



New provider orientation

Aetna Better Health® of Illinois



Agenda

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

Leadership

Terriana Robinson

Lead Director, Provider Relations

Christine Fox-Zapata

Senior Director, Provider Relations

Steve Inzerello

Senior Director, Provider Relations

Overview



Who we are

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

Our footprint



**3200 Highland Avenue
Downers Grove, IL 60515**

**333 W. Wacker Drive
Chicago, IL 60606**

Our local approach

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

Provider Experience

Provider Relations & Contracting

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

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

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

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



Business Enterprise Program (BEP) overview

What is BEP?

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

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

Who can become certified?

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



What are the benefits?

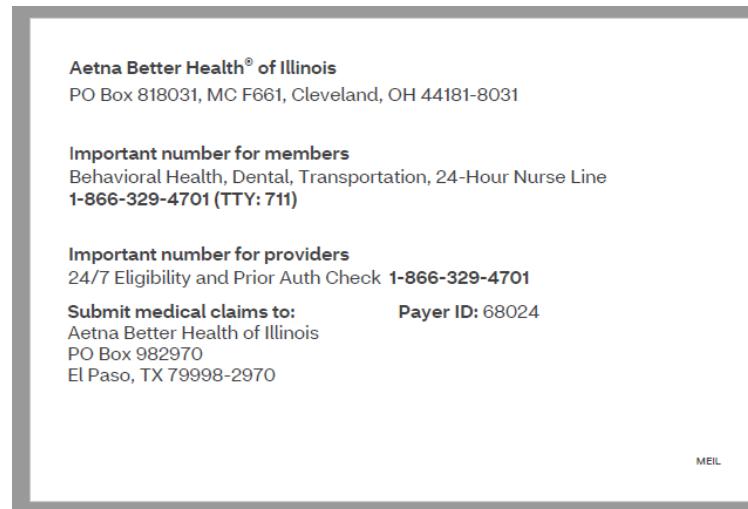
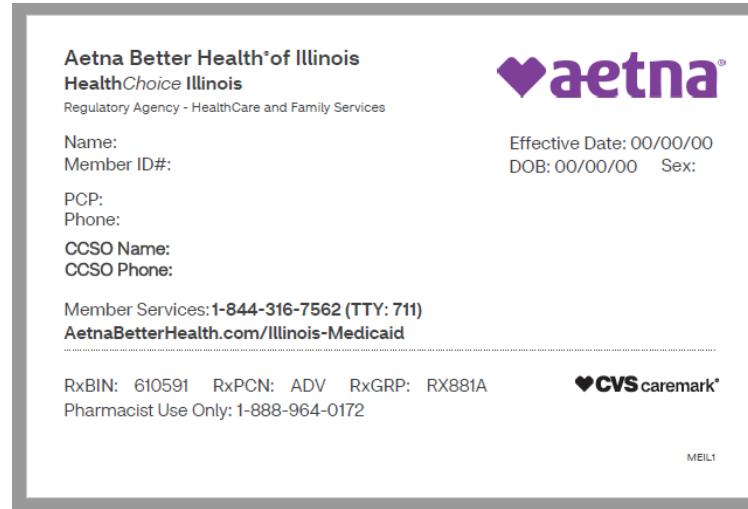
A BEP certification is nationally recognized and can open doors for additional business opportunities. All BEP certified companies are listed within the CMS BEP directory which is used by multitudes of cross-industry businesses seeking diverse suppliers. BEP certification is no cost and ABH IL offers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

Member ID cards

The member ID card contains the following information:

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

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



Prior authorizations

A prior authorization request may be initiated by:

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

- ✓ Please remember that emergencies do not require prior authorization.
- ✓ Submit authorization requests within 7 (seven) days prior to elective procedures.
- ✓ Submit authorization requests within 24 hours of urgent/emergent admission.
- ✓ Turnaround times for processing requests are as follows:
 - Standard – 4 calendar days
 - Urgent – 48 hours

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

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

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

Behavioral Health will continue to use ASAM criteria for Substance Abuse admissions.

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



Aetna Better Health® of Illinois

Prior Authorization Request Form

Phone: **1-866-329-4701**/Fax: **1-877-779-5234**
For urgent outpatient service requests (required within 72 hours) call us.

Date of Request: _____

MEMBER INFORMATION

Name: _____ ID Number: _____

Date of Birth: _____ PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): F M

PROVIDER INFORMATION

Ordering/Requesting Provider:

Name: _____

NPI (Required*) _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Person: _____

Servicing Provider/Facility/Specialist:

Name: _____

NPI (Required*) _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

AUTHORIZATION INFORMATION

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

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

Pharmacy claims

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

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

BIN: 610591
PCN: Rx881A
Group: ADV

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

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

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

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

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

Providers that want to update their payment/Electronic Remittance Advice (ERA) distribution preferences for Aetna Medicaid claims payment on the dedicated [Aetna Better Health/ECHO portal](#). No fees apply when using this dedicated portal, which is identified by the “Aetna Better Health” name in the top left of the page.

To sign up for electronic funds transfer, providers will need to provide an ECHO payment draft number and payment amount for security reasons, as part of the enrollment authentication. The ECHO draft number can be found on all provider Explanation of Provider Payments (EPP), typically above your first claim on the EPP. If you have not received a payment from ECHO previously, you will receive a paper check with a draft number you can use to register after receiving your first payment.

Tax ID: 123456789				EPC Draft #: 999999999		Payment Week: 40			Payment Date: 01/01/2900		Page 1 of 2	
Service Date	Code or Description	Explanation Codes	Charge	Provider Discount	Other Plan Payment	Other Adjustment	Patient Obligation			Net Payment Amount		
				Co Ins	Co-Pay	Deductible	Non-Cov					
Provider: SAMPLE PROVIDER				Patient Acct #: 5555555555				Group/Check Number: ABC/123456				
Network: SAMPLE NETWORK				Member Number: 123456789				Customer Service #: 111.111.1111				
Patient Name: JOHN DOE				Claim Number: 1111111111				Administered By: TPA				
01/23/20	99214	45	142.00	44.40	0.00	0.00	0.00	50.00	0.00	0.00	47.60	
Total:			142.00	44.40	0.00	0.00	0.00	50.00	0.00	0.00	47.60	

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

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

Billing & claims payment

For claim submission:

Electronic claims submission through clearinghouse:

- **Payer ID: 68024 (Claim Submission)**

Submit paper claims to:

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



CHECK RUN IS THREE TIMES A WEEK

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

ERA:

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

Provider disputes, resubmissions and reconsiderations

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

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

Corrected claims

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

Reconsiderations

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

A provider may request a claim resubmissions/reconsiderations using the Provider Dispute & Resubmission form if they would like us to review the claim decision. Claim reconsideration is available to providers prior to submitting an appeal.

Resubmissions must be submitted within **180 days of the date of service**. Reconsideration requests must be submitted within **90 calendar days from the date of the notice** of the claim denial to:

Aetna Better Health of Illinois

P.O. Box 982970

El Paso, TX 79998-2970

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

Provider appeals

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

Provider appeal

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

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

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

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

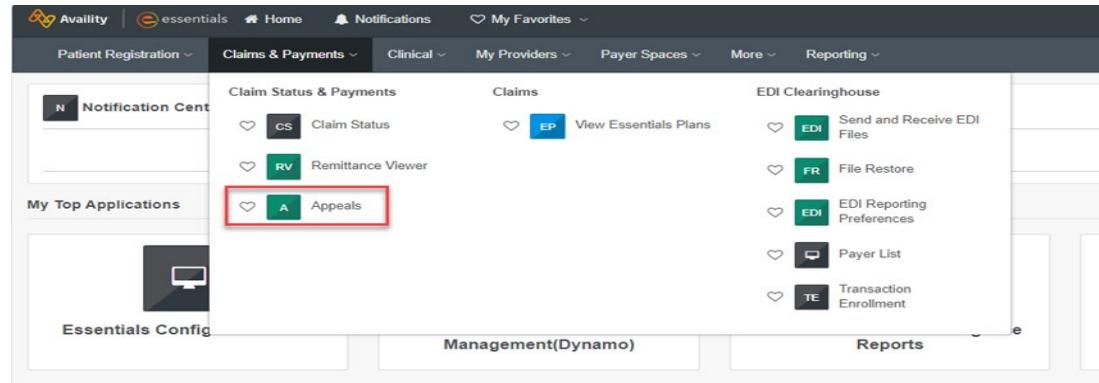
A provider may file an appeal within 60 calendar days of the date of the notice of adverse benefit determination. Provider Appeals can be submitted to:

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

New Availability Enhancement - Enhanced Appeal Submission

Provider Appeal

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

A screenshot of the Aetna Availability software interface showing the 'Appeals' submission form. The form includes fields for 'Request Reason' (set to 'PRICING'), 'Contact Phone Number' (5557779999), 'Fax Number' (5557779999), 'Patient Account Number' (G987654321), 'Service End Date' (05/01/2022), 'Payment Amount' (\$2,647.68), and 'Submit On Behalf Of Provider'. A reminder message states: 'REMINDER: You will NOT be able to attach any additional documentation after you submit the appeal/reconsideration.' Below the form is a table titled 'ATTACHMENTS' showing five uploaded documents: 'AnotherTestDocument' (492 KB), 'TestDocument' (20 KB), 'WordDocument' (23 KB), and 'Imagefile2' (162 KB), all marked as 'Submitted'.

Review Outcome

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

Submission

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

A screenshot of the Aetna Availability software interface showing a finalized reconsideration decision. The top navigation bar is identical to the previous screenshot. The main content area displays a summary for 'Finalized - Reconsideration - Finalized' (Created: 02/20/2024, Updated: 07/18/2024). The summary includes: 'Claim Number: 198760000123', 'Payment Information: NONPAYMENT', 'Patient Name: PETER PATIENT', 'Service Begin Date: 09/01/2023', 'Billed Amount: \$138.00', 'Method of Receipt: Availability', 'Request Reason: ELIGIBILITY', 'Contact Phone Number: 9725551212', 'Fax Number: 9725554321', 'Patient Account Number: C1234500', 'Service End Date: 09/01/2023', 'Payment Amount: \$0.00', and 'Submit On Behalf Of Provider'. Below the summary is a note: 'Rationale Submitted To Payer: Detailed explanation of why payment of this claim should be reconsidered.' The decision status is listed as 'Decision: FINALIZED' and 'Decision Reason: For additional explanation, please refer to EOB'.

Provider grievance

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

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

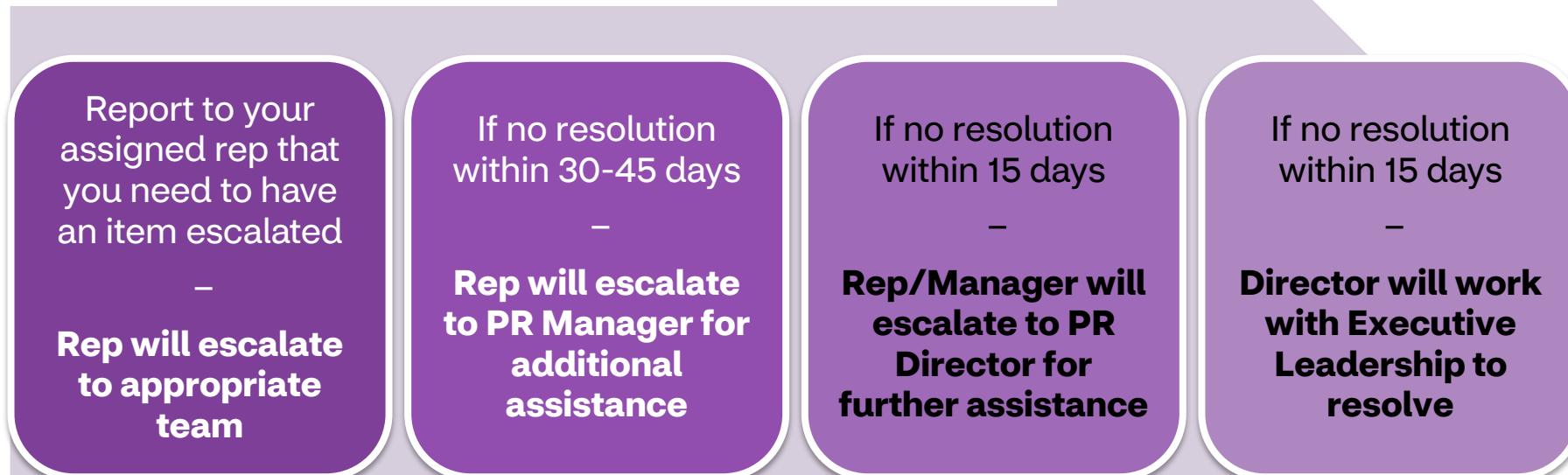
- Administrative issues
- Payment and reimbursement issues
- Dissatisfaction with the resolution of a dispute
- Aetna Better Health staff, service or behavior
- Vendor staff, service or behavior

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

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

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

Provider escalation process



Provider state escalations

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

HFS requirements for submitting a state escalation

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

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

Illinois Medicaid Redetermination

Prepare your patients

GOT MEDICAID? GET READY TO RENEW!

Click Manage
My Case at
abe.illinois.gov



Illinois is checking to see if you are still eligible for Medicaid. Here's what you need to do now:

Click Manage My Case at abe.illinois.gov:

- ✓ Verify your mailing address under "contact us."
- ✓ Find your due date (also called redetermination date) in your "benefit details".

Watch your mail and complete your renewal right away.

If you are no longer eligible for Medicaid, connect to coverage at work or through the official Affordable Care Act marketplace for Illinois, GetCoveredIllinois.gov.



HFS
Illinois Department of
Healthcare and Family Services

1-800-843-6154

Visit HFS Today and access the “Ready to Renew” toolkit

Printable patient flyers available in different languages (post in waiting and exam rooms)

Social medial PNG file available to use

Palm cards available for use

[HFS Ready to Renew Toolkit](#)

¿TIENE MEDICAID? ¡PREPÁRESE PARA RENOVARLO!

Haga clic en
Administrar
mi caso en
abe.illinois.gov



Illinois está verificando si todavía es elegible para Medicaid. Esto es lo que debe hacer ahora:

Haga clic en Administrar mi caso en abe.illinois.gov para:

- ✓ Verificar su dirección postal en "contactenos".
- ✓ Buscar su fecha de vencimiento (también llamada fecha de redeterminación) en sus "detalles de beneficios."

Revise su correo y complete su renovación de inmediato.

Si ya no es elegible para Medicaid, consúltese a la cobertura en el trabajo o a través del mercado oficial de la Ley del Cuidado de Salud a Bajo Precio para Illinois, GetCoveredIllinois.gov.

Escanee aquí ahora y haga clic en Administrar mi caso.



HFS
Illinois Department of
Healthcare and Family Services

1-800-843-6154

How providers can help with redetermination

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

Members can update mailing address with HFS by:

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

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

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

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

Get your patients' redetermination date

Member-level Redetermination Report includes:

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

Available in Availability

Why it's important

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

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

[Illinois Medicaid Redetermination FAQ](#)

Aetna Provider Summit Series

You're invited to our next Provider Summit

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



Our Provider Experience team will be hosting exciting and informative provider summits in Q4. Virtual sessions will be offered on the following dates:

Date/Time
Thursday, November 6, 2025 at 10 AM-12 PM CT
Thursday, November 20, 2025 at 1 PM-3 PM CT

Scan the QR code or use the link below to register.
<https://www.surveymonkey.com/r/RNCFFS9>



Quality

Quality management program

Overview

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

Medical records standards

- ABHIL's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI).
- All providers must adhere to national medical record documentation standards. For a complete list of minimum acceptable standards, please review the ABHIL Provider Manual

Quality management - HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS)

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

What is our ultimate goal?

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

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

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

What is EPSDT?

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

Provider responsibilities:

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

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

EPSDT/Bright Futures

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

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

Required EPSDT/Bright Futures screening services

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



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

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

 **aetna**
Aetna Better Health® of Illinois

Health Risk Screening

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

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

Three (3) documented outreach attempts:

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

Questionnaire & triggers

Questionnaire includes but is not limited to:

- a. Demographic information for verification purposes;
- b. Current and past physical health and behavioral health conditions;
- c. Identifying enrollees with special health care needs and specialized treatment or equipment;
- d. Services or treatment the enrollee is currently receiving, including from out-of-state providers;
- e. Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another plan;
- f. Most recent ER visit, hospitalization, physical exam and medical appointments;
- g. Current medications; and
- h. Questions to address Social Determinants of Health, including food, shelter, transportation, utilities and personal safety.

Member incentives

Aetna Better Care® Rewards

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

In 2025, all earned rewards are loaded onto a gift card, which members can use to shop in store or online at participating retailers.

Annual visits

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

Screenings

- Cervical cancer screening: \$25
 - Women ages 21-64 who have a Pap smear can earn this reward once every 3 years or women ages 30-64 who have HPV testing or HPV/Pap smear co-testing can earn this reward once every 5 years.
- Breast cancer screening: \$25 ages 50-74
 - Reward can be earned once every 2 years

*Controlled HbA1c: diagnosis of type 1 or type 2 diabetes with a hemoglobin A1c (HbA1c) value of less than 8.0%

**Controlled Blood Pressure: systolic blood pressure below 140 mm Hg and diastolic blood pressure below 90 mm Hg

Rewards are one per year unless otherwise stated.

Diabetes care visits

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

Assessments

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

Controlled blood pressure

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

Dental service (Child)

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

Behavioral health follow-up appointments

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

Aetna Better Care® Rewards (cont'd)

Immunizations for children and adolescents

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

HPV series counts as one reward event.

Prenatal and postpartum doctor visits

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

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

Community events

Community events

Each month our team hosts events across Illinois including:

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

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

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



2025 Value-added benefits and resources

Value-added benefits

Baby essentials

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

Behavioral health wellness app

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

Fitness and weight management

- Voucher for monthly memberships at participating gyms. Digital membership for ages 13 and up; Digital or in-person membership for ages 18 and older
- Personalized nutrition counseling for ages 18 and older. Members may also qualify for food assistance.
- Voucher for digital weight management support for ages 18 and older
- **NEW in 2025** Voucher for monthly subscription fees for grocery delivery services

Healthy kids

- Voucher for clothing for members in grades K-12 (ages 5 through 18)
- **NEW in 2025** Members ages 5-21 can get an annual stipend to go towards health activities and/or programming

Educational support

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

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

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

Learn more about how members can qualify at

[**AetnaBetterHealth.com/
Illinois-Medicaid/What's-
Covered**](https://AetnaBetterHealth.com/Illinois-Medicaid/What's-Covered)

**Provider website and
Availity provider portal**

Aetna Better Health® of Illinois Medicaid public website

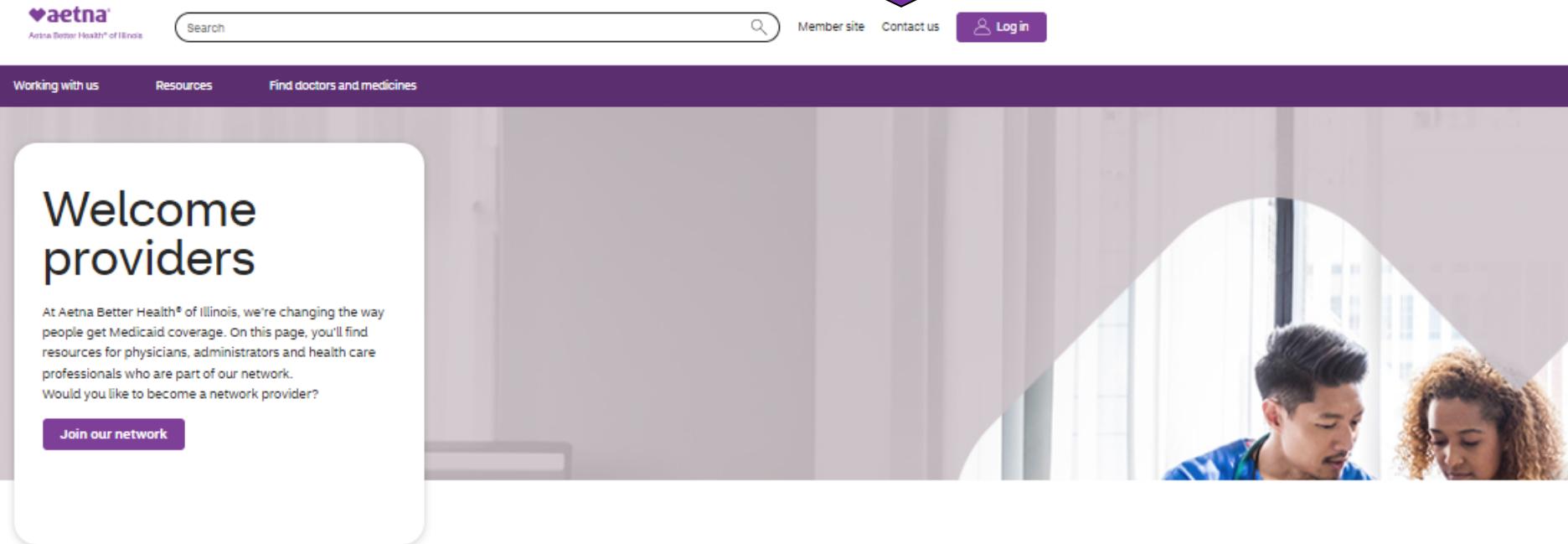
Members and providers can access the Aetna Better Health® of Illinois website at
AetnaBetterHealth.com/Illinois-Medicaid

Providers will be able to access:

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



Provider website



The screenshot shows the homepage of the Aetna Better Health of Illinois provider website. At the top, there is a purple header bar with the Aetna logo, a search bar, and navigation links for "Member site", "Contact us", and "Log in". A large, purple, downward-pointing callout box in the top right corner contains the text "CONTACT US". Below the header, a main content area features a large image of a male and a female healthcare professional looking at a computer screen. To the left of the image, a white callout box contains the heading "Welcome providers" and a paragraph of text about Medicaid coverage and network providers, followed by a purple "Join our network" button. Below the main image, there are four purple callout boxes arranged horizontally, each containing a title, a small icon, and a brief description. The first box is titled "Training" and features a magnifying glass icon with a heart. The second box is titled "Getting started" and features a document icon with a heart. The third box is titled "Provider Manual" and features a clipboard icon with a heart. The fourth box is titled "Provider Portal" and features a clipboard icon with a checkmark.

Training

Orientation and training

Start your orientation today. >

Getting started

Here are some helpful provider links if you're

Provider Manual

Provider manual (PDF)

Download our manual for more provider information. >

Provider Portal

Provider Portal

Request access to check member eligibility and benefits. >

Provider forms

Provider forms

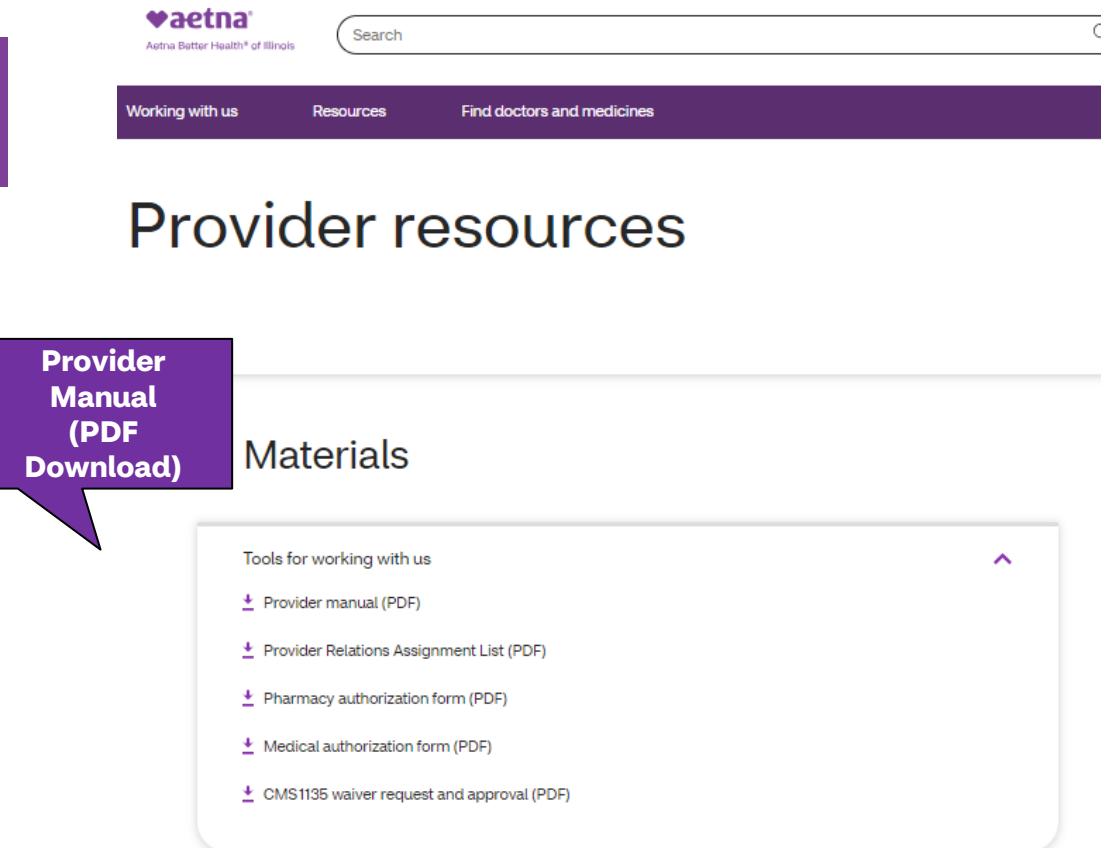
You can find all the forms you need. >

Provider website: Provider manual

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

In addition to policies and procedures, this resource includes:

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



The screenshot shows the Aetna Better Health of Illinois provider website. The top navigation bar includes the Aetna logo, a search bar, and links for "Working with us", "Resources", and "Find doctors and medicines". The main content area is titled "Provider resources". A purple callout box points to a link labeled "Provider Manual (PDF Download)". Below this, under the "Materials" section, is a list of download links:

- Tools for working with us
 - Provider manual (PDF)
 - Provider Relations Assignment List (PDF)
 - Pharmacy authorization form (PDF)
 - Medical authorization form (PDF)
 - CMS1135 waiver request and approval (PDF)

Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters



The image shows the top navigation bar of the Aetna website. It features the Aetna logo with a heart icon and the text "aetna" and "Aetna Better Health® of Illinois". To the right is a search bar with a magnifying glass icon, followed by "Member site", "Contact us", and a "Log in" button with a user icon. Below the search bar is a purple navigation bar with three links: "Working with us", "Resources", and "Find doctors and medicines".

Notices and Newsletters

**NEW:
Provider
events**

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

Provider events

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

Local events

**Quarterly
newsletters**

Newsletters

2025 Newsletters:

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

2024 Newsletters:

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

Notices

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

September 2025

- [Provider claim reconsideration, member appeal and provider complaint/grievance instructions \(PDF\)](#)

- [Updated claims submission process for hospice services in ICF/ID and MC/DD facilities \(PDF\)](#)

August 2025

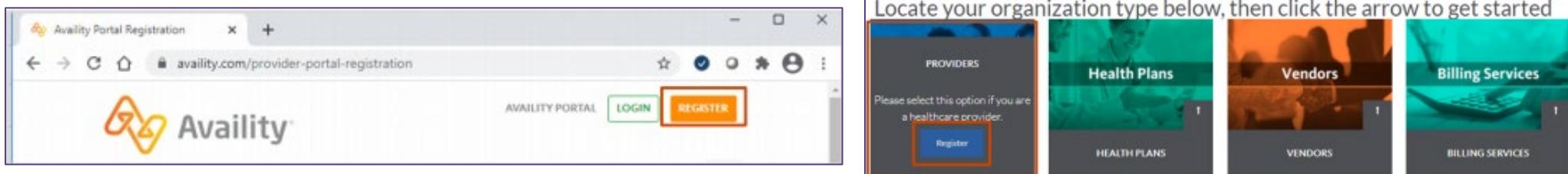
- [H2015 and H2016 code limitations \(PDF\)](#)
- [Enhancement to the EviCore Prior Authorization Process \(PDF\)](#)

Availity portal registration

Availity.com/provider-portal-registration

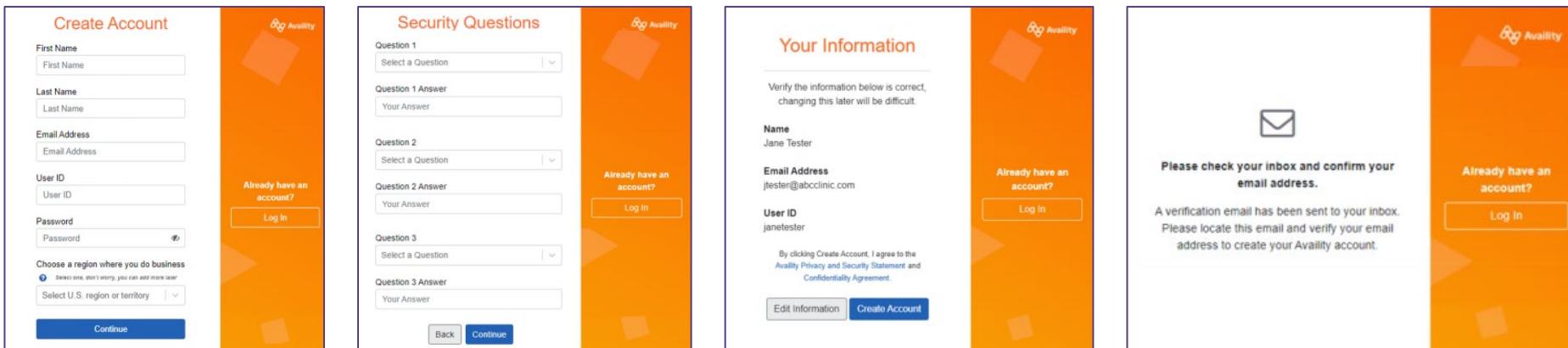
Register your provider organization

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



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

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



Availity Provider Help Center

Crosswalk from Aetna Medicaid Plans to Availity Portal

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

The screenshot shows the Availity Provider Help Center interface. At the top, there is a navigation bar with a question mark icon and the text 'Help & Training'. Below this, there are three main menu items: 'Find Help', 'Payer Help', and 'Get Trained'. A large callout box is positioned over the 'Payer Help' menu item, listing various support tools: 'What's New and Changed', 'Using Availity Payer Help', 'Introduction', 'Contacting Availity', 'Registration', 'Availity Remittance Viewer', 'ERA Correction Tool', 'New Claim Status (Florida Blue)', 'Availity's Requirements', 'Validations, Edits, and Errors', 'Billing', 'Release Schedules and Road Maps', 'Business Functions, Linkouts', 'Provider Maintenance', 'Medical Attachments', 'Attachments', 'Messaging', 'Reporting', 'Spaces Management Tool', 'Training and Resources', 'Support', and 'Glossary'. At the bottom of the interface, there is a 'Dashboard - My Courses' section with a sub-image of a person working on a laptop in a library setting.

The screenshot shows the 'Crosswalk from Aetna Medicaid plans to Availity Portal' page. At the top, there is a navigation bar with the Availity logo and the text 'Provider Help Center'. Below this, there is a search bar with the word 'cross' and a magnifying glass icon. The main content area has a title 'Crosswalk from Aetna Medicaid plans to Availity Portal'. It includes a table with four columns: 'Find the tool or feature you need...', 'In the previous provider portal, you selected a health plan, then from', 'Match it to the Availity tool... (no health plan selection required)', and 'Identify the Availity role you need...'. The table has four rows, each corresponding to a step in the process. The first row is highlighted with a red box around the 'Eligibility and Benefits Inquiry' link in the first column. The second row is highlighted with a red box around the 'Patient Registration' link in the first column. The third row is highlighted with a red box around the 'Express Entry' link in the first column. The fourth row is highlighted with a red box around the 'Administrator' link in the first column. The page also includes a sidebar with links to 'Payer spaces and payer tools', 'Aetna', and 'Aetna Medicaid plans'.

Availity support

Support Tools

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

Key contacts and vendor and partners

Key contact information

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

Vendors and partners

Aetna Better Health® of Illinois subcontracts the following services:

- **DentaQuest** for Dental
 - DentaQuest contacts:
 - Krista.Smathers@dentaquest.com (Central and Southern Illinois)
 - LaDessa.Cobb@dentaquest.com (Northern Chicago)
 - Michelle.ONail@dentaquest.com (Southern Greater Chicago)
- **March Vision** for Vision
 - Optometry claims go to March Vision
 - Ophthalmology claims go to Aetna Better Health of Illinois
 - Enroll contact: MarchVisionCare.com/becomeprovider.aspx or call toll-free at **844-456-2724**
- **Modivcare** for non-emergency medical transportation (NEMT) - **866-329-4701**
- **Availity Provider Portal** - Availity.com/availity/web/public.elegant.login
- **EviCore** for utilization management of advanced imaging/cardiology and interventional musculoskeletal pain management
 - Enroll at Evicore.com or call toll-free at **888-693-3211**
- **Eviti** is a decision support platform for oncology; it covers all medical and radiation oncology treatment plans for members ages 18 and older
 - Provider Support Team is available 8 AM – 8 PM ET or phone at **888-482-8057** or via email at ClientSupport@NantHealth.com

State-mandated training

Appointment and availability standards



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

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

Reminders

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

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

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

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

Cultural, linguistic & disability access requirements & services

Cultural competency

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

Linguistic competency

- **Members with limited English proficiency may experience:**
 - Less adequate access to care
 - Lower quality of care
 - Poorer health outcomes
- **Providers must ensure members have access to medical interpreters, signers, and TTY services to facilitate communication at no cost.**
- **To assist, Aetna Better Health of Illinois provides:**
 - Language Line services 24 hours a day, 7 days a week in 140 languages
 - Information in other formats including Spanish, Russian, Audio, Braille, etc., at no cost
 - TDD/TTY access
 - Translators to your office or the hospital
- **To complete your yearly state mandated Cultural Competency training, please visit: [Cultural competency training \(PDF\)](#)**
- **To complete your attestation please click [here](#).**
- **By completing the attestation, you certify that your organization is committed to ensuring compliance with all applicable federal, state and CMS regulations.**

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

Accommodating people with disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as:

- A person who has a physical or mental impairment that substantially limits one or more major life activity, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability
- The Health Plan ensures equal access in partnership with participating providers by maintaining an ADA Plan. The ADA Plan monitors the following:
 - Physical accessibility of provider offices
 - Quality of the Health Plan's free transportation services
 - Complaints related to the Health Plan and/or provider's failure to offer reasonable accommodations to patients with a disability

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

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

Fraud, Waste and Abuse (FWA)

Fraud, Waste and Abuse

Fraud

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

Waste

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

Abuse

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

Critical incidents

Abuse, neglect & exploitation

Critical incidents: Spot the signs

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



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

Reporting critical incidents

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

800-368-1463

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

866-329-4701

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

866-800-1409

Senior Help Line:

800-252-8966

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

800-252-4343

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

[**https://www.dhs.state.il.us/page.aspx?item=97101**](https://www.dhs.state.il.us/page.aspx?item=97101)

Member Rights and Responsibilities

Member Rights and Responsibilities

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

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

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

For your reference, the rights and responsibilities are:

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

Shared decision-making aids

Shared decision-making aids

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

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

Below are evidence-based aids that provide information about treatment options, lifestyle changes and outcomes. You can access the aids under “Materials” [here](#).

- [Diabetes](#)
- [Flu prevention](#)
- [Statin choice decision aid](#)
- [Depression medication choice](#)
- [Cardiovascular primary prevention choice](#)



Revalidation

All Medicaid providers must revalidate their enrollment

Important notes

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

Need more info?

More information about revalidation — including a list of Frequently Asked Questions — is available from HFS at HFS.Illinois.gov/Impact.

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

Reducing Healthcare Disparities

Supporting Different Languages in Your Practice



Aetna Better Health® of Illinois is proud to be a **Health Equity Accredited Health Plan**. Through this accreditation, we actively work to:

- Reduce health disparities
- Improve patient outcomes
- Build equitable care systems

We achieve this through **data collection, cultural competence, and community partnerships**.

Every three years, we assess our provider network's ability to deliver culturally appropriate care. This includes identifying gaps and offering strategies and tools to address them.

We Need Your Input

Please take a few minutes to complete a short **7-question survey** about your practice's engagement with:

- Availability of bilingual staff
- Use of interpreter services
- Cultural competency training
- Opportunities to enhance cultural competency
- Engagement with Aetna's language services

Reducing Healthcare Disparities

Provider Language Services Survey

Health Equity Accreditation

Standard 6 – Reducing Healthcare Disparities | Element C – Use of data to monitor and assess services

- Factor 2 - Individual experience with language services for organization functions.
- Factor 4 - Individual experience with language services during health care encounters.

Provider Experience with Languages in office – 7 Questions

<https://www.surveymonkey.com/r/9MSLD2X>



Q&A session

Thank you!

