network, you're helping us serve Illinois residents and their health care needs.

About Aetna Better Health of Illinois

For over 30 years, Aetna® Medicaid has honed our approach to serving high-acuity, medically frail and low-income populations with diverse benefits. Our goal is to improve the functional status and quality of life for members, while providing budget predictability to our state partners. Our experience in implementing, managing and caring for Medicaid beneficiaries results in improved access to care, higher quality care in appropriate settings, and a simplified consumer experience in a culturally competent manner. We take our responsibility seriously as a steward of public programs.

Today, Aetna serves more than three million members through Medicaid managed care plans. In partnership with providers, community resources and other key stakeholders, we offer programs and services that combine to meet the individual needs of our most vulnerable members. While our programs and services continue to evolve and expand, our mission remains the same — building a healthier world by improving the lives and well-being of every member we serve.

Experience and innovation

We enhance member and provider satisfaction by using tools such as predictive modeling, care coordination and state-of-the art technology. This helps us achieve cost savings and helps members attain the best possible health care. We work closely and cooperatively with physicians, hospitals and all other providers to achieve demonstrable improvements in service delivery. We're committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

About the Medicaid Managed Care Program

The Illinois Department of Healthcare and Family Services (HFS) is responsible for providing Medicaid Assistance and Children's Health Insurance (SCHIP). The medical assistance programs are administered under provisions of the Illinois Public Aid Code; Illinois Children's Health Insurance Program Act; Covering All Kids Health Insurance Act; and Titles XIX and XXI of the Federal Social Security Act. The department's mission is to improve the health status of the individuals enrolled in its programs, while simultaneously containing costs and maintaining program integrity.

About our Provider Manual

This Provider Manual serves as a guide to the policies and procedures governing the administration of Aetna Better Health of Illinois. It is an extension of and supplement to the Provider Agreement between Aetna Better Health of Illinois and contracted practitioners and providers delivering health care service(s) to our members.

We retain the right to add to, delete and otherwise modify this manual. Revisions to this manual reflect changes made to our policies and procedures updated at least annually. Revisions will be binding and will comply with any statutory, regulatory, contractual and accreditation requirements. As policies and procedures change, we will let you know in advance about updates in our provider newsletter. We'll do this via our website and email and incorporate updates into subsequent versions of this manual.

We're always looking to improve the usefulness of the tools and information we make available to our practitioners and providers. We welcome your comments and feedback. Please email your comments, feedback and suggestions to **ABHILProviderRelations@aetna.com.**

CHAPTER 2: IMPORTANT CONTACT INFORMATION

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Aetna Better Health of Illinois	**PO Box 818031, MC F661** **Cleveland, OH 44181-8031**

Important contact information	Phone number	Hours and days of operation
Aetna Better Health of Illinois Provider Services Email: **ABHILProviderRelations@aetna.com**	**1-866-329-4701 (TTY: 711)** Fax: **1-855-254-1793**	Live agents available: Monday through Friday 8:30 AM–5 PM CT, excluding State holidays Interactive voice response (IVR) system available: 24/7 Secure Web Portal available: 24/7
Aetna Better Health of Illinois Behavior Health Services	**1-866-329-4701 (TTY: 711)**	Live agents available: 24/7 Interactive voice response (IVR) system available: 24/7
Aetna Better Health of Illinois Member Services	**1-866-329-4701 (TTY: 711)** Fax: **1-855-254-1791**	Representatives available Monday through Friday 8:30 AM to 5:30 PM CT, excluding State holidays Interactive voice response (IVR) system available: 24/7 Interpreter services available for members
Aetna Better Health of Illinois care coordination	**1-866-329-4701 (TTY: 711)**	Care coordinators available Monday through Friday 8:30 AM–5 PM CT, excluding State holidays Interactive voice response (IVR) system available: 24/7 For urgent issues at all other times, call our after-hours area through the IVR system

Aetna Better Health of Illinois Utilization Management	**1-866-329-4701 (TTY: 711)** Prior authorization fax: **1-877-779-5234** Concurrent review fax: **1-877-668-2074** Behavioral Health: **1-844-528-3453** Peer-to-peer review: **1-833-491-1090**	UM clinician available: Monday through Friday 8:30 AM–5:00 PM CT, excluding State holidays Interactive voice response (IVR) system available: 24/7 For urgent issues at all other times, call our after-hours area through the IVR system
Aetna Compliance Hotline (Mechanism for reporting compliance and ethics issues for members, staff and providers including Fraud, Waste or Abuse)	**1-866-536-0542 (TTY: 711)**	24/7 through voicemail inbox
Aetna Special Investigations Unit (SIU) (reporting Fraud, Waste or Abuse)	**1-800-338-6361 (TTY: 711)**	24/7
CVS Caremark Pharmacy Network Help Desk	**1-888-964-0172 (TTY: 711)**	24/7

Aetna partners	**Phone number and website**
Dental: DentaQuest	**1-800-508-6780 (Providers)** **1-888-278-7310 (Members)** **Dentaquest.com**
Vision: March Vision	**1-844-456-2724 (Providers)** **1-866-376-6780** **TDD/TYY: 1-877-627-2456 (Members)** **MarchVisionCare.com**
Radiology and pain management: eviCore	**1-888-693-3211** **eviCore.com**
Non-emergent transportation: ModivCare Solutions LLC	**1-866-913-1265**
Lab and Diagnostic Services: Lab Corp	**LabCorp.com**
Clearinghouse: Optum	**1-866-367-9778** **OptumConnectivityPortal.force.com/OptumConnectivityCustomerPortal/s/**

State and Federal contact information	Phone number and website
Illinois Department of Healthcare and Family Services Provider Hotline	**1-844-591-9053** **Illinois.gov** Report fraud: **1-844-453-7283 (1-844-ILFRAUD)**
Illinois Medicaid Program Advanced Cloud Technology (IMPACT)	**1-877-782-5565 (Option #1)** **Email: IMPACT.Health@Illinois.gov IMPACT.Illinois.gov**
Illinois Relay (TTY)	**711**
Illinois Tobacco Quitline	**1-866-QUIT-YES (784-8937)** **QuitYes.org**
24-Hour Elder Abuse Hotline	**1-866-800-1409** **1-888-206-1327 (TTY)** 24/7
Department of Public Health Abuse Hotline (LTC & NFs)	**1-800-252-4343** 24/7
Department of Children and Family Services Child Abuse Hotline	**1-800-25-ABUSE or 1-800-25-2873** **1-800-358-5117 (TTY)**

CHAPTER 3: PROVIDER SERVICES

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Our Provider Services Department functions as a liaison between the Health Plan and the provider community. The Provider Services staff is available and ready to support our provider community with assistance in several areas including, but not limited to:

- Contract status
- Credentialing and recredentialing questions
- Provide information on how to update location/address changes via the IMPACT system
- View recent updates
- Locate forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- How to submit a prior authorization
- Review or search the Preferred Drug List
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Provide information on how to update Tax ID or National Provider Identification (NPI) number change via the IMPACT system
- Obtain a secure web portal or member care login ID
- Review claims or remittance advice

Top 10 reasons to contact our Provider Experience team:

1. To report any change or additions indicated to your universal roster template (i.e., practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance).
2. To obtain assistance with the provider portal
3. To schedule an in-service training for new staff
4. To conduct ongoing education for existing staff
5. To obtain clarification of policies and procedures
6. To obtain clarification of a provider contract
7. To request fee schedule information
8. To obtain responses to membership list questions
9. To obtain responses to escalated claim questions
10. To learn how to use electronic solutions on web authorizations, claims submissions and check eligibility

Our Provider Services Department supports network development and contracting with multiple functions, including evaluation of the provider network and compliance with regulatory network capacity standards. Our staff creates and develops provider communication materials, including the Provider Manual, quarterly newsletters, bulletins, fax/email blasts, website notices and the Provider Orientation Kit.

Provider training

We offer a variety of provider educational training opportunities to our network providers, including but not limited to:

- New provider orientation
- Cultural competency
- Critical incidents
- Fraud, waste and abuse

Web portal training

Our trainings give you the information and tools you need to serve our members as efficiently as possible. To locate or request additional training information, please visit our provider portal at **Availity.com/Essentials**.

Please contact a Provider Services representative if you and your staff would like additional training.

CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

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Provider responsibilities overview

This section outlines general provider responsibilities; however, we include additional responsibilities throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. You are contractually obligated to adhere to and comply with all terms of Aetna Medicaid programs; your Provider Agreement; and requirements outlined in this manual. Aetna Better Health of Illinois may or may not specifically communicate such terms in forms other than your Provider Agreement and this manual.

You must cooperate fully with state and federal oversight and prosecutorial agencies. This includes but is not limited to Illinois Department of Healthcare and Family Services (HFS), Illinois Department of Children and Family Services (DCFS), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), Centers for Medicare and Medicaid Services (CMS), and the U.S. Attorney's Office.

You must also confirm the use of the most current diagnosis, treatment protocols and standards established by the State of Illinois and the medical community. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals on the basis of race, color, national origin, age, disability and sex, except where medically indicated.

Clinical guidelines

Aetna has clinical guidelines and treatment protocols are available to providers to help identify criteria for appropriate and effective use of health care services, and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member.
- Constitute procedures for or the practice of medicine by the party distributing the guidelines.
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical guidelines are available on our website at: **AetnaBetterHealth.com/Illinois-Medicaid.**

Appointment availability standards

Network providers shall offer hours of operation that are no less than the hours of operation offered to persons who are not enrollees. We require that you schedule appointments for eligible members in accordance with minimum appointment availability standards based on the acuity and severity of the presenting condition in conjunction with the member's past and current medical history. Our Provider Experience department routinely monitors compliance and seeks Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. You are contractually required to meet the timely access to care and services below, considering the urgency of and the need for the services.

The following grid considers the timeframes from the Illinois Department of Healthcare and Family Services (HFS) contract and National Committee for Quality Assurance (NCQA) regulations.

PCP appointment time frames

Aetna contractually requires its PCPs to comply with the following appointment access standards:

- Appointments for emergency services are made available immediately upon member's request.
- Appointments for an urgent medical condition are made within 1 business day of the member's request.
- Appointments for routine care are made within five weeks of an adult member's request, and two weeks from the date of request for infants under age six (6) months. This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 10 business days.

Primary care appointment timeframes

Provider type	Emergency services	Urgent care	Preventative and routine care	Wait time in office standard	After hours (voicemail not acceptable)
PCP	Same day	Within one business day	Within 5 weeks	No more than 45 minutes	24/7

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

Provider type	Emergency services	Urgent care	Non-urgent	Preventative and routine care	Wait time in office standard	After hours (voicemail not acceptable)
Specialty referral (includes high-volume specialty care)	Same day	Within one business day	Within 72 hours	Within 3 weeks	No more than 45 minutes	24/7

Oncology and high-impact specialty appointment timeframes

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

Maternity appointment timeframes

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

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

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

Behavioral Health appointment timeframes

Aetna contractually requires its providers to comply with the following behavioral health care appointment access standards. (Measured separately for prescribing versus non-prescribing providers):

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

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

Additionally, behavioral health providers are contractually required to offer:

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

Telephone accessibility standards

Aetna requires that all participating network providers make arrangement for after-hours coverage, either by being available or having on-call arrangements in place with other qualified participating network providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care and verifying member enrollment with Aetna Better Health of Illinois. It's an Aetna policy that a participating network provider may not substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent and/or emergent health care issues are held to the same accessibility standards, regardless of if after-hours coverage is managed by the PCP, current service provider or the on-call provider.

Aetna requires that all participating network providers maintain a system to provide access to primary care 24/7. In addition, Aetna encourages plan providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e- mail) between members, their PCPs and practice staff.

Aetna Better Health of Illinois routinely measures our providers' compliance with these standards as follows:

- Medical and provider management teams continually evaluate emergency department (ED) data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention
- Compliance and provider management teams evaluate member, caregiver and provider complaints and grievances regarding after-hours access to care to determine if a PCP is failing to comply on a monthly basis
- A telephonic survey is conducted on a quarterly basis

If a provider fails to meet after-hours standards, a Provider Services representative contacts the provider to inform them of the deficiency, educate the provider regarding the standards and works to correct the barrier to care.

You are responsible for after-hours coverage either by being available or having on-call arrangements in place with other qualified, participating Aetna providers for the purpose of rendering medical advice and determining the need for emergency or other after-hours services including authorizing care and verifying member enrollment with us.

It is our policy that providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage response for routine, urgent, or emergent health care issues is held to the same accessibility standards, regardless of if after-hours coverage is managed by the PCP, current service provider or the on- call provider.

A published after-hours telephone number must be available to members to enable access to care 24 hours a day, 7 days a week. In addition, we encourage you to offer open-access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs and practice staff. We routinely measure your compliance with these standards as follows:

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

In addition, you must comply with telephone protocols for all of the following situations:

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

We consider a telephone response acceptable/unacceptable based on the following criteria:
Acceptable:
An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voicemail
- The answering service either:
  - Connects the caller directly to the provider
  - Contacts the provider on behalf of the caller and the provider returns the call
  - Provides a telephone number where the provider/covering provider can be reached
- The provider's answering machine message provides a telephone number to contact the provider/covering provider

Unacceptable:

- The answering service:
  - Leaves a message for the provider on the PCP/covering provider's answering machine
  - Responds in an unprofessional manner
- The provider's answering machine message:
  - Instructs the caller to go to the emergency room for care, regardless of the exigencies of the situation, without enabling the caller to speak with the provider for non-emergent situations
  - Instructs the caller to leave a message for the provider

- No answer
- Listed number is no longer in service
- Provider is no longer participating in the Aetna network
- On hold for longer than five minutes
- Telephone lines are persistently busy despite multiple attempts to contact the provider

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

In the event that telephone accessibility standards are not met, a Provider Services representative will be in contact to discuss the deficiency, provide additional education and work to correct the barrier to care.

Covering providers

Providers must notify our Provider Services department if a covering provider is not contracted or affiliated with our network. Notification must occur in advance of providing authorized services. Reimbursement to a covering provider is based on the Services department of covering provider affiliations or other insurance coverage may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying member eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non- emergent, covered services. Providers must verify a member's assigned provider prior to rendering primary care services. We **do not** reimburse providers for services rendered to ineligible members who lost eligibility or who were not assigned to the PCP's panel (unless they are a physician covering for the member's PCP).

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

- The MEDI website provides member eligibility information to Medicaid providers.
- Availity providers can verify up to five members at a time for eligibility verification. The information is displayed in real-time and can be exported for printing or saving to a file. To obtain access to Availity, you may request access at **apps.availity.com/availity/web/public.elegant.login**.
- Call Member Services to verify eligibility at **1-866-329-4701**, Monday through Friday, 8:30 AM to 5:00 PM CT, to speak with a live agent or 24/7 via our automated system. To protect member confidentiality, providers are asked to confirm their identity with the name, tax ID, or NPI. We require providers to provide identifying information to identify the member such as the member's name, identification number, date of birth and address before any eligibility information is released.

Provider secure web portal

Our provider secure web portal is a web-based platform that allows us to communicate member health care information directly with providers and in real-time. Providers can perform many functions within this web-based platform. The following information is available on the secure web portal:

- Member eligibility search – Verify current eligibility of one or more members
- Panel roster – View the list of members currently assigned to the provider as the PCP
- Provider list – Search for a specific provider by name, specialty, or location
- Claims status search – Search for provider claims by member, provider, claim number or service dates. We display only claims associated with the user's account provider ID.
- Clinical practice guidelines
- Preventive health guidelines (adult and child)
- Provider manual
- Remittance advice search – Search for provider claim payment information by check number, provider, claim number or check issue/service dates. We display only remits associated with the user's account provider ID.
- Provider prior authorization look-up tool – Search for provider authorizations by member, provider, authorization data, or submission/service dates. We display only authorizations associated with the user's account provider ID. The tool also allows providers to:
    - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes

simultaneously
- Review Prior Authorization requirement by specific procedures or service groups
- Receive immediate details as to whether the code(s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
- Export CPT/HCPS code results and information to Excel
- Make sure staff works from the most up-to-date information on current prior authorization requirements
    - Submit an authorization request on-line. Three types of authorization are available:
        - Inpatient services including surgical and non-surgical, rehabilitation, and hospice
        - Outpatient
        - Durable medical equipment
    - Non-par providers must receive prior authorization for all treatment
- Healthcare Effectiveness Data and Information Set (HEDIS®) – Check the status of the member's compliance with any of the HEDIS measures. A "Yes" means the member has measures they are not compliant with; a "No" means the member has met the requirements.

Population health platform

The population health platform is a web-based tool set available to select providers who participate in value-based agreements. The strength of the tool resides in the system's ability to timely expose actionable clinical data and other critical pieces of the care record. Available member information includes service and costs as per claims history data, the member's ED and hospitalization risk, HEDIS gaps in care, the care management team's plan of care and other relevant clinical data. The tool also enables near-real awareness of and access to HIE submitted admissions, discharges, transfers and ED visit data.

Specific data and usage may include:

- The ability to view and print a member's service plan
- Ability to view a member's profile, which contains:
    - Member's contact information
    - Member's demographic information
    - Up to one year's claims history
    - HEDIS gaps in care
    - Member's care team: Primary care provider, specialists and other care team members (from claims), health plan care manager
    - Detailed member clinical profile: Claims-based data for conditions, medications and utilization data with the ability to drill-down to the claim level
    - High-risk indicator (based on existing information, past utilization and member rank as compared to the total plan population)
    - Member reported and documented conditions and medications (including over-the-counter (OTC), herbals and supplements)
- The ability to create a registry of gaps in care/care considerations for the entire Aetna population
- Utilize ADT and clinical data to support transition of care management

Providers who have access to the platform, receive education and training and ongoing support for using the system.

Continuity for behavioral health care

The PCP provides basic behavioral health services and refers the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

Preventive or screening services

Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations
- Disease risk assessment
- Age-appropriate physical examinations and health screenings
- Well-women visits (female members may go to an obstetrician/gynecologist for a well-woman exam once a

year without a referral)
- Dental screenings and topical application of fluoride

Educating members on their health care

Aetna does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise the member on:

- The member's health status and medical care or treatment options including any self-administered alternative treatments
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his/her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

Providers may freely communicate with members on items such as these regardless of benefit coverage limitations.

Emergency services

We do not require authorizations for emergency services. If a provider cannot provide services to a member who needs urgent or emergency care — or if the member calls after hours — providers should refer the member to the closest emergency room department or in-network urgent care.

Urgent care services

As the provider, you must serve the medical needs of our members meeting all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the "Find a Provider" link on our website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna reviews unusual urgent care and emergency room utilization. We share trends, which may result in increased monitoring of appointment availability.

Primary care physicians (PCPs)

The primary role and responsibilities of PCPs include, but are not limited to:

- Providing or arranging for urgent covered services as defined in your contract, including emergency medical services, to members 24/7
- Providing primary and preventive care that includes, at a minimum, the treatment of routine illnesses, immunizations, health screening services and maternity services, if applicable
- Acting as the member's advocate
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult members from pediatric to adult providers
- Maintaining the member's medical record
- Conducting office visits during regular office hours
- Office visits or other services during non-office hours as determined to be medically necessary
- Response to phone calls within a reasonable time and on an on-call basis 24 hours per day, 7 days per week (refer to the appointment available requirements in this chapter)

PCPs — in their care coordination role — serve as the referral agent for specialty and referral treatment and services provided to members assigned to them, and attempt to verify that coordinated, quality care is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, specialty providers or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers
- Coordinating with our Prior Authorization Department regarding prior authorizations for members
- Conducting follow-up (including maintaining records of services provided) for referral services rendered to their assigned members by other providers, specialty providers, or hospitals
- Coordinating medical care for the programs the member is assigned to, including at a minimum:

- Oversight of drug regimens to prevent negative interactive effects
- Follow-up for all emergency services
- Coordination of inpatient care
- Coordination of services provided on a referral basis
- Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs

PCPs are responsible for establishing and maintaining hospital admitting privileges sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members.
This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

PCPs should only refer members to Aetna network specialists. If the member requires specialized care from a provider outside our network, PCPs will need to obtain a prior authorization.

Alternative payment arrangements

Alternative payment arrangements are different ways primary care providers can contribute toward improving quality and outcomes while potentially earning financial incentives. New alternative payment arrangements are being created all the time. Some of the opportunities are described below.

Primary Care Case Management (PCCM), Patient Centered Medical Home Program

To promote the "Medical Home" concept, Aetna Better Health of Illinois allows Primary Care Physicians (PCPs) to participate in the Primary Care Case Management (PCCM) Program or Patient Centered Medical Home (PCMH) Program.

Providers who participate in this program may be eligible to receive a monthly capitation amount (PMPM) for each member who meets the following requirements: (i.) eligible member(s) that receives benefits in the Affordable Care Act (ACA) Adults, Supplemental Security Income (SSI) Non -Duals, or Temporary Assistance for Needy Families (TANF) programs (ii) member who is not a resident of a Long-Term Care (LTC) facility (iii) member who is not a Home & Community-Base Services (HCBS) Waiver recipient (iv) member has selected or been assigned to a provider as his/her PCP and (v) has an active provider patient/provider-client relationship, as determined by Aetna based on factors that include the number of office or virtual visits such member has completed with his/her provider in the most recent twelve-month period.

In addition to maintaining active patient-provider relationships, providers participating in the PCCM Program must meet the following criteria in order to qualify for reimbursement:

A. Post-hospital discharge follow-up: Participate in the coordination of the members' care during and after an inpatient admission:

1. For members with an acute inpatient discharge:
   a) 25 percent of members with an acute inpatient discharge must be seen within seven (7) days of discharge by their PCP/PCP group.
   b) Up to five designated Aetna Better Health of Illinois Case Management or Quality liaison staff shall have access to the electronic medical record.
2. Maintain the appointment accessibility standards defined on page 14 and the availability of a follow up appointment within seven days of inpatient discharge.

B. Member Outreach/Engagement: Coordinate with the Aetna Better Health of Illinois Disease Management program including collaborating with case managers, as requested.

1. The Health Risk Screening (HRS) initiates the risk stratification process and the allocation of Case Management and Health Plan resources to the members. For newly assigned members to the practice, PCCM PCP must:
   a) Meet or exceed a 20 percent HRS completion rate within 60 days of new member assignments.
      i. We need your support. Please encourage your Aetna Better Health of Illinois patients to complete this brief survey that earns them a $10 incentive on their Aetna Better Care account. Moreover, engaging your patient early in their membership can help establish a relationship with their assigned PCP, and influence their participation in

care and preventative measures. If you (or your staff) are unable to complete the form with a member, we urge you to inform our members to complete the HRS on their own. Members can complete the HRS over the phone by calling **1-866-329-4701 (TTY: 711).**

b) Educate members and remind them of preventive and immunization services, or preventive services missed or due based on the periodicity schedule.

c) Set up a recall system to outreach to members who have a missed appointment to reschedule the appointment as needed.

C. Provide members with comprehensive primary care services and covered preventive services including:

1. Medically indicated physical examinations
2. Health education
3. Laboratory services referrals for necessary prescriptions and other services including mammograms and pap smears (with HPV test approach preferred)
4. Provide all appropriate immunizations for members

D. Quality: Submit appropriate HEDIS data by Supplemental Data System data exchange. Data elements are:

1. Well-child visits (W30)
2. Blood pressure control (CBP)
3. Child and adolescent well-care visits (WCV)
4. Child BMI and counseling (WCC)
5. Timeliness of prenatal and postpartum care (PCC),
6. Comprehensive diabetes care (CDC)
7. A1c test and result
8. Screen retinopathy
9. Antipsychotic medication use metabolic monitoring (APM)

Upon written notice that Aetna Better Health of Illinois determined an amount of monthly PCCM or PCMH capitation it paid is ineligible for reimbursement pursuant to the foregoing, provider shall return the amount specified in the written notice in no event more than 45 days from the notice date, otherwise, Aetna may offset such amount against future financial obligations it owes to provider.

Provider financial incentives (P4P) program

Aetna Better Health of Illinois offers a Provider Pay for Performance (P4P) incentive program to eligible providers. PCPs who are in-network for the entire calendar year, maintain a minimum panel size and meet or exceed Aetna HEDIS performance goals may be eligible. Specialists may also be able to earn a P4P bonus for certain measures. Each individual measure included in the P4P Program corresponds to a separate financial incentive performance goal using administrative HEDIS measurement data and preset performance targets.

MBR incentive and Medicaid Quality Risk programs

Providers who participate in this program are eligible to receive a bonus. To be eligible, providers must meet the following criteria:

A. By the end of the Contract Year, a provider must see, for a sick or well visit, at least 50% of total assigned covered persons. Calculation will be limited to those assigned covered persons who were continuously assigned to provider from June through December of the applicable Contract Year.

MBR bonuses shall be calculated as follows: MBR bonus = [(Target MBR minus Final Year-End) x Member Months x Applicable Premium x HBR Bonus].

Example: Provider has 5,000 assigned covered persons for all twelve months of the contract year; applicable premium is $250 PMPM; target MBR is 86%; final year-end MBR is 80%; MBR bonus percentage is 25%.
MBR bonus = [(86% – 80%) x (60,000) x ($250) x (25%)] = $225,000

B. Provider will grant Aetna Better Health of Illinois access to EMR systems as requested for HEDIS/quality record review. Provider will also submit appropriate HEDIS data through Supplemental Data System (SDS) feeds in a timely manner as requested by the plan. We will work in good faith to establish secure connections. Examples could include a Secure File Transfer Protocol, EMR integration service (e.g., Epic Payor Platform), or vendor engagement to collect necessary data/records. All service types, diagnostic tests, labs and immunizations must be included in the feed. Required data elements will address closing gaps in the following HEDIS quality measures:

1. Child and Adolescent Well-Care Visits (WCV)
2. Childhood Immunization Status Combination 10 (CIS)
3. Child BMI and Counseling (WCC)
4. Immunizations for Adolescents (IMA)
5. Breast Cancer Screening (BCS)
6. Cervical Cancer Screenings (CCS)
7. Controlling High Blood Pressure (CBP)
8. Prenatal and Postpartum Care (PCC)
9. Adults' Access to Preventive/Ambulatory Health Services (AAP)
10. Comprehensive Diabetes Care (CDC)
11. A1c Test and Result
12. Screen Retinopathy
13. Antipsychotic Medication Use Metabolic Monitoring (APM)
14. Pharmacotherapy for Opioid Use Disorder (POD) (effective 1/1/24)
15. Postpartum Care (PPC) (effective 1/1/24)
16. Timely Prenatal Care (TOPC) (effective 1/1/24)

C. Effective 1/1/24, provider must complete quality requirements of the following:
1. Participate in the Aetna Better Health of Illinois Pay for Performance (P4P) incentive program.
2. Submit an annual Quality Improvement Plan (QIP), which describes current quality efforts and strategies or programs to enhance or further efforts compared to prior year. A template will be provided; however, existing provider formats are accepted if strategic quality plans and initiatives are defined.
3. Achieve quality performance expectations.

Quality program bonuses shall be calculated based on the number of measures at improvement target or NCQA 50th percentile. Measures will align to P4P.

Measure achievement Minimum measure denominator is 1% of assigned membership on December 31 of contract year to count toward surplus	**Surplus earned**
5 measures at improvement target or NCQA 50th percentile	100%
4 measures at improvement target or NCQA 50th percentile	90%
3 measures at improvement target or NCQA 50th percentile	80%
2 measures at improvement target or NCQA 50th percentile	70%
1 measure at improvement target or NCQA 50th percentile	60%
0 measures at improvement target or NCQA 50th percentile	50%
NCQA 75th percentile benchmarks achieved	Bonus 4% Full-Year Surplus earned per measure for up to five (5) measures and total 20% Full-Year Surplus bonus

Updates to preventive and screening measures

Aetna Better Health of Illinois may change preventive and screening service measures, targets, and bonus percentages,

applicable to any programs, at any time, as long as such changes promote and support the State Medicaid quality assurance program. Aetna shall notify provider of such changes in writing, which shall be effective on the date cited in the notice.

How to participate

Aetna Better Health of Illinois reviews provider performance regularly and typically notifies providers who are eligible to participate. We also encourage providers who are interested in participating to contact a provider services representative.

Important limit on Aetna's obligation to pay

Aetna shall not be required to pay more than one financial incentive per applicable member, goal or other measure, per applicable measurement period. Here are some examples:

1. If a provider participates in two programs, one that offers a payment for completing screenings and meeting MBR goals for assigned members, and another that offers a payment for completing screenings for assigned members, at the end of any applicable measurement period, if the provider earned a payment under the first program, Aetna will pay that amount and pay nothing under the second program.

2. If a provider participates in two programs, one that offers $50 per completed test for assigned members, and another that offers $100 for the same completed test for assigned members, at the end of any applicable measurement period, Aetna will pay $100 for each completed test, not $150.

3. If a provider participates in two programs, one that offers a payment for completing screenings and meeting MBR goals with respect to assigned member population #A, and another that offers a payment for completing screenings and meeting MBR goals for assigned member population #B, and population #A and #B overlap, at the end of any applicable measurement period, for the overlapping assigned members, Aetna will pay any financial incentive the provider may have earned under one program, not both programs.

    - This important limitation on Aetna's payment obligation is intended to clarify and illustrate the broader, more general, language in participating provider agreements, including exhibits.

    - Aetna Better Health of Illinois reserves the sole and exclusive right to make any decisions about whether to, and how to limit its payment obligations in accordance with the foregoing, to the extent permitted by law.

Specialty providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna participating specialist. Specialists coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers a member to a different specialist or provider, the original specialist must share their records, upon request, with the referred-to provider or specialist. The sharing of documentation occurs with no cost to the member, other specialists, or other providers.

Specialty providers or primary care sites acting as PCPs

In limited situations, a member may select a physician, specialist or primary care site (PCS) to serve as his/her PCP. In these instances, the specialist or PCS must be able to demonstrate the ability to provide comprehensive primary care. A member may request a specialist or PCS to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period of time and exceeds the capacity of the non-specialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex gerontology/oncology conditions, cystic fibrosis, etc.)
- When a member's health condition is life threatening, degenerative, or disabling in nature to warrant a specialist serving in the PCP role
- In unique situations where terminating the clinician-member relationship would leave the member without access to

proper care or services or would end a therapeutic relationship developed over time leaving the member vulnerable or at risk for not receiving proper care or services

The Aetna Chief Medical Officer (CMO) coordinates efforts to review the request for a specialist to serve as PCP. The CMO has the authority to make the final decision to grant PCP status, taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in this Provider Manual, with respect to those members. This includes arranging for coverage 24 hours a day, 7 days a week.

PCP panel size

The Aetna Better Health of Illinois Provider Experience team will assess the number of members assigned to PCP panels on a quarterly basis to ensure compliance with HFS. Panel sizes are limited as follows:

- Non-disabled adults and children: 1800/physician, 900/APN, PA, or resident physician FTE. Persons with disabilities: 600/physician, 300/APN, PA, or resident physician FTE.

Self-referrals/direct access

Members may refer themselves to certain practitioners/providers including specialists for specific services identified in the member's benefit plan, Member Handbook, or in state or federal regulations. For example, we do not restrict a member's access to emergency services nor require prior authorization or referral. Additionally, we do not restrict a member in his/her choice of health care practitioner or provider for family planning services.

Note: If a provider refers a member to a provider of a non-covered service, the provider must inform the member of his/her obligation to pay for such non-covered services, and the member must sign a form stating they are aware that they must pay for the services.

Members have the right to receive a second opinion, and we provide members with information on how to obtain a second opinion. Aetna maintains a second opinion process as part of the Utilization Management program. Second opinions may be accessed by the member as an option for the diagnosis and treatment of serious chronic conditions, such as cancer or behavior/mental illness, and for elective surgical procedures. Access to a second opinion is not based on a diagnosis. If the member uses in-network practitioners/providers, no prior authorization or referrals are required to obtain a second opinion. A member may use out of network practitioners/providers if the network is limited in the specialty for which the opinion is requested if the plan is unable to provide an in-network option.

Skilled Nursing Facility (SNF)/Nursing Facility (NF) providers

Skilled Nursing Facilities (SNFs)/Nursing Facilities (NFs) provide inpatient skilled nursing care and related services to members who require medical, nursing, or rehabilitative services but do not provide the level of care or treatment available in a hospital or require daily care from a physician.

Members enrolled in the state's long-term services and supports (LTSS) program and whose home is considered the NF (long-stay) are often assigned a "patient liability", also known as a "share of cost", and must contribute this assigned amount to the cost of their NF care. The SNF/NF must collect this assigned amount from the member.
When the SNF/NF submits their claim for a NF resident, the patient liability amount will be subtracted from the payment made by the health plan to the SNF/NF.

LTSS and non-LTSS members admitted for a subacute or SNF stay (short-term stay) from their home or hospital generally will not have an assigned patient liability that has to be paid to the SNF/NF.

Long-term care providers

Long-term care providers are responsible for providing services in accordance with the accepted community standards of care and practices. The long-term care provider is responsible for verifying member eligibility prior to providing services.

When a long-term care provider refers the member to a different long-term care provider, the original long-term care provider must share the member's records, upon request, with the appropriate long-term care provider. The sharing of documentation occurs with no cost to the member, other long-term care provider, or other providers. For custodial care members Aetna would like to request read only remote electronic medical record access for our care coordinators. This will assist them in coordinating care for our nursing facility members in the most effective manner.

Home and Community Based Services (HCBS)

Home and Community Based Providers are obligated to work with Aetna Case Management Coordinators. Care coordinators complete face-to-face assessments with our members. Based on the assessment and the service planning process with the member, Care coordinators identify the appropriate services to meet the member's functional needs including determining which network provider may be available to provide services to the member in a timely manner. Upon completion, the care coordinators create authorizations for the selected provider and fax/e-mail these authorizations accordingly. Care coordinators will follow up with the member to confirm the selected provider started the services as authorized.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for the member. While services may have been authorized for caregivers and agencies, providers should not bill for any days between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Caregivers are not allowed to claim time with the member in the example above since no services could be performed. This is also true for any in-home service.

Personal assistants and community agencies are responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the personal assistant and community agency will be required to pay back any monies paid by Aetna. We do conduct periodic audits to verify compliance with billing requirements. Providers must offer HCBS waiver members residing in Supportive Living Program and other residential care services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms
- Roommate for semi-private rooms
- Locking door to living unit
- Access to telephone and length of use
- Eating schedule
- Participation in facility and community activities

Ability to have:

- Unlimited visitation
- Snacks as desired

Ability to:

- Prepare snacks as desired
- Maintain personal sleeping schedule

Home and Community Based Services (HCBS) in Supportive Living Program

Facilities must collect room and board fees from members (includes alternative residential settings). Room and board fees include, but are not limited to:

- Debt service costs
- Maintenance costs
- Utilities costs
- Food costs (includes three meals a day or any other full nutritional regimen)
- Taxes
- Boarding costs (includes room, hotel and shelter-type of expenses)

Federal regulations prohibit Medicaid from paying room and board costs. Please be aware that:

- The room and board amount may periodically change based on a member's income.

Home and Community Based Services (HCBS) providers may not submit claims when the member has been admitted to a hospital, rehabilitation facility, or nursing facility. Supportive Living Programs can bill up to 30 days for a bed hold. The day of admission or discharge is allowed, but the days in between are not covered including charges such as medical alert system. Providers submitting claims for the days in between may be subject to a Corrective Action Plan (CAP) for improper billing.

Suspending waiver services

A home and community-based services provider may suspend the services of a member if the member or authorized representative causes a barrier to care or unsafe conditions. Any incidents of barriers to care and/or unsafe conditions should be reported to an Aetna care coordinator by calling Member Services. The care coordinator will work directly with the provider to resolve any potential issues, and if necessary, temporarily suspend services.

Out-of-network providers

When a contracted provider is not able to serve a member with a special need for services, Aetna may authorize services through an out-of-network provider agreement. Our Medical Management team arranges care by authorizing services to an out-of-network provider and facilitating transportation through the state's medical transportation program when there are no providers that can meet the member's special need available in a nearby location. If needed, our Network Contracting Department will negotiate a Single Case Agreement (SCA) for the service. Our Network Contracting team will initiate recruitment to join the provider network. We may transition the member to a network provider when the treatment or services have been completed or the member's condition is stable enough to allow a transfer of care.

How to obtain a Single Case Agreement (SCA):

1. First, the provider must obtain a prior authorization from Medical Management.
2. If the out-of-network is not willing to accept the fee schedule rates, then a Single Case Agreement (SCA) is necessary.
3. Medical Management will complete a level one medical necessity review and then send to Advisor Review Committee.
4. The Advisor Review Committee will provide the outcome to Medical Management with a denial or approval decision.
5. If denied, no additional step is necessary.
6. If approved, Medical Management will complete the Single Case Agreement (SCA) request and submit to Network Contracting team.
7. Negotiation between Network Contracting and the provider, will initiate within 24 hours after the receipt from Medical Management.

Out-of-network benefits

The health plan does not generally cover routine non-emergency care (covered services) from providers who are not part of the Aetna Better Health of Illinois provider network. However, there may be times when members need routine care that our provider network cannot provide. If this is the case, members may be able to receive coverage from a provider who is not in the network (a non-participating provider) only if:

(1) the care is medically necessary (as determined by Aetna Better Health of Illinois); and
(2) there are no Aetna Better Health of Illinois in-network providers who can provide the same service.

We have the right to say where the care or service can be provided, and it must be preauthorized. This means the member or their provider needs to contact us before a visit for it to be covered.

Reminder: Emergency services are always covered and don't require preauthorization.

Provider-requested member transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna member to leave the practice. Such requests cannot be based solely on the member filing a grievance, an appeal, or a request for a Fair Hearing or other action by the member related to coverage, high utilization of resources, or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

1. The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
   Aetna Better Health of Illinois
   Provider Services Manager
   3200 Highland Avenue, MC F648
   Downers Grove, IL 60515
2. The provider must support continuity of care for the member by giving a 30-calendar day notice and opportunity to make other arrangements for care.
3. Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, we will work with the member to inform him/her on how to select another PCP.

Medical records review

Aetna adopted our standards for medical records from NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our provider network. Below is a list of our medical record review criteria. We require consistent organization and documentation in patient medical records as a component of our Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Providers are required to assist members in accessing their records in a timely manner. Providers are also required to protect the confidentiality and privacy of members and abide by all federal and state laws regarding the confidentiality and disclosure of medical records, mental-health records, and any other information about members.

Providers are required to share member records with the Department upon request and in accordance with professional standards. Medical records must include Provider identification. Medical records reporting requirements must be adequate to provide for acceptable Continuity of Care to members. All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable:

- Enrollee identification
- Personal health, social history and family history, with updates as needed
- Risk assessment
- Obstetrical history and profile
- Hospital admissions and discharges
- Relevant history of current illness or injury and physical findings
- Diagnostic and therapeutic orders
- Clinical observations, including results of treatment
- Reports of procedures, tests, and results
- Diagnostic impressions
- Enrollee disposition and pertinent instructions to the Enrollee for follow-up care
- Immunization record
- Allergy history
- Periodic exam record
- Weight and height information and, as appropriate, growth charts
- Referral information
- Health education and anticipatory guidance provided
- Family planning and counseling

Medical record audits

Aetna, the Department of Healthcare and Family Services or CMS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, for administrative responsibilities, or for quality of care issues.
Providers must respond to these requests promptly within 14 days of request. Medical records must be made available upon

request and free of charge. A performance goal of eighty-five percent (85%) must be met for the provider's/practitioner's performance on Aetna Medical Record Review. If the review score does not meet Aetna standards, the health plan may require the practitioner/provider to develop and implement a corrective action plan approved by Aetna.

Access to facilities and records

We require providers to retain and make available all records pertaining to any aspect of services furnished to a member through their contract with Aetna for inspection, evaluation and audit for the longer of:

- A period of 10 years from the date of service
- 10 years after final payment is made under the provider's agreement and all pending matters are closed

Documenting member appointments

When scheduling an appointment with a member over the telephone or in person (i.e., when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record.

Missed or cancelled appointments

Providers must:

- Document in the member's medical record and follow-up on, missed or canceled appointments, including missed EPSDT appointments.
- Conduct affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member's care into compliance with the standards.
- Notify our Member Services department when a member continually misses appointments.

Documenting referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists, within our network. Providers must follow the policies for emergency room care, second opinion, and noncompliant members.

Self-referrals/direct access

Members may refer themselves to certain practitioners/providers including specialists for specific services identified in the member's benefit plan, Member Handbook, or in state or federal regulations. For example, we do not restrict a member's access to emergency services and do not require prior authorization or referral. Additionally, we do not restrict a member in his/her choice of health care practitioner or provider for family planning services.

Note: If a provider refers a member to a provider of a non-covered service, the provider must inform the member of his/her obligation to pay for such non-covered services and the member must sign a form stating they are aware that they must pay for the services.

Members have the right to receive a second opinion and we provide members information on how to obtain a second opinion. Aetna maintains a second opinion process as part of the Utilization Management program.
Second opinions may be accessed by the member as an option for the diagnosis and treatment of serious chronic conditions, such as cancer or behavior/mental illness, and for elective surgical procedures. Access to a second opinion is not based on a diagnosis. If the member uses in-network practitioners/providers, no prior authorization or referrals are required to obtain a second opinion. A member may use out of network practitioners/providers if the network is limited in the specialty for which the opinion is requested if the plan is unable to provide an in-network option.

Confidentiality and accuracy of member records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, our providers must:

- Maintain accurate medical records and other health information.
- Help verify timely access by members to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of behavioral health records, medical

records, other health information, and member information.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA contains many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA contains established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **HHS.gov/hipaa.** In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

We require providers to safeguard and maintain the confidentiality of data encompassed in medical records as well as confidential provider and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA
- Have a patient sign-in sheet at the front desk out of view of other patients
- Keep patient records, papers, and computer monitors out of view
- Have electric shredder or locked shred bins available

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, which includes:
    - The individual's past, present, or future physical or behavioral health or condition
    - The provision of health care to the individual
    - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
    - Many common identifiers (e.g., name, address, birth date, Social Security Number)
- Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna.
- Release of data to third parties requires advance written approval from the department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records. For additional training or Q&A, please visit the following site at **aspe.hhs.gov/admnsimp/final/pvcguide1.htm**.

Providers must follow both required and voluntary provision of medical records consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (**hhs.gov/ocr/privacy/**).

This manual is not intended to detail all legal requirements pertaining to your use and disclosure of patient information. Please consult with your own legal counsel to ensure your compliance with all privacy laws and regulations requirements as they apply to you.

Member privacy rights

The Aetna privacy policy states that members are afforded privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements.

Our policy also assists our personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise their privacy rights through privacy requests, including:

- Making information available to members or their representatives about our practices regarding their PHI
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests
- Documenting requests and actions taken

Member privacy requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local laws:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

The member or member's authorized representative may make a privacy request. A member's representative must provide documentation or written confirmation that he/she is authorized to make the request on behalf of the member or the deceased member's estate.

Advance directives

We require providers to comply with federal and state law regarding advance directives for adult members. Providers must prominently display the advance directive in the adult member's medical record. Provider requirements include:

- Providing written information to adult members regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections)
- Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed
- Provide Aetna with a copy of the member's advance directive
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care

Cultural competency and health equity

Aetna regards cultural competency as a significant strategy within a comprehensive health equity approach. We strive for the ability to effectively and respectfully bridge differences between one's own culture and the culture of others. At Aetna we believe that 1) Everyone has the opportunity to attain their highest level of health, 2) Personal and organizational values impact health care delivery, 3) Communication and empathy create connections, and 4) Knowledge and skill integration improve outcomes.

Cultural competency refers to the practices and behaviors that ensure that all members receive high-quality, effective care, irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a member's characteristics. In this way, members feel like they have been understood and that their beliefs, values, and behaviors are considered. Along with our provider network, we will embrace principles of equal access and nondiscriminatory practices, identify and understand the needs and help-seeking behaviors of individuals and families and work with natural, informal support and helping networks within culturally diverse communities.

Aetna is committed to following the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and requires our providers to commit to the same. Aetna complies with applicable federal civil rights laws and does not discriminate against members based on race, color, national origin, age, disability or sexual orientation, except where medically indicated, or any other basis that is prohibited by law. Aetna expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, being sensitive to cultural diversity, and fostering respect for member's cultural backgrounds for all members including:

- Those with limited English proficiency (LEP) or reading skills

- Those with diverse cultural and ethnic backgrounds
- Those experiencing homelessness or who are at risk of being homeless
- Those with physical, intellectual, or developmental disabilities

Aetna reviews provider satisfaction and CAHPS surveys to ensure culturally competent services are being provided and places providers on a corrective action plan and/or additional training for their actions related to complaints, grievances, audits, and other reports indicating potential problems.

Providers and their office staff are responsible for:

- Ensuring all services, both clinical and non-clinical, are provided in an equitable manner and are accessible to all members
- Ensuring that patients are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages from all staff members
- Honoring members' beliefs, being sensitive to cultural diversity, and fostering respect for members' cultural backgrounds. For additional questions, please contact us directly.

Health Equity education has been developed that encourages respect for diversity, foster skills that facilitate communication within different cultural groups, and explains the relationship between trauma, social determinants, health disparities and health outcomes. We provide specific information on the diversity of our Senior, LGBTQ, and Youth in Foster Care populations that includes the various cultural, racial, and linguistic challenges our members may experience, as well as methods for responding to those challenges.

Providers receive education about important topics such as:

- The reluctance of certain cultures to discuss behavioral health issues and the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in nontraditional healing practices)
- The barriers created by health illiteracy and the need to provide members with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care

Inclusive patient care

In accordance with federal, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna is required to verify that members with LEP have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons with LEP are often excluded from programs they are eligible for, experience delays, denials of services, or receive care & services based on inaccurate or incomplete information.

We require providers to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, we make our telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, our Member Services representatives assist the member via a conference call to communicate in the member's native language.
    - For outgoing calls, Member Services staff dials the language interpretation service using an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, our staff (e.g., care coordinators) can conference in an interpreter to communicate with a member in his/her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call us to link with an interpreter.

We provide alternative methods of communication for members who are visually impaired, including large print and other formats.

Contact our Member Services department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's offices, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity; or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office inspections are conducted by our Provider Services staff to verify that our providers are compliant.

Clinical guidelines

Aetna has clinical guidelines and treatment protocols are available to providers to help identify criteria for appropriate and effective use of health care services, and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member
- Constitute procedures for or the practice of medicine by the party distributing the guidelines
- Guarantee coverage or payment for the type or level of care proposed or provided Clinical

guidelines are available on our website at **AetnaBetterHealth.com/Illinois-Medicaid.**

Office administration

Providers are responsible to notify our Provider Services department of any changes in professional staff at their offices (physicians, physician assistants, or staff practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Services department to schedule staff training.

Aetna Better Health of Illinois has adopted the IAMHP Universal Roster template to use for enrollment and any other provider updates. The Universal roster encompasses practitioners, provider groups and facilities, and can be used for HCBS providers as well. Using the IAMHP template helps providers to streamline the enrollment and update process for multiple plans as the single roster fulfills the data needs for all IL.

Continuity of care

We require providers terminating their contracts without cause to continue to treat our members until completing the treatment course or care is transitioned. An authorization may be necessary for these services. You may also contact our care coordination department for assistance.

Credentialing/recredentialing

Aetna has partnered with HFS to provide a seamless credentialing process for providers and practitioners. Prior to participation, the state requires all providers and practitioners to enroll through IMPACT. If you indicate that you would like to enroll with Aetna, we will contact you and begin the process.

Any subsequent change in ownership or corporate structure that necessitates a new federal tax identification will also necessitate re-enrollment in the IMPACT system as participation and approval is not transferrable. Claims submitted by a new owner using the prior owner's assigned Medicaid ID number will not be accepted.

Interested providers

If you're interested in applying for participation with Aetna Better Health of Illinois (Medicaid), you must first register in the State's provider enrollment system. This requirement is regulated by Title 42 Code of Federal Regulations (CFR) §438.602(b) (1). This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

IMPACT- Enrollment and Contract Status	**1-877-782-5565 (Option #1)** **Email: IMPACT.Health@Illinois.gov IMPACT.Illinois.gov**

Once credentialed through the IMPACT system, Aetna will also require additional provider enrollment documents in order to enroll providers into the Aetna Medicaid product. Such documents will include the Disclosure of Ownership and Control Interest Statement, W-9 Form, and the Universal IAMHP Roster Template. In order to initiate the enrollment process, visit **AetnaBetterHealth.com/Illinois-Medicaid**.

You may check the status of enrollment by contacting the Provider Services Department at **1-866-329-4701 (TTY: 711)**. During the enrollment process, you will remain classified as an out-of-network provider until the enrollment process is complete and you receive a copy of your countersigned agreement. As an out-of-network provider, refrain from rendering service to Aetna members unless you secure a prior authorization or single case agreement in advance of rendering a service.

Providers may visit IMPACT to complete credentialing/recredentialing **Illinois.gov/hfs/impact.**

Council for Affordable Quality Healthcare ProView

Practitioners enrolled with IMPACT must also ensure that demographic information is up-to-date with IMPACT.

Initial credentialing individual practitioners

Initial credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, (with the exception of hospital-based providers) including practitioners joining an existing participating practice with Aetna must complete the credentialing process and be approved by the Credentialing Committee.

Recredentialing individual practitioners

Aetna recredentials practitioners on a regular basis (every 36 months based on state regulations) to make sure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA) requirements. Termination of the provider contract can occur if a provider misses the 36- month timeframe for recredentialing.

Ongoing monitoring

Ongoing monitoring consists of monitoring practitioner and or provider sanctions, or loss of license to help manage potential risk of sub-standard care to our members.

The health plan performs Primary Source Verification via the organization or entity that originally conferred or issued an element used in credentialing or the data bank/s to which those organizations report (e.g., state licensing boards, schools/training programs, certifying boards, NTIS), NPDB, professional liability carriers, Office of Inspector General (OIG), Office of Personnel Management. Please find the Credentialing Data elements and how they are validated in the following grid:

Data element/requirement	Sources
Valid, current, unencumbered license for the state/s in which the applicant will provide care for members	State Licensing Agency
Valid, current, unencumbered Drug Enforcement Administration or state narcotics registration (CDS)	National Technical Information Service (NTIS)
	Confirmation with the Drug Enforcement Agency (DEA) or Controlled Drug Substance (CDS) Agency
	Copy of the DEA or CDS Certification
Current active, in-force professional liability insurance	Provider's application including disclosure questions and release
	Copy of malpractice insurance face sheet
Work history	Provider application
	Curriculum Vitae (CV)

Medicaid sanctions	Office of Inspector General (OIG)
	Office of Personnel Management (OPM)
	National Practitioner Data Bank (NPDB)
Malpractice insurance claim history	National Practitioner Data Bank (NPDB)
	Self-reported explanation from practitioner
Board certification	
• Physicians	American Medical Association (AMA)
	American Board of Medical Specialties (ABMS) or its member boards
	BoardCertifiedDocs.com
	American of Osteopathic Association (AOA) Physician Profile Report (web site)
• Podiatrists	American Board of Podiatric Surgery (ABPS)
	American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
• Medical Dentist	American Dental Association Counsel on Dental Education and Licensure (CDEL) Boards:
	- American Board of Endodontics
	- American Board of Oral & Maxillofacial Pathology
	- American Board of Oral & Maxillofacial Surgery
	- American Board of Orthodontics and Orthopedics
	- American Board of Pediatric Dentistry
	- American Board of Periodontics
	- American Board of Prosthodontics
	- American Board of Dental Public Health
• Advance Practice Nurse	State Licensing Agency
	National Committee for Certifying Agencies:
	- American Nurse Credentialing Center (ANCC)
	- American Academy of Nurse Practitioner (AANP)
	- Pediatric Nursing Certification Board (PNCB)
• Neuropsychologists	American Board of Clinical Neuropsychology
• Applied Behavior Analyst	Behavioral Analyst Certification Board
Residency/Post-graduate training	American Medical Association (AMA)
	American of Osteopathic Association (AOA) Physician Profile Report (web site)
	Federation Credentials Verification Service (FCVS)
	State Licensing Board (for DPM's ONLY)
	American Dental Association Counsel on Dental Education and Licensure (CDEL) Boards
	Residency/Training Institution
	American Medical Association (AMA)
	American of Osteopathic Association (AOA) Physician Profile Report (website)
	State Licensing Agency
	Medical/Dental/Chiropractic/Podiatrist School

Medical/professional school	Degree Verify
	ECFMG certificate or number for international medical graduates licensed after 1986
	American Dental Association Counsel on Dental Education and Licensure (CDEL) Boards
Disciplinary history or adverse actions related to licensure/certification	National Practitioner Data Bank (NPDB)
	State Licensing Agency
	Chiropractic Information Network/Board Action Databank (CIN-BAD)
Hospital privileges	Primary admitting hospital
	Provider's application including disclosure questions and release
Medical condition which may impair ability to practice medicine (reasons for any inability to perform the essential functions of the position, with or without accommodation)	Disclosure questions
	Curriculum Vitae (CV)
	Self-reported explanation from practitioner

Community-based, atypical and non-traditional providers

Aetna credentials non-medical community-based providers according to the requirements that best fit the standards of the profession in which they practice, or as required by the State. Providers in this category include home and transportation, and respite. In line with other traditional provider types, all HCBS, atypical and non- traditional providers must register with the HFS IMPACT system and have an active Medicaid number.

Any subsequent change in ownership or corporate structure that necessitates a new federal tax identification will also necessitate re-enrollment in the IMPACT system as participation and approval is not transferrable. Claims submitted by a new owner using the prior owner's assigned Medicaid ID number will not be accepted.

Data element/requirement	Sources
Valid, current, unencumbered business license for the state/s in which the applicant will provide care for members.	State Licensing Agency
Disclosure of ownership	System for award management
	Provider's application including disclosure questions and release
	Copy of the Disclosure of Ownership form
Current active in force professional/general liability insurance	Provider's application including disclosure questions and release
	Copy of insurance face sheet
Medicaid sanctions	Office of Inspector General (OIG)
	NPPES (National Plan and Provider Enumeration System)
	NPIDB (National Provider Identifier Database)

Discrimination laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act of 1990 as amended
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to

applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)
- Affordable Care Act
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164
- Title IX of the Education Amendments of 1972
- Titles XIX and XXI of the Social Security Act

In addition, our providers must comply with all applicable laws, rules, and regulations, and as provided in applicable laws, rules, and regulations, our providers are prohibited from discriminating against any member on the basis of health status.

Financial liability for payment for services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna. However, a provider may collect patient liability, client obligation or spenddown from members in accordance with the terms of the Member Handbook. Providers must agree to the following terms:

- Not to hold members liable for payment of any fees that are the legal obligation of Aetna; and must indemnify the member for payment of any fees that are the legal obligation of Aetna for services furnished by providers authorized by Aetna to serve such members, as long as the member follows Aetna rules for accessing services described in the approved Member Handbook.
- Not to bill a member for medically necessary services covered under the plan, and to always notify members prior to rendering services of their potential financial responsibility.
- Prior to furnishing a non-covered service, the member should sign a document notifying them that the service is not covered and that they agree to pay.
- When referring a member to another provider for a non-covered service, providers must verify the member is aware of his or her obligation to pay in full for such non-covered services and must obtain a signed document from the member notifying them that the service is not covered and that they agree to pay.

Recovery notifications

How to refund an overpayment

If you identify that you have received an overpayment, please submit the following information within 60 days of the identification:

- A check issued to Aetna in the amount of the overpayment
- The name and ID number of the member for whom we have overpaid (Include a copy of the member's Aetna ID card, if available)
- The dates of service
- Supporting documentation, including but not limited to:
    - A letter explaining the reason for the refund
    - A copy of your Remittance Advice
    - Any other documentation to assist in accurate crediting of the refund

Mail this information to the address(s) below.

If you are submitting a check:

Aetna Better Health of Illinois
Attention: Finance
PO Box 843083
Dallas, TX 75284-3083

If you are returning the original check issued by Aetna, please mail within 60 days to:

Aetna Better Health of Illinois
Attention: Finance
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Once we receive the information, we will process your identified overpayment.

Note: In the event of an overpayment and prior to any adjustment we make in future claims payments, we will notify the provider in writing within 12 months of the overpayment of a claim(s) with a detailed explanation of the request for reimbursement, the impacted claim(s), member's name, and dates of services. If cause for overpayment is by fraud or misrepresentation, this process is not applicable.

If a provider has concerns about the overpayment notice, the provider may contact us in writing and contest, within 30 business days of notice, to:

Aetna Better Health of Illinois
Attention: Provider Services
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

If Aetna does not receive a contest notice within the above timeframes, provider authorizes Aetna to recoup the requested reimbursement amount or current claims payments.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

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The tables on the following pages show what services we cover. Some limitations and prior authorization requirements may apply. To receive reimbursement, all services must be medically necessary.

Covered services		
Abortion services	Family planning services and supplies	Pharmacy services
Advanced practice nurse services	Home health agency visits	Physician services
Ambulatory surgical treatment center services	Hospice services	Podiatric services
Audiology services	Hospital ambulatory (outpatient) services	Preventive medicine schedule (services to members ages twenty-one (21) years or older)
Behavioral health services including - Community based services - Crisis services - Inpatient psychiatric services - Intensive outpatient services - Partial hospitalization services - Residential rehabilitation services	Hospital inpatient services	Renal dialysis services
Chiropractic services	Hospital emergency department services	Sub-acute alcohol and substance abuse services
Clinic services	Imaging services	Telehealth services
Dental services	Laboratory services	Transportation to secure covered medical services
Durable medical equipment	Long-term care services	
Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) services for members age twenty-one (21)	Medical supplies, equipment, prostheses and orthoses	

Value-added benefits

In addition to the services listed above, value-added benefits are also available to members. Please note that there are no grievance and appeal rights for these benefits.

No-cost cell service

Members may be eligible for Assurance Wireless Lifeline cell service plus an Android™ smartphone. We know how important it is to stay connected to health care, jobs, emergency services and family. That's why Aetna partners with Assurance Wireless Lifeline service.

Each month, eligible Assurance Wireless customers receive the following at no cost:

- Data
- Unlimited texts
- Voice minutes
- Plus, an Android Smartphone

A member may qualify for this service if they are on certain public assistance programs, like Medicaid or Supplemental Nutrition Assistance Program (SNAP).

Baby essentials

Pregnant members can receive a car seat or highchair OR play yard, plus a diaper bag. To qualify, members need to:

- Complete a health risk screening
- Complete 1 prenatal appointment within first four months of pregnancy; or for new enrollees, 1 prenatal visit within 42 days of enrollment

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

- Child to complete 6 well-child visits by 15 months; complete an additional 2 visits by 30 months

Healthy kids

Members in grades K through 12 (ages 5 through 18) can get a voucher for clothing through select online retailers.

Members ages 5–21 can get an annual stipend for healthy activities and/or programs. To qualify for kids clothing and the activity stipend, members need to:

- Complete a health risk screening
- Complete an annual wellness visit
- Be up-to-date on all immunizations

Fitness and weight management

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

Members ages 18 and up can receive a voucher to cover weight management app membership. To qualify for gym membership and weight management app, members need to:

- Complete a health risk screening
- Complete an annual wellness visit
- Fill out a member marketing consent

Healthy living

Members ages 18 and up can get monthly subscription fees covered for certain grocery delivery apps. To qualify, members need to:

- Complete a health risk screening
- Complete an annual wellness visit
- Fill out a member marketing consent

Members ages 18 and up can get personal nutrition counseling services. You may also get food assistance. To qualify, members need to:

- Complete a health risk screening
- Complete an annual wellness visit
- For food assistance, have a diagnosis of either Diabetes Mellitus (type 2), congestive heart failure or chronic kidney disease (stage 3-5)

Educational support

Members ages 18 and up can receive career training, skill building and GED support through CampusEd. To qualify, members need to:

- Complete a health risk screening
- Complete an annual wellness visit
- Fill out a member marketing consent

Behavioral health wellness

Members ages 12 and up can receive a voucher to cover behavioral health wellness app membership. To qualify, members need to:

- Complete a health risk screening
- Complete an annual wellness visit
- Fill out a member marketing consent

In the event a benefit changes, we will notify providers 30 days in advance.

Rewards program

Aetna® Better Care Rewards is a program that lets members earn rewards for completing healthy activities. Activities include wellness checks, immunizations, prenatal care and cancer screenings.

Members get rewards on a gift card that can be used to shop in store or online at participating retailers. A full list of healthy activities and rewards is available at **AetnaBetterHealth.com/Illinois-Medicaid/Rewards-Program**.

Nurse Advice Line

When our members have questions about their health, their primary care provider and/or access to emergency care, we are here for them. Aetna Better Health of Illinois offers a 24/7 Nurse Advice Line service to encourage members to talk with their physician and to promote education and preventive care.

Registered nurses provide basic health education, nurse triage and answer questions about urgent or emergency access. The staff often answers basic health questions but is also available to triage more complex health issues using nationally recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use the Nurse Advice Line to request information about providers and services available in their community after hours, when the Member Services department is closed. The staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse on a daily basis. If you have any additional questions, please call Provider Services or the Nurse Advice Line at **1-866-329-4701 (TTY: 711)** and follow the prompts.

Maternity program

A healthy pregnancy begins with the timely identification of pregnant women, an initial comprehensive assessment and ongoing assessment of risk, and interventions designed to address identified risks. Providers play a key role in this process. Providers are encouraged to notify Aetna Better Health of Illinois when they are aware of a member's pregnancy. This occurs through the completion of the Notification of Pregnancy (NOP) Form.

After the level of risk is determined, our team of highly skilled clinicians (including the OB Medical Director, OB nurses, social workers, behavioral health clinicians and support staff) will work with your team, nurse midwives, doulas, perinatologists, other specialists, and the member to ensure that members at greatest risk for an adverse pregnancy outcome have access to the care, resources and supports they need. Women who are less at risk will also receive care coordination commensurate with their needs. At a minimum, all pregnant women will be screened within two weeks of the beginning of each trimester to determine if the member has any health or service needs and to assist with those needs and also to determine if the member has developed any high-risk pregnancy issues, including the need for 17-P or any other specialty care.

This specialized Care Management will occur from the point the NOP is received, or the plan is otherwise notified of a member's pregnancy through at least day 84 of the postpartum period. Members who require additional support may receive Care Management for one year after delivery. Members always have the right to decline or elect to discontinue care management services at any time.

Transportation

Members can schedule transportation to and from a medical visit. Call Member Services two business days in advance and ask for a transportation specialist, and they will arrange appropriate transportation.

Community Health Services

Community Health Services is the Aetna Better Health of Illinois outreach program designed to provide coaching and education to our members on how to access health care and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link Aetna and the community

served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Aetna Better Health of Illinois within the community. The program has various components that can be provided depending on the needs of the member.

Community Health Worker Program Health Services representatives are non-clinical outreach employees hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.

These representatives are an integral part of our Integrated Care Team which benefits our members and increases our effectiveness. Representatives will make home visits to members we cannot reach by phone or that require a face-to-face approach. They assist with member outreach, conduct member home visits, coordinate with social services and attend community functions to provide health education and outreach. Community Health Worker Program Community Health Services works with providers to organize healthy lifestyle events and works with other local organizations for health events. To refer a member, contact us at **1-866-329-4701 (TTY: 711)**.

Care coordination

As a part of Aetna Better Health of Illinois services, disease management programs are offered to members. Components of the programs available include:

- Increasing coordination between medical, social and educational communities.
- Severity and risk assessments of the population.
- Profiling the population and providers for appropriate referrals to providers.
- Ensuring active and coordinated physician specialist participation.
- Identifying modes of delivery for coordination care services such as home visits, clinic visits, and phone contacts depending on the circumstances and needs of the member and his/her family.
- Increasing the member's and member's caregiver ability to self-manage chronic conditions.
- Coordination with an Aetna Better Health of Illinois care coordinator for case management services.

The disease management programs target members with selected chronic diseases which may not be under control. The new members are assessed and stratified in order to accurately assign them to the most appropriate level of intervention. Interventions may include mailed information for low intensity cases, telephone calls and mailings for moderate cases, or include home visits by a care coordinator for members categorized as high risk. In addition, Aetna Better Health of Illinois provides telemonitoring services to the highest-risk members. These home wireless biometric monitoring devices will allow care coordinators and treating Providers to monitor key health indicators and provide opportunities for real-time, "teachable moment" interventions.

To refer a member for disease management, call **1-866-329-4701 (TTY: 711)**.

Telemedicine

Telemedicine services are available to members and may be provided as medically necessary. Telemedicine is the delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. These services include telehealth and remote patient monitoring. Telemedicine services expand both the access and the reach of network providers, while increasing access for members in rural and underserved areas as well. Telemedicine services are provided with an aim to increase care coordination and continuity and address gaps in care through the use of innovative technologies.

Telehealth is the delivery of physical or behavioral health care services or consultations through the use of a real- time two-way audio-visual platform. Providing telehealth services to our members can break down access barriers and help our members receive high quality care where and when they need it. Telehealth also provides an easy-to- use option for providers to deliver, and members to receive care. Member can be referred or can self-refer and be connected to licensed professionals, receiving answers to general health questions or medical services.

Practitioners who have been identified through outreach or who have expressed an interest in participating in telehealth services provision are given access to the web-based platform. They receive education on the use of the telehealth platform and how to

conduct virtual e-visits with their patients.

Remote patient monitoring is the remote monitoring of a member's vital signs, biometrics, or other subjective data through a device that transmits this information to a clinician for analysis, storage, and when indicated, intervention. Through the Remote Patient Monitoring program, members with chronic or high-risk conditions such as congestive heart failure and diabetes will receive member-centric in-home health management support focused on early intervention, self-management and adherence to a prescribed plan of care. Members enrolled in the Remote Patient Monitoring program receive a kit with plug-and-play, Wi-Fi enabled devices that measure, and record results obtained by the member during a daily health session. The results can include vital signs and biometrics such as blood pressure, weight, or blood sugar, as well as subjective data such as responses to surveys or presentation of educational material. Participation is voluntary, and members can be referred to the program by their health plan care manager, their primary care provider, a network Specialist or even self-refer. Practitioners are actively included in the program and given access to the monitoring tools to follow the progress of their patients. In addition, network providers have access to detailed information and materials to introduce their patients to the Remote Patient Monitoring program.

Spenddown

The Medically Needy program offers coverage to people who have income over the maximum allowable income standard. The spenddown amount is the member's share of their family's medical bills. The spenddown amount is like an insurance deductible. If the member has a spenddown amount, they are responsible for that amount and we would only pay any medical bills over that amount.

A spenddown can be set for members who fall into one or more of the following groups:

- Pregnant women
- Children under the age of 19
- Seniors age 65 and over
- Persons determined disabled by Social Security

The member's spenddown amount is different for every family. The eligibility worker determines the amount of the spenddown amount and sends a letter to the member outlining the amount. A medical card is sent for each person in the member's family who lives with them and is on their spenddown program. Members are informed that the medical card will not pay any bills until the spenddown amount is met. Members on a spenddown will give the medical card to their provider while in the "unmet" status in order for the provider to bill. Although the provider bills, the amount is not paid. However, that amount is deducted from the members overall spenddown amount. If the member has any questions, please ask that they call Member Services at **1-866-329-4701 (TTY: 711)**.

Long Term Services and Supports (LTSS)

Some of our members are eligible for LTSS. To qualify for LTSS, a member must meet the state's criteria for needing an institutional level of care or be at imminent risk of being institutionalized without services, as well as meet certain financial requirements. A member does not need to reside in a nursing facility or some other institutional facility to get LTSS. A member can get these services in their home or supportive living facility

Home and Community Based Waivers (HCBS)

Aetna Better Health of Illinois manages home and community-based services (HCBS) waivers for our members. These services are provided to members to assist them in remaining out of nursing homes and live independently in the community. Aetna Better Health of Illinois is responsible for managing the following HCBS waivers:

- Persons who are Elderly Waiver: For individuals 60 years and older that live in the community.
- Persons with Disabilities Waiver: For individuals that have a physical disability
- Persons with HIV or AIDS Waiver: For individuals that have been diagnosed with HIV or AIDS.
- Persons with Brain Injury Waiver: For individuals with an injury to the brain.
- Supportive living programs for individuals who need assistance with the activities of daily living, but do not need the care of a nursing facility.

Long-Term Care (LTC)

Aetna Better Health of Illinois manages room and board for members that reside in Long-Term Care (LTC) facilities. This also includes managing their medical, behavioral health, dental, vision and pharmacy benefits. If member's eligibility changes mid-month, file the reconsideration with a copy of the MEDI screenshot.

Managed Long-Term Services and Supports (MLTSS)

For members with Managed Long-Term Services and Support (MLTSS) benefits, some services are covered by Medicaid, by Medicare, and by Aetna Better Health of Illinois. Aetna covers the services available in HCBS waivers and LTC. If member's eligibility changes mid-month, file the reconsideration with a copy of the MEDI screenshot. MLTSS services include:

- MLTSS Services covers LTC, HCBS waiver services (excluding DD waivers), non-Medicare outpatient behavioral health, and non-emergency transportation. Medicaid FFS covers many services not covered by Medicare or the MCO.

Long-Term Support Services (LTSS) care coordination

Members who are eligible for LTSS are assigned a care coordinator for as long as they are eligible for the LTSS program. The member's care coordinator will work with you (the provider), the member and their representative or guardian (if applicable) to help decide which services will best meet the member's needs.

Service plan

Aetna follows the DHS policy specific to the development, monitoring and evaluation of the Service Plan, and participated in internal and regulatory audits to ensure compliance with rules and regulations.

The service plan will be sent to waiver service providers in the form of an authorization. You will be expected to provide service hours up to the limit outlined by the authorization. Your monthly billing should include the monthly service report outlining any service plan deviations and the reason for those deviations. The forms can be emailed to **ABHILHCBS@Aetna.com**. The Care Coordination Team will contact you and/or your agency, as applicable, to discuss how things are going with our members at a minimum of a quarterly basis. This is your opportunity to discuss any trends you see with our members, unmet needs that have developed from your perspective and any other relative information related to the quality of care for our HCBS waiver members.

Billing should be submitted to our plan only for services rendered. Your billing needs to be submitted within six (6) months of the provision of those services. If you have any questions regarding your authorization, first review it in the portal. If this does not provide enough information, please reach out to the waiver authorization team at **ABHILHCBS@Aetna.com**. Illinois will honor any existing service plan for a period of 90 days (COC – continuity of care) for any member beginning their enrollment with the plan.

Medical necessity

Medically necessary services are accepted services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria and guidelines.

If you are not already registered for Availity, or if you have questions or would like to get training on the secure provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Services department at **1-866-329-4701 (TTY: 711)**.

Emergency services

Aetna covers emergency services without requiring prior authorization for members, whether a contracted or non-contracted provider provides the emergency services. Aetna will not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

Aetna recognizes treatment for an emergency medical condition or cases in which prudent layperson, who possesses an average knowledge of health and medicine, reasonably thought that the absence of immediate medical attention would result in at least one of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part; when the absence of immediate medical attention would not have resulted in placing the individual in serious jeopardy, pursuant to 42 C.F.R. § 438.114

Aetna abides by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Emergency transportation

If a member has an emergency and has no way to get to a hospital, please have them call 911. Effective with dates of service beginning April 1, 2021, emergency ground ambulance services have been carved out from the HCI managed care plans' contracts. MCOs will cease paying any emergency ground ambulance claims with dates of service on or after April 1, 2021. Claims for emergency ground ambulance services must be billed directly to the Department for persons covered under one of the HCI managed care plans.

Non-emergency transportation

Aetna members can receive non-emergent transportation services through ModivCare Solutions LLC. For routine appointments, transportation requests should be scheduled two (2) business days in advance. To find out how a member can get a ride to his/her doctor's appointment, please reference the contact information below:

Members can schedule a ride through (reservations): **1-866-329-4701 (TTY: 711).**
The member should have the following information when calling to schedule transportation:

- Name of the doctor
- Address
- Telephone number
- Appointment date and time
- Type of transportation needed (e.g., regular car, wheelchair-accessible van)

If the member has an urgent need for transportation, have them contact Member Services to request assistance with the urgent request.

Effective with dates of service beginning January 1, 2022, non-emergency ground ambulance services have been carved out from the Aetna Better Health of Illinois. The member or the care coordinator must contact First Transit via Passport system (**PassPORT Login ft-passport-il.com**) or by phone at **1-866-503-9040** to secure non-emergent ground ambulance requiring Advance Life Support or Basic Life Support level of service.

Laboratory services – Lab Corp

Lab Corp provides laboratory services. If a member has questions about lab services, please have them visit the Lab Corp website at **LabCorp.com**. If a member and/or provider have questions about lab services, please call Lab Corp at **1-888-522-2677**.

Pharmacy services

You can find a more comprehensive description of covered services in Chapter 15.

Vision services – March Vision

March Vision provides vision services. March Vision covers the following services for members:

- For members under age 21, one preventative vision exam, eyeglasses and repairs as needed
- For members over age 21, one preventative vision exam and eyeglasses or contact lenses, along with $50 to use for non-covered vision services.

If a member has questions about vision services, please have them call March Vision at **1-866-376-6780**. If a provider has questions, please call **1-844-456-2724** or go to **MarchVisioncare.com**.

Dental services – DentaQuest

Dental services are provided through DentaQuest. If a member has questions about dental services, please have them call DentaQuest at **1-888-286-2447**. If a provider has questions, call **1-800-508-6780** or go to **Dentaquest.com**.

Interpretation services

Telephonic interpretive services are available at no cost to members. Personal interpreters, sign language services are also available. These services can be arranged in advance by calling Member Services at **1-866-329-4701 (TTY: 711)**.

Mental Health/Substance Use Disorder (MH/SUD) services

We define behavioral health as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Substance use disorders include inability to control the use of alcohol and other drugs. To meet the behavioral health needs of our members, Aetna Better Health® of Illinois supports a continuum of services for members at risk of or experiencing g mental health and substance use disorders We have contracted with experienced h behavioral health providers to support the behavioral health needs of our population.

We work collaboratively with health care providers, including Community Mental Health Centers (CMHCs) and Community Developmental Disability Organizations (CDDOs), as well as a variety of community agencies and resources to successfully meet the needs of members with mental health and substance use disorders.

Assessments

Aetna Better Health of Illinois will administer a health risk screening tool, which includes behavioral health risk, to all new enrollees within 60 days after enrollment. This and other tools are utilized to support the health care needs of our members.

Availability

Mental Health/Substance Use Disorder (MH/SUD) providers must be accessible to members, including telephone access, in order to advise members requiring urgent or emergency services. Mobile Crisis Response providers must see members within 90 minutes of referral from CARES and send IM-CAT and Crisis Safety plan to the health plan within 48 hours. If the MH/SUD provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged. We require MH/SUD providers to meet our contractual standards for urgent and routine behavioral health appointments. For a complete list, please see Chapter 5 of this manual.

Mobile crisis safety

In-network providers of Mobile Crisis Response Services, staff that is responsible for providing services, must hold the following credentials:

- Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional (QMHP);
- Qualified Mental Health Professional; or
- Licensed Practitioner of the Healing Arts

In-network providers providing Mobile Crisis Response Services for CARES to authorize and dispatch Mobile Crisis Response Services, shall be reimbursed by Aetna Better Health of Illinois. In the event that CARES is unable to dispatch the Mobile Crisis Response Service, CARES shall engage the fee-for-service SASS Program to ensure crisis response to the Enrollee. In the event that an Enrollee is screened, due to necessity, by a non-network provider of SASS services, Aetna Better Health of Illinois will pay for the screening at the Medicaid rate.

Provider requirements:

- Network Provider to educate Enrollees who may be eligible for the State-funded Family Support Program (FSP).
- Network Provider to deliver MCR services consistent with all service requirements established by the Department, including, but not limited to, those outlined in the Department's Handbook for Providers of Community-Based Behavioral Services, such as the usage of the IM-CAT as the standardized MCR screening tool and face-to-face response to the crisis location or arranging for an alternate, mutually agreed upon location when safety for Enrollee or Provider is a documented concern.
- Network Provider to provide immediate and sufficient Crisis and Stabilization services to stabilize an Enrollee in the community when at all possible and appropriate for the Enrollee

Behavioral health for children

There are enhanced documentation requirements for children ages 0-20 for Behavioral Health Acute providers. This requirement is in alignment with the HealthChoice Illinois Contract standards for transition of care.

As part of the discharge documentation, we'll be requiring that facilities provide:

- Medication reconciliation/summary
- Confirmation that PCP has been made aware of any new medication member has been prescribed during admission
- Confirmation of physical examination within 24 hours of admission
- Member-centered crisis safety plan
- Post-discharge follow up appointment details

Documents provided must include signature by the member and/or member's support (i.e., parent, guardian) as confirmation of receipt and understanding.

Residential treatment facilities must also provide the following information:

- Medication reconciliation/summary

Confirmation that PCP has been made aware of any new medication member has been prescribed during admission

- Confirmation of physical examination within 24 hours of admission to a behavioral health facility is required for all members, including adults

Pathways to Success

Pathways to Success is a program that provides intensive care coordination and additional home and community-based services for eligible members under age 21 with complex behavioral health needs. Providers will educate members who may be eligible about the benefits of the program and offer to complete an IM+CANS assessment to determine eligibility or refer to an appropriate provider for completion. Providers may also work with health plan representatives to coordinate an appointment and further education. Providers will comply with recommendations and requirements set forth by the Joint Pathways Oversight Committee convened by the Department as well the CCSO Provider Handbook located on the HFS website. The Joint Pathways Oversight Committee shall be responsible for monitoring and providing oversight of all components of Pathways administration and operation, including but not limited to:

- Provider network development
- Conducting provider audits and quality reviews
- Establishing standardized reporting templates and processes for Pathways providers and N.B. class members
- Reviewing process and outcome reports
- Establishing corrective action plans, incentive strategies or other quality improvement efforts with providers of Pathways services; and,
- Providing technical assistance and support to providers in the implementation of Pathways

Referral process for members needing mental health/substance use disorder assistance

Members can self-refer to any participating MH/SUD provider within our network without a referral from their Primary Care Provider (PCP).

Continuity of care

When members are newly enrolled and have been previously receiving behavioral health services, Aetna Better Health® of Illinois will make the best efforts to maximize the transition of members care by providing for the transfer of pending prior authorization information and work with the member's provider to honor those existing prior authorizations.

PCP role in behavioral health services

We promote early intervention and health screening for the identification of behavioral health symptoms and patient education. We expect providers to:

- Screen, evaluate, treat and refer (as medically appropriate) any behavioral health symptom/disorder
- Treat mental health and substance use disorders within the scope of their practice
- Inform members on how and where to obtain behavioral health services
- Promote and maintain the continuity, coordination and integration of members behavioral and physical health services. Understand that members may self-refer to an Aetna Better Health of Illinois behavioral health care provider without a referral from the member's PCP

Coordination between behavioral health and physical health services

We are committed to coordinating medical and behavioral health care for members who are appropriately screened, evaluated, treated and referred for physical health, behavioral health, or substance use disorder, dual, or multiple diagnoses, or developmental disabilities. With the member's permission, our care coordination staff can facilitate services related to substance use screening, evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. We encourage PCPs to use behavioral health screening tools, treat behavioral health issues within their scope of practice and refer members to behavioral health providers when appropriate. Providers screen members seen by behavioral health providers for co-existing medical issues. Behavioral health providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. We ask MH/SUD providers to communicate any concerns regarding the member's medical condition to the PCP, with the members consent, if required, and work collaboratively on a plan of care.

We share information with participating behavioral health and medical providers to verify interactions with the member resulting in appropriate coordination between medical and behavioral health care.

BH providers should communicate and coordinate with the member's PCP and with any other behavioral health service providers whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered to the member. Examples of some of the items to be communicated include:

- Prescription medication
- Results of health risk screenings
- If the member is known to misuse over the counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment
- If the member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse)
- If the member's progress toward meeting their goals was established in their treatment plan

BH providers can identify the name and contact information for a member's PCP by performing an eligibility inquiry on the Aetna Better Health of Illinois Provider Portal or by contacting Provider Services.

Practitioners should screen for the existence of co-occurring mental health and substance use conditions and make appropriate referrals. Practitioners should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES

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Aetna Better Health® of Illinois is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year.

Treating a member with respect and dignity can often improve health outcomes. Providers must comply with member rights and responsibilities, especially treating members with respect and dignity. Understanding member rights and responsibilities is important because you can help members to better understand their role in and improve their compliance with treatment plans.

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

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

Members have the following rights and responsibilities:

Member rights

All members, their families, powers of attorney and guardians have the right to information related to their treatment or treatment options in a manner and language appropriate to the member's condition and ability to understand. This includes, but is not limited to:

The member's rights and responsibilities and the member's freedom to exercise those rights without negative consequences. The member's rights include the right to:

- Be treated with respect and with due consideration for the member's dignity and privacy.
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Participate in decisions regarding the member's health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of the member's medical records, and to request that the records be amended or corrected.
- Exercise the member's rights, with the assurance that the exercise of those rights will not adversely affect the way the member is treated.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization's member rights and responsibilities policy.

In addition, members have the following rights:

- Each member will receive information in accordance with 42 CFR § 438.10.
- A right to information regarding applicable copays or other costs for which the member is responsible.
- A right to treatment that is nondiscriminatory based on race, color, national origin, age, disability or sex.
- A right to receive information and treatment considerate of members' cultural or ethnic backgrounds that considers members' language limitations/reading needs and limitations, and visual or auditory limitations.
- A right to free interpreter services for members with limited English proficiency or with hearing impairments.
- A right to receive information about advance directives and to execute or nullify advance directives

- A right (of the member or member's authorized representative) to access member records in accordance. with applicable federal and state law, including Health Insurance Portability and Accountability Act (HIPAA)
- A right for members or members' authorized representatives to request amendments and corrections to the member's medical record in accordance with law.
- A right to choose a primary care provider from our network.
- A right to a second opinion from an appropriately qualified participating health care professional at no cost to the member. If a network provider is not available, we will arrange for a second opinion out-of-network at no more cost to the member than if the service was obtained in-network.
- A right to obtain emergency care without prior approval from us or the member's PCP regardless of whether the emergency care facility is in network.

Member responsibilities

Aetna Better Health of Illinois members, their families, or guardians have the responsibility to:

- Supply information (to the extent possible) that we and our practitioners and providers need to provide care
- Follow plans and instructions for care that have been agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the best degree possible
- Read the Member Handbook and other plan documents that convey information pertinent to utilizing services and working with the health plans
- Follow our rules explained in the Member Handbook and other plan documents
- Know the name of their assigned PCP and care coordinator
- Show their identification (ID) card to each provider and pharmacy before obtaining services
- Protect their member ID card and to report lost or stolen ID cards to the health plan
- Use the emergency room (ER) for true emergencies only
- Schedule and keep appointments with providers and practitioners, allowing for 24-hour notice when the appointment must be changed or canceled
- Treat the providers, practitioners and other staff with respect
- Inform the health plan and the Clearinghouse when the member's address or phone number changes
- Report family changes that might affect eligibility or enrollment to the Clearinghouse including changes in family size, employment and movement out of state
- Report other health insurance coverage, including Medicare, to the health plans and the Clearinghouse
- Provide the treating practitioner with a copy of the member's living will and advance directive as applicable

Member rights under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in and have access to program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People with a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members on the basis of disability may not:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services or other benefits
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

CHAPTER 8: ELIGIBILITY AND ENROLLMENT

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To become a member with Aetna Better Health® of Illinois, a member must first be eligible for Medicaid.

Our members may include individuals that fall into one or more of the following categories:

- All Medicaid recipients
- Seniors 65 years of age and older
- Individuals ages 19 and older who receive benefits under the Aged, Blind, and Disabled (AABD) program
- Disabled individuals receiving Supplemental Security Income (SSI)
- Eligible pregnant women and their babies up to one year of age
- Families (and/or Caretakers) responsible for a child 18 years of age or younger
- Beneficiaries receiving long-term care, including institutional care, HCBS and Money Follows the Person (MFP)
- Youth whose care is subsidized by DCFS, as well as through DCFS's adoption and foster care assistance programs

Open enrollment

Members have the option to change health plans during the initial 90 days after the effective date of enrollment. Thereafter, members can change health plans annually during open enrollment.

ID card

Members should present their Aetna Better Health of Illinois ID card at the time of service. The ID card notes whether the member has a copay. Currently, our members do not have copays.

The member ID card contains the following information:

- Member name
- Member ID number
- Date of birth of member
- Member's gender
- PCP name
- PCP phone number
- Effective date of eligibility
- Claims address
- Health plan name: Aetna Better Health of Illinois
- Aetna Better Health of Illinois logo
- Aetna Better Health of Illinois website address
- Carrier Group Number
- RX Bin Number
- RX PCN Number
- RX Group Number
- CVS Caremark Number (for pharmacists use only)

Sample ID card

Verifying eligibility

Presentation of an Aetna Better Health of Illinois ID card is not a guarantee of eligibility or reimbursement. The provider is responsible for verifying a member's current enrollment status before providing care. We will not reimburse for services provided to members not enrolled with the health plan. Providers can get the most up-to-date eligibility information at HFS's **Medical Electronic Data Interchange (MEDI) system**. Providers can also verify member eligibility online through the Secure Web Portal at **AetnaBetterHealth.com/Illinois-Medicaid** or by calling the Member Services department at **1-866-329-4701 (TTY: 711)**.

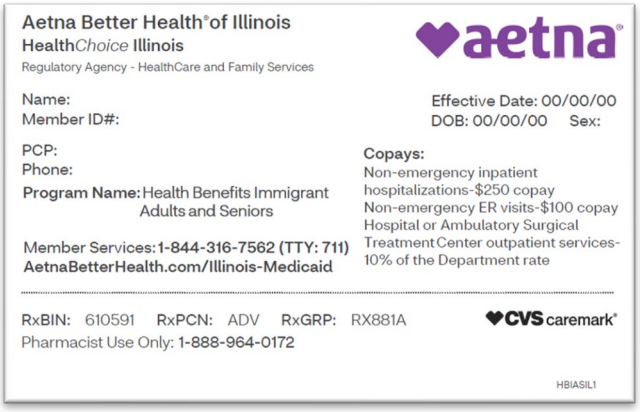
Health benefits for immigrant adults and seniors (HBIA and HBIS)

Effective January 1, 2024, Aetna Better Health® of Illinois will serve the Health Benefits for Immigrant Adults (HBIA) and Health Benefits for Immigrant Seniors (HBIS). These populations were previously covered under Fee for Service.

The HBIS program provides health care coverage to qualifying individuals ages 65 and older. The HBIA program provides similar coverage for individuals ages 42 to 64. Members covered by HBIA and HBIS are current Medicaid populations who are moving into managed care. The programs are closed and are not accepting new applications.

HBIA and HBIS members will have a copay for certain services. Application of copays will begin for claims with dates of service on or after February 1, 2024. Learn more about copays, covered and noncovered services on the provider website Notices and Newsletters page.

Sample ID card for HBIA and HBIS members



CHAPTER 9: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

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The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive health program for individuals under the age of 21. The EPSDT Program was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.

The EPSDT Program consists of two mutually supportive, operational components:

1. Assuring the availability and accessibility of required health care resources
2. Helping members and their guardians effectively use these resources

These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention, health services and assistance available to them; to provide them and their families the tools on how to use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations in order to diagnose and treat any health problems found before they become more complex and their treatment costlier.

Handbook for Providers of Healthy Kids Services – EPSDT-specific requirements

Illinois has adopted the Periodicity Schedule located in the "Handbook for Providers of Healthy Kids Services. The handbook

can be found here: **Illinois.gov/hfs/MedicalProviders/Handbooks/Pages/HK200.aspx.**

EPSDT services

EPSDT services include:

- A comprehensive health and developmental history including assessments of both physical and mental health and the provision of all medically necessary diagnostic and treatment services to correct or ameliorate a physical or mental condition identified during a screening visit.
- A comprehensive physical examination including vision and hearing screening; dental inspection; and nutritional assessment.
- Appropriate immunizations according to age, health history and the schedule established by ACIP for pediatric vaccines. Providers must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits and necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented.
  - Appropriate laboratory tests i.e.:
    - Hemoglobin/Hematocrit/EP
  - Urinalysis
  - Tuberculin Test – intradermal, administered annually and when medically indicated
  - Lead screening using blood lead level determinations must be done for every Medicaid-eligible and person:
    - Between 9 months and 18 months, preferably at 12 months of age
    - At 18-26 months, preferably at 24 months of age
    - Test any child not previously tested
  - Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and obtained as necessary
- Health education/anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable or require maintenance therapy uncovered or suspected (referral may be to the provider conducting the screening examination, or to another provider, as appropriate)
- EPSDT screening services reflect the age of the child and are provided periodically according to the following schedule:
  - Neonatal exam

- 3 – 5 days after birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Annually through age 20 years

Identifying barriers to care

Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that less than 50% of children in the study sample received any documented EPSDT services. To address this, we instruct our Member Services and care coordination staff to identify potential barriers to care during communications with members, their family/caregivers, PCPs, and other relevant entities and work to help members maintain access to services.

Examples of barriers to preventive care we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Linking members with other needed community-based support services
- Arranging block scheduling for EPSDT services

Aetna Better Health of Illinois closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. We also notify members annually of their eligibility for EPSDT services and encourage the use of the services.

Educating members about EPSDT services

Aetna Better Health of Illinois informs members about the availability and importance of EPSDT services, including information regarding wellness programs that we offer, through the following avenues:

- Member Handbook and Evidence of Coverage
- Member newsletters and bulletins
- Aetna Better Health of Illinois website
- Educational flyers
- Reminder postcards
- Care plan interventions for high-risk members enrolled in care coordination

Provider responsibilities in providing EPSDT services

Participating providers are contractually required to provide EPSDT screenings and immunizations to children aged birth to 21 years of age in accordance with Bright Futures/AAP periodicity schedule, including federal and state laws standards and national guidelines (i.e., American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and as federally mandated). Details of required services are found under "EPSDT Services" shown above. Additionally, participating providers are contractually required to:

- Comply with our Minimum Medical Record Standards for Quality Management, EPSDT Guidelines, and other requirements under the law
- Cooperate with our periodic reviews of EPSDT services, which includes chart reviews to assess compliance with standards
- Report members' EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form
- Document in medical record and follow-up on missed or cancelled appointments, including contacting members or their parents/guardians after a missed EPSDT appointment to reschedule
- Have systems in place to document and track referrals including those resulting from an EPSDT visit. The system should document the date of the referral, date of the appointment, and date information is received verifying the appointment occurred

We require providers to make the following recommended and covered services available to EPSDT-eligible children, at the ages recommended on the state Medicaid regulator's periodicity schedule:

- Immunizations, education and screening services provided at recommended ages in the child's development, including all of the following:
  - Comprehensive health and developmental history (including assessment of both physical and mental health development)
  - Comprehensive physical exam
  - Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines
  - Laboratory tests
  - Health education/anticipatory guidance: Health education is a required component of screening services and includes anticipatory guidance. The physical or dental exams provide the initial context for providing health education. Health education and counseling to both parents (and guardians) and children is required. This is designed to assist in understanding what to expect in terms of the child's development, and to provide information about the benefits of healthy lifestyles, practices, as well as accident and disease prevention.
  - Vision services, including periodic screening, treatment for defects in vision, including eyeglasses
  - Dental services, including oral screening, periodic direct referrals for dental examinations according to the state periodicity schedule, relief of pain and infections, restoration of teeth, and maintenance of dental health
  - Hearing services, including, at a minimum diagnosis and treatment for defects in hearing, including hearing aids
  - Lead toxicity screening consists of two components: verbal risk assessment and blood lead testing in accordance with CMS and IL state requirements.
- Diagnostic services, including referrals for further evaluation as indicated through a screening examination
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services

Provider monitoring

The methods we utilize to monitor our providers' and members' compliance/success in obtaining the appropriate care associated with Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) include a multi- pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

1. Analysis and evaluation of provider utilization
   - EPSDT Audit and other provider office visits
   - EPSDT Compliance Report
2. Tracking and trending provider data
3. Evaluation of performance measures and outcome data including Healthcare Effectiveness Data, Information Set (HEDIS®) and EPSDT results (monitoring results on a monthly basis)

4. Review and tracking of member complaints, grievances, and appeals and provider complaints to identify trends
    - Peer review of quality, safety, utilization, and risk management referrals
    - Credentialing review activities
    - Review of gaps in care reports and analysis of data from PCP profiles and performance reports
    - Review of Critical Incidents
5. Monitoring network capacity and availability and accessibility to care delivery systems
6. Remediation due to survey fails (CAHPS, appointment/access/availability)

Our Provider Services team educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Services staff may take referrals from a provider to have a member outreached by care coordination staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Provider Services staff may also take referrals from providers who identify problems through EPSDT exams.

PCP notification

Aetna Better Health® of Illinois provides all PCPs with a list of members who have not had a visit or who have not complied with the EPSDT periodicity and immunization schedules for children.

Direct-access immunizations

Members may receive influenza and pneumococcal vaccines from any provider without a referral at no cost to the member if it is the only service provided at that visit.

Vision services

At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. The vision screening of an infant means, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment for each child beginning at three years of age.

Dental services

Dental services are not limited to emergency services. Dental exams in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at or after one year of age or soon after the eruption of the first primary tooth is mandatory. Thereafter, there must be, at a minimum, a dental visit twice a year with confirmation by the PCP during well child visits to verify that all needed dental preventative and treatment services are provided through the age of 20 years.

Mental health/substance use disorder

When there is an indication of possible MH/SUD issues, a MH/SUD screening tool is used to evaluate the member and pertinent findings are documented. Based on findings of the screening(s), necessary mental health and substance use referrals are made, and services/treatments are provided. If you experience EPSDT-related issues, please contact us.

CHAPTER 10: MEMBERS WITH SPECIAL NEEDS

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Members with special needs

Adults with special needs include our members with complex or chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders, and developmental disabilities. Members may be identified as having special needs because they are enrolled in HCBS waiver and, are homeless, or are living in institutional settings. Children with special needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition, youth in foster care, and those who require health and related services of a type or amount beyond that generally required by children. These children are identified by the state.

Aetna Better Health of Illinois has developed methods for:

- Promoting well-childcare to children with special needs who may be cared for by multiple subspecialists
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
- Diagnostic and intervention strategies to address the specific special needs of members
- Coordination and approval of home therapies and home care services when indicated
- Care coordination for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so long-term complications may be treated as necessary
- Care coordination systems to confirm that children with serious, chronic, and rare disorders receive appropriate and timely diagnostic work ups
- Access to specialty centers inside and outside of our network for diagnosis and treatment of rare disorders

The initial health screening for new members assists us in identifying those with special needs. We also review hospital and pharmacy utilization data. Additionally, we rely on you, our provider, to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care. Once identified, we follow up with a health risk assessment and comprehensive needs assessment (including condition specific assessments).

Aetna has policies and procedures to allow for continuation of existing relationships with out- of-network providers when considered to be in the best medical interest of the member.

Aetna develops service plans that address the member's service requirements with respect to specialist physician care, durable medical equipment (DME), medical supplies, home health services, social services, transportation, etc. Our care coordination and utilization management teams collaborate closely so all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out- of-network.

We work to provide immediate transition planning for a new member with complex or chronic conditions or any special needs. The transition plan includes the following:

- Review of existing service plans
- Preparation of a transition plan to maintain continual care during transfer to the plan
- Coordination and follow-through to approve and provide any necessary DME, if it was ordered prior to the member's enrollment with the health plan and was not received by the date of enrollment

Outreach and enrollment staff are trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English and they use our Relay system and American Sign Language interpreters, if necessary.

If upon enrollment or diagnosis a member requires very complex, highly specialized health care services, the member may receive care from a contracted specialist, or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center is responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, can treat the member without a referral from the member's PCP, and may authorize such referrals, procedures, tests, and other medical services. If approval is obtained to receive services from an out-of-network provider, the care is provided at no additional cost to the member. If our network does not have a specialist or specialty care center with the expertise the member requires, we authorize out-of- network care.

We arrange for the provision of dental services to members with developmental disabilities. At a minimum, dental services coverage provides:

- Consultations and assistance to the member's caregivers
- Adequate time for members with developmental disabilities, knowing that initial and follow-up comprehensive dental visits may require up to 60 minutes on average. Our standards allow for up to four visits annually without prior authorization.
- Home visits when medically necessary and where available
- Adequate support staff to meet the needs of the members
- Use and replacement of fixed, as well as removable, dental prosthetic devices as medically necessary and appropriate
- Reimbursement for preoperative and postoperative evaluations associated with dental surgery
- A dental management plan
- Processing of authorizations for dental required hospitalizations by consulting with our dental and medical consultants in an efficient and time-sensitive manner

After-hours protocol for members with special needs is addressed during initial provider trainings and in this Provider Manual. Providers must be aware that non-urgent conditions for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Nurse Advice Line is available 24 hours a day, 7 days a week for members with questions or concerns that can be dealt with after hours by a registered nurse.

We require our providers to confirm the use of the most current diagnosis and treatment protocols and standards established by the State of Illinois and medical community. During initial provider orientations, we highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

CHAPTER 11: CARE COORDINATION

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Care coordination

Aetna Better Health® of Illinois care coordination program consists of a team of registered nurses, licensed mental health professionals, social workers and non-clinical staff. The model is designed to help Aetna members obtain needed services and assist them in the coordination of their health care needs whether they are covered within the Aetna array of covered services, from the community, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice, large multi-specialty group setting, long-term care facility, supportive living facility, or a home and community-based service provider.

The program is based upon a coordinated care model that uses a multi-disciplinary care coordination team in recognition that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and the member's PCP to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for the early identification of members, completion of their needs assessment tools, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers, support services, as well as outcome monitoring and reporting back to the PCP. The PCP is included in the creation of the care plan as appropriate to assure that the plan incorporates considerations related to the medical treatment plan and other observations made by the provider. The care plan is made available to the provider in writing or verbally.

Our care coordination team will integrate covered and non-covered services and provide a holistic approach to a member's medical and behavioral health care, as well as functional, social, and other needs. Our program incorporates clinical determinants of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care coordination team is available to help all providers improve the health of Aetna Better Health of Illinois members. Contact us to refer a member for care coordination by calling **1-866-329-4701 (TTY: 711)**.

Transition-of-care coordination functions

Once the appropriate state agency determines eligibility, Aetna Better Health of Illinois will be responsible for all care coordination for Aetna members including those members who are part of the home and community-based waiver services and residing in long term care facilities or supportive living facilities.

Aetna has processes and procedures in place to ensure smooth transitions to and from Aetna care coordination to other plans/agencies such as another Managed Care Organization, the Department on Aging, the Department of Rehabilitative Services and the Department of Healthcare and Family Services. During transitions between entities, Aetna will assure 90 days of continuity of services and will not adjust services without the member's consent during that time frame.

Integrated care teams

Care coordinators are familiar with evidence-based resources and best practice standards specific to conditions common among Aetna members. These teams will be led by clinically licensed care coordinators who are experienced in working with people with physical and/or mental health conditions. In addition, a team will be specifically dedicated to assisting members with developmental disabilities. The teams will have experience with the member population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services.

Aetna will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care and education to assist members in making better health care choices.

Care plans

The following members "can" have a care plan developed and implemented:

- HealthChoice Illinois: Members in high and moderate acuity
- HCBS Waivers and LTC: All members

This care plan will be developed in conjunction with the member, his or her family and caregiver, as well as individuals in the member's care team. The member will agree to the developed care plan, and it will be shared with the member's primary care physician via mail.

For members receiving waiver services, the care plan will include services such as home health, home delivered meals, personal emergency response systems, adult day care, home modification, adaptive equipment, and more. Based on each member's plan, Aetna Better Health® of Illinois care coordinators will work directly with home and community-based services providers in order to execute the care plan. This includes securing the service with the provider and authorizing the number of hours/ units approved. The care coordinator will give an authorization number to the provider. The provider is then able to render the service that has been authorized.

The care coordination team will guide members through the process of obtaining covered services. Each member is assigned to a care coordinator. Care coordinators responsibilities include:

- Helping members obtain services
- Visiting members in their residence to assess health status, needs, and develop a care plan
- Communicating with providers on services that are authorized according to the care plan
- Discharge planning
- Supporting quality of life for members

Please contact the care coordination department for changes in a member's status, questions regarding services, or other member issues.

Transplants

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Aetna Better Health of Illinois medical management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

Model of care

Our person-centered model of care integrates behavioral health, physical health and social determinants of health to promote and support independence for the entire population we serve. Our model of care offers an integrated care coordination approach, with enhanced assessment and management for enrolled members. The processes, oversight committees, provider collaboration, and care coordination result in a comprehensive and integrated service plan for members. We utilize evidence-based practices for all members including those with special needs, such as children in foster care, children with intensive behavioral health needs, adults with behavioral health needs, individuals in an institutional setting, and individuals enrolled in HCBS waiver and other employment programs. We collaborate with child welfare agencies, criminal and juvenile justice systems, community service organizations such as Area Agencies of Aging (AAAs), targeted case management agencies, and educational systems to meet the needs of our members.

With our members at the center of all we do, our care coordination roles and responsibilities include the following, among others:

- Completion of health screening, health risk needs and condition-specific assessments
- Development, implementation, monitoring, and approval of a plan of service
- Disease management
- Trauma-informed care
- Physical health coordination
- Behavioral health coordination
- Transportation coordination
- Member contacts and home visits
- Linkage and referral to community resources and non-Medicaid supports
- Health and safety monitoring

- Education, employment, and housing support, including referrals, advocacy, and follow-up
- Coordination with case managers from child-placing agencies, CDDOs, ADRCs, CMHCs, etc.
- Chronic condition management
- Screening for depression, substance use, and other conditions impacting quality of life and wellness
- Transition of care support
- Options counseling and care coordination for independent living in the community from institutional care
- Referrals for home and community-based services
- Referrals for education, housing and employment supports
- Provider engagement and, outreach
- Facilitation of continuity of care
- Monitoring PCSPs

Our inclusive and integrated system of care includes a coordinated network of physical, behavioral health, and LTSS providers. Our program's combined provider and care coordination activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improving access to affordable care
- Promoting the provision of the right care in the least restrictive setting
- Supporting recovery and resiliency
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings and providers
- Promoting appropriate utilization of services and cost-effective service delivery
- Providing caregiver support, peer groups, and workshops
- Providing housing specialists to link members to resources for accessible housing, utility assistance, and resources for home modifications

Our efforts to promote cost-effective health service delivery include, but are not limited to the following:

- Review network adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- An integrated care coordination program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services
- Promote strategies and interventions to support member independence and living in the least restrictive environment whenever possible, which includes:
  - Safe housing needs
  - Services and supports to assist the member in the least-restrictive community setting
  - Comprehensive care including meeting the needs of the member's chronic conditions, and their functional and behavioral health needs
  - Medication management including mail order options
  - PCP visits post-transition as medically indicated
  - Clinical preventive services including adult screenings
  - Non-Medicaid covered community services to improve health and quality of life
  - Supported employment or volunteer work for members who choose this experience
  - A dedicated transition coordinator who works closely with our UM and care coordination staff to initiate transition planning activities and to evaluate the member's ability to transition to an alternative setting
  - Interdisciplinary care team that is connected to the array of resources necessary to help ensure members safely transition to alternative settings with sustainable success
  - Population health specialist to advance the capabilities and knowledge of our provider network by helping providers move along the continuum of value-based payment models
  - Support of provider partners to expand our capacity and expertise, such as increasing availability of alternative levels of care (e.g., medication-assisted treatment and intensive outpatient services for substance use)

Our care coordinators are responsible for identifying the member-centered cross-functional team. The cross- functional multidisciplinary team includes the member and circle of support, external stakeholders, community service organizations, advocacy organizations, and providers as appropriate to support initial service plan development for members with complex

conditions, transitions of care, etc.

Many components of our integrated care coordination program influence member health. These include:

- Bi-directional communication approaches, such as providing BH health education to physical health providers and vice versa
- Encouraging and incentivizing provider use of SBIRT, an evidence-based practice to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs, improving early initiation of treatment
- Training and incentivizing physical health and behavioral health providers on the use of Z-codes to identify and address social determinants of health and independence that affect the member's total health
- Consultative behavioral health services for primary care providers
- Comprehensive member assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care coordination elements help to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This promotes improved functional status and allows members to reside in the least restrictive environment possible.
- Assessments and service plans that identify a member's personal and social determinants of health and independence needs, which direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Care coordinator referrals and predictive modeling software that identify members at increased risk of functional decline, hospitalization, and emergency department visits.

Our care coordination program includes members in cohort groups required by the State and individuals with other conditions that benefit from care coordination, including high-risk members with substance use disorders, women with high-risk pregnancies, infants with neonatal abstinence, and members with chronic pain. All members are eligible for care coordination. Providers referring a member to care coordination can call Member Services, complete a care coordination referral form located on the website, or make a request through the provider portal.

Integrated care coordination and disease management

We designed our Integrated Care Coordination (ICC) to identify our most complex and vulnerable members with whom we have an opportunity to make a significant difference. We engage these members in integrated care coordination programs to remove or lessen barriers that limit their ability to manage their own health and well-being, to educate them about their chronic conditions, and to help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness, and availability of family or other supports.

We encourage autonomy and active self-management of acute and chronic conditions where clinically appropriate with tools and education directed at each member's unique needs and health literacy. A well-trained care coordinator serves as the single point of contact for the member. We collaborate with the member/member supports/integrated care team to create a service plan that includes mutually agreed upon member-centered goals and actions for the member/member supports. The care coordinator and the care team coordinate both covered and non-covered services for the member.

All members will receive person-centered outreach and follow-up, from those who are very healthy to those who are very sick or most at-risk due to their medical, behavioral, and social comorbidities.

We assign a care coordinator to all members identified as eligible for our Long-Term Services and Supports program and waiver programs who will provide care coordination activities with the member and their significant others. This will include a focus on helping the member achieve their health goals, live healthier lives, and reduce or prevent unnecessary institutional care.

The LTSS service care coordinator completes a comprehensive assessment which is inclusive of home and community-based service needs and works with the member and the interdisciplinary team on developing the PCSP that includes recommendations regarding amount, scope and duration of services. The service care coordinator works to ensure that signatures occur timely and that the approved, signed plan is distributed to members of the interdisciplinary team within fourteen days of the establishment of waiver eligibility. Service care coordinators work with providers to ensure that required signatures of the PCSP are collected prior to service delivery.

The Integrated Care Coordination (ICC) program reflects our belief that care coordination must address the member's medical, behavioral and social needs in an integrated fashion and must address the continuum of acute, chronic, and long-term services

and supports needs. Care coordination staff assists members in coordinating medical and behavioral health services as well as those available in the community or that are not covered in the member's benefits package.

Based on the member's needs, care coordinators use condition-specific assessments and service plan interventions to assist with chronic condition management, thereby including traditional "disease management" within the ICC process rather than it being managed separately. Members with diabetes, COPD, heart failure, asthma, depression, chronic kidney disease, bi-polar, schizophrenia, arthritis, hepatitis C, cancer, HIV and coronary artery disease are identified by our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk assessments, care coordination assessments, concurrent review/prior authorization referral, as well as member and provider referrals.

Any psychosocial issues and cognitive limitations are incorporated into the individualized service plan as are the cultural practices and beliefs that are most important to the member. We specifically address barriers to improving health and root causes of poor health outcomes to help both the care coordinator and the member better understand what has prevented full engagement with a suggested clinical treatment or service plan. Once the member identifies these issues and the care team is informed, truly individualized and collaborative service planning can begin.

The ICC program manages the unique needs of each member's experience. Whether they have short term acute needs, longstanding chronic health issues, or need information, resources, or care coordination, we tailor the program to each specific member's situation. Using available information, we employ clinical algorithms and care coordinator judgment to recommend a level of Integrated Care Coordination best suited to address the member's needs. If you have patients that need Integrated Care Coordination or you have any questions about these services, call Member Services.

Concurrent review overview

Aetna Better Health® of Illinois conducts concurrent review for each member admitted to an inpatient facility. Inpatient facility includes Acute Hospital, Skilled Nursing Facilities for skilled services only, Inpatient Rehabilitation and Freestanding Specialty Hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission and appropriateness of the level of care using the MCG® criteria (formerly known as Milliman Care Guidelines). We conduct admission certification within three days of receiving notification. Hospitals must notify us within 1 business day of an unscheduled admission.

We conduct continued stay reviews at a regular cadence throughout the course of the hospitalization.
We notify providers of approval or denial of length of stay in accordance with the clinical information received and partner with the Medical Affairs department (Medical Directors) in rendering these determinations. These determinations are communicated in alignment with the notification guidelines (see grid below).

We apply the MCG® criteria along with state and federal guidelines to verify consistency and appropriateness in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. We update MCG® criteria regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our concurrent review clinicians work with the hospital discharge team and attending physicians to verify that quality of care and early identification of member centric discharge needs are provided to ensure a seamless transition to the next most appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning is initiated
- Facilitating or attending discharge planning meetings for members with complex or multiple discharge needs
- Providing hospital staff and attending physicians with names of our providers (i.e., home health agencies, durable medical equipment (DME)/medical supply companies, other outpatient providers)
- Informing hospital staff and attending physicians of covered benefits as indicated
- Working with the care coordination team who will work with the provider and family to ensure comprehensive and member centered discharge planning and a safe transition back to the community.

Discharge from a Skilled Nursing Facility

All discharges from a Skilled Nursing Facility (SNF) will be coordinated with the member’s care coordinator. In accordance with federal law, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, for resident’s choice to transition, or for nonpayment (except as prohibited by Medicaid Title XIX of the Social Security Act. Regardless of the reason, the member, his or her representative, and the member’s care coordinator must be involved in discharge planning.

CHAPTER 13: PRIOR AUTHORIZATION

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PCPs or treating providers are responsible for initiating and coordinating a member's request for authorization. Providers are encouraged to utilize the Availity portal for authorization submission; this efficiency promotes efficacy in authorization submission and decision status.

The requesting practitioner or provider is responsible for complying with our prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims when indicated. We do not prohibit or otherwise restrict providers acting within the lawful scope of their practice from advising or advocating on behalf of an individual who is a patient and member of ours about the member's health status, medical care, or treatment options (including any alternative treatments that may be self- administered) including the provision of sufficient information to provide an opportunity for the member to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Emergency services

We permit emergency medical services to be delivered in or out-of-network without obtaining prior authorization if the member was admitted for the treatment of an emergency medical condition. Aetna Better Health of Illinois does not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms. We do not withhold payment from providers in or out-of-network. However, we encourage notification for appropriate coordination of care and discharge planning.

Post-stabilization services

We cover post-stabilization services under the following circumstances without prior authorization, whether or not a network provider provides the services:

- The post-stabilization services were approved by the health plan
- The provider requested prior approval for the post-stabilization services, but we did not respond within one hour of the request
- The provider could not reach the health plan to request prior approval for the services
- Our representative and the treating provider could not reach an agreement concerning the member's care, and our Medical Director was not available for consultation

Note: In such cases, we provide the treating provider an opportunity to consult with a Medical Director; therefore, the treating provider may continue with the member's care until a Medical Director is reached or any of the following criteria are met:

- The provider with privileges at the treating hospital assumes responsibility for the member's care
- The provider assumes responsibility for the member's care through transfer
- We and the treating provider reach an agreement concerning the member's care
- The member is discharged

Services requiring prior authorization

A link to our Secure Web Portal, located on our website, **AetnaBetterHealth.com/Illinois-Medicaid**, lists the services that require prior authorization, consistent with Aetna policies and governing regulations. We update the list annually and periodically as appropriate.

We do not reimburse unauthorized services, and authorization is not a guarantee of payment. All out-of-network services must be authorized.

Notwithstanding any other provision of law, if a claim is properly coded and submitted timeline to Aetna, payment shall be made in accordance with the terms of coverage for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one of the following occurs:

- The provider delivered services requiring prior authorization without obtaining approval first.

- Is it determined that the service was not actually provided.
- Services rendered were contrary to the instructions of the health insurance issuer of its contracted utilization review organization or delegated reviewer if contact was made between those parties before the services being rendered.
- Determination was made, based on review of the members enrollment, that the member was not eligible for the service rendered on that DOS
- Approval was based on a material misrepresentation by the patient or provider. "Material" means a fact or situation that is not minor or technical and would result in a significant change in the situation.

Exceptions to prior authorization

- Prior authorization for emergency services or post-stabilization services whether provided by an in-network or out-of-network provider
- Access to family planning services
- Retroactive eligibility, in which case, a retrospective review will be completed
- Aetna Better Health of Illinois shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim

Provider requirements

A prior authorization request must include the following:

- Current, applicable codes, which may include:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, 10th Edition (ICD-10 CM)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth and identification number of the member
- PCP or treating provider
- Name, address, phone and fax number, and signature, if applicable, of the referring provider
- Name, address, phone and fax number of the consulting provider
- Reason for the request
- Supporting objective clinical information, such as clinical notes, laboratory and imaging studies, comorbidities, complications, progress of treatment, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

Ways to request prior authorizations

- Submit the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health of Illinois website at **AetnaBetterHealth.com/Illinois-Medicaid**
- Fax the request form to **1-877-779-5234** for medical or **1-844-528-3453** for behavioral health. Copies of the form are available on our website: **AetnaBetterHealth.com/Illinois-Medicaid**. Use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.
- Call **1-866-329-4701 (TTY: 711)**

To check the status of a prior authorization request you submitted or to confirm we received the request, please visit the Provider Secure Web Portal at **AetnaBetterHealth.com/Illinois-Medicaid**, or call us at **1-866-329-4701 (TTY: 711)**. The portal allows you to check status and view authorization history.

For further information about the Secure Web Portal, please review Chapter 4 of this manual.

If you do not receive a response for non-emergency prior authorization within 14 days, please contact us at **1-866-329-4701 (TTY: 711)**.

Medical necessity criteria (physical and behavioral health)

Aetna Better Health of Illinois uses nationally recognized, community developed, evidence-based criteria to support prior authorization decisions, which are applied based on the needs of individual members and characteristics of the local delivery system. Service authorization staff who make medical necessity determinations are trained on the criteria, which are established and reviewed according to Aetna policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna uses the following medical review criteria. We review criteria sets annually for appropriateness to our population needs and update as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. We consistently apply the criteria, consider the needs of members, and allow for consultations with requesting providers when appropriate. The criteria are consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Aetna Better Health of Illinois Pharmacy Prior Authorization Clinical Criteria
- Applicable MCG® as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health of Illinois Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Illinois Policy Council Review

If MCG® states "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna CPBs, is consulted and utilized.

For prior authorization of outpatient and inpatient behavioral health services, Aetna Better Health of Illinois uses:

- Criteria required by applicable State or federal regulatory agency
- MCG-BH, LOCUS/American Society of Addiction Medicine (ASAM)
- Aetna Better Health of Illinois Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Illinois Clinical Policy Council Review

Medical, dental, and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Criteria for Long Term Services and Support (LTSS) and state plan only services are based on program benefits. We refer authorizations for LTSS to the member's assigned care coordinator and approval is based on the member's needs as identified through a comprehensive assessment and as aligned with the LTSS benefits.

Timeliness of decisions and notifications to providers and members

Aetna Better Health of Illinois makes prior authorization decisions and notifies practitioners and providers and applicable members in a timely manner unless otherwise required by the State of Illinois. We adhere to the following decision/notification time standards. We verify the availability of appropriate staff between the hours of 8:30 AM and 5:00 PM, 7 days a week, to respond to authorization requests within the established timeframes. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/notification requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Within 48 hours of receipt of the request	Practitioner/Provider	Oral or electronic
Urgent pre-service denial	Within 48 hours of receipt of the request	Practitioner/Provider and Member	Oral or electronic and written. Written must be no later than three calendar days after oral notification.
Non-urgent pre- service approval	Within 96 hours of receipt of the request	Practitioner/Provider	Oral or electronic

Decision	Decision/notification timeframe	Notification to	Notification method
Non-urgent pre- service denial	Within 96 hours of receipt of the request	Practitioner/Provider and Member	Written
Urgent concurrent approval	Within 3 calendar days of receipt of the request	Practitioner/Provider	Oral or electronic
Urgent concurrent denial	Within 3 calendar days of receipt of the request	Practitioner/Provider and Member	Written
Elective concurrent approval	Within 3 calendar days of receipt of the request	Practitioner/Provider	Oral or electronic
Elective concurrent denial	Within 3 calendar days of receipt of the request	Practitioner/Provider and Member	Written
Post-service approval	Within 30 calendar days of receipt of the request	Practitioner/Provider	Oral or electronic
Post-service denial	Within 30 calendar days of receipt of the request	Practitioner/Provider and Member	Written
Termination, suspension, or reduction of prior authorization	At least 10 calendar days before the date of the action	Practitioner/Provider and Member	Written

Prior authorization period of validation

Prior authorization numbers are valid for the dates of service authorized or for a period not to exceed 90 days after the dates of service authorized, unless extended by the Public Health Emergency. The member must be enrolled and eligible on each date of service.

For information about how to verify member eligibility, please review Chapter 8 in this manual.

Out-of-network providers

When approving or denying a service from an out-of-network provider, Aetna Better Health® of Illinois assigns a prior authorization number which refers to and documents the approval. Aetna provides notification of the approval or denial to the out-of-network provider within the timeframes appropriate to the type of request.

Occasionally, a provider may refer a member to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health of Illinois makes such decisions on a case-by-case basis in consultation with an Aetna Medical Director.

Aetna will permit American Indian members to obtain covered services from non- participating Indian Health Center Providers (IHCP) from whom the member is otherwise eligible to receive such services. Aetna will permit a non-participating IHCP to refer an American Indian member to a participating provider.

Notice of Adverse Benefit Determination requirements

Aetna Better Health of Illinois provides the provider and the member with written notification [i.e., Notice of Adverse Benefit Determination (NABD)] of any decision to deny, reduce, suspend, or terminate a prior authorization request to authorize a service in the amount, duration, or scope less than requested; or deny payment, in whole or part, for a service.

The NABD includes:

- The action Aetna Better Health® of Illinois has taken or intends to take and the effective date of that action
- The specific reason for the action, customized to the member circumstances, and in an easily understandable language
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based
- Notification that, upon request, the practitioner/provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeal process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The right of the member or practitioner/provider (with written permission of the member) to request a State Fair Hearing and instructions about how to request a State Fair Hearing
- A description and the circumstances under which an expedited appeal process and resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a State Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services
- Translation service information
- The procedures for exercising the rights specified in this section

Aetna gives an NABD by the date of the action for the following circumstances including:

- The death of a member
- A signed written member statement requesting termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information)
- The member's admission to an institution where he/she is ineligible for further services
- The member's address is unknown, and mail directed to him/her has no forwarding address
- The member is accepted for Medicaid services by another local jurisdiction
- The member's physician prescribes the change in level of medical care
- An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions
- The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers)

Aetna gives an NABD on the date of action when the action is a denial of payment.

Aetna gives an NABD at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five days if probable member fraud has been verified.

Continuation of benefits

Aetna Better Health® of Illinois continues the member's benefits during the appeal process if:

- If an enrollee files for continuation of benefits on or before the latter of ten (10) days of contractor sending the adverse benefit
- Determination, or the intended effective date of the proposed adverse benefit determination
- The member or the provider files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e., a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal
- The member requested continuation of benefits in writing within 10 days of the date of the NABD for those eligible who requested the State Fair Hearing Process or the intended effective date of the proposed action

Aetna continues the member's benefits until one of the following occurs:

- The member withdraws the appeal
- A State Fair Hearing office issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met or service limits of a previously authorized service has been met

Prior authorization and coordination of benefits

If other insurance is the primary payer before Aetna Better Health of Illinois, prior authorization of a service is not required unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Other insurance

Providers must adhere to all contract and regulatory cost sharing guidelines. When a member has other health insurance, such as a commercial carrier, Aetna will coordinate payment of benefits in accordance with the terms of the contract and federal and state requirements.

Aetna is the payer of last resort, unless specifically prohibited by State or Federal law. This means that Aetna will be a source of payment for covered services only after all other sources of payment have been exhausted. Aetna Better Health of Illinois will take reasonable measures to identify potentially legally liable third-party sources.

Cost avoidance

Aetna will take reasonable measures to determine all legally liable parties — any individual, entity, or program that is or may be potentially liable to pay all or part of the expenditures for covered services. Aetna will cost avoid a claim if it has established the probable existence of a liable third-party at the time the claim is filed. For purposes of cost avoidance, establishing probably liability takes place when the health plan receives confirmation that another party is, by statute, contract or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a member. If we do not establish the probable existence of a party's liability, we will adjudicate the claim for payment. Aetna will then utilize post-payment recovery, described in further detail below, if it turns out a legally liable third-party is responsible for payment of covered services.

If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the health plan is responsible for making these payments.

Coordination of benefits

Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information, at each visit.

When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment.

CHAPTER 14: QUALITY MANAGEMENT

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Overview

Our Quality Management (QM) program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness and effectiveness of care. We use this approach to measure conformance with desired medical standards and develop activities designed to improve member outcomes.

We perform QM through a Quality Assessment and Performance Improvement (QAPI) program with the involvement of multiple organizational components and committees. The primary goal of the QM Program is to improve the health status of members or maintain current health status when the member's condition is not amenable to improvement.

Our QM program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM processes enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

The use of data in the monitoring, measurement, and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Our QM program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization, and committees from the Board of Directors to the Member Advisory Committee. This structure allows members and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. Our QM department and the Quality Management Oversight Committee (QMOC) and subcommittees support the Medical Director in this effort.

The QMOC's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee provides executive oversight of the QAPI program, makes recommendations to the Board of Directors about our quality management and performance improvement activities, and makes sure the QAPI is integrated throughout the organization among all departments, delegated organizations, and our providers. Major functions of the QMOC Committee include:

- Confirm that quality activities improve the quality of care and services provided to members
- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators, and satisfaction surveys
- Advise and make recommendations to improve health plan operations
- Review and evaluate company-wide performance monitoring activities including care coordination, customer service, credentialing, claims, grievance and appeals, prevention and wellness, provider relations, and quality and utilization management

Additional committees such as Service Improvement, Credentialing and Performance, Appeals/Grievance, Quality Management and Utilization Management further support our QAPI Program. We encourage provider participation on key medical committees. Providers may contact the Medical Director or inform their Provider Services

representative if they wish to participate.

Our QM staff develops and implements an annual work plan that specifies projected QM activities. Based on the work plan, we conduct an annual QM Program evaluation, which assesses the impact and effectiveness of QM activities.

Our QM department is an integral part of the health plan. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards and recommend and promote improvements in the delivery of care and service to our members. Our QM and Medical Management departments maintain ongoing coordination and collaboration regarding quality initiatives, care coordination, and disease management activities involving the care of our members.

Our QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, we — in collaboration with providers — monitor and continually assess the quality of services provided to our members. Providers are obligated to support our QAPI and utilization management program standards.

Note: Providers must participate in CMS and Aetna quality improvement initiatives. Any information provided must be reliable and complete.

Identifying opportunities for improvement

Aetna Better Health® of Illinois identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data Aetna monitors to identify opportunities for quality improvements include:

- **Formal feedback from external stakeholder groups:** We take the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys [Consumer Assessment of Healthcare Providers and Systems (CAHPS)] or focus groups with individuals such as members and families, providers and state and community agencies.
- **Findings from external program monitoring and formal reviews:** Externally initiated review activities, such as annual external quality program assessments or issues identified through a State's ongoing contract monitoring oversight process assist us in identifying specific program activities/processes needing improvement.
- **Internal review of individual member or provider issues:** In addition to receiving complaints, grievances and appeals from members, providers and other external sources, we proactively identify potential quality of service issues for review through daily operations (i.e., Member Services, prior authorization, and care coordination). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care coordination processes, access to provider care and covered services and quality of care), we identify specific opportunities for improving care delivered to individual members.
- **Findings from internal program assessments:** We conduct a number of formal assessments/reviews of program operations and providers used to identify opportunities for improvement. This includes, but is not limited to, record reviews of contracted providers, credentialing/recredentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment and an assessment of provider accessibility and availability.
- **Clinical and non-clinical performance measure results:** We use an array of clinical and non-clinical performance standards (e.g., call center response times and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, we identify opportunities for improvement in clinical and operational functions. These measures include:
    - Adherence to nationally recognized best practice guidelines and protocols
    - Prior authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals)
    - Provider availability and accessibility, including:
        - Length of time to respond to requests for referrals
        - Timeliness of receipt of covered services
        - Timeliness of the implementation of members' care plans
        - Availability of 24/7 telephonic assistance to members and caregivers receiving home care services
- **Data trending and pattern analysis:** With our innovative information management systems and data mining tools, we extensively use data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- **Other service performance monitoring strategies:** We use numerous monitoring processes to confirm effective

delivery of services to our members, such as provider and member profiles, service utilization reports, and internal performance measures. Aspects of care that we monitor include, but are not limited to:

- High-cost, high-volume, and problem prone aspects of the long-term care services our members receive
- Effectiveness of the assessment and service planning process, including its effectiveness in assessing a member's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization
- Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services

Potential Quality of Care (PQoC) concerns

Aetna has a process for identifying PQoC concerns related to our provider network, including researching and resolving these care concerns in an expeditious manner and following up to make sure providers implemented needed interventions. This may include referring the issue to peer review and other appropriate external entities. In addition, we track and trend PQoC cases and prepares trend reports organized according to provider, issue category, referral source, number of verified issues, and closure levels. We use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Credentialing and Performance Committee or identify the need for possible quality improvement initiatives.

Performance Improvement Projects (PIPs)

We design our PIPs, a key component of our QM Program, to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs follow CMS protocols. We participate in state- mandated PIPs and select PIP topics that:

- Target improvement in areas that address a broad spectrum of key aspects of members' care and services over time
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect our enrollment in terms of demographic characteristics, prevalence of disease, and potential consequences (risks) of the disease

PIP proposals prepared by our QM department are reviewed and approved by our Medical Director, Quality Management/Utilization Committee and the Quality Management Oversight Committee (QMOC) prior to submission to HFS for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units, as well as from providers who participate in our QM/UM Committee.

The QM department conducts ongoing evaluation of study indicator measures throughout the length of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance, we immediately conduct additional analyses to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Peer review

The Credentialing and Performance Committee evaluates peer review activities. This committee may act if they identify a quality issue. Such actions may include, but are not limited to, development of a Corrective Action Plan (CAP) with time frames for improvement, evidence of education, development of policies and procedures, monitoring and trending of data, or discontinuation of the provider's contract with the plan. The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, as well as other quality issues.

Although the Quality Management department coordinates peer review activities, they may require the participation of Utilization Management and Care Coordination, Provider Relations, or other departments. We may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plan's peer review process adheres to our policies as well as applicable state and federal laws and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in our network has been limited or terminated for a reason based

on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension or termination of a contract under specific circumstances.

Satisfaction survey

Aetna conducts member and provider satisfaction surveys to gain feedback regarding members' and providers' experiences with quality of care, access to care and service/operations. We use member and provider satisfaction survey results to help identify opportunities and implement improvement. We describe each survey below.

Member satisfaction surveys

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) are a set of standardized surveys that help assess patient satisfaction with their experience of care. CAHPS surveys (Adult and Children) are administered by a NCQA-certified vendor according to NCQA and CMS survey protocols. The survey is based on randomly selected members and the results offer an indication of how well health care organizations meet member expectations. In addition to CAHPS, ABH IL may administer other member experience and satisfaction surveys to targeted member populations to help us better understand our members' needs and improve our ability to deliver quality services.

Provider satisfaction surveys

Aetna conducts an annual provider survey to assess satisfaction with our operational processes. Topics include key functions of the health plan including, but not limited to, claims processing, provider training and education and our response to inquiries.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act. States are to contract with an independent external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness, and access to services. EQR refers to the analysis and evaluation of aggregated information on timeliness, access and quality of health care services furnished to members. We make the results of the EQR available upon request to specified groups and to interested stakeholders.

We cooperate fully with external clinical record reviews assessing our network's quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by the Illinois Department of Healthcare and Family Services. We assist in the identification and collection of any data or records to be reviewed by the independent evaluation team. We also provide complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. We require our contracted providers to provide any records that the EQRO may need for its review.

We share the results of the EQR with providers and incorporate them into our overall QM and medical management programs as part of our continuous quality improvement process.

Provider feedback

In an effort to promote the provision of quality care, we provide measurement and feedback to providers. Individual providers and practices are profiled for multiple measures, and results are compared with colleagues in their specialty. In addition, we provide feedback to providers on screening and treatment in relations to evidence-based guidelines.

The Provider Feedback Program shares standardized utilization data with physicians in an effort to improve clinical outcomes. We support clinical decision-making and patient engagement by sharing information about how practice patterns compare to those of their peers.

We include several measures in the provider feedback, which include but are not limited to:

- Frequency of individual patient visits to the PCP
- EPSDT services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (i.e., appropriate asthma management linked with correct use of inhaled steroids)
- Use of medications

Pharmacy management overview

Aetna Better Health® of Illinois covers prescription medications and certain over-the-counter medicines when you write a prescription for a member. We use CVS/Caremark for pharmacy benefit management services. CVS/Caremark provides members access to a retail pharmacy network and other services, including claims processing, mail order and a specialty pharmacy program.

E-prescribing

E-prescribing is the transmission, using electronic media, of a prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager or health plan, either directly or through an intermediary, including an e-prescribing network such as Surescripts. We provide member eligibility and coverage status, medication history and formulary information to providers who use e-prescribing tools.

Formulary/Preferred Drug List (PDL)

Aetna adheres to the Illinois Medicaid PDL. You can use our online formulary search tool to validate drug coverage information, such as preferred status, prior authorization (PA) and quantity level limits (QLL). You can also download a print version of our formulary/PDL from the website. When prescribing medications and over the counter drugs, check the coverage status of the drug to identify any restrictions or limitations. For drugs on the formulary/PDL that require prior approval, there are pharmacy PA requests forms available on our website. If you do not have access to the Internet, you may contact us telephonically or by fax to submit a PA request or have a PA form mailed to your office. If a drug is not listed on our formulary/PDL, a Pharmacy PA Request form must be completed before an exception to the formulary/PDL is considered. Please include supporting medical records that assist with the review of the exception and PA request.

We update the formulary/PDL posted to our website on a monthly basis or more frequently as applicable. Please visit the pharmacy page on the Aetna website at **AetnaBetterHealth.com/Illinois-Medicaid** to view the most recent formulary/PDL updates and access our up-to-date formulary search tool.

Quantity Level Limits (QLL)

Quantity Level Limits (QLL) apply for certain medications to promote the safe and appropriate use of these medications. QLLs are developed based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat. Review the formulary/PDL online search tool to determine if a prescribed medication has a QLL. To request an exception to the QLLs, submit a PA request by calling our Pharmacy PA team at **1-866-329-4701 (TTY: 711)**, faxing the request to **1-844-802-1412 (TTY: 711)**, or by submitting an electronic PA request through the health plan website, **AetnaBetterHealth.com/Illinois-Medicaid**.

Prior authorization process

Certain medications listed on the formulary/PDL require prior authorization to make sure they are utilized appropriately prior to the dispensing of those medications. There may also be a need for a prescribed drug that is not listed on the formulary/PDL. In those instances, a provider may make an exception request for coverage of a non- formulary/non-preferred drug. Typically, we require providers to obtain prior authorization/exception approval before prescribing or dispensing the following drugs:

- Select specialty medications, including injectables and oral medications
- Non-formulary/non-preferred drugs not excluded under a State's Medicaid program

- Prescriptions that do not conform to our evidence-based utilization practices (e.g., QLLs, age restrictions, or ST)
- Brand name drug requests, when an "A" rated generic equivalent is available

To request a prior authorization, the prescribing provider can contact the Aetna Pharmacy Prior Authorization Department at **1-866-329-4701 (TTY: 711)**, submit a fax request to **1-844-802-1412**, or submit an electronic PA through the health plan website, **AetnaBetterHealth.com/Illinois-Medicaid**. In the event of an immediate need after business hours, the call should be made to Member Services at **1-866-329-4701 (TTY: 711)**.

Prescribing providers can download the drug-specific prior authorization form or general pharmacy prior authorization forms from the health plan website. To support the timely review of a prior authorization request, prescribers are asked to supply the following information:

- Member's name, date of birth and identification number
- Prescribing practitioner's/provider's name, telephone and fax numbers
- Medication name, strength, frequency, quantity and duration
- Diagnosis for which medication is prescribed
- Other medications tried for the same indication
- Medical records to support the necessity for the authorization (e.g., non-formulary drug, age limit, QLL, ST override, generic override or vacation override)

The prescribing provider and member are notified of all decisions in accordance with regulatory requirements and timelines. Prior to making a final decision, we may contact the prescriber to discuss the case or consult with a board- certified physician from an appropriate specialty area such as a psychiatrist. In the event that a prior authorization or exception request has an adverse determination, the prescribing provider may contact the issuing Medical Director/Pharmacist to discuss the decision by calling our Pharmacy Prior Authorization team at **1-866-329-4701 (TTY: 711)**.

Benefit exclusions

The following drug categories are not covered by Aetna:

- Drugs manufactured by companies that have not signed a rebate agreement with the federal government
- Weight loss drugs
- Agents to promote fertility
- Agents used for cosmetic purposes (e.g., hair growth or wrinkle removal)
- Drugs identified by the FDA as being in Drug Efficacy Study Implementation (DESI) status
- Drugs dispensed after the termination date included on the quarterly drug tape provided by the federal Centers for Medicare and Medicaid Services
- Drugs indicated only for the treatment of erectile dysfunction

Maintenance medication prescriptions

Aetna offers the maintenance medication program, which allows members to receive a 90-day supply of non-specialty maintenance medications. The program is available at most in-network retail pharmacy locations, as well as through the CVS Caremark mail service. If you have a member who may benefit from our mail order program and would like more information on our program, visit our website at **AetnaBetterHealth.com/Illinois-Medicaid**.

CHAPTER 16: ADVANCE DIRECTIVES (THE PATIENT SELF-DETERMINATION ACT)

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We require providers to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life Sustaining Treatment Act (POLST), Illinois Advance Directive Health Care Act, and all other federal and state laws regarding advance directives for adult members.

Advance directives

Aetna Better Health® of Illinois maintains written policies and procedures related to advance directives that describe the provision of health care for an incapacitated member. These policies promote the member's ability to make known his/her preferences for medical care before they face a serious injury or illness.

We define advance directives as a legal document through which a person may provide directions or express preferences concerning his/her medical care and appoint someone to act on his/her behalf. Physicians and others use advance directives when a person is unable to make or communicate decisions about his/her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes someone to be unable to actively decide about his/her medical care.

The advance directive policy details our obligations with respect to all adult individuals receiving medical care by or through us. These obligations by both federal and state laws include, but are not limited to:

- Before implementing a health, care decision made for a member, a supervising health-care provider, if possible, will communicate to the member the decision made and the name of the person making the decision.
- A supervising provider who knows of the existence of an advance directive, a withdraw of an advance directive, or a termination of the named person making decisions on the behalf of the member will promptly record its existence in the member's medical record if it is available in writing, he/she will request a copy and, if one is furnished, will arrange for its update in the medical record.
- A PCP who makes or is informed of a determination that a member lacks or has recovered capacity, or that another condition exists that will affect an individual instruction or the authority of an agent, guardian, or surrogate, will promptly record the determination in the member's medical record and communicate the determination to the member, if possible, and to any person then authorized to make health care decisions for the member.
- Except when a provider declines to comply with an individual instruction or health care related decision as described below, a provider or institution providing care to a member must:
    - Comply with an individual instruction of the member and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the member.
    - Comply with a health care decision for the member made by a person then authorized to make health care decisions for the member to the same extent as if the member had made the decision while having capacity.
- A provider can decline to comply with an individual instruction or health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health-care decision if contrary to a policy of the institution expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.
- A provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
- A provider or institution that declines to comply with an individual instruction or health care decision will:

- Promptly inform the member, if possible, and any person authorized to make health care decision on their behalf, continuing care until transfer
- Immediately make all reasonable efforts, if member or authorized representatives are not already doing so, to assist in the transfer to another provider or institution willing to comply with the instructions and or decision.

A provider or institution may not require or prohibit the execution or revocation of an advance directive as a condition for providing health care. Providers and institutions must comply with the following:

- Maintain written policies and follow certain procedures with respect to advance directives
- Document in the member's medical record whether or not the patient has executed an advance directive (including a psychiatric advance directive)
- Provide Aetna with a copy of the executed advance directive once received
- Comply with all federal and state laws regarding advance directives (this includes complying with any state law on psychiatric advance directives)
- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This does not mean, however, that a provider is required to provide care that conflicts with an advance directive.
- Inform the individual that complaints concerning implementation of these advance directive requirements may be filed with the state agency that surveys and certifies Medicaid providers
- Provide staff and community education on issues related to advance directives

Visit **nrc-pad.org/images/stories/PDFs/fedaddirectives2a.pdf** for more information on both federal and Illinois- specific advanced directive.

Proxy directive

A proxy directive (durable power of attorney for health care) is a document the member will use to appoint a person to make health care decisions for them in the event they become unable to make them on their own. This document goes into effect whether the member's inability to make health care decisions is temporary because of an accident or permanent because of a disease. The person the member will appoint is known as their "health care representative". They are responsible for making the same decisions the member would have made under the circumstances. If they are unable to determine what the member would want in a specific situation, they are to base their decision on what they think is in the member's best interest.

Instruction directive

An instruction directive (living will) is a document the member uses to tell their doctor and family about the kinds of situations they would want or not want to have life-sustaining treatment in the event they are unable to make their own health care decisions. The member can also include a description of their beliefs, values and general care and treatment preferences. This will guide their doctor and family when they have to make health care decisions for the member in situations not specifically covered by their advance directive.

Advance directives are important for everyone to have, no matter what their age or health condition is. They let the member say what type of end of life care they do and do not want.

- Illinois law authorizes the form.
- The person must be at least 18 years old and competent when signing a living will.
- There must be a witness at least 18 years of age who is not related to the person by blood, marriage, or adoption and they cannot have financial interest in the person's medical care.
- The living will only applies when the person is diagnosed and certified as terminally ill by at least two doctors.
- The living will does not apply to a person in a coma or vegetative state unless the person is diagnosed with a terminal illness.
- Pain relief or comfort care can be given with the living will.

We advise our members of the following if they have an advance directive:

- Keep a copy of your advance directive for yourself.
- Give a copy to the person you choose to be your medical power of attorney.
- Give a copy to each one of your providers and tell them to put a copy in your medical records.
- Take a copy with you if you have to go to the hospital or the emergency room.
- Keep a copy in your car if you have one.

We also advise our members that we can help them find a provider that will carry out their advance directive instructions. They can talk to their provider if they need help or have questions. We also advise that their doctor cannot discriminate against them based on their choice to have or not have an advance directive. We also advise that their doctor cannot base the decision of treatment on whether or not the member chooses to have an advance directive. Providers in our network must follow state laws regarding advance directives. If a member feels the need to file a complaint, we provide them with information on how to do so in our Member Handbook. We will educate staff and providers on advance directives at least once a year.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions later due to illness.

The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. We require our providers to comply with this act.

For additional information about the PSDA, please visit **gapna.org/patient-self-determination-act-psda**.

Physician Orders for Life Sustaining Treatment (POLST)

We require providers to comply with the Physician Orders for Life Sustaining Treatment Act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the POLST program. The POLST protocol requires a health care professional to discuss available treatment options with seriously ill members (or their advocate/family member) and the member's preferences are documented on a standardized medical form the member keeps with them.

A member's attending provider or advanced practice staff must sign the form. This form must become part of a member's medical record, as this form will follow the member from one health care setting to another, including hospital, home, nursing home, or hospice. For more information, please refer to **POLST.org.**

CHAPTER 17: BILLING AND CLAIMS OVERVIEW

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Aetna processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable federal and state laws, rules, and regulations. We do not pay non-emergency claims submitted by a provider not participating in the Illinois Medicaid program or excluded from any program under federal law.

We use our business application system to process and adjudicate claims. We accept both Professional CMS-1500 and Institutional-UB04 electronic and paper claims submissions. To assist us in processing and paying claims efficiently, accurately, and timely, we encourage providers to submit claims electronically. To facilitate electronic claims submissions, we have developed a business relationship with Optum. We receive electronic claims through our claims processing system directly from Optum, process them through pre-import edits to maintain the validity of the data, HIPAA compliance, and member enrollment, and then upload them into our business application each business day. Within 24 hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission. For vendor claim submission details, please see the billing section in the below chapter.

Billing and claims overview

We process claims in accordance with Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Providers must also use the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in rejection of the diagnoses in the Risk Adjustment Processing System.

  Note: The ICD-10 CM codes must be to the highest level of specificity. Assign three-digit codes only if there are no four-digit codes within that code category. Assign four-digit codes only if there is no fifth-digit sub- classification for that subcategory. Assign the fifth-digit sub-classification code for those sub-categories where it exists.

- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should indicate all diagnoses addressed were reported. Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

Information on billing and claim submission

Timely filing of claims

In accordance with contractual obligations, providers must submit claims for services provided to a member in a timely manner. Our timely filing limitations are as follows:

- New claims must be submitted within 180 days from the date of services. Claims will deny if not received within the required time frames.
- Corrected claims must be submitted within 180 days from the date of service.
- Claims with TPL (or coordination of benefits) should be submitted within 90 days from primary insurer's EOB date.

Failure to submit claims within the prescribed time period may result in payment delay or denial. There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits/subrogation. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party's Explanation of Benefits.
- Cases where a member has retroactive eligibility. In situations of enrollment in Aetna with a retroactive eligibility date, the time frames for filing a claim will begin on the date that we receive notification from the enrollment broker of the member's eligibility/enrollment.

Clean claims payments

A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity. Once a claim has been determined to be non-fraudulent, it must be resubmitted to be considered a clean claim. We will adjudicate clean claims to a paid or denied status within:

- 90 percent of all clean claims, including adjustments processed and paid or processed and denied, within 30 days of receipt
- 99 percent of all clean claims, including adjustments processed and paid or processed and denied, within 90 days of receipt

How to file a paper claim

1) Select the appropriate paper claim form (refer to the table below).

Service	Claim form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**UB-04 Form**
American Dental Association	**ADA Dental Claim Form**

You can find instructions on how to fill out the claim forms on our website at **AetnaBetterHealth.com/Illinois- Medicaid**.

2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   Note: Handwritten claim forms are accepted but must be legible.
   b) We may reject the claim form unprocessed (unaccepted) if illegible, poor-quality copies are submitted or required documentation is missing. This could result in us denying the claim for untimely filing upon resubmission. If your claim is denied for untimely filing, you will need to submit proof of timely filing to have the claim considered.
   Note: Please submit the letter that was sent with the rejection as this can prevent the resubmitted claim from being denied for untimely filing.
3) Submit original copies of claims through the mail (do NOT fax). To include supporting documentation, such as member's medical records, clearly label and send to Aetna Better Health of Illinois.

   Paper claims through the mail:

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

Billing

Aetna processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable federal and state laws, rules, and regulations. We do not pay claims submitted by a provider not participating in the Illinois Medicaid Program or excluded from any program under federal law.

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Aetna for payment of covered services. It is important to ensure Aetna has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend providers notify Aetna 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a provider's TIN and/or address are not acceptable when conveyed via a claim form.

Providers have a variety of ways to submit claims:

For medical submissions (claims that are not dental, vision or non-emergency transportation claims):

Claims (Professional-CMS 1500 and Institutional-UB04)	
Electronic portal *(Professional-CMS 1500 and Institutional-UB04)*	Aetna secure web portal: **Medicaid.Aetna.com/MWP/login** *Our clearinghouses can be accessed through our secure Web portal. For specific clearinghouse information, please see Optum details below.*
Paper submission *(Professional-CMS 1500 and Institutional-UB04)*	**Mail paper claims to:** Aetna Better Health of Illinois P.O. Box 982970 El Paso, TX 79998-2970
Professional-CMS 1500 and Institutional UB04 Electronic Clearinghouse – Optum	Includes claim submissions for: Professional-CMS 1500 claims and Institutional-UB04 claims that are Medicaid primary and Medicaid tertiary. Professional CMS 1500's can be keyed through **Change Healthcare Web Connect** (**changehealthcare.com**): Payer ID's: 68024 (Claim Submission) **Important:** Dental providers must submit using DentaQuest's payer ID. See below grid for the DentaQuest Change Healthcare payer ID information.

	Note: Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Optum.

For vendor submissions, please see below. For electronic claim submissions:

Dental	Electronic submissions: Direct entry at: **Dentaquest.com** Via clearinghouse: Payer ID CX014 Include address on electronic claims: DentaQuest, LLC PO Box 2906 Milwaukee, WI 53201-2906 Payer ID: CX014 Paper claims: PO Box 2906 Milwaukee, WI 53201-2906 Claims questions: **denclaims@dentaquest.com**
Vision	Electronic submissions: March prefers to receive claims electronically via **providers.eyesynergy.com**, their web-based solution for electronic transactions. Providers.eyesynergy.com helps reduce claim errors, resulting in faster processing times. Clearinghouse submissions: March Vision has a direct agreement with Optum to accept electronic claims. Their payor ID for Optum is **52461**. Paper claims: March Vision imposes a $2 processing fee for all paper claim submissions, excluding corrected claims and COB claims. Paper claims will be accepted if submitted on an original red CMS-1500 form that is typed or computer generated with clear and legible black ink. Paper claims that are handwritten, contain light ink, or submitted on a copied CMS-1500 form are not acceptable and will be returned. Paper claims in the approved format can be mailed to: MARCH® Vision Care 6601 Center Drive West, Suite 200 Los Angeles, CA 90045
Transportation	For paper submissions: ModivCare Solutions LLC 2552 W. Erie Drive, Suite 101 Tempe, AZ 85282

Note: Aetna does not perform any 837 testing directly with its providers but performs such testing with Change Healthcare or Office Ally Inc.

Coordination of benefits

Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information at each visit.

When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment. **Please refer to the billing instruction above.**

Specific claim type instructions

Skilled Nursing Facilities (SNF): Providers submitting claims for SNFs should use UB-04 Form.

Home health claims: Providers submitting claims for home health should use 8371 CMS 1450 Form. RHC and FQHC must bill on a CMS 1500 Form.

Durable Medical Equipment (DME) rental claims: Use CMS 1500 Form when submitting claims for durable medical equipment (DME) rental. We only pay DME rental claims up to the purchase price of the DME.

Units billed for the program equal one per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is one unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from date and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Federally Qualified Health Center (FQHC)/Freestanding Rural Health Clinic (RHC)

- FQHC & RHC, claims should be billed with the registered rendering practitioner's NPI and billing group National Provider Identifier (NPI) see IAMHP billing guide **iamhp.net/providers**
- FQHC & RHC Behavioral health (BH) claims should be billed with a BH modifier
- FQHC & RHC claims should be billed on a HCFA 1500

Any contract or subcontract between Aetna and a FQHC or a RHC shall be executed in accordance with Sections 1902(a) (13) (C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997, and shall provide payment that is not less than the level and amount of payment that ABHIL would make for the Covered Services if the services were furnished by a Provider that was not a FQHC or an RHC.

Patient Credit File

In order for long term care facility claims to be processed, the member for whom the facility is billing must be on the Patient Credit File. This file is provided by the Department of Healthcare and Family Services and shows the amount the member needs to pay for residing in the facility. In certain instances, there can be a delay in the member appearing on the Patient Credit File. As a result, some LTC facility claims may be denied. A specific denial description will display on the claim that reads: "Mbr not currently on PT Credit File – will reconsider once on file."

Aetna has put a process in place to ease the administrative burden of long-term care facilities in these instances. Each month, when the Patient Credit File is received, Aetna will check each member on the file against any previously denied claims. If there are claims that have been denied as a result of the member not appearing on the Patient Credit File, and all necessary information is included on the claim, Aetna will reprocess and pay the previously denied claim.

Same-day readmission

Use UB-04 Form when submitting claims for inpatient facilities.

There may be occasions where a member is discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission within 24 hours.

Example: Discharge date: 10/2/10 at 11:00 AM Readmission Date:
10/3/10 at 9:00 AM

Since the readmission was within 24 hours, this is considered a same day readmission per the above definition.

Coding overview

Aetna general claims payment information

We always pay claims in accordance with the terms outlined in your provider contract. Prior authorized services from non-participating health providers are paid in accordance with Medicaid claim processing rules.

Correct Coding Initiative (CCI)

Aetna follows Medicaid Correct Coding Initiative (CCI) logic, and we perform CCI edits and audits on claims for the same provider, same recipient and same date of service. For more information on this initiative, please visit **Medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html**

Note: National codes are not necessarily the same as Illinois rules. Each state has their own set of rules and variations, as approved by CMS.

We also utilize ClaimsXten as our comprehensive code auditing solution to assist payers with proper reimbursement. CCI guidelines are followed in accordance with Illinois Medicaid state supplied editing. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimsXten. It enables us to share the claim auditing rules and clinical rationale inherent in ClaimsXten with our providers.

Providers have access to ClaimsXten Connection through our website through a secure login. ClaimsXten Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. We consider a service integral to a procedure bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure
- Are necessary to accomplish the comprehensive procedure
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect coding

Examples of incorrect coding include:

- Unbundling – Fragmenting one service into components and coding each as if it were a separate service
- Breaking out bilateral procedures when one code is appropriate

- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

You must bill a modifier to reflect services provided and to appropriately pay claims. Aetna can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59 – Distinct procedural services** can be used for a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be used on E&M service codes or on code 77427.
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** can be used to indicate that an E&M service is significant and separately identifiable from the other services performed on the same day. This modifier can only be submitted with E&M codes. Documentation in the patient's medical record must support the use of this modifier.
- **Modifier 50 – Bilateral Procedure**. When a procedure is identified as one that can have modifier 50 added to the base code when performed bilaterally, bill the procedure code as a single line item on the claim form with modifier 50 and units of service equal to one. When a code states 'unilateral' or 'bilateral' in the description, do not add modifier 50. In this instance, the base code is billed only once on the claim and the number of units is one.
- **Modifier 57 – Decision for Surgery** indicates an E&M service resulted in the initial decision to perform surgery either the day before a major surgery (90-day global period) or the day of a major surgery (90-day global period). Modifier 57 can only be used on E&M codes.

Please refer to your CPT Manual or the DHF for further detail on all Medicaid allowable modifier usage.

Claim resubmission

Providers have 180 days from the date of service to submit a corrected claim. The review and reprocessing of a corrected claim does **not** constitute as a claim reconsideration.

Providers may resubmit a claim for a variety of reasons including:

- Originally denied because of missing documentation, incorrect coding, etc.
- Incorrectly paid or denied because of processing errors
- Retroactive eligibility

Note: Providers have 180 days to submit a corrected claim.

Include the following information when filing a paper claim:

- Any additional documentation required
- A brief note describing requested correction
- Clearly label as "Corrected Claim for Resubmission" at the top of the claim and mail to appropriate claims address

Providers can submit corrected claims electronically if no additional documentation is required. For electronic resubmissions, providers must submit a frequency code of seven or eight.

Note: Providers may call our CICR department during regular office hours to speak with a representative about their claim concern. The CICR department can verbally acknowledge receipt of the corrected claim. Our staff can discuss, answer questions, and provide details about status. Providers can access our secure web portal to submit claims through our clearing houses, check the status of a corrected /reprocessed or adjusted claim. We identify these claims as "Paid" in the portal. To view our portal, please click on the portal tab, which is located under the provider page on the following website at **AetnaBetterHealth.com/Illinois-Medicaid**.

Remittance advice

Aetna generates up to two checks weekly. Claims processed during a payment cycle appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend you keep all remittance advices and use the information to post payments and reversals and make corrections for

any claims requiring resubmission. Providers have access to view remittance advice through the secure web portal.

We provide a separate remit for each line of business in which the provider participates. Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna for previous overpayments not yet recouped or funds advanced.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds the provider has returned to Aetna due to overpayment. We list these to identify claims that have been recouped. We include the reversed amounts in the Processed Amount above. We note claims that have refunds applied with a claim status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna after this payment cycle. This will result in a negative Amount Paid.
- We list the Payment Number and Check Amount if there is a check associated with the remit. If we make payment electronically, the Electronic Funds Transfer (EFT) Reference number and EFT Amount are listed along with the last four digits of the bank account to which the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Line of Business refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
    - Member name
    - ID
    - Birth date
    - Account number
    - Authorization ID, if obtained
    - Provider name
    - Claim status
    - Claim number
    - Refund amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

We can provide an electronic version of the Remittance Advice. To qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through the claims processing system and receive payment for claim by EFT. You must also be able to receive ERA through an 835 file. We encourage our providers to take advantage of the claims processing system, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact Provider Services for assistance with this process.

Remit sample on the next few pages:

aetna™

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Aetna Better Health of Illinois
4500 E Cotton Center Blvd
Phoenix, AZ 85040

Return Service Requested

MIXED AADC 625
1589 0.7648 FP 0.526
xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxx
111

Check Number: xxxxxxxxxxxxxxx
Check Date: 10/15/2022
Check Amount: $141.96

Remit Date:	10/15/2022
Beginning Balance:	0.00
Discount:	0.00
Interest:	0.00
Refund Amount:	0.00
Amount Recouped:	0.00
Amount Paid:	141.96
Ending Balance:	0.00
Payment #:	xxxxxxxxxx

Billing Provider Name: xxxxxxx xxxxxx
TIN: xxxxxxxxxx
NPI: xxxxxxxxxx
Line of Business: Aetna Better Health of Illinois

We have a new remit design. If you need assistance in understanding any of the information on this remittance advice, go to our website www.aetnabetterhealth.com and view the How to Read document. For other concerns please call the number on the back of the member's ID card. Prefer to use electronic transactions, contact your current EDI vendor, and request Aetna Better Health through Change Healthcare.

Member Name: xxxx xxxx | **Member #:** xxxxxxx | **Claim#:** xxxxxxxxxx | **Claim Status:** PAID
Acct #: 0.0 | **Date Received:** 20221011 | **Auth#:** xxxxxxxxxx | **Place of Service:** xx
Claim Provider: xxxxxxx xxxxxxx | **NPI #:** | **Billed DRG:** | **DRG:**

Line #	Service From - To	Serv Code	Modifier	Rev Code	Units	FFS/ CAP	Billed Amt.	Allowed Amt.	Net Payable	Remark	Member Responsibility: Ded PR1	Coin: PR2	Copay PR3	Other	Remark	Paid Amount
1	08/02/22	S5130			16	FFS	99.84	24.96	74.88	CO45	0.00	0.00	0.00			24.96
2	08/05/22	S5130			16	FFS	99.84	24.96	74.88	CO45	0.00	0.00	0.00			24.96
3	08/11/22	S5130			12	FFS	74.88	18.72	56.16	CO45	0.00	0.00	0.00			18.72
4	08/12/22	S5130			16	FFS	99.84	24.96	74.88	CO45	0.00	0.00	0.00			24.96
5	08/16/22	S5130			16	FFS	99.84	24.96	74.88	CO45	0.00	0.00	0.00			24.96
6	08/19/22	S5130			15	FFS	93.60	23.40	70.20	CO45	0.00	0.00	0.00			23.40
	Payment #	xxxxxxxxxxxx				Claim Total:	567.84	141.96	425.88		0.00	0.00	0.00	0.00		141.96

Provider Summary:			Billed Amt.	Allowed Amt.	Net Payable	Ded	Coin:	Copay	Other	Paid Amount
Interest Paid: 0.00	Discount/Penalty: 0.00	Provider Claim Total:	567.84	141.96	425.88	0.00	0.00	0.00	0.00	141.96
Check Date: 20221015	Check Number: xxxxxxx	Check Amount: 141.96								

Code/Description
CO - Contractual Obligations. Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.
OA - Other adjustments.
PI - Payor Initiated Reductions. Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer.
PR - Patient Responsibility.

CO45 CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT

If you have any questions please contact the Claims Department at 866-212-2851
Check History ID xxxxxxxxxxx **Payment ID** xxxxxxxxxx

Messages

Aetna Better Health of Illinois offers the following resources for additional information and assistance:

1) **Claims Inquiry**: please call 866-329-4701 (TTY: 711) Opt 3, Monday - Friday, 8:30 AM to 5:00PM CT to verify that your claim processed correctly, or for clarification of information. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

2) **Revised Claims Resubmission (Corrected Claims):** A "resubmission" is defined as a claim originally denied because of missing information or incorrect coding that prevents Aetna Better Health from processing the claim. Per Federal regulation 42 CFR § 424.44(a), health care providers must submit a corrected claim within 180 days from the date of service.

Mark at the top of the claim "RESUBMISSION" and include the following:

- An updated copy of the claim - all lines must be rebilled
- A copy of the remittance advice on which the claim was denied or incorrectly paid
- A copy of the original claim (a reprint or a copy is acceptable)
- A brief note describing the requested correction
- Any additional appropriate documentation
- Corrected Claim Resubmissions should be submitted to:

Mail to:

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

3) **Claim Reconsideration:**
A RECONSIDERATION can be submitted if a claim does not require any changes, but a provider is not satisfied with the claim disposition and wishes to dispute the original outcome. Pursuant to the Health Choice Illinois Contract 2018-24-401 (section 5.29.7.1) , Aetna Better Health of Illinois establishes a claim dispute process that allows providers to contest a payment decision after a claim has been adjudicated.

To submit a reconsideration - submit a claim form and mark the top of the request "Reconsideration" along with the completed Provider Dispute and Reconsideration Form found on the Aetna Better Health of Illinois Provider Portal and include the following:

- Submit additional information required to reconsider the claim
- Information should be submitted single sided
- Reconsideration should be submitted within 90 days from the date of the explanation of payment
- Reconsiderations should be submitted to:

Mail to:

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

4) **A Retrospective Authorization Dispute (Post Service)**
Providers can request a review of post-service, authorization related claim denials for potential reprocessing when they are: 1) attributed to authorizations not kept current due to extenuating circumstances or 2) medical necessity disputes requiring review of medical records.

Note: a Retrospective Authorization Dispute must be received within 60 days from the date of denial. A response will be issued within 30 business days from the date of receipt.

Mail to:

Aetna Better Health of Illinois
ATTN: Grievance & Appeals
P.O. BOX 81040
Cleveland, OH 44181
Fax: 1-844-951-2143
Email: ILappealandgrievance@Aetna.com

Please note: A retroactive authorization dispute reference number will be the appeal number (APxxxxxxxxxxxxxx) located on the acknowledgment letter.

5) Providers are encouraged to review our website: www.aetnabetterhealth.com/Illinois for updates to our Provider Manual and provider notifications.

6) If you would like to report healthcare fraud related issues please call the toll-free hotline at 1-866-670-6885, contact us by e-mail at aetnasiu@aetna.com, or online at https://www.aetnabetterhealth.com/illinois/fraud-abuse.

If you are returning the original check issued by Aetna, please mail within 60 days to:

Aetna Better Health of Illinois
Attn: FINANCE
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Please mail a refund check for any overpayments or claim processing errors within 60 days to:

Aetna Better Health of Illinois Inc
Attn: FINANCE
P.O. BOX 843083
Dallas, TX 75284-3083

Missing diagnosis codes

Aetna Better Health® works with Edifecs to enable CRA — a solution designed to alert providers when diagnosis codes are potentially missing from a claim. This is accomplished by sending the biller the standard EDI response files (277CA) associated with claim status that are integrated into the claim submission process. The automated messages appear in the billing solution rejection notification queue and are triggered on claims that may be incomplete or inaccurate for patients with historic claims data, such as evidence of an established diagnosis of a chronic condition that is not present on the current claim.

Program benefits:

Edifecs CRA - Capture diagnosis codes to accurately capture a member's chronic conditions and deliver complete and accurate claims the first time.

As the health care industry faces unprecedented change, we're focused on helping our members receive the specific care they need at the time they need it. We're also focused on helping providers ensure that the care they provide to our plan's members is completely, accurately and efficiently reported and submitted within the provider's existing submission workflow.
For the member, the CRA solution enhances the medical provider's awareness of their potential medical conditions, increasing the opportunity or need to receive the right level of care and services or follow-up care and services from their medical health plan and its provider network.

For the provider, the CRA solution brings another opportunity for awareness of their patient's medical history and ensures a line of sight to the accuracy of their billing practices within the medical office. The solution may also reduce some of the administrative rework associated with the existing health plan's chart review process that frequently occurs to maximize health plan quality standards and measures. The CRA solution fosters improved accuracy and agreement between the patient's medical record and the claim submission. CRA does not create an administrative burden because it targets only the claims where the rendering provider's specialty relates to chronic medical conditions in the member's medical history. At the rendering provider level, CRA sends an average of less than three claim alerts per month. Responses to the alerts by the biller will be received by Aetna Better Health within one business day, so there is very little impact to the providers.

Sample alert message (277CA):
The following is an example of a CRA notification you will receive in the Practice Management System's rejection notification queue when there is a suspected diagnosis coding omission, presenting up to five (5) diagnosis codes**:**

> Patient history includes ICD: [ICD-10 Code History Here]; review the medical record for DOS, validate claim Dx codes are complete and accurate; resend claim. Questions, visit **https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm**

If your office receives a CRA message via (277CA):
Once CRA is enabled, your office may receive this message for those members with evidence of an existing diagnosis of a chronic condition within medical history. At that time, you should take the following actions:

- **Engage a qualified coder** or appropriate professional to review the patient's medical record to confirm that the diagnosis(es) coded on the claim are complete and accurate.
- If the coding on the **claim is complete** as-is, resubmit the claim for clearinghouse processing maintaining the using the original patient control number (CLM01/CMS-1500 Box26).
- If **changes are necessary**, make the changes where appropriate and resubmit the claim maintaining the original patient control number (CLM01/CMS-1500 Box26).
- If a **diagnosis is added to** or **removed from** the claim, billers should ensure that the medical record for the date of service completely supports the revised claim. Also ensure that all affected claim fields are aligned appropriately (i.e., order of the diagnoses reported, Diagnosis Pointers), being careful to consider claim form and ICD-10 Coding Guidelines.

Provider resources and options:

Visit **https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm** to review the support materials, which includes a Question and Answer resource.

Email **CRA_Aetna@EDIFECS.com** if your preference is to not participate in the solution. Please include your:

- Rendering NPI
- Rendering provider name
- Billing NPI
- Billing provider name
- Contact name
- Contact email or phone number

If you have **questions about a claim status message**, visit **AetnaBetterHealth.com** and select your state to be guided to your state-specific Provider Services Call Center.

Enrollee appeal and grievance system overview

Enrollees or their representative that is designated in writing can file an appeal or grievance with Aetna Better Health of Illinois orally or in writing. A representative is someone who assists with the appeal or grievance on the enrollee's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney.

Representatives must be designated in writing with the exception of a network provider requesting an expedited appeal. A network provider, acting on behalf of an enrollee, may file an expedited appeal without written consent. **In all cases, when representatives, including a provider, file an appeal or grievance on behalf of an enrollee the case is considered an enrollee appeal or enrollee grievance and is subject to the enrollee appeal or grievance timeframes and policies.**

Enrollees and their designated representatives, including providers, with written consent may also file:

- A State Fair Hearing
- An External Independent Review

Aetna informs enrollees and providers of the enrollee appeal and grievance system processes for appeals, grievances, External Independent Reviews (EIR), also called external review and State Fair Hearings. This information is contained in the Enrollee Handbook and in this Manual and is available on the Aetna website. When requested, we give enrollees reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services, alternate formats and toll- free numbers that have adequate TTY/TTD and interpreter capability at no cost to the enrollee.

Aetna verifies that no punitive action is taken in retaliation against an enrollee who requests an appeal or grievance or against a provider who requests an expedited resolution or supports an enrollee's appeal or grievance. Providers may not discriminate or initiate disenrollment of an enrollee for filing an appeal or grievance with Aetna.

Aetna processes for resolving enrollee appeals and grievances are described below.

Extensions

The decision-making timeframe on a standard or expedited appeal or on a standard grievance may be extended by fourteen (14) calendar days if the enrollee requests the extension or if Aetna believes that there is a need for additional information and that obtaining the information is in the enrollee's best interest.
Aetna will make reasonable attempts to give oral notification of delay and will send written notice of extension within two calendar days of the decision to delay[1] and within the original standard or expedited timeframe to the affected parties. The written notice of delay will include the enrollee's right to file a grievance if they disagree with Aetna taking an extension.

Enrollee complaint process

A complaint is a verbal expression of dissatisfaction by an enrollee or their representative, including a provider authorized in writing to act on the enrollee's behalf, to the plan, provider or facility that can be resolved the same day. If the case cannot be resolved the same day, it will be documented and processed as a grievance and subject to grievance procedures.

[1] 42 C.F.R. § 438.408(c)(2)(ii).

All expressions of dissatisfaction resulting from an adverse benefit determination are automatically classified as an appeal.

Enrollee grievance process

Standard grievances

A grievance is an expression of dissatisfaction regarding any aspect of Aetna Better Health® of Illinois policies, procedures or services and/or a provider care or service. This includes quality of care concerns. Grievances may be filed with Aetna orally or in writing by the enrollee or their designated representative at any time.

Aetna responds to standard grievances within ninety (90) calendar days of receipt.

Expedited grievances

Aetna resolves all grievances effectively and efficiently. Expedited grievances occur in situations where the enrollee was denied expedited processing of a prior authorization or appeal; or when Aetna Better Health of Illinois took an extension on the decision-making time frame for a prior authorization or on an appeal. An enrollee or his/her authorized representative, including providers, may request an expedited grievance either orally or in writing. Expedited grievances are resolved within twenty-four hours of receipt of all information, not to exceed forty-eight (48) hours of receipt.

For expedited grievances, Aetna makes reasonable effort to provide oral notice of the grievance decision and follows the oral notice with written notification. Enrollees are advised in writing of the outcome of the investigation of all grievances within the specified processing timeframe. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the enrollee can speak with someone regarding the decision.

How to file a grievance

Grievances may be filed by calling Enrollee Services at **1-866-329-4701 (TTY: 711)** or submit in writing via fax, email or postal mail to:

Aetna Better Health of Illinois
Appeal and Grievance Department PO
Box 81139
5801 Postal Rd
Cleveland, OH 44181

Fax: **1-844-951-2143**
Email: **ILAppealandGrievance@AETNA.com**

Enrollee appeal process

Standard appeal

Appeals are a formal request for Aetna to reconsider an adverse benefit decision.

Enrollees or their designated representative can file a standard appeal with Aetna orally or in writing within sixty (60) calendar days from the date on the Aetna initial decision, also called the Notice of Adverse Benefit Determination (ABD).

The Aetna ABD informs the enrollee of the following:

- Our decision and the reasons for our decision
- A clear explanation of further appeal rights and the time frame for filing
- The availability of assistance in filing an appeal
- That the enrollee may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them at any time during the appeal process
- Their right to request an expedited resolution and the process for doing so
- The policies or procedures which provide the basis for the decision
- Enrollees may request that their benefits continue through the appeal process, when all of the following criteria are met:
    - The enrollee or provider on behalf of the enrollee files the appeal within ten (10) calendar days of the postmarked ABD or prior to the effective date of Aetna Better Health of Illinois ABD
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
    - The services were ordered by an authorized provider

- The original period covered by the initial authorization has not expired
- The enrollee requests extension of benefits

- The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is averse to the enrollee

Aetna responds to standard appeals within (15) business days. The enrollee or their designated representative may extend the time frame at any time. If we are unable to resolve an appeal within the specified time frame, the appeal decision date may be extended

All parties to the appeal are advised in writing of the outcome of the investigation of the appeal. The Appeal Decision letter includes the decision reached, the reasons for the decision and the telephone number and address where the enrollee can speak with someone regarding the decision. The notice also tells the enrollee how to obtain information on filing a State Fair Hearing or External Independent Review.

Expedited appeal
Enrollees or their designated representative can file an expedited appeal with Aetna Better Health® of Illinois orally or in writing within (60) calendar days from the date on the initial decision, also called the Adverse Benefit Determination (ABD) and do not need to be confirmed in writing.

Aetna resolves all appeals as quickly as the enrollee's health condition requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where the enrollee's provider or Aetna determines that waiting the standard appeal timeframe could seriously harm the enrollee's health. An enrollee or their designated representative, including providers, may request an expedited appeal either orally or in writing. Expedited appeals are resolved within (24) hours of receipt of all information not to exceed (48) hours of receipt.

If Aetna determines that waiting for the standard timeframe will not harm the enrollee's health the enrollee's appeal will be transferred to a standard appeal and will be decided within the normal (15) business. We make reasonable effort to provide oral notice that the appeal is being processed following the standard timeframe and we send written notification within (2) calendar days with this information. The notification includes information that the enrollee may file a grievance if they are dissatisfied with the denial of expedited processing time of their appeal.

Post-service items or services are not eligible for expedited processing.

How to file an appeal
Appeals may be filed by calling Enrollee Services at **1-866-329-4701 (TTY: 711)** or they may be submitted in writing via fax, email or postal mail to:

Aetna Better Health of Illinois Appeal
and Grievance Department
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

Fax**: 1-844-951-2143**
Email: **ILAppealandGrievance@aetna.com**

State Fair Hearing
Enrollees or their designated representative, including a provider acting on their behalf, with written consent may request a State Fair Hearing through Illinois Department of Healthcare and Family Services (HFS) after the appeal with Aetna. Enrollees have one-hundred-twenty (120) calendar days to file following receipt of the appeal decision letter. Information on how to submit a State Fair Hearing appeal is included in the Appeal Decision Letter.

The request for a State Fair Hearing must be submitted in writing to the following:

Mail: For medical services or items, or Elderly Waiver (Community Care Program (CCP)) services:
Illinois Department of Healthcare and Family Services

Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, Illinois 60602

For mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver Services, HIV/AIDS Waiver Services, or any Home Services Program (HSP) service:

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: DRS Waiver Services: **312-793-8573**
Aging Waiver Services: **312-793-2005**
Medicaid Non-waiver; **312-793-2005**

Email: DRS Waiver Services: **DHS.HSPAppeals@illinois.gov**
Aging Waiver Services: **HFS.FairHearings@Illinois.gov**
Medicaid Non-waiver Services: **HFS.FairHearings@Illinois.gov**

Call: DRS Waiver Services: **1-800-435-0774** (TTY users call **1-877-734-7429**) Aging Waiver Services: **1-855-418-4421** (TTY users call: **1-800-526-5812**)
Medicaid Non-waiver Services: **1-855-418-4421** (TTY users call: **1-800-526-5812**)

Online: Visit **abe.illinois.gov/abe/access/appeals** to set up an ABE Appeals Account and submit a State Fair Hearing request online. This will allow you to track and manage your appeal online, view important dates and notices, and submit documentation.

Enrollees may request that their benefits continue through the State Fair Hearing process, when all of the following criteria are met:

- The enrollee or provider on behalf of the enrollee files the appeal within ten (10) calendar days of the postmarked adverse benefit determination or prior to the effective date of adverse benefit determination
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the initial authorization has not expired
- The enrollee requests extension of benefits

The department renders the final decision and will notify all parties. If the decision agreed with the previous decision from Aetna, and the enrollee **continued to receive services,** the enrollee may be responsible for any cost of services received during the State Fair Hearing. If the State Fair Hearing decision favors the enrollee, then Aetna Better Health of Illinois will authorize items/services within (72) hours of the receipt of the decision.

External Independent Review (EIR)
Enrollees or their designated representative, including a provider acting on their behalf, with written consent may request an EIR through Aetna at the same time as or instead of filing a State Fair Hearing. Enrollees have thirty (30) calendar days to file following the receipt of the appeal decision letter. Information on how to submit an EIR External Review is included in the Appeal Decision Letter.

The request for an External Independent Review must be submitted in writing to the following: Aetna Better Health of Illinois
Appeal and Grievance
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

Fax: **1-844-951-2143**
Email: **ILAppealandGrievance@aetna.com**

The external review organization will render the final decision and notify all parties. If the enrollee requested both an external independent review and a State Fair Hearing the State Fair Hearing is the one that counts.

Provider appeal and grievance on behalf of the member system overview

Providers may file an appeal or grievance verbally or in writing. Verbal appeals or grievances may be required to be submitted in writing.

A network provider, acting on behalf of an enrollee, and with the enrollee's written consent, may file a grievance or appeal. Representatives must be designated in writing with the exception of a network provider requesting an expedited appeal. **In all cases, when a provider files on behalf of an enrollee the case is considered an enrollee appeal or grievance and is subject to the enrollee appeal or grievance timeframes and policies.**

Aetna informs providers of the provider appeal and grievance system processes in this manual and on the Aetna Better Health of Illinois website.

Aetna verifies that no punitive action is taken in retaliation against an enrollee who requests an appeal or grievance or against a provider who requests an expedited resolution or supports an enrollee's appeal or grievance. Providers may not discriminate or initiate disenrollment of an enrollee for filing an appeal or grievance with Aetna.

1. When filing a dispute by calling our Customer Service at **1-866-329-4701 (TTY: 711)**, providers will receive a tracking/reference number from the agent handling your inquiry (i.e., #PDXGR1234567).
2. When mailing in or submitting a claim dispute/reconsideration through our Provider Portal, the provider must complete the requested information and attach or upload any appropriate supporting documentation. The dispute decision will be sent in the form of a provider remittance and the tracking/reference number will be the adjusted claims number from that remittance (i.e., the claim number ending in A1, A2, A3, etc.).
3. When filing an appeal or grievance you will receive an appeal or grievance number in the acknowledgment and resolution letters. (APXXXX, or GRXXXX)

The Aetna processes for resolving provider appeals and complaints are described below.

Provider reconsideration

Network providers may file a reconsideration related to a claim denial or claim payment discrepancy within (90) calendar days from date of remittance advice (EOP) in writing directly to Aetna Better Health® of Illinois to resolve disputes about a claim that was denied in whole or in part; as a duplicate, untimely filed or due to a coding edit or missing information such as itemized bill, coordination of benefits or proof of timely filing. If a claim does not require any changes, but a provider is not satisfied with the claim disposition, a claim reconsideration can be submitted. A provider can submit a reconsideration both in writing and electronically.

NOTE: An EOB is not needed when disputing Third Party Liability (TPL); however, the provider should indicate in their dispute that they have validated Third Party Liability (TPL) is inactive for the date of service.

To submit in writing, submit a Claim Reconsideration Form found under the Dispute section of the Provider Forms page. Submit additional information to support the request for claim re-adjudication, information should be submitted single sided.

Reconsiderations should be submitted to:

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

To submit electronically providers can use the provider portal: **Medicaid.aetna.com/MWP/login.fcc**

Plan will provide response to electronic reconsiderations within 30 days of receipt and issuance of tracking number

- Please use the Claim Number as the tracking number.
- This is the preferred method for participating providers when filing claims reconsiderations; non-participating providers will need to utilize the paper reconsideration process noted below.

The reconsideration will be reviewed and processed according to the definitions in this document. Provider Claim Reconsiderations do not include pre-service denials that were denied due to not meeting medical necessity. Pre- service

denials are processed as **enrollee appeals** and are subject to enrollee policies and time frames.

If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department. For all reconsiderations, Aetna Better Health of Illinois notifies the provider of the dispute resolution through the remittance advice.

Retrospective Authorization Dispute (Provider Appeal)

Providers may file a request for review of post-service, authorization related claim denials for potential reprocessing when they are: 1) attributed to authorizations not kept current due to extenuating circumstances or 2) medical necessity disputes requiring review of medical records.

Examples of Retrospective Authorization Disputes:
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 request.

Retrospective Authorization Disputes must be submitted within 60 days of the date of denial.

The request will be acknowledged either orally or in writing within five (5) business days of receipt. Aetna will respond to Respective Authorization Disputes within thirty (30) business days.

Submit your request by fax or mail with all supporting documentation clearly marked as "**FILING A RETROSPECTIVE AUTH DISPUTE**" to:

Aetna Better Health of Illinois
Attn: Appeal and Grievance Department
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Fax: 844-951-2143

Retrospective Authorization Requests can also be submitted electronically, again marked as "**FILING A RETROSPECTIVE AUTH DISPUTE**" to:

Email: **ILAppealandGrievance@aetna.com**
Via Provider Portal: Use Provider Appeal option with the heading bolded above

Provider complaints (Provider grievance)

Both network and out-of-network providers may file a non-claims related complaint verbally or in writing directly with Aetna Better Health® of Illinois in regard to our policies, procedures, or any aspect of our administrative functions. Providers can file a complaint with Aetna by calling **1-866-329-4701 (TTY: 711)**.

To file a complaint in writing, providers can submit via, fax, email or postal mail to:

Aetna Better Health of Illinois
Appeal and Grievance
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

Fax: **1-844-951-2143**
Email: **ILAppealandGrievance@aetna.com**

Provider complaints will be acknowledged either orally or in writing within five (5) business days of receipt. Aetna Better Health of Illinois responds to provider complaints within thirty (30) business days of receipt. If the complaint requires research or input by another department, the Appeal and Grievance department will engage the affected department and will coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Illinois written policies and procedures, collecting pertinent facts from all parties. The complaint with all research will be reviewed for resolution and may be presented to the Grievance Committee for resolution. None of the reviewers or members of the Grievance Committee will have been involved in any prior decision making related to the complaint. When the complaint includes a clinical issue a provider with same or similar specialty will participate and render the final resolution.

State complaints – HFS Portal

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

Following the resubmission process, you may make a complaint through the Illinois Department of Healthcare and Family Services (HFS) through the state portal.

When attempting to resolve issues with Aetna, you'll receive a unique reference number based on how you attempt to resolve the issue.

- When contacting our **Customer Service** at **1-866-329-4701**, providers will receive a tracking/reference number from the agent handling your inquiry (i.e., #PDXGR1234567).
- When contacting **Network Relations Consultants**, they'll provide a reference number (i.e., #1234).
- When **mailing** in a claim dispute/reconsideration, the provider must complete the requested information and attach or upload any appropriate supporting documentation. The decision will be sent in the form of a provider remittance and the Tracking ID is the adjusted claims number from that remittance (i.e., the 13 digit claim number #####X######## plus characters ending in A1, A2, A3, etc.).
- When submitting an **electronic claim dispute through our Provider Portal**, the provider will receive a tracking ID in the following format: TMMDDYY#X##X#. This number will always begin with a T (for tracking) followed by mm/dd/yy format, and then a combination of letters and numbers. Providers can view it in the Portal via the "Claims Search" section by searching and selecting the claims in question. This functionality was live as of 2/27/2022.

  You'll receive a provider complaint or grievance number in the acknowledgment and resolution letters. (APXXXX or GRXXXX)

To submit through the portal, follow the directions at **Medicaid.aetna.com/MWP/login**.

HFS will review all documentation and will notify all parties. If the decision disagreed with the previous decision of Aetna Better Health of Illinois, Aetna Better Health® of Illinois will authorize items/services within ten (10) calendar days of the receipt of the decision. If the decision agreed with the previous decision of Aetna Better Health of Illinois, the State Complaint decision notification will include information on how to HFS for review.

Department review

If the MCO's written proposal for resolution is contested, the provider has 30 calendar days to request HFS to review the dispute and make a final determination.

- If a provider does not receive a written resolution from Aetna to the State complaint or they disagree with the written resolution they may request a Department review. Both the provider and Aetna must submit all relevant materials including contact information for knowledgeable personnel to the Department within thirty (30) calendar days
- The Department will review the request against applicable contract terms, policies, procedures, State and Federal regulations and will render a final decision within thirty (30) days after the receipt of all relevant information

If the decision disagreed with the previous decision from Aetna Better Health of Illinois, the health plan will authorize items/services within ten (10) calendar days of the receipt of the decision.

Fraud, waste and abuse

Aetna has an aggressive, proactive fraud, waste, and abuse program that complies with state and federal regulations. Our program targets areas of health care related fraud and abuse including internal fraud, electronic data processing fraud, and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste or abuse to appropriate state and federal agencies as mandated by Illinois General Assembly. During the investigation process, we maintain the confidentiality of the member, or people referring the potential fraud and abuse case.

We use a variety of mechanisms to detect potential fraud, waste and abuse. All key functions including Claims, Provider Services, Member Services, Medical Management, as well as providers and members share the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation and data analysis.

Special investigations unit

Our SIU conducts proactive monitoring to detect potential fraud, waste and abuse, and is responsible to investigate cases of alleged fraud, waste and abuse in all markets. With a total staff of approximately 150 individuals, the SIU is comprised of experienced, full-time investigators, analysts, a full-time dedicated information technology organization and supporting management and administrative staff.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring the huge volume of Aetna claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate to conduct in-depth analyses of case-related data.

Reporting suspected fraud and abuse

Participating providers are required to report to Aetna all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

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

- By phone to the confidential Aetna Compliance Hotline at **1-866-536-0542**
- By phone to our confidential SIU at **1-800-336361 Note:**

We keep your identity confidential.

You can also report provider fraud to the following:

- HFS Medical Program via the Department's Office of Inspector General at **Illinois.gov/hfs/oig/Pages/Welcome.aspx**
- Medicaid Fraud Control Unit (MFCU) of the Office of Attorney General at **oig.hhs.gov/fraud/report-fraud/index.asp**
- Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477)** or **oig.hhs.gov/fraud/report-fraud/index.asp**

The MFCU is a division of the Office of Attorney General created by statute to preserve the integrity of the Medicaid

program by conducting and coordinating fraud, waste, and abuse control activities for services funded by Medicaid. A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy – verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Take action if you identify a problem
- Remember you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Fraud, Waste and Abuse defined

- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste:** Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse:** Provider practices inconsistent with sound fiscal, business, or medical practices resulting in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of fraud, waste and abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna due to improper payments to providers or overpayments
- Physical or sexual abuse of members

Fraud, waste and abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members, a cash payment to encourage enrollment in a specific plan
- Selecting or denying members based on their illness profiles or other discriminating factors
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider)
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment)

- Billing for services not rendered or supplies not provided includes billing for appointments the members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for 20 nursing home visits without furnishing any specific service to the members.
- Double billing (billing both Aetna and another health plan)
- Misrepresenting the date services were rendered or the identity of the member who received the services
- Misrepresenting who rendered the service or billing for a covered service other than the non-covered service that was rendered

Fraud, waste and abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the member's medical history
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addiction

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another member's ID)
- Forging and altering prescriptions
- Doctor shopping (i.e., when a member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.)

Elements of a compliance plan

An effective compliance plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote commitment to compliance and address specific areas of potential fraud, waste, and abuse.
2. Designation of a compliance officer: Designation of an individual and a committee responsible for and with authority for operating and monitoring the compliance program.
3. Effective compliance training: Development and implementation of a regular, effective education and training program.
4. Internal monitoring and auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas.
5. Disciplinary mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities excluded from participating in the Medicaid program.
6. Effective lines of communication: Between the Compliance Officer and employees, managers, directors, and members of the compliance committee, as well as related entities.
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant laws

Providers contracted with Aetna must agree to be bound by and comply with all applicable state and federal laws and regulations.

There are several relevant laws that apply to Fraud, waste and abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when health care providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:
  - Knowingly presenting a false or fraudulent claim for payment or approval
  - Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government
  - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

  "Knowingly" means that a person, with respect to information:
  1. Has actual knowledge of the information
  2. Acts in deliberate ignorance of the truth or falsity of the information
  3. Acts in reckless disregard of the truth or falsity of the information
- Anti-Kickback Statute
  - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a federal health care program. Remuneration includes anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.
- Self-Referral Prohibition Statute (Stark Law)
  - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship unless an exception applies.
- Red Flag Rule (Identity Theft Protection)
  - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
- Health Insurance Portability and Accountability Act (HIPAA) requires:
  - Transaction standards
  - Minimum security requirements
  - Minimum privacy protections for protected health information
  - National Provider Identification (NPI) numbers
- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims' penalty is to be adjusted periodically for inflation in accordance with a federal formula.
- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health® of Illinois providers will follow federal and state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, including programs for children and families accessing Aetna Better Health of Illinois services through the state of Illinois, Inc..
- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program prohibits identified entities and providers excluded by the OIG or GSA from conducting business or receiving payment from any federal health care program.

Administrative sanctions

Administrative sanctions can be imposed by regulatory authorities, as follows:

- Denial or revocation of Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Authority and responsibility

The Compliance Officer has overall responsibility and authority for carrying out the provisions of our compliance program. We are committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Aetna provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
    - Suspension
    - Exclusion
    - Prison time

Exclusion lists and death master report

We check the Office of Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS, or System of Award Management (SAM)), the Social Security Death Master Report (DMF), and any other such databases as the state may prescribe.
IMPACT also performs monthly screenings of all enrolled providers. Screenings include licenses, OIG, SAM, Medicare Exclusion database (TIBCO), DMF, and Drug Enforcement Agency (DEA) database.

Aetna does not participate with or enter into any provider agreement with any individual or entity excluded from participation in federal health care programs, who has a relationship with excluded providers, or who has been terminated from Medicaid or any programs by the state for fraud, waste, or abuse. The provider must agree to assist Aetna as necessary in meeting our obligations under the contract with the state to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Mandated reporters

As mandated by Illinois General Assembly, Department of Human Services Act (20 ILCS 1305/1-1 et seq.), the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.), the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.), and any other similar or related applicable federal and State laws, all providers who work with or have any contact with an Aetna Better Health® of Illinois member are required as "mandated reporters" to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency.

Children

Providers must report suspected or known child abuse and neglect to the Illinois Department of Children and Family Services (DCFS) or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

If the child is in immediate danger, call **911**.

Vulnerable adults

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

- The Department of Human Services Office of Inspector General: **Illinois.gov/hfs/oig/Pages/Welcome.aspx**
- Adult Protective Services: To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18-59 call the statewide, 24-hour Adult Protective Services Hotline**:** **1-866-800-1409, 1-888-206-1327 (TTY)**
- For residents who live in nursing facilities, call the Illinois Department of Public Health's Nursing Home Complaint Hotline**:** **1-800-252-4343**
- For residents who live in Supportive Living Facilities (SLFs), call the Illinois Department of Healthcare and Family Services' SLF Complaint Hotline**: 1-800-226-0768**
- The National Domestic Violence Hotline at **1-800-799-SAFE (7233)**
- The local county police or sheriff's Department

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine or imprisonment up to six months.

Reporting identifying information

Any provider who suspects that a member may need protective services should contact the appropriate state agencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers, if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information)

Provider Services staff notified of suspected abuse or neglect must alert their Aetna Director/Manager/Supervisor immediately. Aetna managers will take appropriate action and notify the health plan Compliance Officer who will determine

if further action is necessary.

Our providers must fully cooperate with the investigating agency and make related information, records, and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to determine abuse or neglect

When a state agency or an Aetna care coordinator becomes aware of a potential case of neglect or abuse of a member, we work with the agency and the PCP to help the member receive a timely physical examination for determination of abuse or neglect. In addition, we notify the appropriate regulatory agency of the report.

Depending on the situation, our care coordinators provide the member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, behaviors and signs

Abuse

Examples of abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (bed sores)
- Missing teeth
- Broken bones/sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence
- Emotional abuse

Behavior indicators of a child wary of adult contacts:

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
- Reports injury by parents

Behaviors of abusers (caregiver or family member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of neglect:

- The intentional withholding of basic necessities and care
- Not providing basic necessities and care because of lack of experience, information or ability

Signs of neglect:

- Malnutrition or dehydration
- Unkept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities such as washing, dressing and bodily functions

Examples of financial exploitation:

- Caregiver, family member or professional expresses excessive interest in the amount of money spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets