2026 Medicaid Provider Summit

Aetna Better Health® of Illinois
February 2026

Agenda

Introductions & Overview

Care Management

Pharmacy

Business Enterprise Program

Community Outreach

Marketing

Member Value-added Benefits

Quality Management

Availity Portal & Reporting

Value-based Partnerships

Health Equity

Claims Corner

Provider Escalations

Mandated Training

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Welcome from our senior leaders

Melanie Fernando
Chief Executive Officer

Andrew Hyosaka
Chief Operating Officer

Mary Cooley
Health Services Officer

Garett Thomas
Lead Director, Network Management

Elizabeth Leonard
Executive Director, Marketing

Sally Szumlas
Chief Quality Officer

Hassan Gardezi
Chief Compliance Officer

Dianne Robinson
Chief Financial Officer

Steve Sproat
Principal Clinical Leader, Pharmacy

Terriana Robinson
Lead Director, Provider Relations

Denise Gaines
Lead Director, Government Affairs

Shaan Trotter
Health Equity Officer

Introduction to our Provider Relations leadership

Terriana Robinson
Lead Director, Provider Relations

Christine Fox
Senior Manager, Provider Experience

Latahra Smith
Senior Manager, Provider Experience

Steve Inzerello
Senior Manager, Provider Experience

Our footprint

3200 Highland Avenue
Downers Grove, IL 60515

525 W Monroe St
Chicago, IL 60661

Our local approach

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

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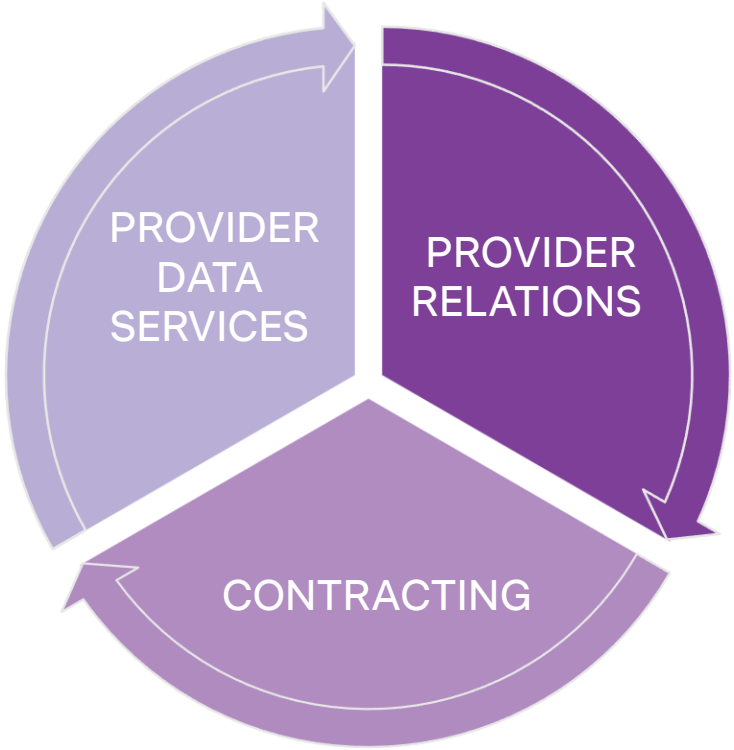
Who we are

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

Provider network overview



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

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

Top 10 reasons to connect with a provider network team member

1. For claims questions, inquiries and reconsiderations

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

3. To request a change for provider demographics

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

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

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

7. For questions related to contractual language or terms

8. For clarification or updates on bulletins or policies

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

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

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Locating your network relations representative

Outreach to Provider Relations via email
ABHILProviderRelations@aetna.com

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

Outreach to Provider Services via phone
1.866.329.4701

Network Relations contact information and coverage areas

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

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

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

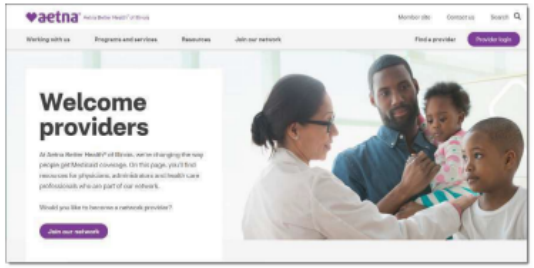
Aetna Better Health of Illinois offers a provider services line by calling **(866) 329-4701**
(Monday through Friday 7 AM-7 PM)

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

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

Save time by accessing our online resources

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



Health plan website

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

Availity

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

Mandatory IMPACT Revalidation

Mandatory IMPACT Revalidation

All Medicaid providers must revalidate their enrollment

Important notes

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

Need more info?

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

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

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Illinois Medicaid Redetermination

Prepare your patients

Visit HFS Today and access the "Ready to Renew" toolkit

- ❑ Printable patient flyers available in different languages (post in waiting room and exam rooms)
- ❑ Social media PNG file available to use
- ❑ Palm cards available for use

HFS Ready to Renew Toolkit

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How providers can help with redetermination

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

  Members can update mailing address with HFS via:

  - ✓ 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 redetermination date or ask questions via the Application for Benefits Eligibility (ABE) hotline:

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

Get your patients' redetermination date

Member-level Redetermination Report includes:

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

Available in Availity

Why it's important

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

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

Illinois Medicaid Redetermination FAQ

Care management

Care management

Role of care management:

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

How to refer to care management

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

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

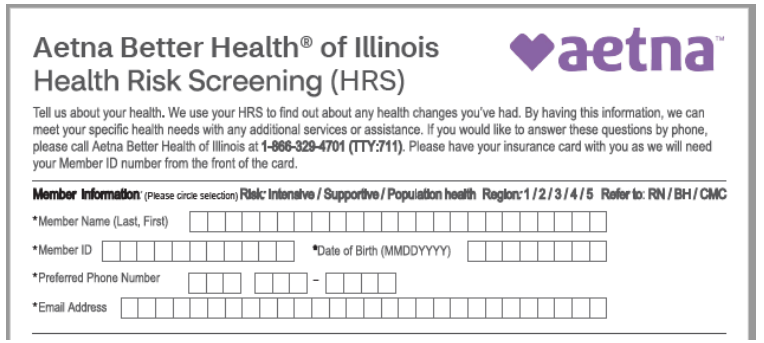
Health Risk Screener (HRS): provider partnership

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

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

Partnership benefits:

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



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

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

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

*Member Name (Last, First)

*Member ID *Date of Birth (MMDDYYYY)

*Preferred Phone Number -

*Email Address

Provider playbook:

Provider Playbook

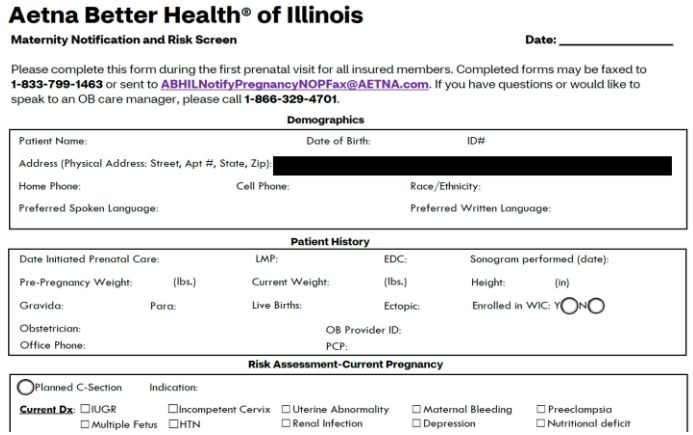
Notification of Pregnancy (NOP): Provider partnership

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

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

Partnership benefits:

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



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

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

Demographics

Patient Name: Date of Birth: ID#

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

Home Phone: Cell Phone: Race/Ethnicity:

Preferred Spoken Language: Preferred Written Language:

Patient History

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

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

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

Obstetrician: OB Provider ID:

Office Phone: PCP:

Risk Assessment-Current Pregnancy

◯ Planned C-Section Indication:

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

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

Pharmacy

Pharmacy resources

Preferred drug list

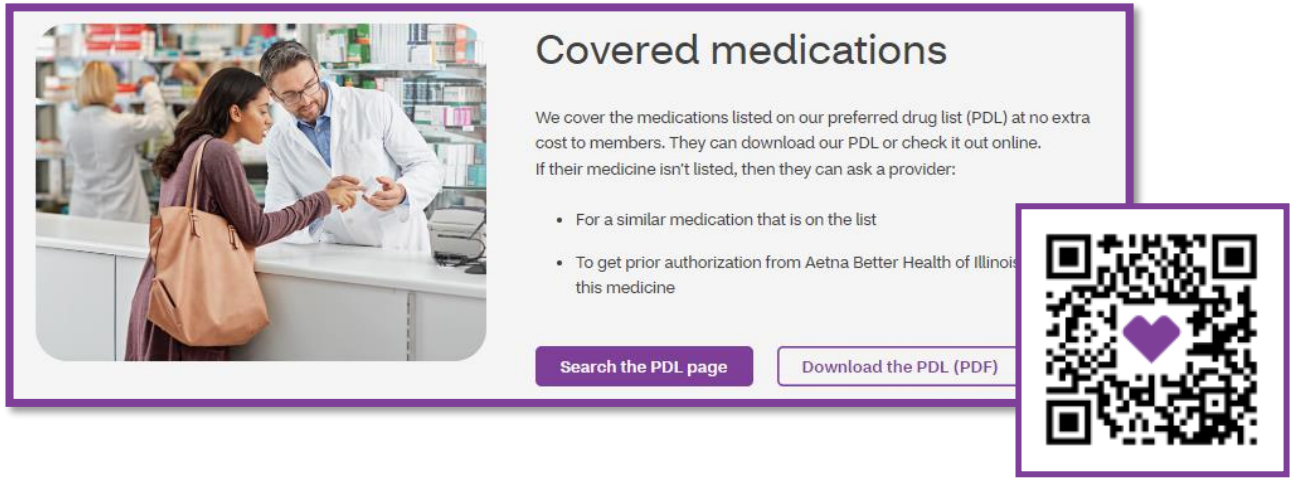
- Drug list available in PDF format as well as in the Aetna search tool.

Medication prior authorization resources

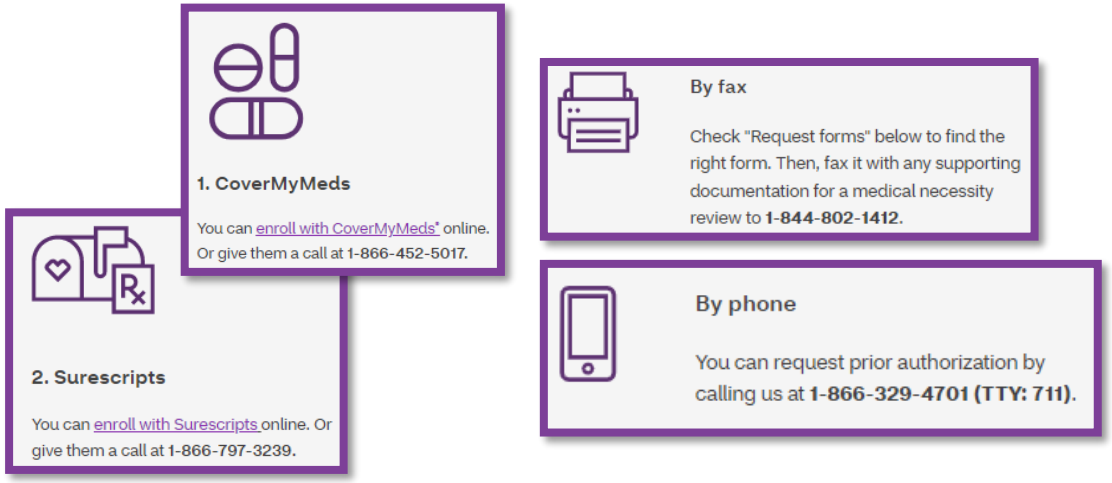
- All Rx prior authorizations reviewed within 24 hours.
- Full PA criteria are available on the provider website.
- All criteria are preloaded into CoverMyMeds in question format.

Pharmacy PA Support Team

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



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



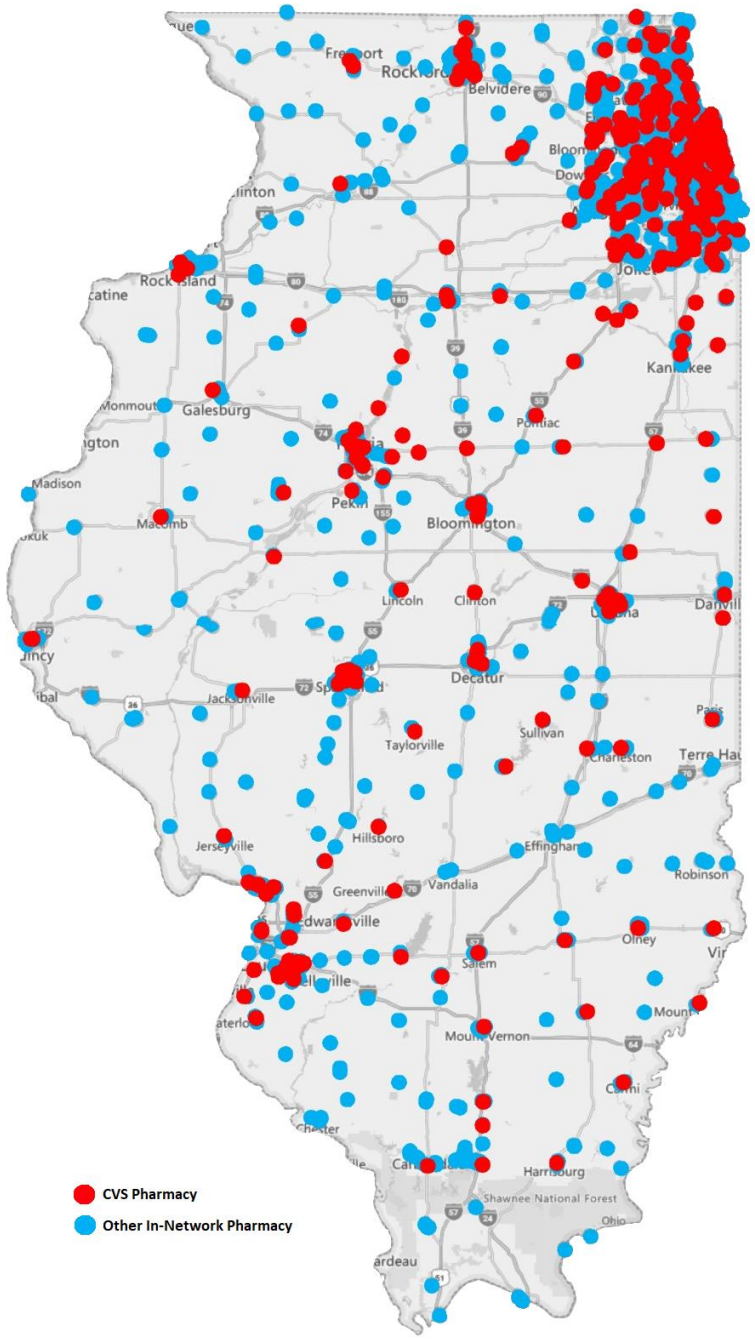
Filling Prescriptions (Pharmacy Network)

Aetna Better Health provides members with a robust network of pharmacies to fill their prescriptions.

All participating pharmacies and prescribers must be enrolled through IMPACT at the individual NPI level.

Additional options for filling prescriptions:

Local Same-Day Delivery	Mail Order	Dose-Pack Medication Delivery
• Available at all IL CVS locations • Free for ABHIL members • Requested at point-of-sale	• 90-day supply of maintenance medication	• Delivered through local IL pharmacies • Ideal for members on complex medication regimens.



PDL Updates (effective 1/1/26)

ADHD Agents - Stimulants

Drug Name	Dosage Form	New PDL Status	Previous PDL Status
QUILLIVANT XR	SRER	PREFERRED w/ PA	NON_PREFERRED
QUILLICHEW ER	CHER	PREFERRED w/ PA	NON_PREFERRED

ADHD Agents - Misc

Drug Name	Dosage Form	New PDL Status	Previous PDL Status
QELBREE	CP24	PREFERRED	NON_PREFERRED
ONYDA XR	SUER	PREFERRED w/ PA	NON_PREFERRED

Diabetic Testing Supplies

- The preferred diabetic testing kit (Contour) is being reinstated, following resolution of prior shortages and supply issues. Expected go live March 1st, 2026.

Business Enterprise Program (BEP)

Business Enterprise Program (BEP) overview

What is BEP?

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

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

Who can become certified?

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

What are the benefits?

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

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Community outreach

Community events

Each month our team hosts events across Illinois including:

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

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

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

Value-added benefits

Value-added benefits

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

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

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

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

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

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

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

Learn more about how members can qualify at

AetnaBetterHealth.com/Illinois-Medicaid/Whats-Covered

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Provider and Member Enablement Initiatives

2026 ABHIL Pay for Performance Program – Key Updates

- ~$4M Total Provider Earning Potential
- Three scheduled payments
  - Q3 2026 for 1H2026
  - Q1 2027 for 2H2026 (reconciled)
  - Q2 2027 for claims runout
- 19 Measures Eligible for Tiered Incentives
- 13 Specialty Measures Eligible for Flat Rate Incentives
- Program Accuracy Improvement:
  - Provider TIN Validation
  - Recent W-9 on file
  - Payment point of contact data

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2026 ABHIL Pay for Performance Program

2026 Pay for Performance measures, targets and payment tiers*

Measure	Submeasure	Tier 1 Rate	Tier 2 Rate	Tier 3 Rate	Tier 1	Tier 2	Tier 3
Adult access to primary care	AAP	-	-	89%	-	-	$10
★ Metabolic Monitoring of Children on Psychotropic Medications	APM	39%	49%	58%	$10	$15	$25
Breast Cancer Screening (2026 MY gaps only)	BCS	59%	64%	70%	$10	$25	$50
Blood Pressure Control for Patients with Diabetes	BPD	72%	79%	80%	$10	$25	$50
Cervical Cancer Screening (2026 MY gaps only)	CCS	56%	62%	69%	$10	$15	$25
Childhood Immunization Status (Combo 10)	CIS	26%	31%	38%	$25	$50	$75
★ Chlamydia	CHL	58%	68%	73%	$10	$15	$25
★ Colorectal Cancer Screening	COL	46%	54%	58%	$10	$15	$25
Controlling High Blood Pressure	CBP	72%	74%	78%	$10	$25	$50
Eye Exams for Patients with Diabetes	EED	60%	68%	72%	-	$20	$30
Glycemic Status Assessment for Patients With Diabetes (<8)	HBD	65%	68%	71%	$10	$25	$50
Immunizations for Adolescents (Combo 2)	IMA	37%	46%	51%	$25	$50	$75
★ Oral Evaluation Dental Services (Total)	OED	-	51%	56%	-	$5	$10
Pharmacotherapy for Opioid Use Disorder	POD	27%	33%	37%	$25	$50	$75
Well-Child Visits 3-11 Years	WCV 3-11	-	65%	71%	-	$15	$20
Well-Child Visits 12-17 Years	WCV 12-17	-	59%	65%	-	$15	$20
Well-Child Visits 18-21 Years	WCV 18-21	-	34%	42%	-	$15	$20
Well-Child Visits 0-14 Months	W30	-	65%	69%	-	$15	$20
Well-Child Visits 15-30 Months	W30	-	72%	79%	-	$15	$20

Annual flat rate per member

Measure	Submeasure	Incentive per member
Follow-Up After ED Visit for Alcohol	FUA (30-Day: 18+)	$25
Follow-Up After ED Visit for Alcohol	FUA (7-Day: 18+)	$70
Follow-Up After ED Visit for Mental Illness	FUM (30-Day: 6-17)	$25
Follow-Up After ED Visit for Mental Illness	FUM (7-Day: 6-17)	$70
Follow-Up After ED Visit for Mental Illness	FUM (30-Day: 65+)	$25
Follow-Up After Hospitalization for Mental Illness	FUH (7-Day: 18-64)	$70
Follow-Up After Hospitalization for Mental Illness	FUH (30-Day: 6-17)	$25
Follow-Up After Hospitalization for Mental Illness	FUH (7-Day: 6-17)	$70
Initiation and Engagement of Substance Use Disorder Treatment	IET - I	$20
Initiation and Engagement of Substance Use Disorder Treatment	IET - E	$50
Prenatal Immunization Status	PRS-E	$20
Timeliness of Prenatal Care	TOPC	$50
Postpartum Care	PPC	$50

★ New measure for 2026

*program is subject to change per contract

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Provider Incentives & Enablement Initiatives

Provider partnership bonuses

Measure	Detail	Provider Incentive
HRS Completion (w/in 60 days)	per new member HRS completed within the first 60 days	$25
HRS Completion	per any HRS completed	$10
SDS Data Exchange	one time bonus, per provider feed*	$1,000
Z-Code (Z59.XX homelessness series)	once per member	$25
Notification of Pregnancy	per notification of pregnancy	$30
CPT II Code	Per compliant CBP, BPD, HBD, EED (negative only) codes on each claim billed	$25

*requires panel size greater than 1,000 members

Member Incentives

- Continuing $50 for Breast Cancer and Cervical Cancer Screenings ($100 for both)
- Restructuring Healthy Kids Incentives for NEW Passport to Wellness Program ($25 reward for well child visits at 0-30days, 3 months, 9 months, 24 months, and 3 Years – Total $150) – *Live in April*

Provider and Vendor Partnerships

- Telehealth Support
  - Affinity (Adult & Child Well Visits, IM)
  - SCCP (FUH, HBD, BPD) A
  - Signify Health (AAP, BPD, CBP, EED, COL and A1C)
  - Equal Hope (Breast and Cervical Cancer Screenings)
- Telehealth/Care CVS Minute Clinics (CCS, CHL, BCS, HPV, A1C and CBP)
- In-Home
  - Exact Sciences (Colorectal Cancer Screening)
  - HealPros (Eye Exams, A1C Testing)
  - Sprinter Health (contracting vendor solution now)

- Mobile
  - Roseland (Mammography Events)
  - CIMPAR (In-home pediatric immunizations and lab draws)

ABHIL 2026 P4Q reporting* - Availity

Aetna Better Health of Illinois P4Q Report - Provider Group Performance
Report Date : 4/25/2025 Data Refreshed On: 4/3/2025 4:14:02 PM

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Measure Key	Submeasure Key	Measure Description	NCQA 50%ile	NCQA 75%ile	NCQA 90%ile	Provider Numerator	Provider Denominator	Provider Rate	Max Earnings	Total # Needed to Reach 50%ile	Total # Needed to Reach 75%ile	Total # Needed to Reach 90%ile
AAP	TOTAL	Adult Access to Preventive/Ambulatory Health Services	74%	79%	83%	308	1,570	19.62%	$31,400	856	932	994
BCSE	BCS	Breast Cancer Screening	53%	62%	64%	47	113	41.59%	$9,040	13	23	26
BPDB		Blood Pressure Control for Patients With Diabetes	72%	79%	80%	15	167	8.98%	$16,700	106	117	119
CBPB	CBP	Controlling High Blood Pressure	68%	73%	76%	11	169	6.51%	$16,900	104	113	117
CCS		Cervical Cancer Screening	58%	62%	67%	250	681	36.71%	$40,860	143	171	208
CIS	CO10	Childhood Immunization Status – Combo 10	29%	37%	44%	12	58	20.69%	$11,600	6	10	14
EEDB	EYEEXAM	Eye Exams for Patients with Diabetes	60%	66%	68%	44	167	26.35%	$16,700	56	66	70
GSDB	HBA1C8	Glycemic Status Assessment for Patients With Diabetes (<8)	60%	64%	66%	22	167	13.17%	$16,700	79	85	89
IMA	CO2	Immunizations for Adolescents - Combination 2	37%	44%	51%	35	106	33.02%	$14,840	4	12	20
POD	TOTAL	Pharmacotherapy for Opioid Use Disorder	26%	34%	38%	0	6	0.00%	$840	2	3	3
PPC	PPC	Postpartum Care	0%	0%	0%	9	14	64.29%	$0	0	0	0
PPC	TOPC	Timeliness of Prenatal Care	0%	0%	0%	9	14	64.29%	$0	0	0	0
PRSE	INFLUENZA	Prenatal Immunization Status	0%	0%	0%	4	6	66.67%	$0	0	0	0
PRSE	TDAP	Prenatal Immunization Status	0%	0%	0%	5	6	83.33%	$0	0	0	0
PRSE	COMBO	Prenatal Immunization Status	0%	0%	0%	4	6	66.67%	$0	0	0	0
W30	0TO14MTH	Well-Child Visits in the First 30 Months of Life (First 14 Months)	60%	65%	69%	17	59	28.81%	$3,540	19	22	24
W30	15TO30MTH	Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	68%	72%	79%	45	66	68.18%	$3,960	0	3	7
WCV	3TO11	Child and Adolescent Well-Care Visits (3-11)	59%	65%	71%	5	867	0.58%	$34,680	510	562	611
WCV	12TO17	Child and Adolescent Well-Care Visits (12-17)	52%	59%	65%	5	609	0.82%	$24,360	315	354	394
WCV	18TO21	Child and Adolescent Well-Care Visits (18-21)	28%	34%	42%	3	244	1.23%	$9,760	66	80	101
		Grand Total				**860**	**5,117**	**16.81%**	**$251,880**			

*Does not include projected earnings rendering provider measures (BH, PPC, etc.)

Earnings opportunity for 90th percentile performance

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CPT II coding to optimize your earning potential

Opportunities

- The P4Q and Quality Care Gaps report are available in Availity and updated monthly. These empower your practice to:
  - See members with open care gaps assigned to your practice
  - **Maximize your earnings-** ABHIL incentivizes provider groups with **$25 Per compliant CBP, BPD, GSD, and EED (negative only)** codes on each claim billed

Measures

•Controlling High Blood Pressure (CBP)
•Diabetes - Blood Pressure Control (<140-90) (BPD)
•Diabetes - Eye Exam (EED)
•Diabetes – Hemoglobin A1c Control (<8) (GSD)

2026 HEDIS Reference Tool →


AETNA

HEDIS REFERENCE TOOL

HRT

EYE EXAM FOR PATIENTS WITH DIABETES (EED) (negative results only)	
2023F	Dilated retinal eye exam with interpretation by an opthalmologist or optometrist documented and reviewd: without evidence of retinopathy
2025F	7 standard field stereoscopic retinal photos with interpretation by an opthalmogist or optometrist documented and reviewed: without evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidency of retinopathy
GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)	
3044F	Hemoglobin A1c level less than 7.0%
3046F	Hemoglobin A1C level greater than 9.0%
3051F	Hemoglobin A1c level greater than or equal to 7.0% and less than 8.0%
3052F	Hemoglobin A1c level greater than or equal to 8.0% and less than or equal to 9.0%
BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD)	
3074F	Systolic blood pressure less than 130 mm Hg
3075F	Systolic blood pressure 130-139 mm Hg
3077F	Systolic blood pressure greater than or equal to 140 mm Hg *(out of range result, will not close care gap)*
3078F	Diastolic blood pressure less than 80 mm Hg
3079F	Diastolic blood pressure 80-89 mm Hg
3080F	Diastolic blood pressure greater than or equal to 90 mm Hg *(out of range result, will not close care gap)*
CONTROLLING BLOOD PRESSURE (CBP)	
3074F	Systolic blood pressure less than 130 mm Hg
3075F	Systolic blood pressure 130-139 mm Hg
3077F	Systolic blood pressure greater than or equal to 140 mm Hg *(out of range result, will not close care gap)*
3078F	Diastolic blood pressure less than 80 mm Hg
3079F	Diastolic blood pressure 80-89 mm Hg
3080F	Diastolic blood pressure greater than or equal to 90 mm Hg *(out of range result, will not close care gap)*

EMR Access

What is Remote EMR Access?

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

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

Benefits

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

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

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2026 Member Enablement Strategies

Empowering members by providing them with the tools, knowledge, and resources to actively participate in their own care

Member Rewards

Aetna Betters Care (AAP, WCV, CIS, FUH, CCS, BCS, A1C, BPD, CBP, OED, EED, TOPC/PPC)	Value Added Benefits

Health Tags

Prescription Message Reminders BCS, CCS, WCV, CIS, EED, BPD, CBP, AIC	Pharmacy Tech Engagement

mPulse

HEDIS Reminders (AAP, BCS, CCS, CHL, COL, FUA, IMA, OED, PPC)	Welcome, EPSDT and CAHPS

Next Best Action

Mail, Email	Outreach

HEDIS Outreach Campaigns

Schedule in person and telehealth appointments	In home care

Online Tools & App

Member Portal –Open care gaps	Medicaid 360 TANF Population – HEDIS Reminder

Priority Measures 2026

Cancer Screening & Prevention

- Breast Cancer Screening **(BCS)**
- Cervical Cancer Screening **(CCS)**
- Colorectal Cancer Screening **(COL)**

Chronic Conditions

- Controlling High Blood Pressure **(CBP)**
- Blood Pressure Control Diabetes **(BPD)**
- Glycemic Status Assessment Diabetes **(GSD)**
- Eye Exam for Patients Diabetes **(EED)**
- Kidney Health Evaluation Diabetics **(KED)**

Healthy Kids

- Well child visits in the first 15 months **(W30)**
- Immunizations for Adolescents **(IMA)**
- Childhood Immunization Status **(CIS)**
- Weight Assessment & Counseling **(WCC BMI)**

Maternal Health

- Timeliness of Prenatal Care **(TOPC)**
- Postpartum Care **(PPC)**

Behavioral Health

- Follow up After Hospitalization Mental Illness **(FUH)**
- Follow up After ED Visit for Substance Abuse **(FUA)**
- Follow Up After ED Visit Mental Illness **(FUM)**
- Initiation & Engagement of Substance Use Disorder **(IET)**

Medication Management

- Metabolic Monitoring Children & Adolescents on Antipsychotics **(APME)**
- Pharmacotherapy Opioid Use Disorder **(POD)**
- Statin Therapy CV Disease **(SPC)**
- Statin Therapy Diabetics **(SPD)**

Population Health/ Access to care

- Adults' Access to Preventative/ Ambulatory Health Services **(AAP)**

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Q4 Push – THANK YOU!

Your partnership was invaluable and final data from the Q4 push will be available in Q2.

	Breast Cancer Screening **(BCS)** Cervical Cancer Screening **(CCS)** Colorectal Cancer Screening **(COL)**
	Controlling High Blood Pressure **(CBP)** Blood Pressure Control for Patients with Diabetes **(BPD)** Glycemic Status Assessment for Patients with Diabetes **(GSD)** Eye Exam for Patients with Diabetes **(EED)**
	Well child visits in the first 15 months **(W30)** Immunizations for Adolescents **(IMA)** Childhood Immunization Status **(CIS)**
	Timeliness of Prenatal Care **(TOPC)** Postpartum Care **(PPC)**

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MY25 YRMRR Update

MY25 YRMRR medical record collection and abstraction began in late September and officially closed at 8:00 a.m. on February 6th. During this period, we successfully collected and abstracted a total of **2,272 medical records.**

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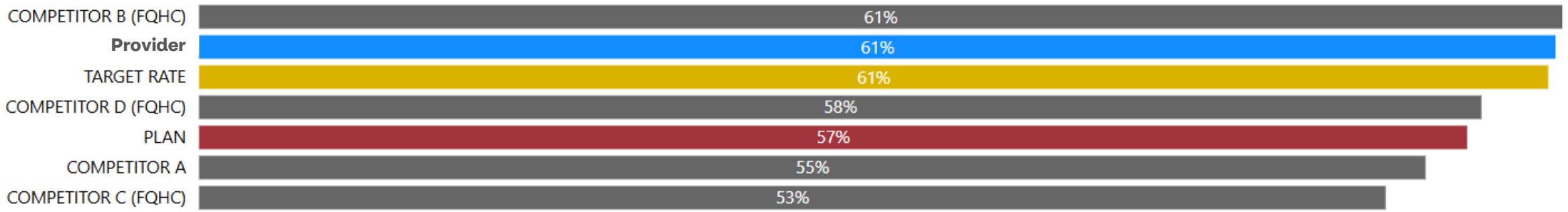
Provider Scorecards

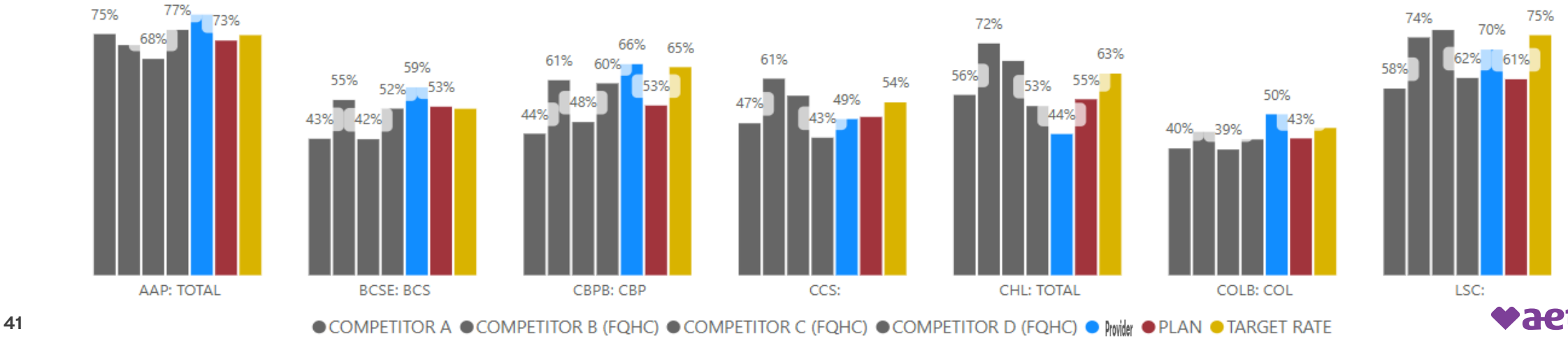
Provider Performance Comparison Reports

Composite Rate (All P4P Measures)

Composite Closure Rate



Measure Closure Rate



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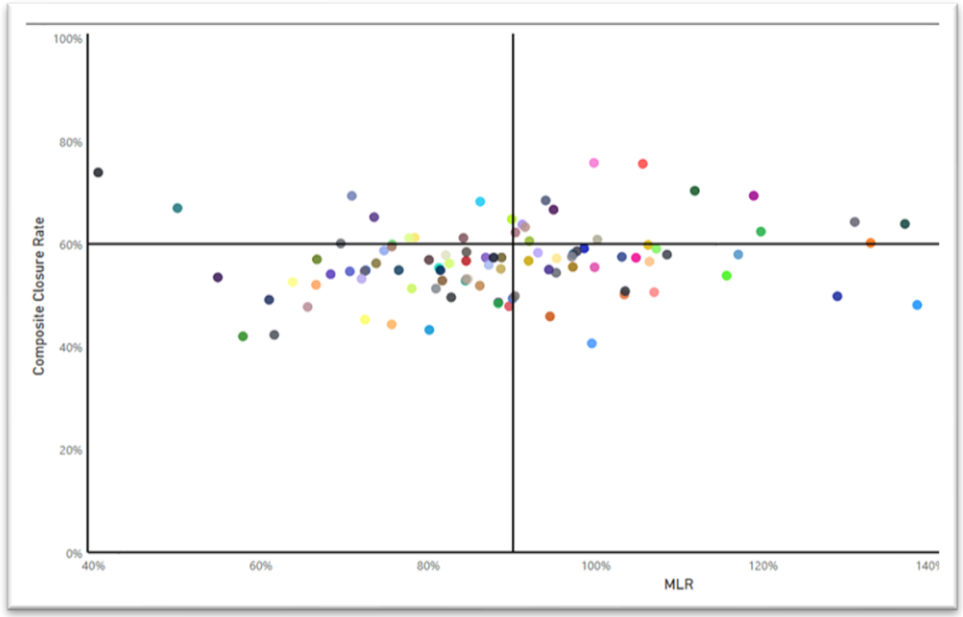
Quality of Care vs. Cost: Four Box Analysis



- *New for 2026*
- Helps understand where care delivery falls today
- Prioritizes quality followed by cost

Benefits

- Allows for stronger partnerships
- Provides additional opportunities for targeted support
- Keeps focus on clinical quality improvement

Goal

Our goal is to move every provider into the top-right quadrant through collaboration and support

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CAHPS

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

2025 Survey Results

Child CAHPS results reported to NCQA – Scored

Focus Areas:
Rating of Personal Doctor
Rating of Health Care
Rating of Health Plan

2026 Survey Period
Feb 10 – May 12

Composite/Rating Area- ADULT	2025	2024	2023	2022	Variance	2025 Projection Star Rating	2024 Star Rating
Rating of Personal Doctor	67.79%	66%	64%	63%	2%	3	2
Getting Care Quickly	80.25%	77%	78%	80%	2%	3	2
Getting Needed Care	78.3%	76%	81%	79%	2%	2	2
Rating of Health Plan	52.21%	50%	51%	53%	2%	1	1
Rating of All Health Care	45.65%	51%	48%	51%	-5%	1	2

Composite/Rating Area- CHILD	2025	2024	2023	2022	Variance	2025 Projection Star Rating	2024 Star Rating
Rating of All Health Care	63.3%	67%	68%	66%	-4%	2	3
Rating of Health Plan	60.18%	61%	67%	57%	-1%	1	1
Getting Care Quickly	84.79%	85%	NA	NA	0%	3	3
Getting Needed Care	82.23%	82%	NA	NA	0%	3	3
Rating of Personal Doctor	70.57%	71%	75%	73%	-1%	1	1

Plan/Survey	Response Rate 2025	Response Rate 2024	Response Rate 2023	Response Rate 2022	Variance
IL Child	18.9%	20.6%	13.2%	15.5%	-1.7%
IL Adult	18.7%	17.0%	14.3%	13.3%	+1.7%

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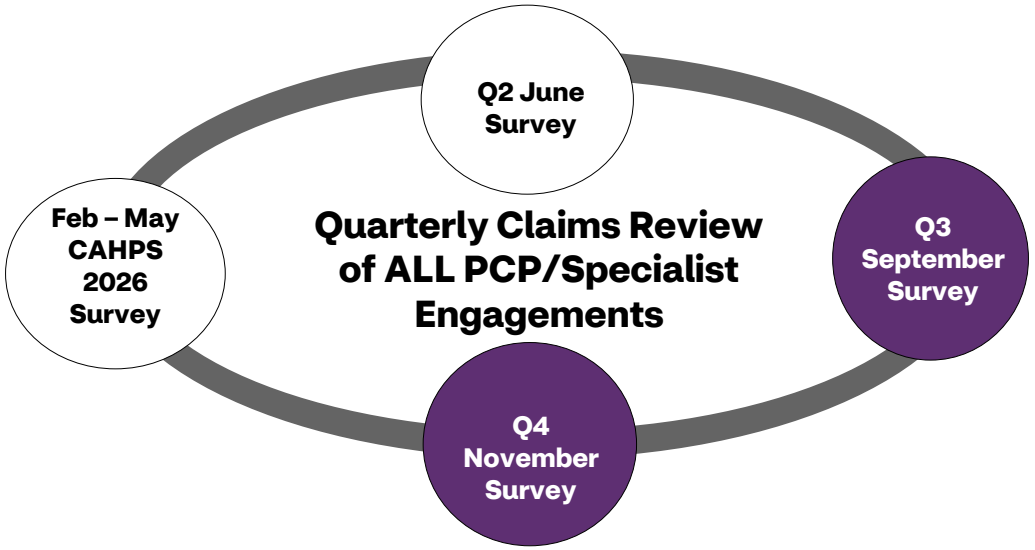
Year Round CAHPS Process | Measuring Satisfaction

Continuous Feedback from Members to Aetna & Providers



2025 Responses

- 2617 Total Surveys Submitted (Complete)
- 40% Adult & 60% Child

Off Cycle Surveys For all PCP/Specialist Engagement

Getting Needed Care

- In the last 6 months, if needed, how often was it easy to get the necessary medical care, tests, and/or treatment you needed?

If ALWAYS, press 1. if USUALLY, press 2. If SOMETIMES, press 3. If NEVER, press 4. If NOT APPLICABLE, press 5.

Getting Care Quickly

- In the last 6 months, if you needed an appointment with a specialist, how often were you able to make an appointment when it was needed?

If ALWAYS, press 1. if USUALLY, press 2. If SOMETIMES, press 3. If NEVER, press 4. If NOT APPLICABLE, press 5.

Coordination of Care

- Picking a number from 0-5, with 0 being the worst health care received and 5 being the best health care received, how would you rate your overall health care in the past 6 months?
- Picking a number between 0-5, with 0 being the worst health plan and 5 being the best health plan, how would you rate the overall health plan?

*Doctors' Communication

- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?

If NEVER, press 1. if SOMETIMES, press 2. USUALLY, press 3. If ALWAYS, press 4. If NOT APPLICABLE, press 5.

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Call to Action

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

- Familiarize yourself with the ABHIL Provider Manual
- Providers not in a shared risk arrangement who offer after-hours appointments and walk-in clinic availability may be eligible for a partnership bonus. Contact your Practice Transformation team member for more details.

2. Engage with provider resources for quality improvement monitoring and support

- Routinely access your data through Availity (e.g., P4Q reporting and gaps in care).
- Attend quality team meetings with the Practice Transformation Team to receive actionable insights and understand your strengths and opportunities for improvement.

3. Be aware of our ABHIL Member Resources

Our members can contact us through the **Member Services site** or at 1-866-329-4701 (TTY: 711), M-F 8:30 AM to 5:00 PM.

Members also have access to:

- The **24-hour nurse line** at 1-866-329-4701 (TTY: 711)
- **Telehealth and free life resources** (e.g., food, housing/rent, employment assistance) through Care Navigator - Aetna – MyOwnDoctor
- **Appointment transportation** through the Aetna Transportation Benefit

4. Educate providers on equitable care delivery across populations

As part of our commitment to health equity, we offer a clinical education hub for health care professionals. You can get on-demand, free, accredited courses to earn digital Care Champion badges for your provider profile in three clinical areas of focus:

- Culturally responsive care
- LGBTQ+ responsive care
- Culturally responsive PCP behavioral health care

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Aetna Better Health Webinar | Building Vaccine Confidence and Addressing Vaccine Hesitancy

Building Vaccine Confidence and Addressing Vaccine Hesitancy

This 45-minute Aetna Better Health webinar will be presented by our partners at Merck and focus on building vaccine confidence and addressing vaccine hesitancy. There are two date/time offerings for this webinar. Please use the links below to register via Microsoft Teams.

This webinar will include:

- What is vaccine confidence?
- Strategies to help build vaccine confidence
- Using motivational interviewing to foster change
- Addressing vaccine misinformation
- Q&A session and an opportunity to give feedback via survey

March 10, 2026
12:00 PM ET/9:00 AM PT

Register Now

March 12, 2026
1:00 PM ET/10:00 AM PT

Register Now

Issues with registration? Please reach out to Grace DelMastro at **delmastrog@aetna.com.**

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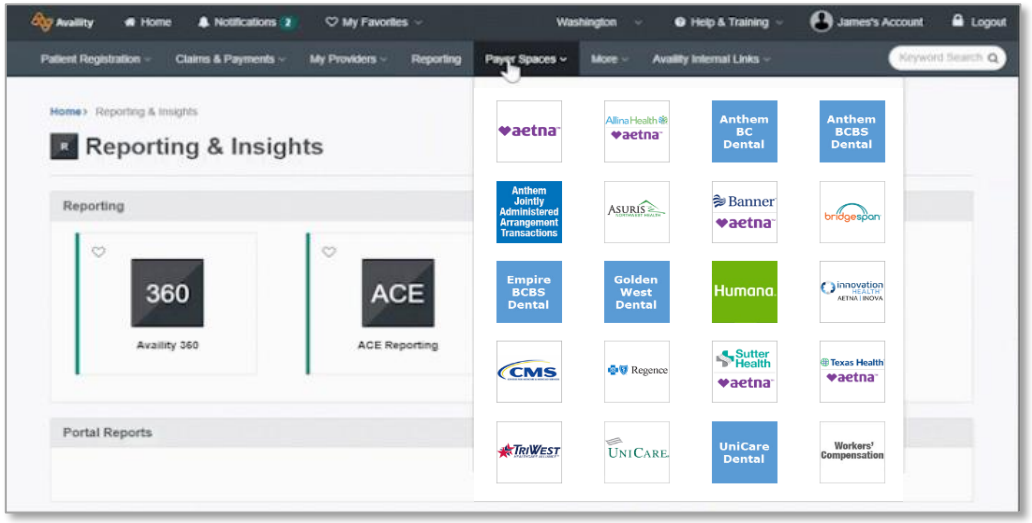
Availity reporting

Availity Reporting

Capabilities active now

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



Upcoming capabilities

- New user interface for provider reporting
- Ambient reports and enhancements to existing reports are continuously in development

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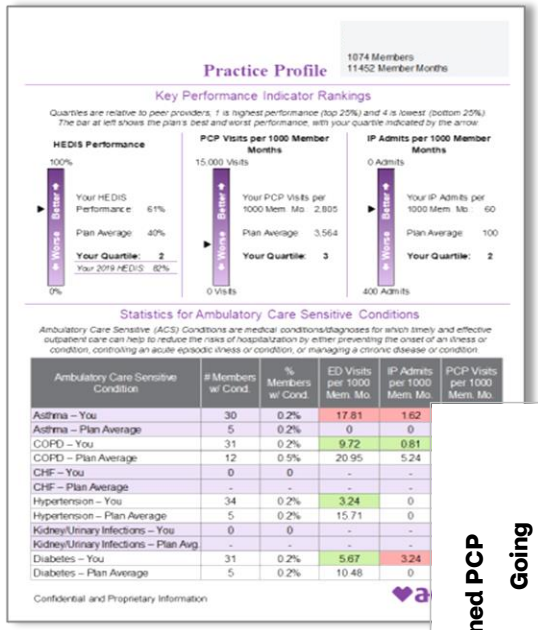
Provider Analytics Reporting Suite (PARS)

Availity®


Practice Profile

1074 Members
11452 Member Months

Key Performance Indicator Rankings

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

HEDIS Performance
100%
Your HEDIS Performance: 61%
Plan Average: 40%
Your Quartile: 2
Your 2019 HEDIS: 62%
0%

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

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

Statistics for Ambulatory Care Sensitive Conditions

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

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

Confidential and Proprietary Information

Provider and Practitioner Handbooks

Member Attribution Grid

Assigned PCP

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

Total Membership: 6,682

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

Prioritized Member List

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

Daily Census

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

P4Q Performance

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

Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive Condition	Distinct Member Count	% of Members with ASC	IP Admits per K	ED Visits per K	PCP Visits per K	SPC Visits Per K	Plan Distinct Member Count
Asthma in Younger Adults	6	0.2%	0.00	0.09	0.00	0.18	1,935
Chronic Obstructive Pulmonary Disease (COPD) or Asthma	32	0.9%	0.07	0.13	0.11	1.03	6,323
Diabetes ShortTerm Complications	11	0.3%	0.04	0.09	0.00	0.16	965
Heart Failure	19	0.6%	0.09	0.09	0.02	0.47	4,261
Hypertension	161	4.7%	0.00	0.18	2.27	1.64	20,856
Pneumonia	31	0.9%	0.00	0.22	0.11	0.45	4,055
Uncontrolled Diabetes	62	1.8%	0.00	0.20	0.81	0.49	5,240
Urinary Tract Infection	72	2.1%	0.02	0.70	0.22	0.92	9,335

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Availity reporting capabilities

Refresh cadence

Monthly | Weekly | Daily

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

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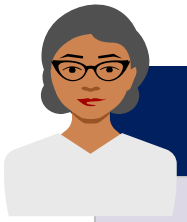
Value-based partnerships

Value-based care benefits

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



Patient Benefits

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

Healthier patients, lower costs

Provider Benefits

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

In 2024, VBC groups performed better than the ABHL plan average across multiple metrics.

10%
Fewer
ED Visits per K

9%
Fewer
IP Admits per K

7%
Fewer
Days per K

13%
Fewer
Readmissions per K

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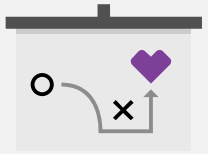
Tools for success in value-based care

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

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



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

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

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

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

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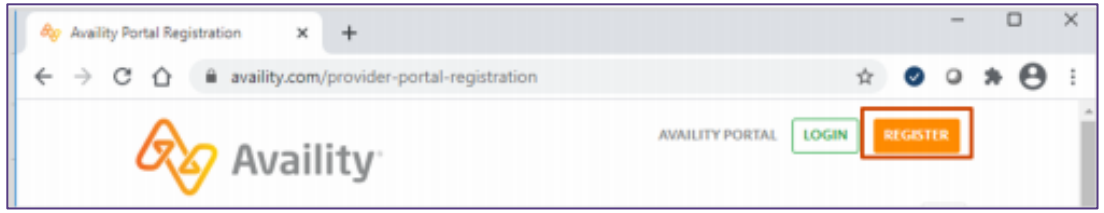
Availity provider portal

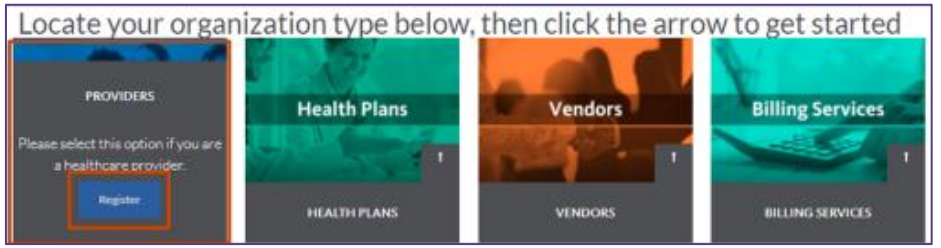
Availity portal registration

Availity.com/provider-portal-registration

Register your provider organization

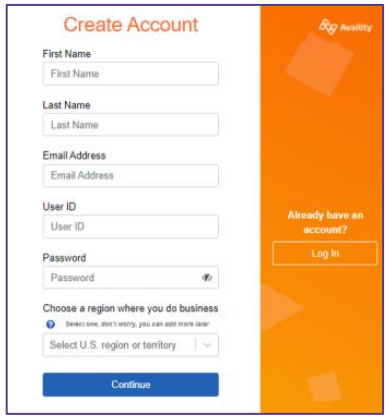
Important: This only applies to users who are brand new to Availity and need to register their provider organization.

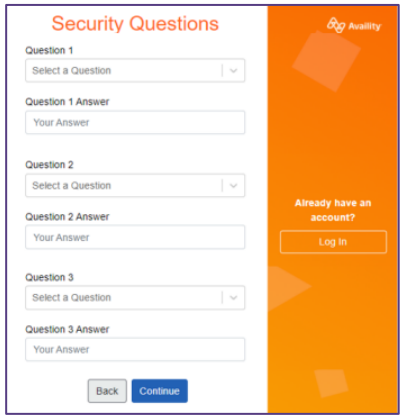


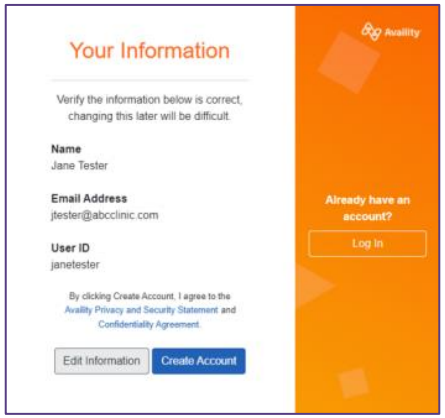


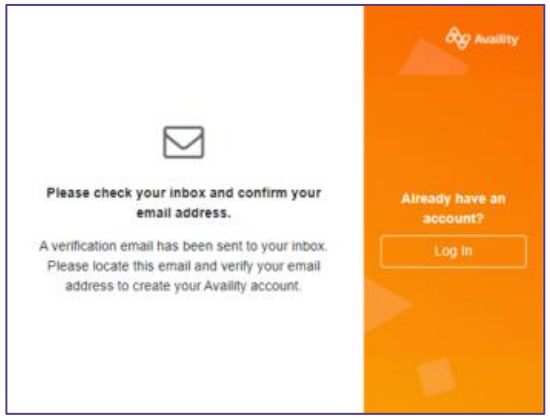
When you set up your new user account, you'll be asked to do the following tasks in the wizard:

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





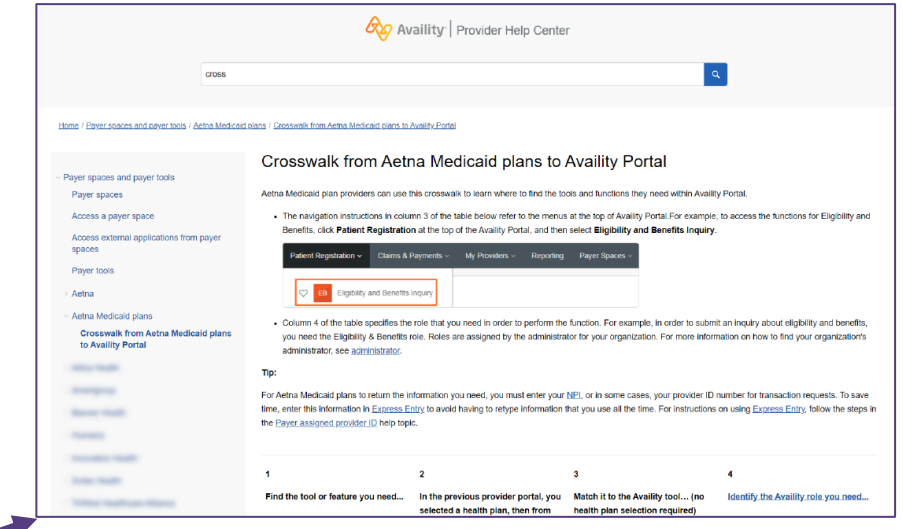


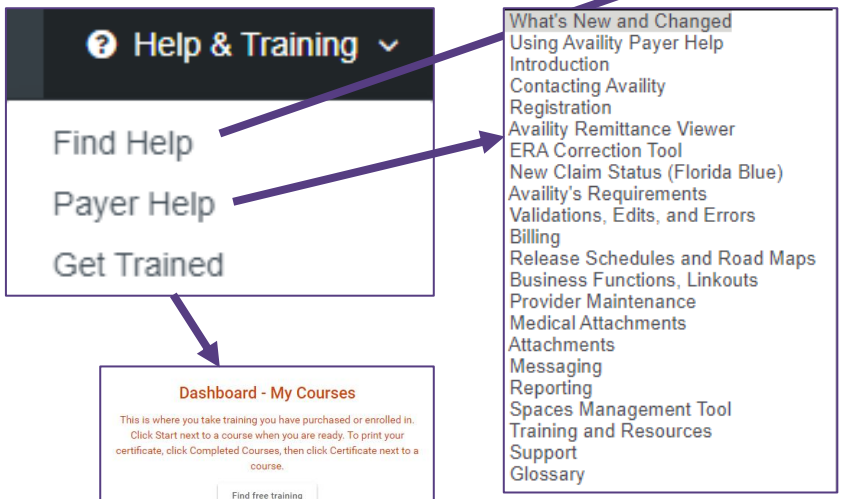


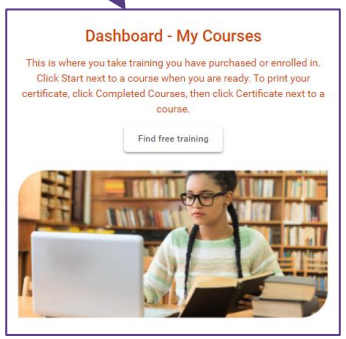
Availity Help Center

Crosswalk from Aetna Medicaid plans to Availity portal

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







Availity support

Support tools

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

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Aetna Better Health® of Illinois Medicaid Tools and Resources

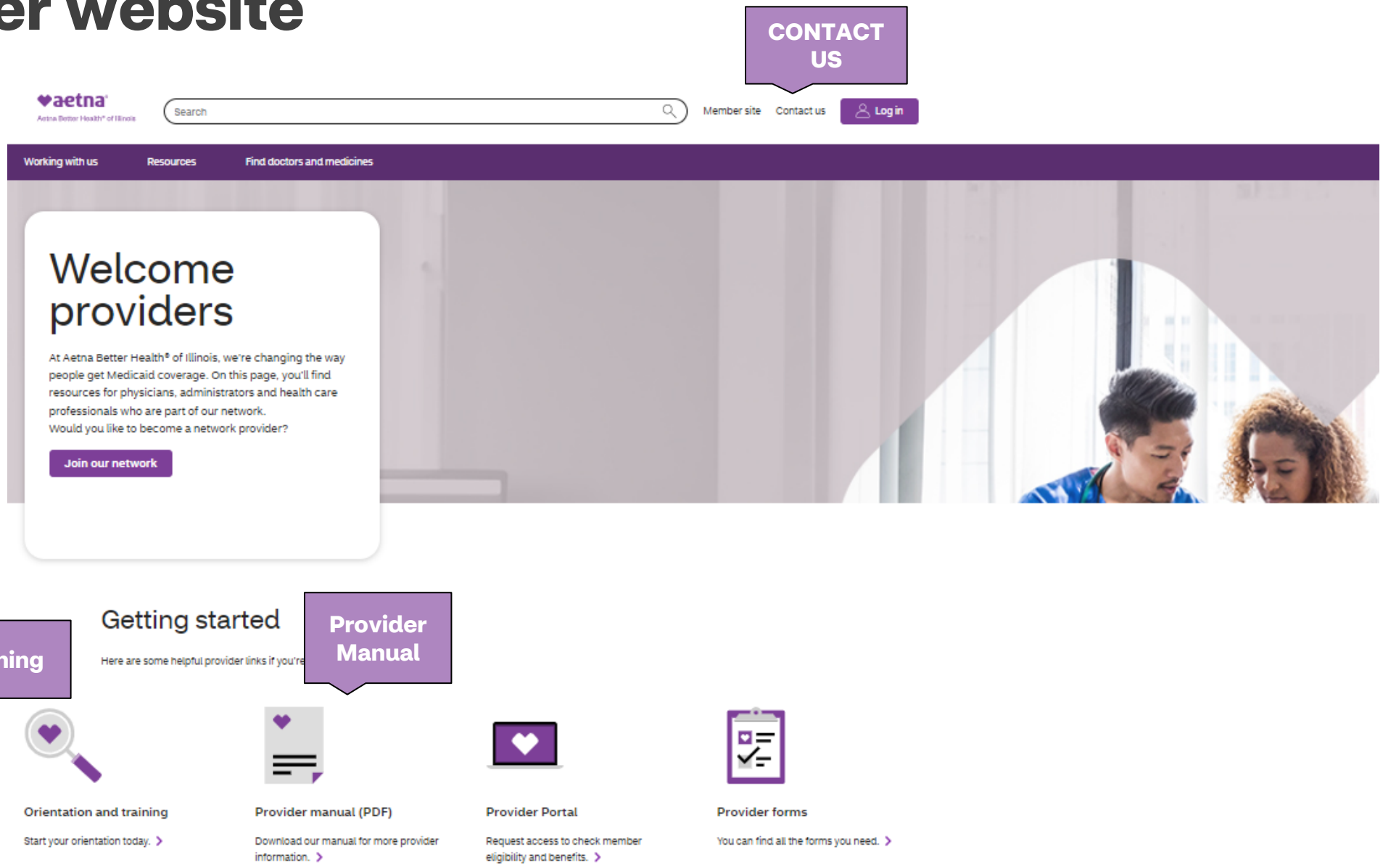
Aetna Better Health® of Illinois Medicaid public website

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

Providers will be able to access:

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

Provider website

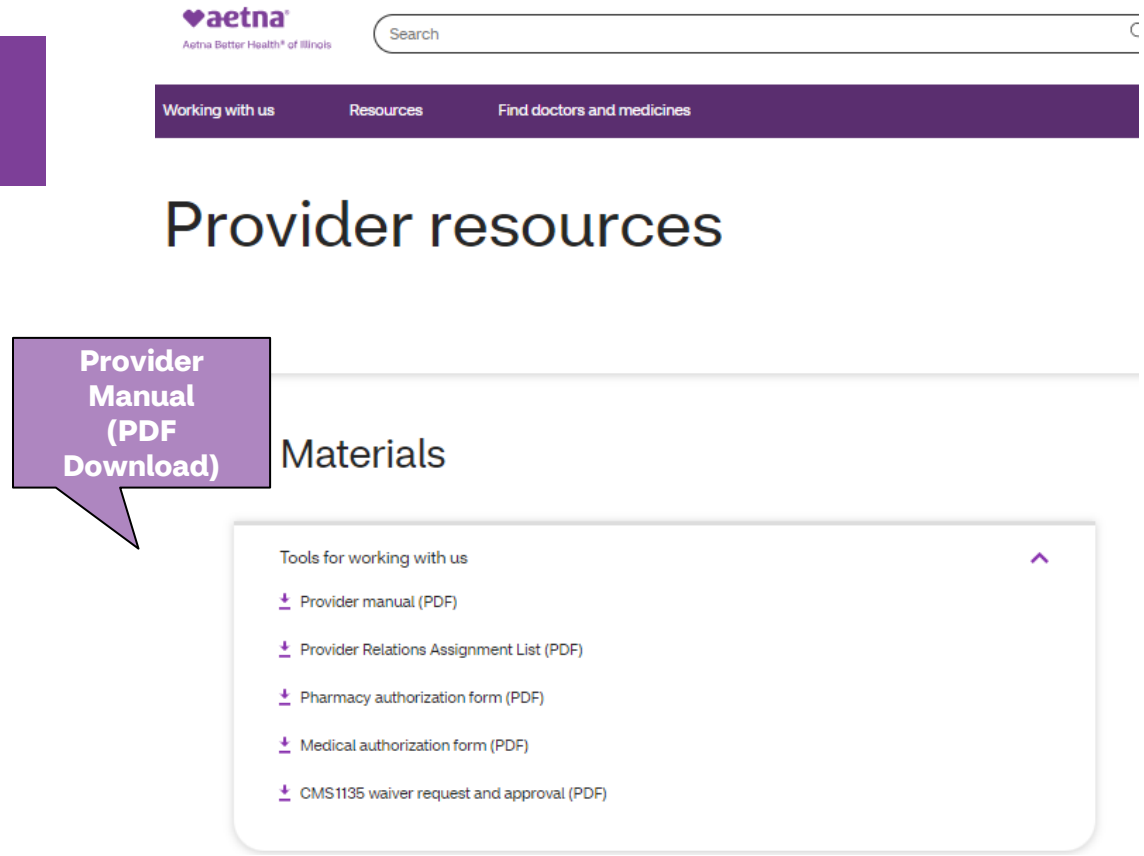


Provider website: Provider manual

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

In addition to policies and procedures, this resource includes:

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



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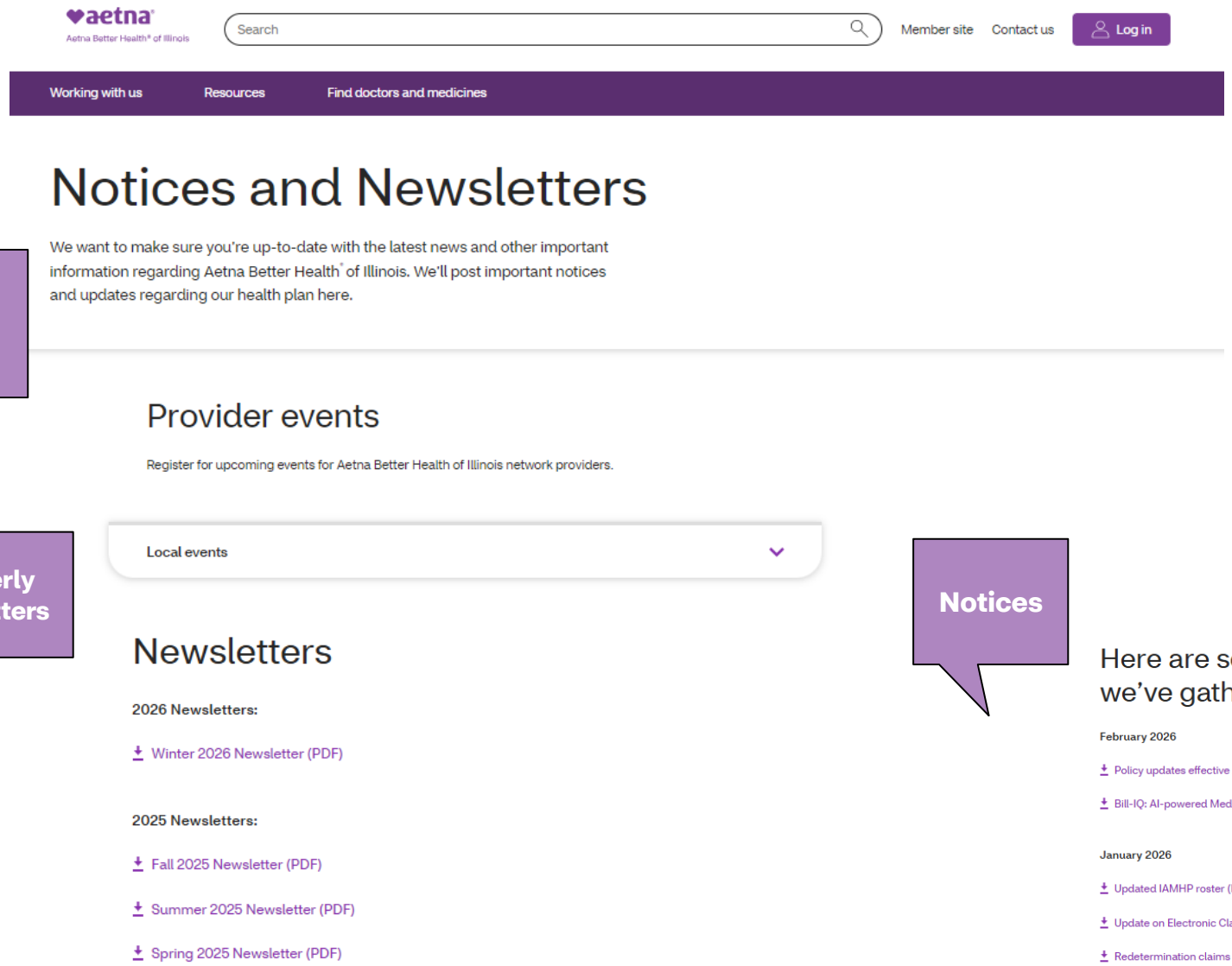
Provider website: Notices, newsletters and events

Resources > News and updates > Notices and newsletters



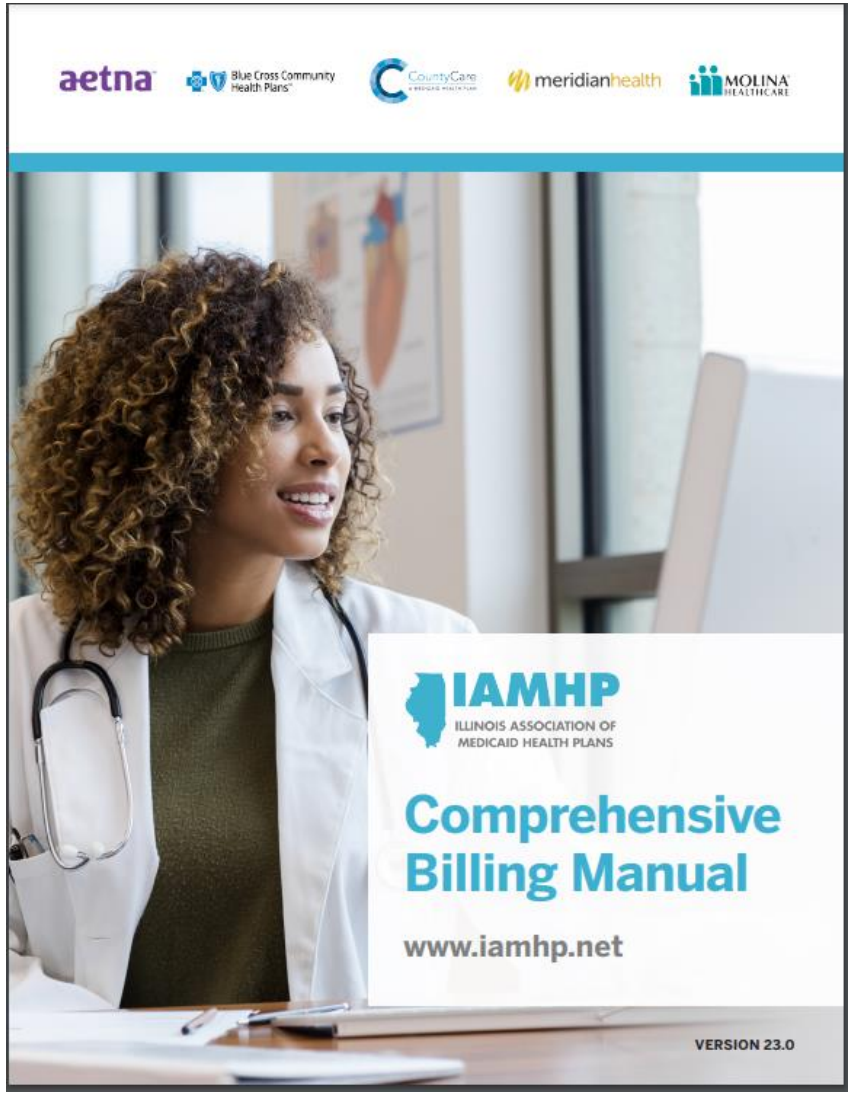
NEW: Provider events

Quarterly newsletters

Notices

Claims Corner

IAMHP billing manual



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

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

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

Bill IQ

Bill IQ: Medicaid Billing

Introduction

Bill IQ is a conversational AI provider support agent designed to help Medicaid providers seamlessly navigate the complex landscape of Illinois Medicaid billing guidelines.

Here are some FAQs related to Bill IQ:

1. What is Bill IQ?
Answer: Bill IQ is a conversational AI tool developed by Everlign to help users quickly find answers to billing-related questions. Right now, it is focused on helping users understand billing rules and policies based on the **Illinois Association of Medicaid Health Plans (IAMHP) Billing Manual**.

2. What kind of questions can I ask Bill IQ?
Answer: You can ask questions related to billing guidelines that can be sourced directly from the IAMHP Billing Manual. An example question could be "are there any exceptions to this rule regarding therapeutic procedures and office visits?

3. What kind of questions can Bill IQ not answer right now?
Answer: Currently, Bill IQ cannot:

- Answer questions about specific claims (e.g., "Why was my claim denied?")
- Provide information that is not included in the IAMHP Billing Manual
- Access or interpret member or provider-specific data.

4. Why can't Bill IQ answer my question about a rejected claim?
Answer: At this stage, Bill IQ is only trained to answer questions based on the IAMHP billing manual. It does not have access to individual claims data or case-specific systems.

5. Will Bill IQ get smarter over time?
Answer: Yes! This is a soft launch. We plan to expand Bill IQ's capabilities by adding more data sources - such as provider notices, policy bulletins, and potentially FAQs from payer portals. As more content is added, Bill IQ will be able to answer a broader set of questions.

6. How can I tell where Bill IQ is getting its answers from?
Answer: Bill IQ always tells you the source of its answers. For now, all answers come from the IAMHP Billing Manual. When we add new sources, those will also be clearly cited.

7. Is my data being stored or tracked when I use Bill IQ?
Answer: ***No personal health or claims information is used or stored by Bill IQ***. It simply answers general billing questions based on public or shared resources.

8. Who do I contact if I have issues or need support using Bill IQ?
Answer: Please reach out to our claims specialist by emailing us at: *ABHILClaimSpecialist@aetna.com*.

Link: https://abhil.everlign.com/billiq

Contact Us

Aetna Better Health of Illinois
abhilclaimspecialist@aetna.com

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Verifying member eligibility

Verifying member eligibility

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

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

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

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

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

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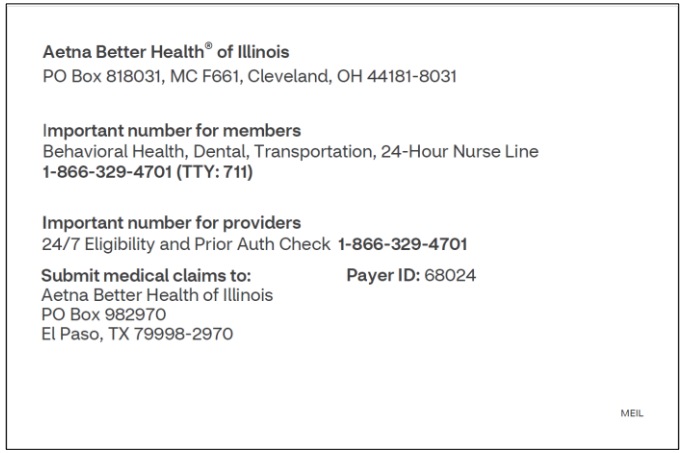
Member ID cards

The member ID card contains the following information:

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

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



Roster/demographic submissions

Universal IAMHP Roster Template (Updated 2/2026)

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

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

ADA Compliance Update for Provider Data

Mandatory ADA Information Requirement

ADA Compliance Update

Effective November 1, 2025, all provider data updates must include ADA information for compliance.

Required Accessibility Details

Submissions must include wheelchair access, interpreter services, and other disability accommodations.

Avoiding Processing Delays

Missing ADA data will cause submission returns and processing delays for providers.

Questions?

Please contact your assigned **Provider Relations representative** with any questions.

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Prior authorizations

A prior authorization request may be initiated by:

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

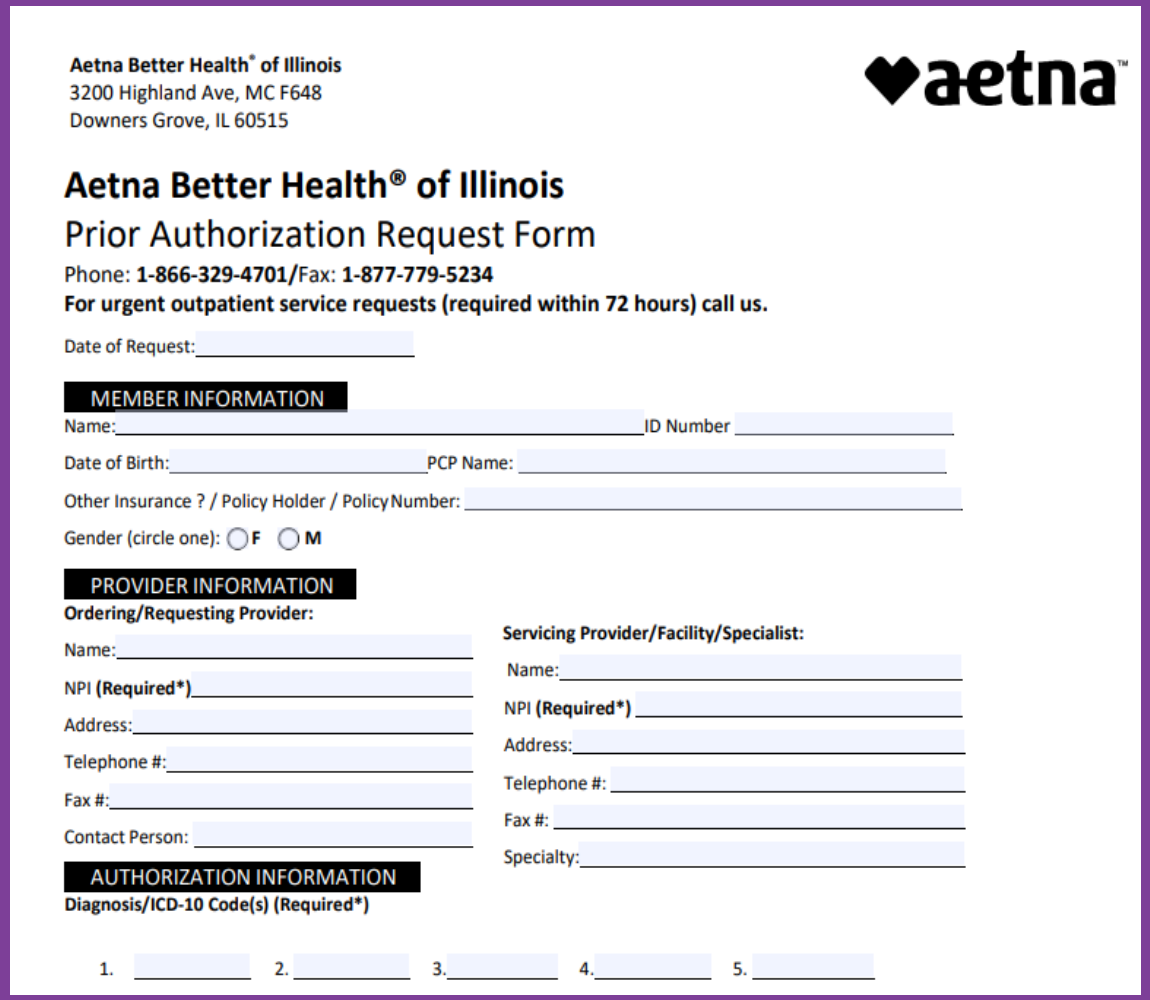
IMPORTANT ITEMS to remember:

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

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

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

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



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

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Aetna Better Health® of Illinois

Prior Authorization Request Form

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

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

Date of Request: _____

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____ PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): ◯ F ◯ M

PROVIDER INFORMATION

Ordering/Requesting Provider:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Person: _____

Servicing Provider/Facility/Specialist:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

AUTHORIZATION INFORMATION

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

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

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Utilization Management Legislative Update

Utilization Management Legislative Update

Healthcare Protection Act (HPA) as amended in Public Act 104-0028 (2025): 104-0028, establishes new requirements regarding utilization management and notification of behavioral health treatment. **This provision is effective January 1, 2026, and applies to services provided to Aetna Better Health® of Illinois members. Authorization is still required for claims payment purposes.**

Notification Requirements	
Acute Inpatient Mental Health	Providers must **notify Aetna Better Health® of Illinois within 48 hours of admission**. If notification is timely: **No utilization review for the first 72 hours** of admission. If notification is late: **Utilization review begins immediately upon admission**.
Substance Use Detox & Residential Rehab	Applies to **ASAM levels 4.0, 3.7, and 3.5**. Providers must **notify Aetna Better Health® of Illinois within 1 business day** from the start of treatment. If notification is timely: **Initial authorization approved for the first day of treatment**. **Utilization review begins after the 1-business-day notification period**. If notification is late: Only **first day approved**, and **utilization review starts immediately**.
Outpatient Mental Health & SUD Services	Providers must **notify Aetna Better Health® of Illinois within 1 business day** from the start of treatment. If notification is timely: **Initial authorization approved without utilization review** for: **Partial Hospitalization Program:** 5 sessions / 7-day span **Intensive Outpatient Treatment:** 6 sessions / 14-day span **Transcranial Magnetic Stimulation:** 36 sessions / 6-week span **Electroconvulsive Therapy:** 12 sessions / 4-week span **Community-Based Services:** No initial authorization required; concurrent review applies later. After initial approval: **Concurrent utilization review applies for additional days requested**. If notification is late: Only **first day approved**, and **utilization review begins immediately**.

Additional changes effective January 1, 2026

- Psychiatric and Neuropsychiatric testing will no longer require authorization.
- Assertive Community Treatment (H0039) will have no authorization required for the first 800 units per member, per provider.

How to notify us

Continue to submit notification of inpatient admissions for members using your current method. You can use the Provider Portal, call 1-866-329-4701 (TTY: 711), or fax the request to 1-844-528-3453 for behavioral health.

Questions?

Please contact your assigned Provider Relations representative if you have questions.

Link to Notice: Aetna Better Health of Illinois

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Billing & Claims Payment

Billing & claims payment

For claim submission:
Electronic claims submission through clearinghouse:

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

Submit paper claims to:

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

CHECK RUN IS THREE TIMES A WEEK

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

ERA:

- Remittance advices are available within the Availity provider portal
- Electronic 835s and ERAs come from ECHO Health Electronic Payment System

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Pharmacy claims

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

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

BIN: 610591
PCN: ADV
Group: Rx881A

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

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

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

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

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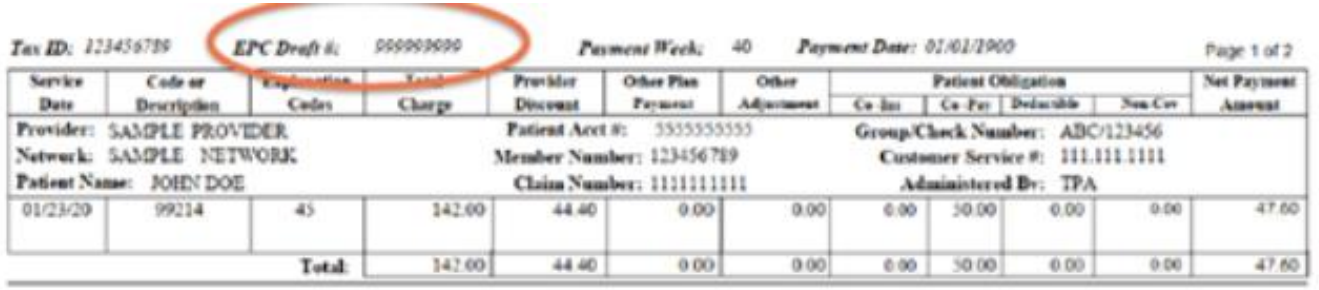
Electronic Funds Transfer (EFT)
Electronic Remittance Advice (ERA)

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

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



Tax ID: 123456789 EPC Draft #: 999999999 Payment Week: 40 Payment Date: 01/01/1900 Page 1 of 2

Service Date	Code or Description	Explanation Codes	Total Charge	Provider Discount	Other Plan Payment	Other Adjustment	Patient Obligation				Net Payment Amount
							Co Ins	Co Pay	Deductible	Non Cov	
Provider: SAMPLE PROVIDER				Patient Acct #: 555555555			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.

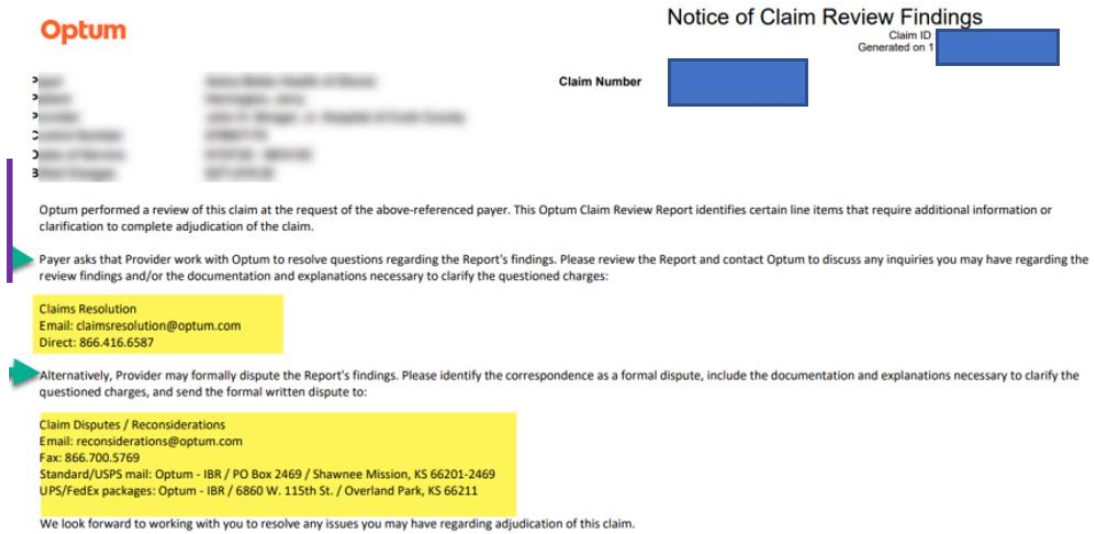
Itemized bill process

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

There are three ways to submit an itemized bill:

1. If a provider's clearinghouse is able to submit a 275 transaction to Aetna, the provider may submit an itemized bill along side their first-time claim submission.
2. Following electronic claims submission, the provider may upload the Itemized Bill via the Availity portal.
3. When mailing the itemized bill via claim reconsideration, the provider should attach the Itemized Bill and **should not attach or send a copy of the claim form, as doing so will cause a duplicate claim in the system**. Instead, please reference the claim number on the reconsideration form or on your letterhead and mail the reconsideration request directly to: Aetna Better Health of Illinois
   PO Box 982970
   El Paso, TX 79998-2970

SAMPLE OPTUM NOTICE



Optum

Notice of Claim Review Findings

Claim ID
Generated on 1

Claim Number

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

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

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

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

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

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

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Provider disputes (resubmissions/reconsiderations)

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

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

Corrected claims

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

Reconsiderations

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

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

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

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

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Provider 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 the member appeal and grievance system will apply.

Provider appeal

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

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

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

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

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

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

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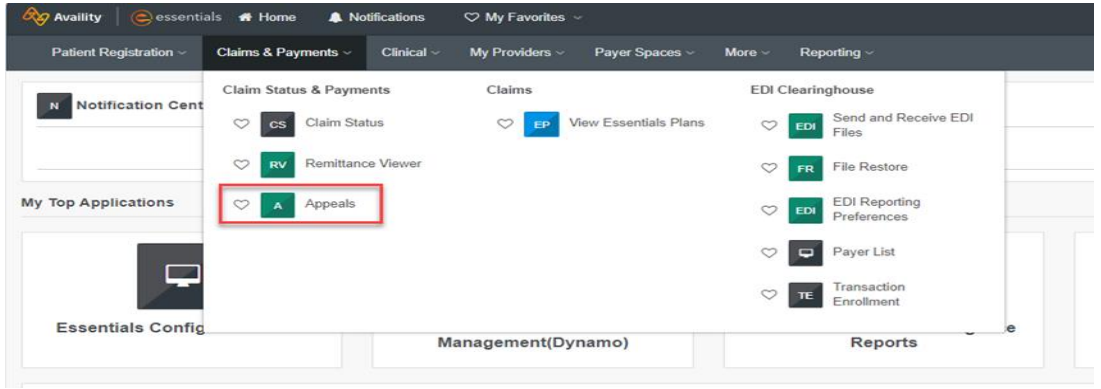
Appeal Submission Enhancement via Availity

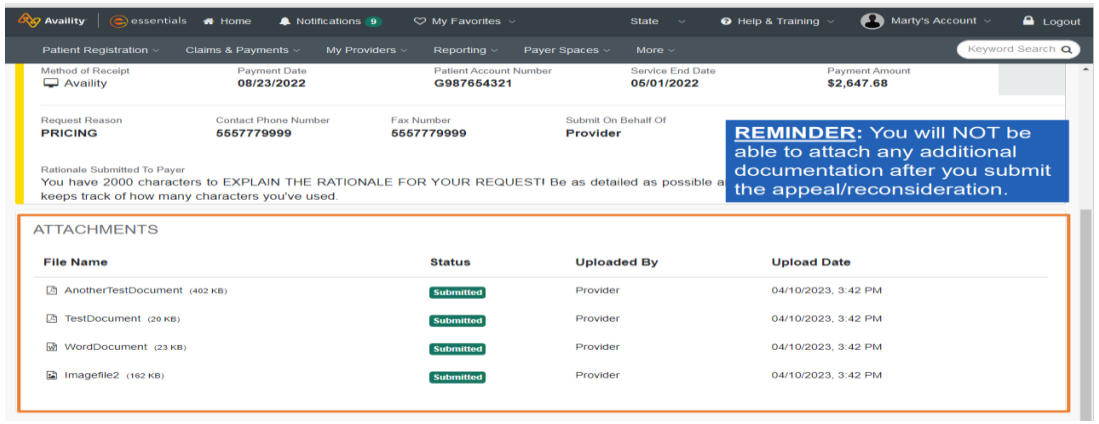
Provider Appeal

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



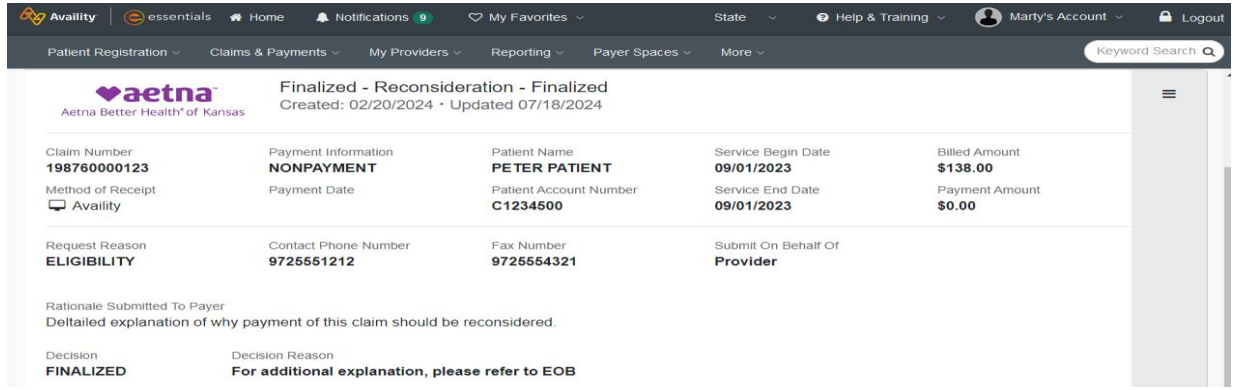
Submission

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



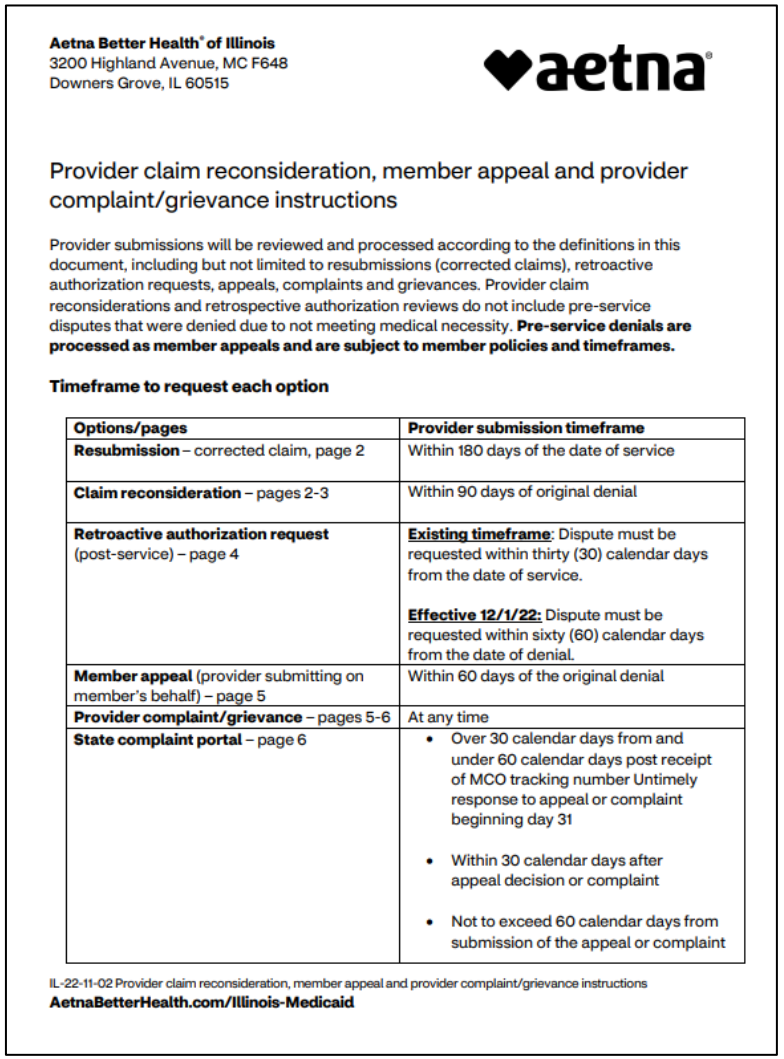
Review Outcome

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



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

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



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

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

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

Timeframe to request each option

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

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

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

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

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

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

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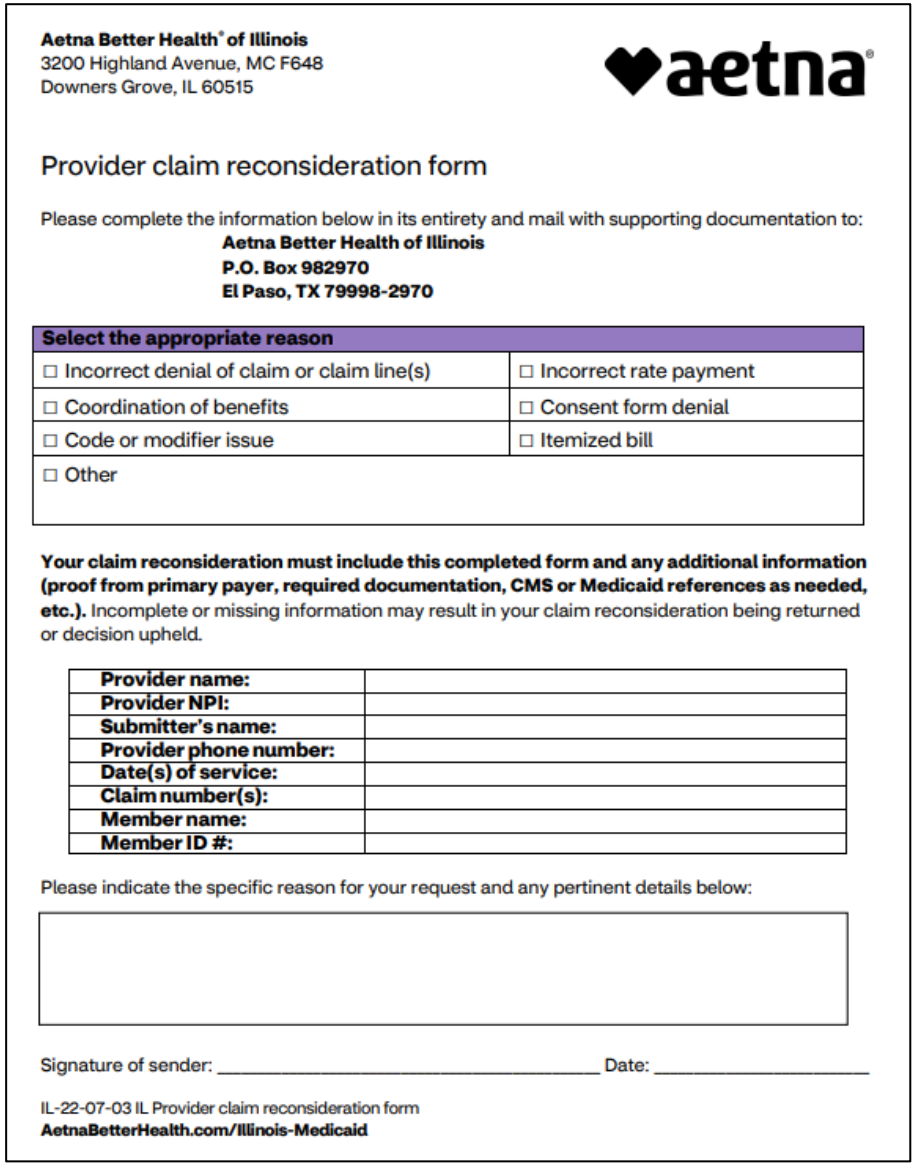
Provider claim reconsideration form

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



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Provider claim reconsideration form

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

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

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

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

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

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

Signature of sender: _____ Date: _____

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

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Recoupments

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

Provider notifications will include:

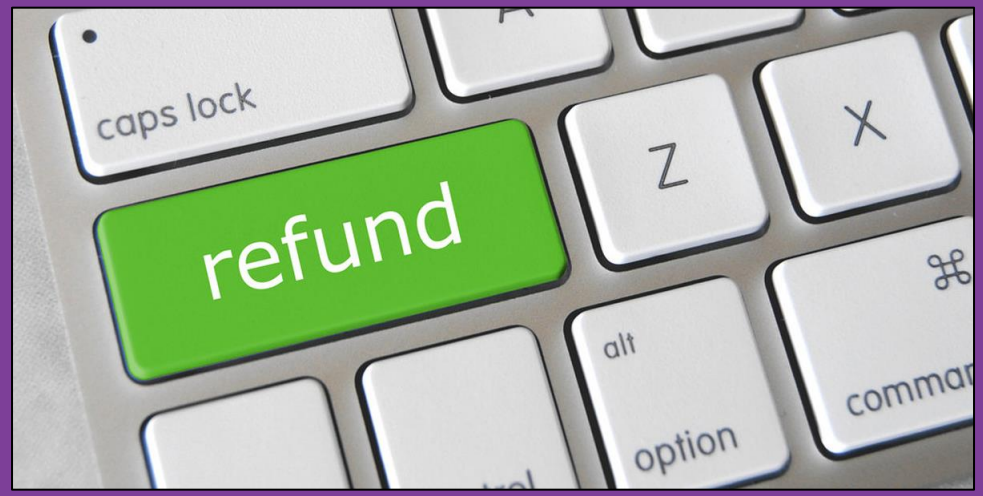
- Impacted claims
- Member's name
- Date of service

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

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

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

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



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Provider Escalations

Provider Experience escalation process

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Provider grievances

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

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

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

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

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

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

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Provider state escalations

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

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

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

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

Health equity

Medicaid Health Equity

Vision
We are dedicated to shaping a future where all our members thrive in communities built on shared prosperity, unity, and a commitment to equitable access and outcomes - regardless of race, place, or identity

Deliverable
Strategic plans from Pop Hlth/HE Committee that can be utilized across ABHIL

Medicaid Health Equity Objectives

2026 Health Equity Team Activities

Colleague Education & Training
- A journey through Cultural Responsiveness and Conscious Inclusion 3741329911 WBT
- Women's Health Care 0000335002
- Person Centered Care 0000334999
- Culturally Respectful Care: Foundation Principles for Self and Practice 3743288776

Data Reporting & Stratification
- Collection, Reporting and Analysis of Standardized Data
- Assess Root Causes of Disparities and Address Inequities in Products and Operations to close gaps
- Advance Language Access, Health Literacy, and Culturally Tailored Services

Provider Empowerment
- Provider race and ethnicity data capture
- Provider badging promotion and implementation of flags in directory
- Build Capacity of Health Care Organizations and Workforce
- Advance Cultural and Linguistically Appropriate Services (CLAS) Standards

Local Programs & Initiatives
- Maternal health
- Controlling blood pressure
- Workforce Development & training
- Prioritize Accessibility
- Housing and Tenancy Support
- Behavioral Health
- Food Security

Key Partners: Clinical Solutions, Medicaid Market, Enterprise HE Team, Provider Network

Market Leadership: Advancing Health Equity

ICD-10-CM Z-Code Training Opportunities

Why Z-Codes Matter

- Document and track factors influencing health status and touchpoints with health services
- Not primary disease or injury – not procedure codes – must be accompanied by *CPT* or *HCPCS* procedure codes
- Documentation by provider or care team member into the EHR
- RESOURCE: CDC ICD-10-CM Official Guidelines for Coding and Reporting

Market Leadership: Advancing Health Equity

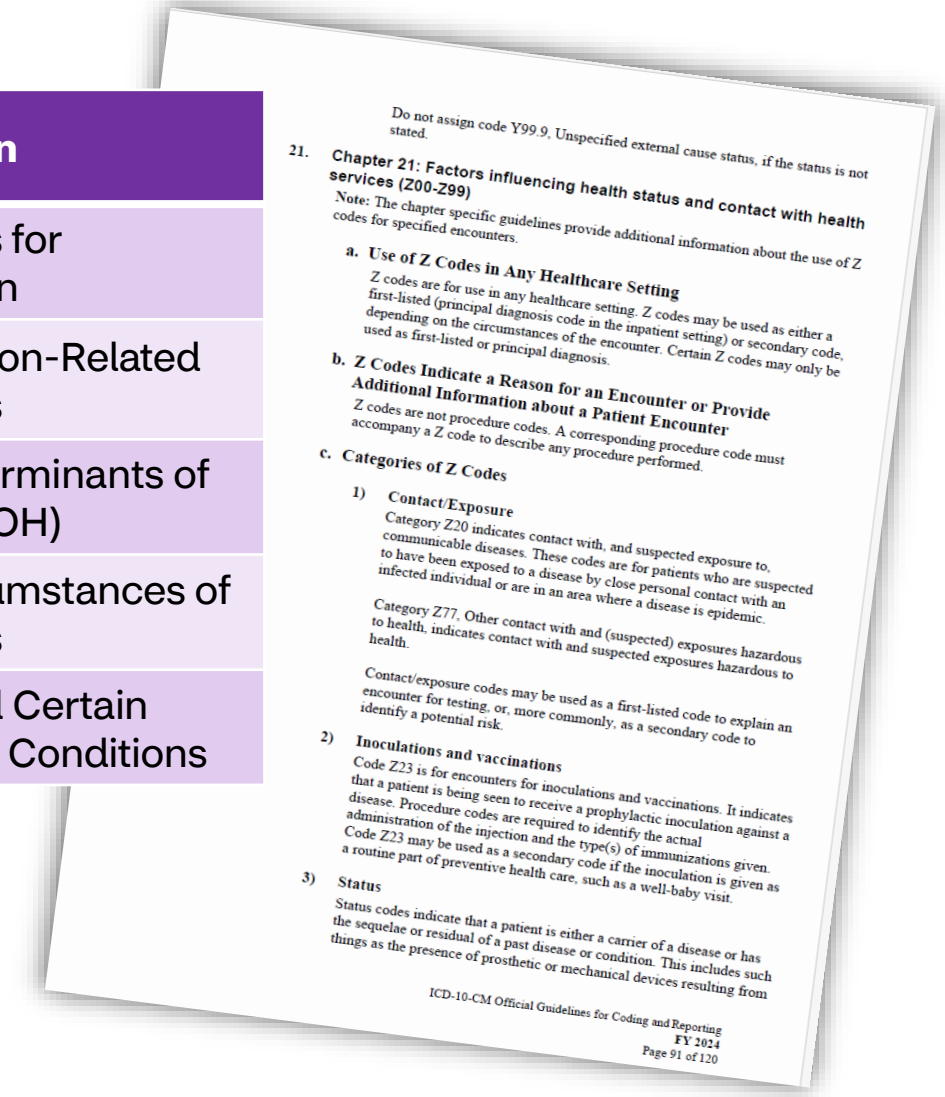
ICD-10-CM Z-Code Training Opportunities

Provider Workflow Process:

1. **Screening** – use of validated tools or provider/care team interaction
2. **Documentation** – recording the issue in the EHR
3. **Mapping** – converting the documented issue to the right Z-code
4. **Action** – using the code to alert referrals, resources, and follow-up

Category (Z00 – Z99)	Description
Z00 – Z13	Encounters for Examination
Z30 – Z39	Reproduction-Related Encounters
Z55 – Z65	Social Determinants of Health (SDOH)
Z69 – Z76	Other Circumstances of Encounters
Z77 – Z99	History and Certain Influencing Conditions

CDC ICD-10-CM Official Guidelines for Coding and Reporting



Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

21. **Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)**

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

a. **Use of Z Codes in Any Healthcare Setting**

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

b. **Z Codes Indicate a Reason for an Encounter or Provide Additional Information about a Patient Encounter**

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

c. **Categories of Z Codes**

1) **Contact/Exposure**

Category Z20 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who are suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, Other contact with and (suspected) exposures hazardous to health, indicates contact with and suspected exposures hazardous to health.

Contact/exposure codes may be used as a first-listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2) **Inoculations and vaccinations**

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) **Status**

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from

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Member Portal: Community Resource Directory

Local Programs & Initiatives

Community Resource Directory

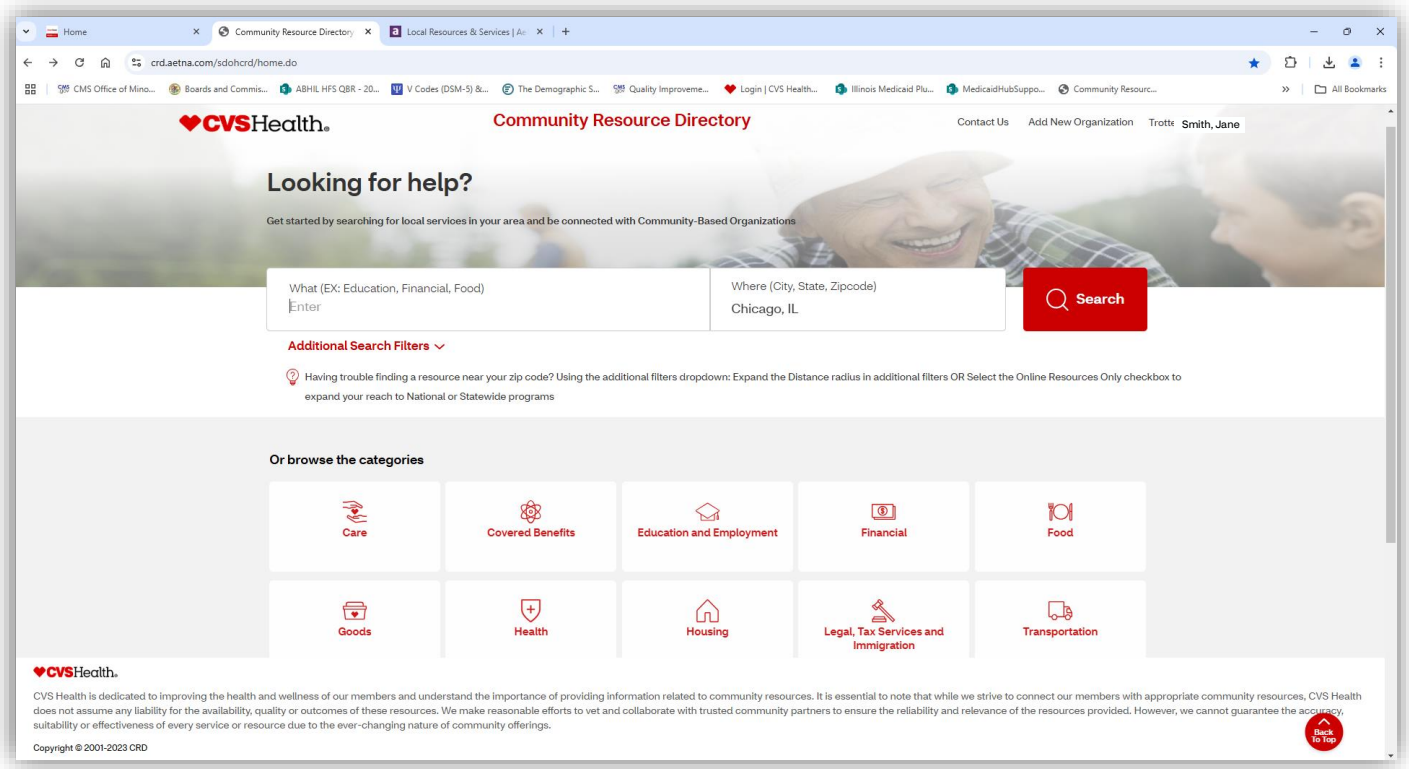
Caring and helpful resources are just around the corner. Using the Community Resource Directory (CRD) tool in your Member Portal, you can find support and services near you. From food and housing services to wellness and mental health support and more.

Aside from searching for resources, the CRD also allows you to:

- Save your resources
- Share feedback and suggest new resources
- Suggest edits to existing resources

How to get to the CRD

- Log in to your Member Portal, or sign up if you don't already have an account.
- Under the "Resources" column, go to "Community Resource Directory."



Learning Hub: Clinician Training and Badging

Clinician and colleague learning courses and Health Equity badging

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Health Equity Clinician Trainings

Jan 22, 2025

Health Equity Badge Curriculums for Clinician Colleagues

These trainings are recommended for clinician colleagues across the enterprise.

Health Equity Badge Curriculums	Learning Hub Curriculum Number	Credit Type
Culturally Responsive Care Champion Badge	0000330675	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
LGBTQ+ Responsive Care Champion Badge	0000330676	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
Culturally Responsive PCP Behavioral Health C		
Healthy Aging Care Champion Badge		
Women's Health Care Champion Badge		
Person Centered Care Champion Badge		

Health Equity Trainings for Clinician Colleagues

These trainings are recommended for clinician colleagues across the enterprise.

Training	Learning Hub Course Number	Credit Type
For Pharmacists: Actionable Strategies in Your Role as a Pharmacist in Inclusive Patient Management and Respectful Care (30 minutes)	3743288797	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
Disparities in Behavioral Health: Addressing Barriers and Improving Patient Outcomes (30 minutes)	3743288799	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
Engaging Hearts and Minds: Pathways to Equitable Cardiovascular Care (30 minutes)	3743288802	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
Disparities in Women's Health Across the Lifespan: Actionable Strategies to Improve Patient Outcomes (30 minutes)	3743288804	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
Disparities in Cancer Screenings: Addressing Race and Gender in Patient Care to Improve Outcomes (30 minutes)	3743288807	ACCME, ANCC, ACPE, IPCE, AAPA, ABIMMOC, CDR
Oral Care and Health Disparities: Inclusive Patient Management and Respectful Care (60 minutes)	3747341212	IPCE, ACCME, ANCC, ACPE, AAPA, ABIM MOC, ADA CERP

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Health Equity Courses: Continuing education credits focused on health equity empower professionals to address systemic disparities in healthcare access, outcomes, and quality. These programs foster cultural competence, policy awareness, and evidence-based strategies that improve care for underserved populations. By integrating equity into lifelong learning, healthcare systems can better meet the needs of diverse communities and promote justice in health outcomes.

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Compliance and mandated training

Cultural, Linguistic & Disability Access Requirements & Services

Cultural competency

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

Linguistic competency

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

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

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

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

Using Interpreter Services

Step 1: Identify Language Needs

- **Asking Preferred Language**

Always ask members for their preferred language during initial contact to ensure effective communication.

- **Documenting Language Needs**

Record the member's language preference accurately in their records for future reference and compliance.

- **Sign Language & Alternative Formats**

Identify members needing sign language or alternative communication due to visual or hearing impairments.

Step 2: Select the Appropriate Scenario

- **Interpreter Services for Phone Calls**

Member Services facilitate interpreter-assisted conference calls using interactive voice response systems to connect members and interpreters.

- **Face-to-Face Meeting Interpretation**

Care coordinators or staff can dial in an interpreter during home visits or in-person meetings for effective communication.

- **Provider Access to Interpreter Services**

Providers without onsite interpreter access can call to connect with interpreters, ensuring communication support in various locations.

Step 3 : Contact Member/ Provider Services

- **Accessing Interpreter Services**

Providers should contact Member Services at 866-329-4701 or TTY 711 to arrange telephonic interpretation for members in need.

- **Alternative Communication Formats**

Member Services also provides alternative formats for visually impaired members to ensure accessibility.

- **Cost-Effective and Compliant**

Using Aetna's free telephonic interpretation service saves costs and maintains compliance for providers.

Aetna's interpretation services are **free** for members and providers.

If providers choose to use another interpretation resource, they are financially responsible for those costs.

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Accommodating people with disabilities

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

- ❑ A person who has a physical or mental impairment that substantially limits one or more major life activity, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability

- ❑ The Health Plan ensures equal access in partnership with participating providers by maintaining an ADA Plan. The ADA Plan monitors the following:

    - Physical accessibility of Provider offices
    - Quality of the Health Plan's free transportation services
    - Concerns related to the Health Plan and/or Provider's failure to offer reasonable accommodations to patients with a disability

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

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

Appointment and availability standards

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

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

Reminders

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

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

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

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

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Fraud, Waste, and Abuse (FWA)

Fraud, Waste and Abuse

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

Critical incidents

Abuse, Neglect & Exploitation

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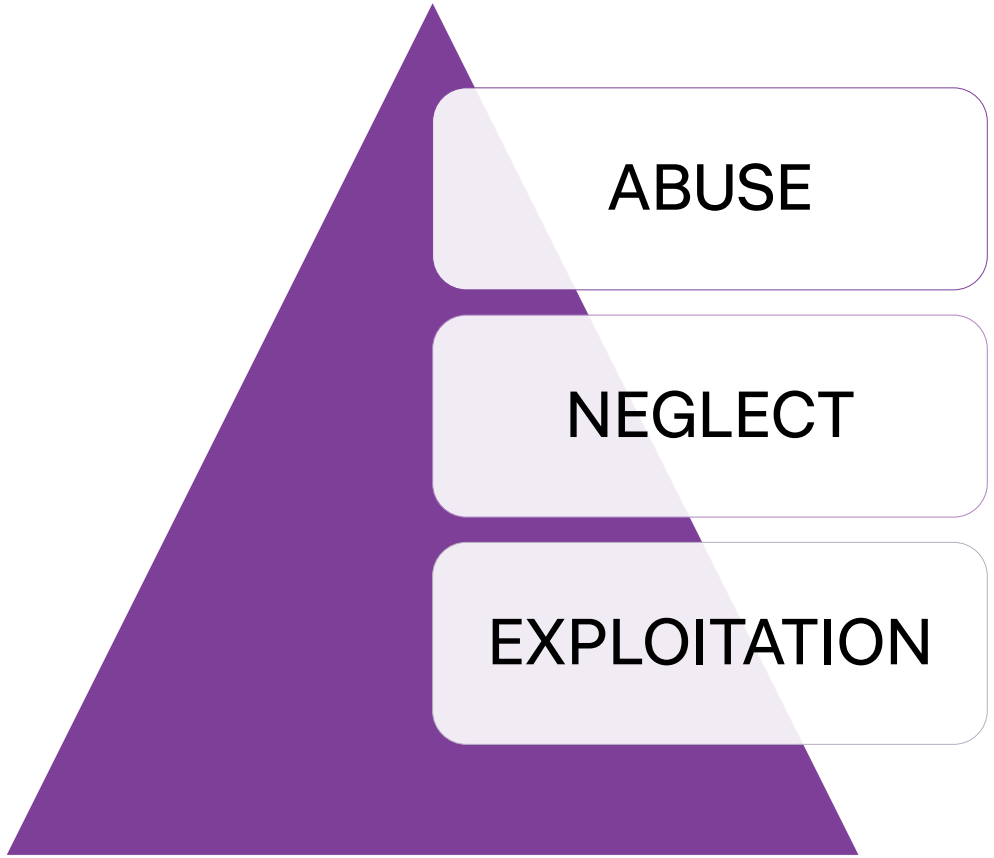
Critical incidents | Spot the signs

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



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

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Reporting critical incidents

Office of Inspector General (OIG):

800-368-1463

Aetna Better Health of Illinois Provider Services:

866-329-4701

IL Department on Aging (IDoA):

866-800-1409

Senior Help Line:

800-252-8966

IL Department of Public Health (IDPH):

800-252-4343

Critical Incident Reporting and Analysis System (CIRAS):

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

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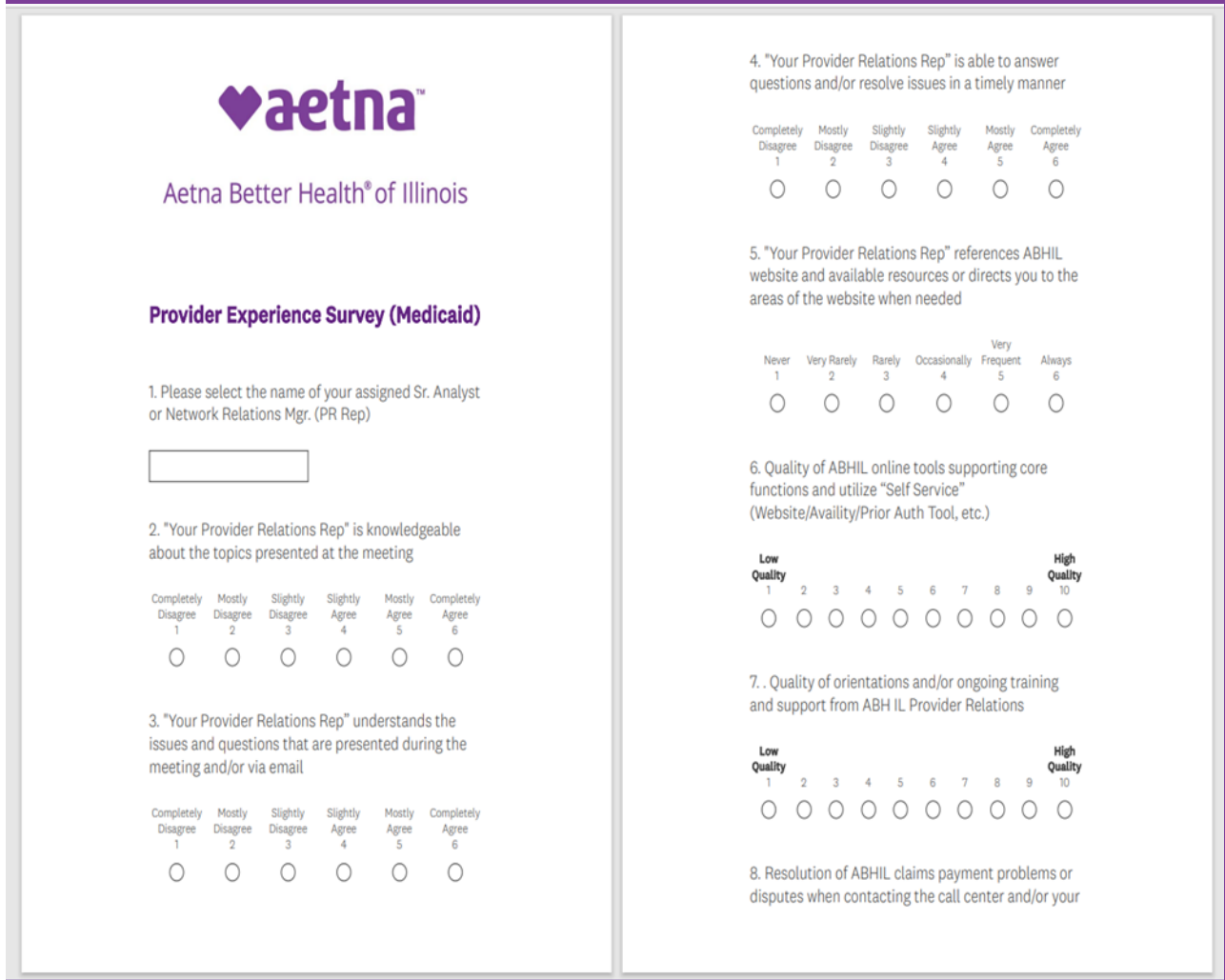
Provider Experience Survey

New Provider Experience Survey

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

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

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



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Aetna Better Health® of Illinois

Provider Experience Survey (Medicaid)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Key contacts

Key contact information

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

Vendors and partners

Vendors and partners

Aetna Better Health® of Illinois subcontracts the following services:

- **DentaQuest** for Dental
  - Phone: 1-800-508-6780
  - Website: DentaQuest.com
- **March Vision** for Vision
  - Optometry claims go to March Vision
  - Ophthalmology claims go to ABHIL
  - Enroll contact: **https://marchvisioncare.com/becomeprovider.aspx** or call toll-free at **844-456-2724**
- **Modivcare** for Non-emergency Medical Transportation (NEMT) - **866-329-4701**
- **Availity** for ABHIL Provider Portal - **https://apps.availity.com/availity/web/public.elegant.login**
- **EviCore** for utilization management of advanced imaging/cardiology and interventional musculoskeletal pain management
  - *To Enroll contact:* **www.evicore.com** or call toll-free at **888-693-3211**
- **Eviti** is a decision support platform for oncology; it covers all medical and radiation oncology treatment plans for members ages 18 and older
  - Provider Support Team is available 8 AM – 8 PM ET by phone at **888-482-8057** or via email at **ClientSupport@NantHealth.com**


Thank you!

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