Aetna Better Health® of Illinois
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Aetna Better Health® of Illinois

HBIA/HBIS members transitioning to managed care January 1, 2024

Aetna Better Health® of Illinois wants providers to be aware that effective January 1, 2024, we'll be serving the **Health Benefits for Immigrant Adults (HBIA) and Health Benefits for Immigrant Seniors (HBIS**). These populations were previously covered under Fee for Service.

What are HBIA and HBIS?

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

What should providers expect?

We're organizing our systems to serve these members, including covered benefits, rates, codes, etc. Providers should be aware of the following:

- HBIS and HBIA members will be included in our existing Medicaid plan and will have a Medicaid ID card (example shown here).
- These members will have a co-pay for certain non-emergency hospital or surgical center services.
- There will be no changes to our processes for submitting claims or appeals for the HBIA/HBIS population.
- When someone switches from one plan to another, there is no grace period.
- Aetna Better Health of Illinois does not cover any health care prior to the member's active date of January 1, 2024.

Copays

HBIA and HBIS members will have a copay for certain services. We will reduce payments to providers according to the schedule below. It's up to the provider to collect copays or coinsurance. Providers must tell the member if they will charge cost sharing and what the amount will be **before providing the service**. **Application of copays will begin for claims with dates of service on or after February 1, 2024.**

Copays for HBIA and HBIS will be as follows:

- Non-emergency inpatient hospitalizations: $250 copay
- Hospital or Ambulatory Surgical Treatment Center outpatient services: 10% of the Department rate

Note: HFS removed a previously planned $100 copay for non-emergency hospital ER services.

The 10% coinsurance is only for services billed under hospital NPIs. Any Provider-NPI billed services has no coinsurance. Note: No copay or cost sharing can be charged for an emergency service needed to evaluate or stabilize an emergency medical condition.

Covered services

Most services covered by these programs will be at no cost to members, including:

- Doctor and hospital care
- Primary care visits
- Care at a Federally Qualified Health Center (FQHC)
- Lab tests
- Vaccinations at a pharmacy or doctor's office
- Rehabilitative services such as physical and occupational therapy
- Home health, mental health and substance use disorder services
- Kidney and stem cell transplant services
- Dental, transportation and vision services
- Prescription drugs

Services not covered

- Long-term care (exception: post-acute care rehab stays up to 90 days are covered)
- Transplant services (exception: kidney, stem cell, bone marrow and transplant services are covered services)
- Home and Community-Based Services (waiver services)

Emergency medical need

Any emergency service provided in the ER or hospital will not have a copay, specifically, services billed with an Emergency Revenue Code of 450, 451 or 456 and priority type of admission 1 for emergency.

Learn more

Providers can find more information about HBIA and HBIS on the **HFS** website.