2024 Medicaid Provider Summit

Aetna Better Health® of Illinois

February 2024

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Agenda

Introductions & overview

Care management

Pharmacy

Business Enterprise Program

Community outreach

Marketing

2024 member value-added benefits & resources

Availity portal & reporting

Value-based partnerships

Tools & resources

Claims Corner

Provider escalations

Quality management

Mandated training

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Welcome from our senior leaders

Rushil Desai
Chief Executive Officer

Melanie Fernando
Chief Operating Officer

Dr. Lakshmi Emory
Chief Medical Officer

Dianne Robinson
Chief Financial Officer

Mary Cooley
Chief Clinical Officer

Elizabeth Leonard
Executive Director, Marketing

Fallon Moore-Huff
Chief Network Officer

Hassan Gardezi
Chief Compliance Officer

Andrew Hyosaka
Lead Director, Service Operations

Steve Sproat
Principal Clinical Leader, Pharmacy

Terriana Robinson
Lead Director, Provider Relations

Denise Gaines
Lead Director, Government Affairs

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Introduction to our Provider Relations leadership

Terriana Robinson
Lead Director, Provider Relations

Christine Fox-Zapata
Senior Manager, Provider Experience

Steve Inzerello
Senior Manager, Provider Experience

Our footprint

3200 Highland Avenue
Downers Grove, IL 60515

333 W. Wacker Drive
Chicago, IL 60606

Our local approach

- **Illinois-based staff for local member and provider servicing**
- **Over 900 Illinois-based employees**
- **Currently serving approximately 398,000 Medicaid members in the State of Illinois**
- **Network of more than 46,000 providers statewide**
- **Dedicated, local contracting and provider relations staff, with Illinois-based executive leadership**

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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

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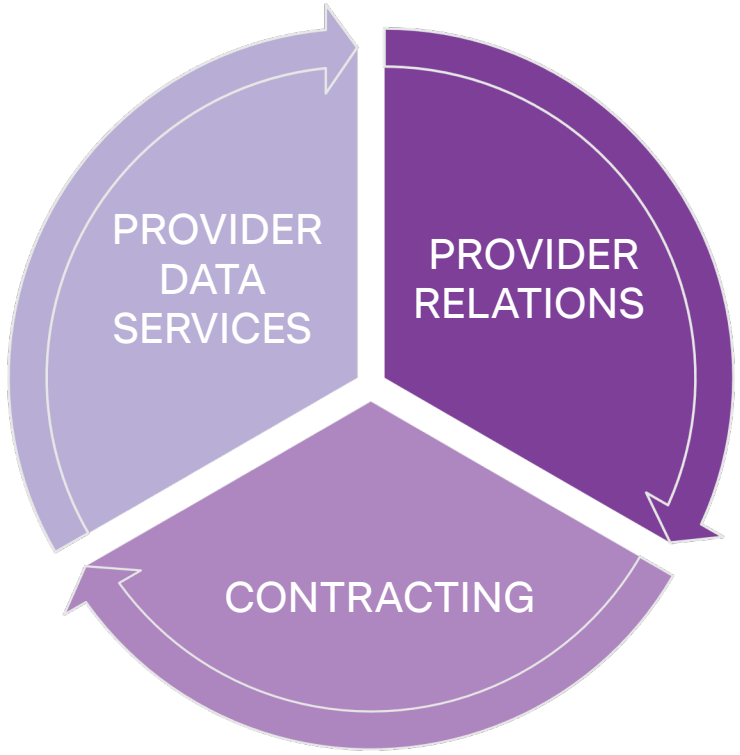
Provider network overview



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:
https://www.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.

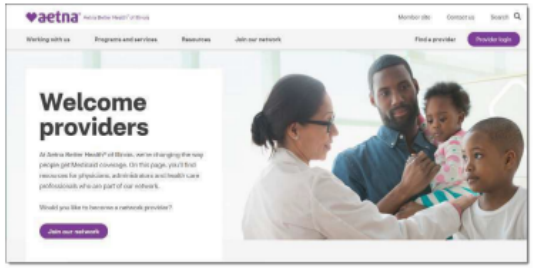
Aetna Better Health of Illinois offers a provider services line by calling **(866) 329-4701**
(Monday through Friday 7 AM-7 PM)

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.

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Care management

Care management

Role of care management:

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

How to refer to care management

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

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

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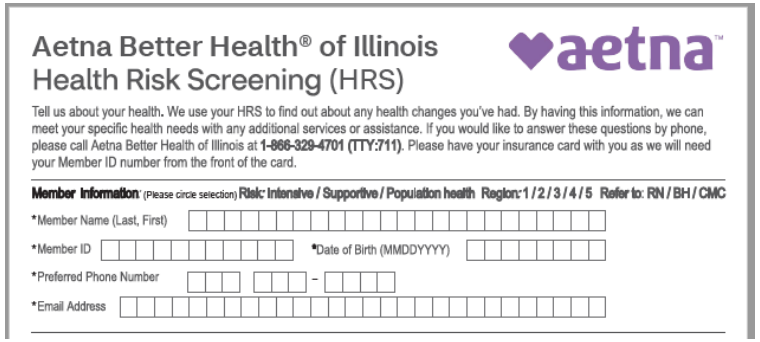
Health Risk Screener (HRS): provider partnership

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

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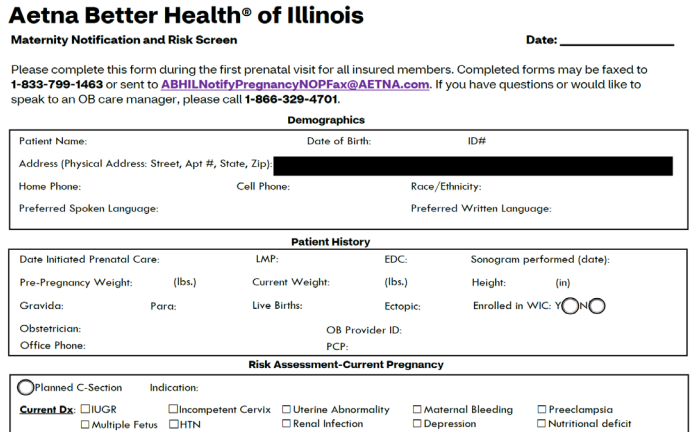
Notification of Pregnancy (NOP): Provider partnership

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



Aetna Better Health® of Illinois

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

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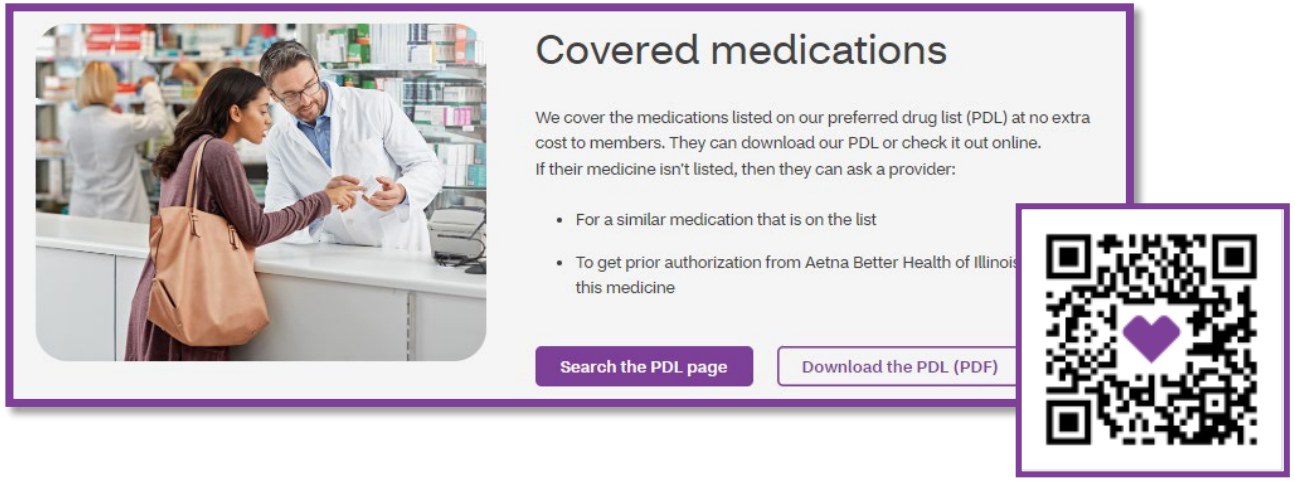
Pharmacy

Pharmacy resources

Preferred drug list

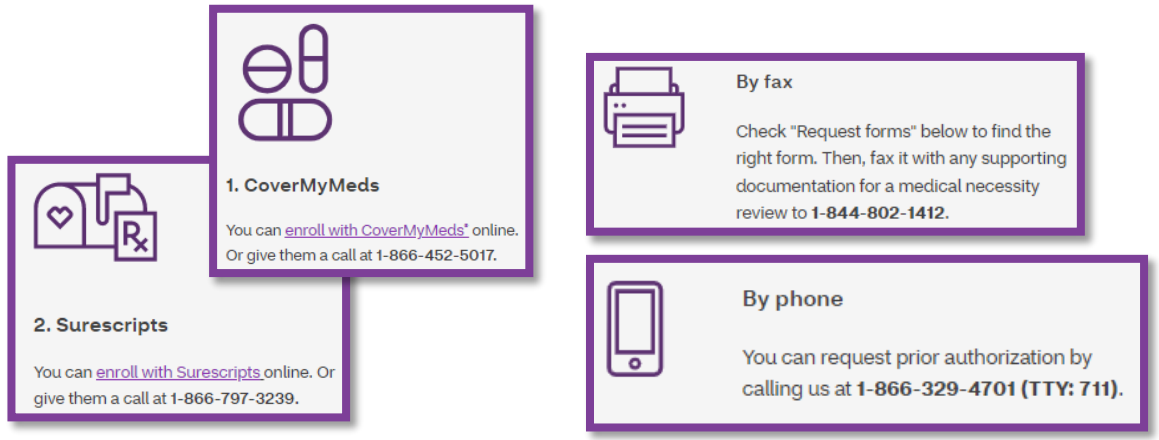
- Drug list available in PDF format as well as in the Aetna search tool.



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

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.



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Health Tag program

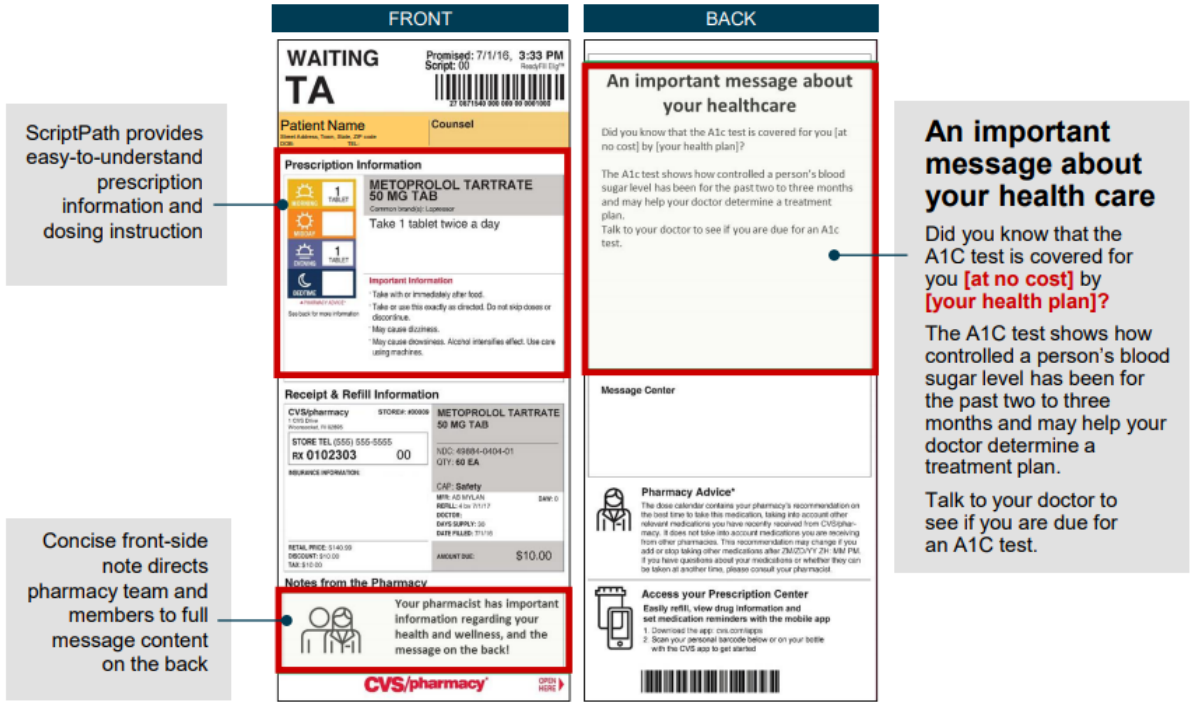
- Program delivers critical messages to member when they pick up their prescription.
  - Written message on prescription
  - Message reinforced verbally by pharmacy staff.
- Members are targeted based on quality gaps and health needs.

Quarter 1
OTC Campaign (Multilingual)

Quarter 3
Colon cancer screening (COL)
Child well visit (0-30 mon)
A1C (HBD)
Flu/Covid/Booster

Quarter 2
Child Immunization (CIS)
Eye exam (EED)
Cervical cancer screening (CCS)

Quarter 4
Breast cancer screening (BCS)
Blood pressure - MC (CBP)
Child well visit (3-21)



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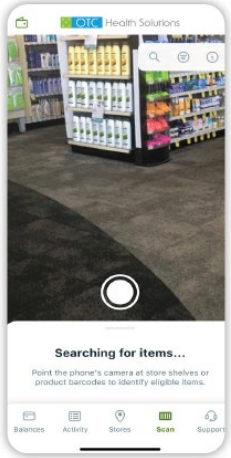
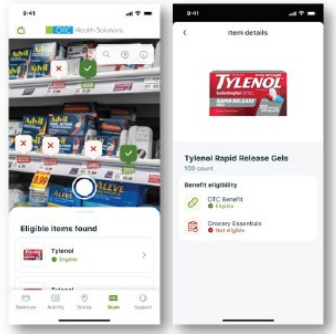
OTC Health Solutions

- Members receive a $25 monthly benefit
- Products can be ordered via:
  - In-store CVS location
  - IVR and call center
  - Online catalog
- No prescription required
- No cost to Aetna members

New OTC Health Solutions App

- Check account balance
- View order history
- Store locator
- Order tracking info
- Check product eligibility while at a CVS location





1. Scan or enter the items' barcode inside of the store to confirm if it is approved.

- Approved items
- Non-approved items

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Pharmacy program highlight

A focus on member safety

The retrospective safety review solutions act as safety nets for situations that may have a negative clinical impact on a member.

Retrospective safety review

Retail and mail prescriptions are reviewed daily for serious drug-to-drug interactions and the prescriber
is notified with an actionable member-specific communication within 72 hours of the claim processing.

Value

- Near real-time review and intervention
- Increased member safety
- Increased prescriber engagement

Prescribers are notified of the potential safety opportunity via fax/letter.

Opioids vs. Antipsychotics

Selected CCBS vs. beta blockers

Clopidogrel vs. PPIs

Tramadol vs. various agents 3

Clonidine vs. beta blockers

Selected SSRIs vs. Warfarin

Azole antifungals vs. HMG CoA reductase inhibitors

Tramadol vs. various agents 4

Various anticoagulants vs. NSAIDs

Selected anticoagulants vs. antiplatelet agents

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Business Enterprise Program (BEP)

Business Enterprise Program (BEP) overview

What is BEP?

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

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

Who can become certified?

Businesses **at least 51% owned and controlled** by a **minority** or **woman** or designated as a **disabled business** are eligible. The owner must be a **United States citizen** or resident alien and the business must have an annual gross sale of **less than $75 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

Q1 & Q2 community events

Date	Event	Event description
January	New Year, New You Health & Resource Fair	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, and family-friendly activities.
February	Heart Health Resource Fair	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, and family-friendly activities.
March	Aetna Better Health of Illinois Laundry & Literacy	Laundry & Literacy events support basic living needs and encourages healthy living. Events include health awareness education, community resources, free laundry services, and childhood literacy development.
April	Aetna Better Health of Illinois Pop-Up Farmers Market	Pop-Up Farmers Market events aim to combat food insecurity within underserved communities throughout the state. The health plan will partner with youth organizations, park districts, libraries, and subsidized housing authorities to provide community members access to fresh produce.
May	Spring Fling Health & Resource Fair	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, and family-friendly activities.
June	Summer Bash	Health and resource fair designed to encourage healthy living, provide health education, health screenings, community resources, and family-friendly activities.

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Redetermination

Redetermination efforts

Aetna uses a messaging calendar to reach members approaching their redetermination date, which includes the following tactics:

- Emails
- Outbound phone calls
- Postcards
- Text messages
- Outreach events

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

In addition, timely renewal can help prevent claims denials due to eligibility discrepancies and keeps patient panels accurate.

Availity redetermination report available to providers and includes:

1. All assigned members due for redetermination
2. Members whose redetermination forms haven't been received by the 20th of the month it's due
3. Members whose cases require follow-up because HFS hasn't received redetermination info from member OR the member was determined to be ineligible for over-income

Redetermination FAQs

AetnaBetterHealth.com/Illinois-Medicaid/Providers/Provider-Resources.html

2024 Value-Added Benefits and resources

Value-added benefits

In 2024, our members can take advantage of these free extra benefits:

Baby essentials
Eligible pregnant members can receive a car seat or highchair or play yard, plus a diaper bag.

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

Behavioral health wellness app
Eligible members ages 12 and up can get a voucher for digital behavioral health wellness support.

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

Eligible members ages 18 and up can receive a voucher to cover meal delivery services with personalized nutrition and dietitian services.

Eligible members ages 18 and up can get a voucher for digital weight management support.

School clothes
Eligible members in grades K – 12 can get three outfits each year.

Educational support
Eligible members ages 18 and up can receive career training, skill building and GED support through CampusEd.

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AetnaBetterHealth.com/Illinois-Medicaid/Whats-Covered

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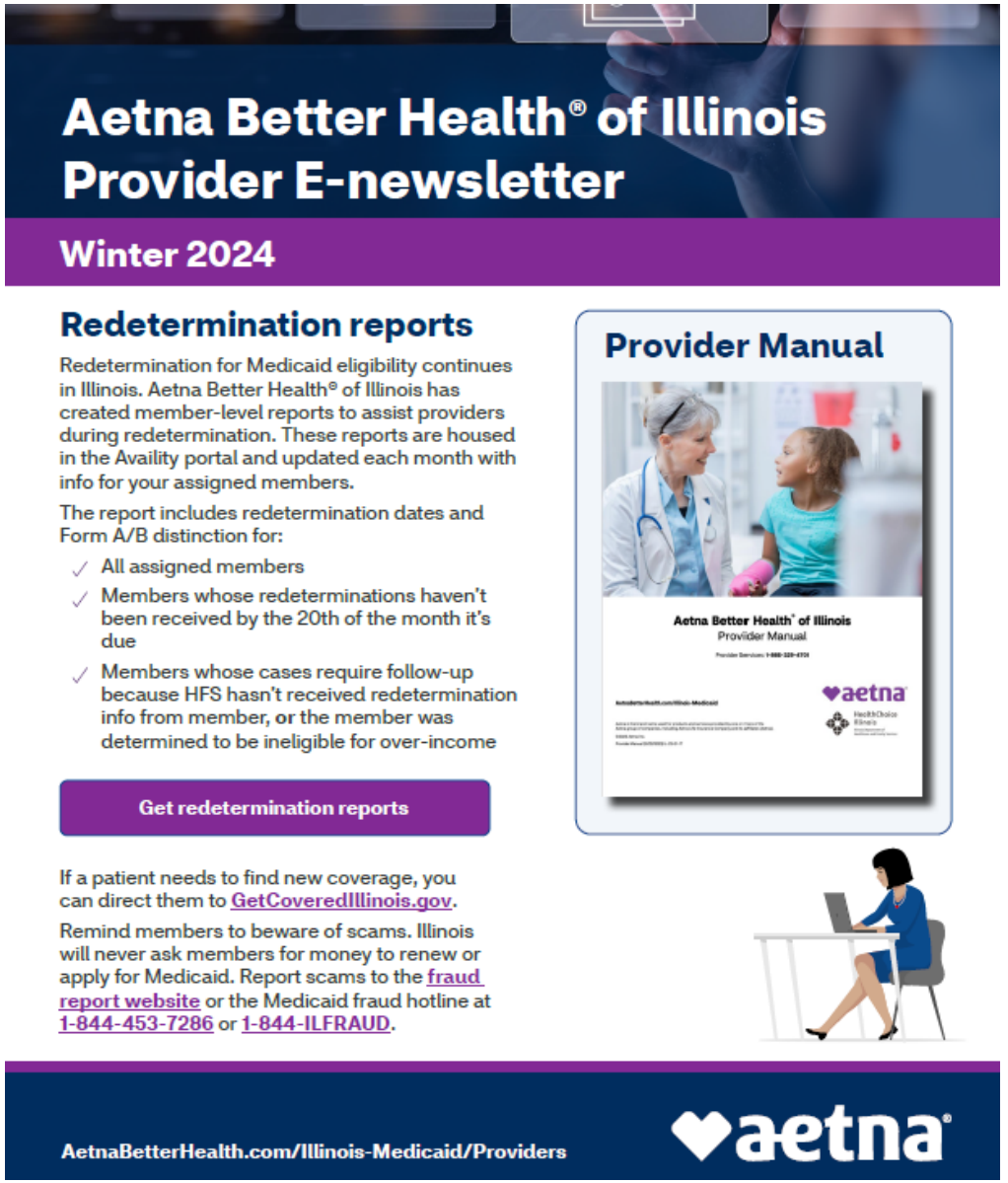
Provider e-newsletter

In our latest issue:

- 2024 Pay-for-Performance incentives
- Value-added benefits for members
- Health equity education for providers
- New provider orientation
- And more



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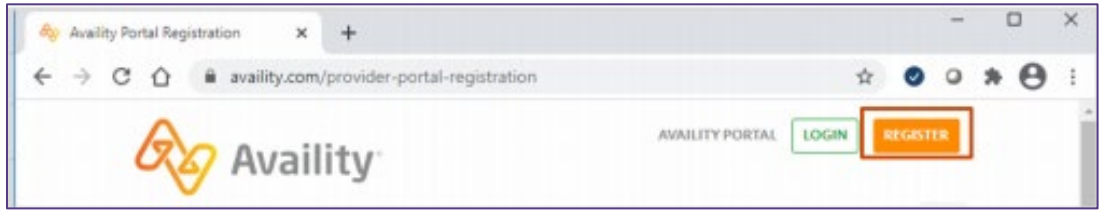
Availity provider portal

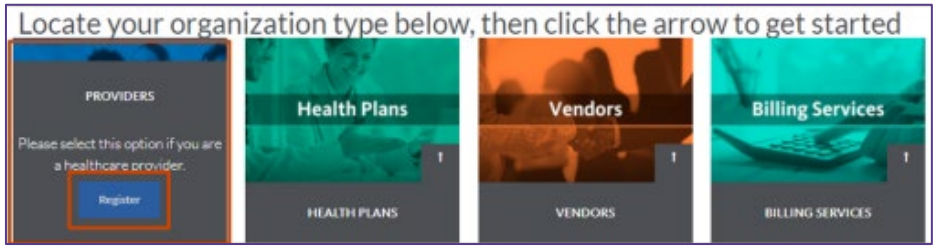
Availity portal registration

Availity.com/provider-portal-registration

Register your provider organization

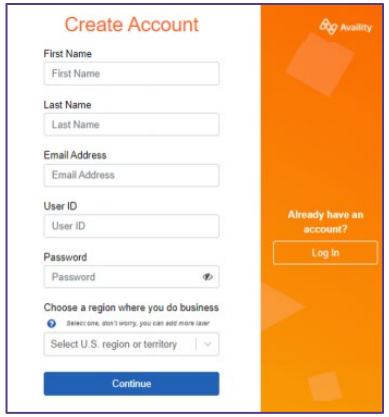
Important: This only applies to users who are brand new to Availity and need to register their provider organization.

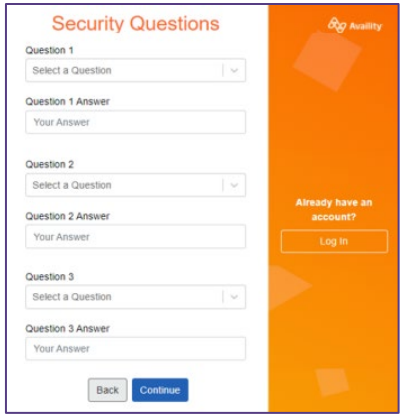


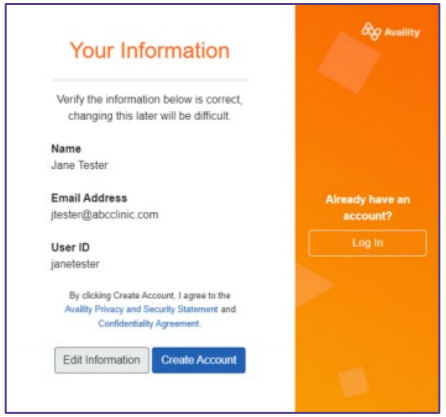


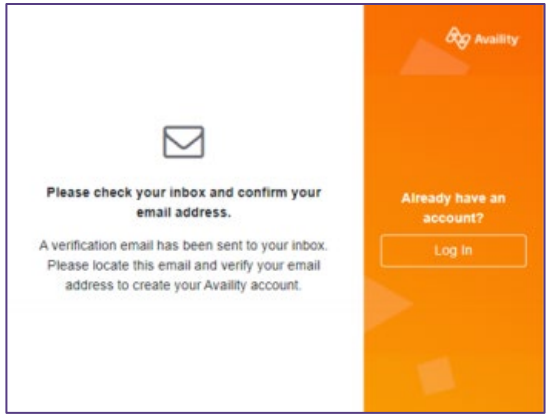
When you set up your new user account, you'll be asked to do the following tasks in the wizard:

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









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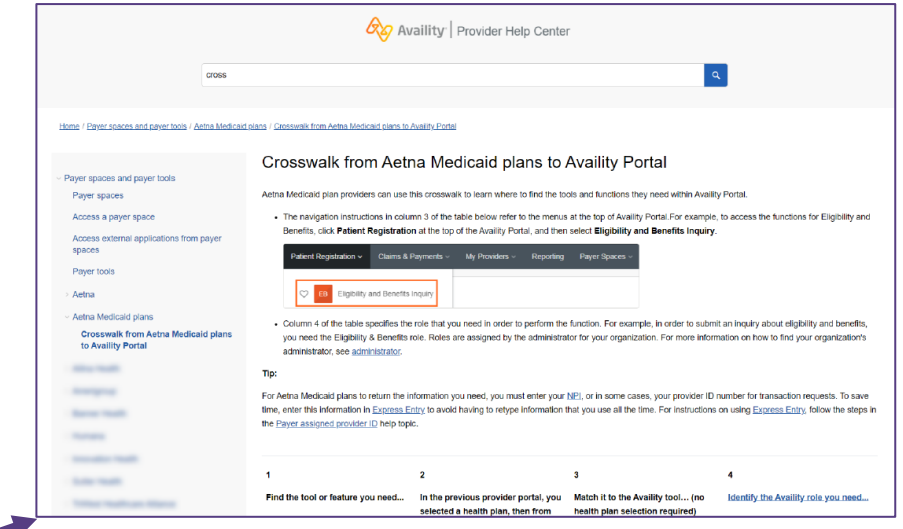
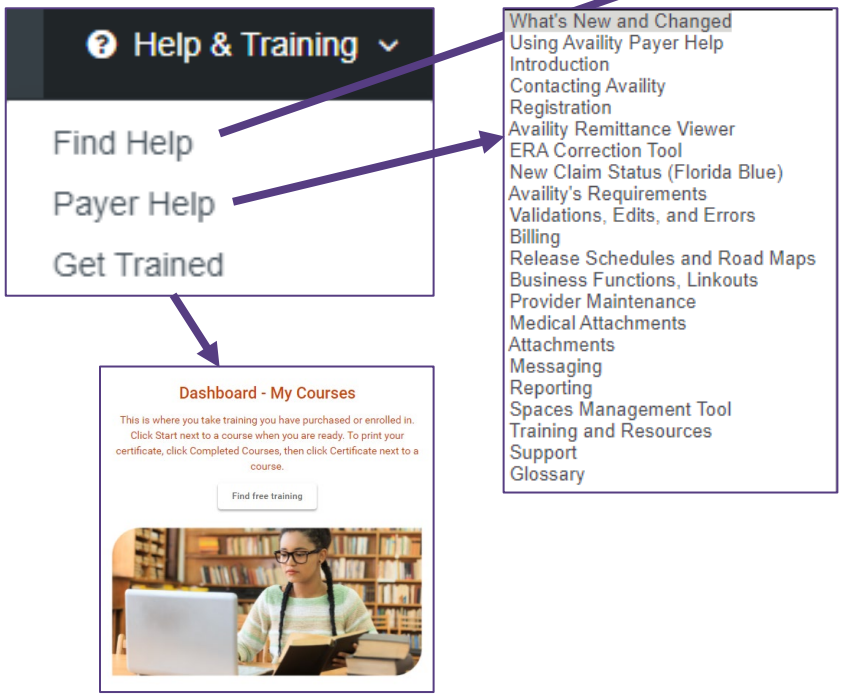
Availity Help Center

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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For additional Availity training please reach out to Market Development Specialist, Jackie Knox.

Jackie Knox
Market Development Specialist, Client Engagement Services
Jackie.Knox@availity.com

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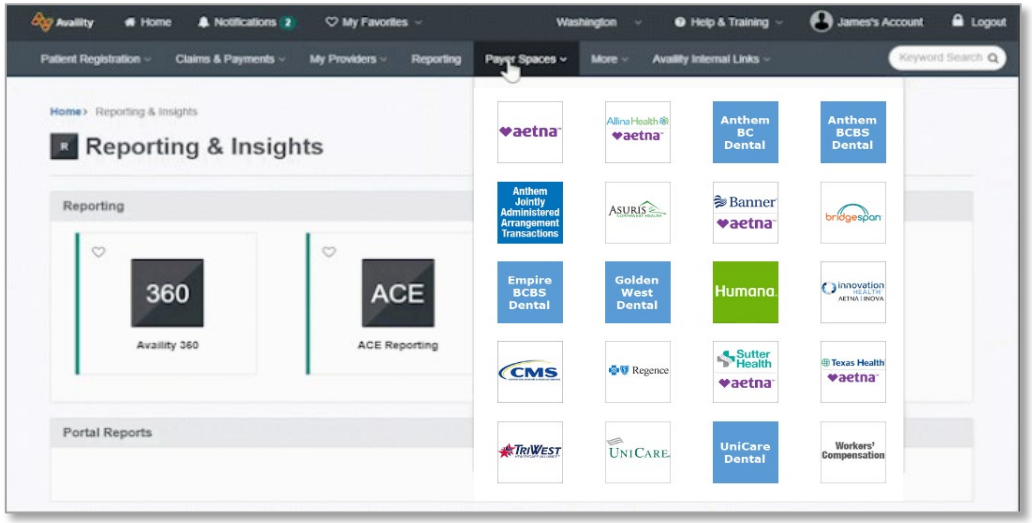
Availity reporting

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

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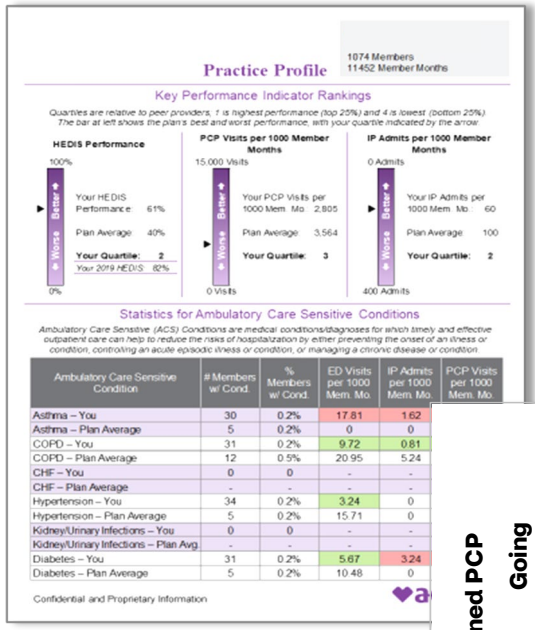
Provider Analytics Reporting Suite (PARS)

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: 82%
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

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**

Member Attribution Grid

Prioritized Member List

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

Daily Census

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

P4Q Performance

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

Cost and Utilization Dashboard

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

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Availity reporting capabilities

Refresh cadence

Monthly | Weekly | Daily

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

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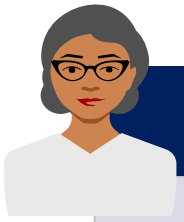
Value-based partnerships

Value-based care benefits

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



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

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

39%
Fewer ED visits

77%
Fewer IP admissions

$24PMPM
Less in ED spend

$55PMPM
Less in IP spend

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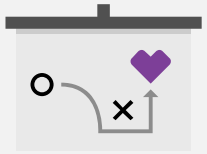
Tools for success in value-based care

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

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



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

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

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

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

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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

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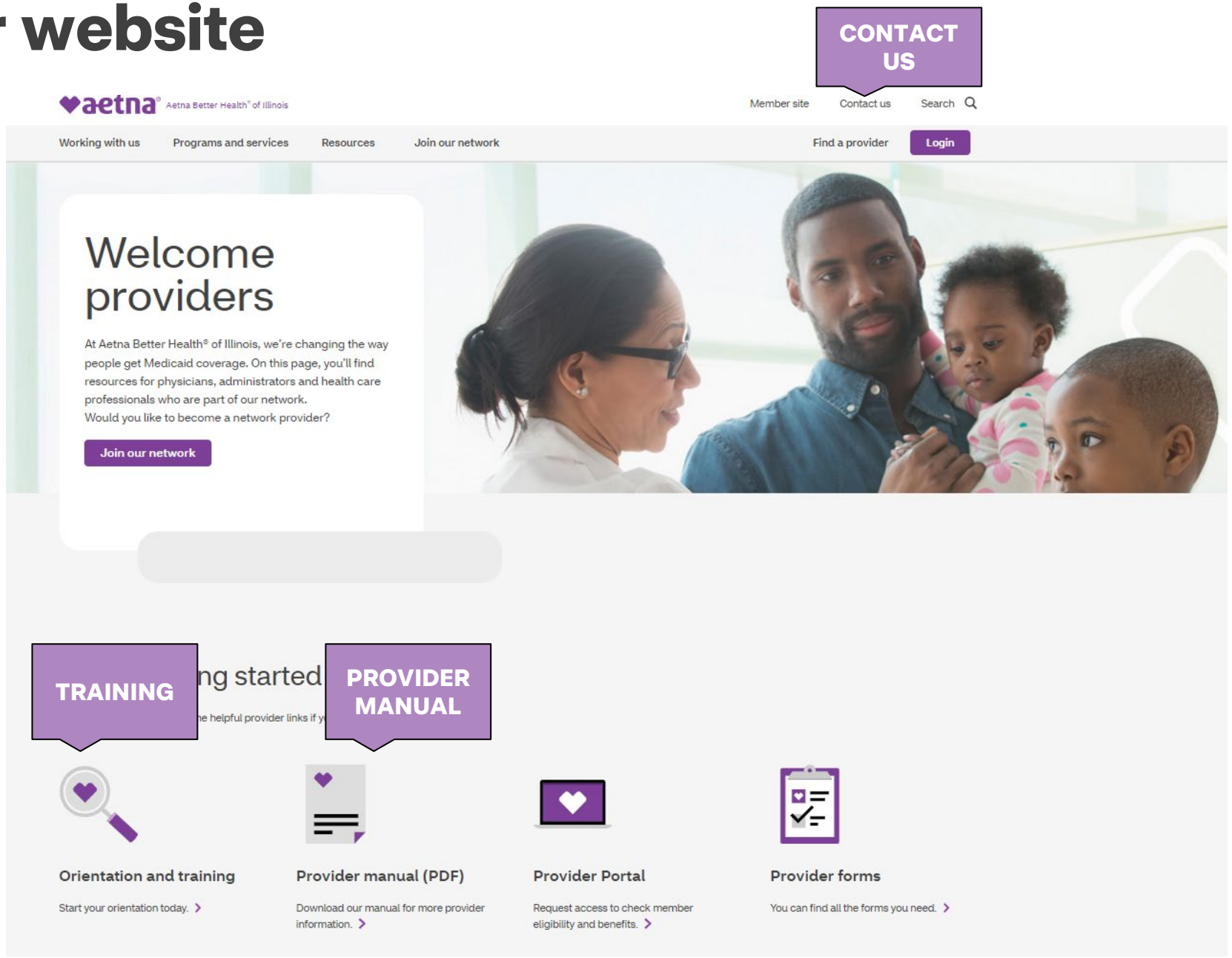
Provider website



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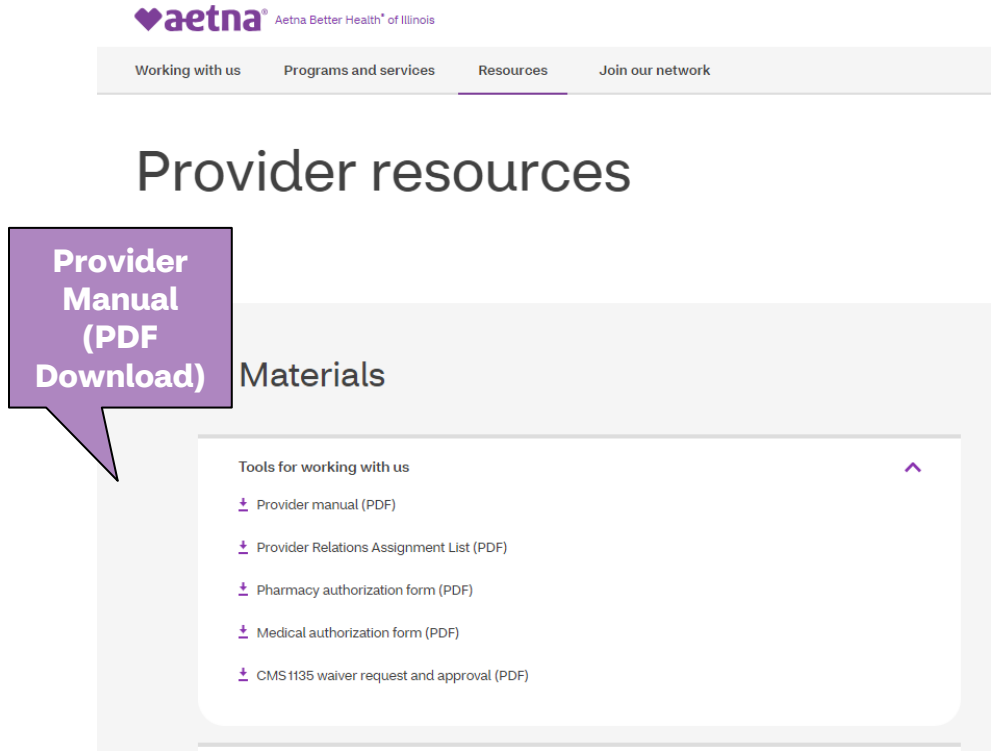
Aetna Medicaid provider manual

In addition to policies and procedures, this resource includes:

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



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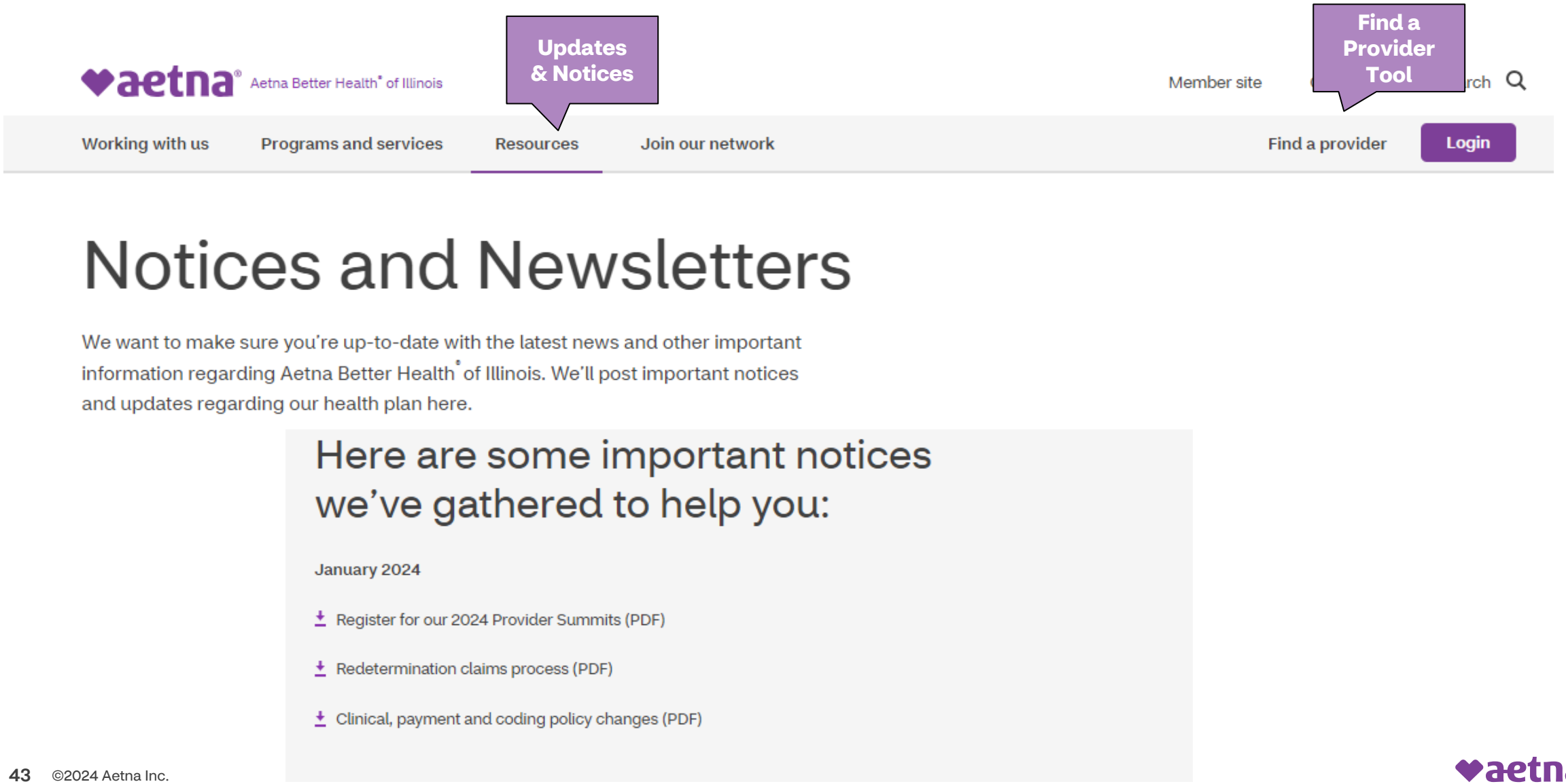
Provider website

Notices found under Resources > Provider news > Notices and newsletters



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Health Benefits for Immigrant Adults/Seniors (HBIA/HBIS)

HBIA/HBIS overview

Aetna Better Health® of Illinois wants providers to be aware of a member population we'll be serving effective January 1, 2024.

- The Health Benefits for Immigrant Adults (HBIA) and Health Benefits for Immigrant Seniors (HBIS) Programs cover immigrants not otherwise eligible for any other medical benefits. **These populations were previously covered under Fee for Service.**
- HFS developed this program as part of its vision to encourage positive outcomes for our customers, address the social and structural determinants of health and foster the well-being of the Illinoisans we serve.
- Medical coverage is available to adults ages 42 through age 64 regardless of their immigration status.

Note: The programs are closed and are not accepting new applications.

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.
- These members will have a co-pay for certain services.
    - 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.
- There will be no changes to our processes for submitting claims or appeals for the HBIS/HBIA population.
- Members will have the opportunity to switch MCOs during their 90-day post-enrollment period.
- Aetna Better Health of Illinois does not cover any health care prior to the member's active date of January 1, 2024.

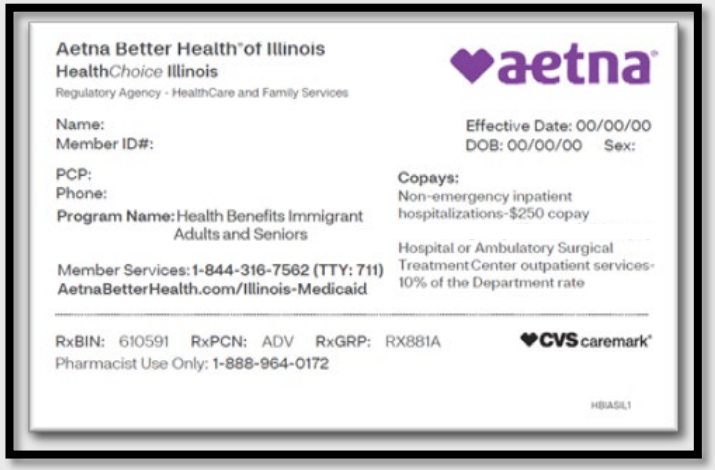
HBIA/HBIS overview (cont.)

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

Notes:

- No copay or cost sharing can be charged for an emergency service needed to evaluate or stabilize an emergency medical condition.
- 10% coinsurance is only for services billed under hospital NPIs.
- Any Provider-NPI billed services has no coinsurance.
- Previously planned $100 copay for Non-emergency ER visits has been removed.



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

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

- Doctor and hospital care
- Primary care visits
- Care at FQHCs
- Vaccinations at pharmacy or doctor's office
- Rehabilitative services such as physical and occupational therapy
- Home health
- Kidney and stem cell transplant services
- Dental
- Transportation
- Vision services
- Prescription drugs
- Mental health and substance use disorder services
- LARCs

Note: This list above is not a complete list, just examples. Members should always check with their providers about whether they will have any out-of-pocket costs.

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

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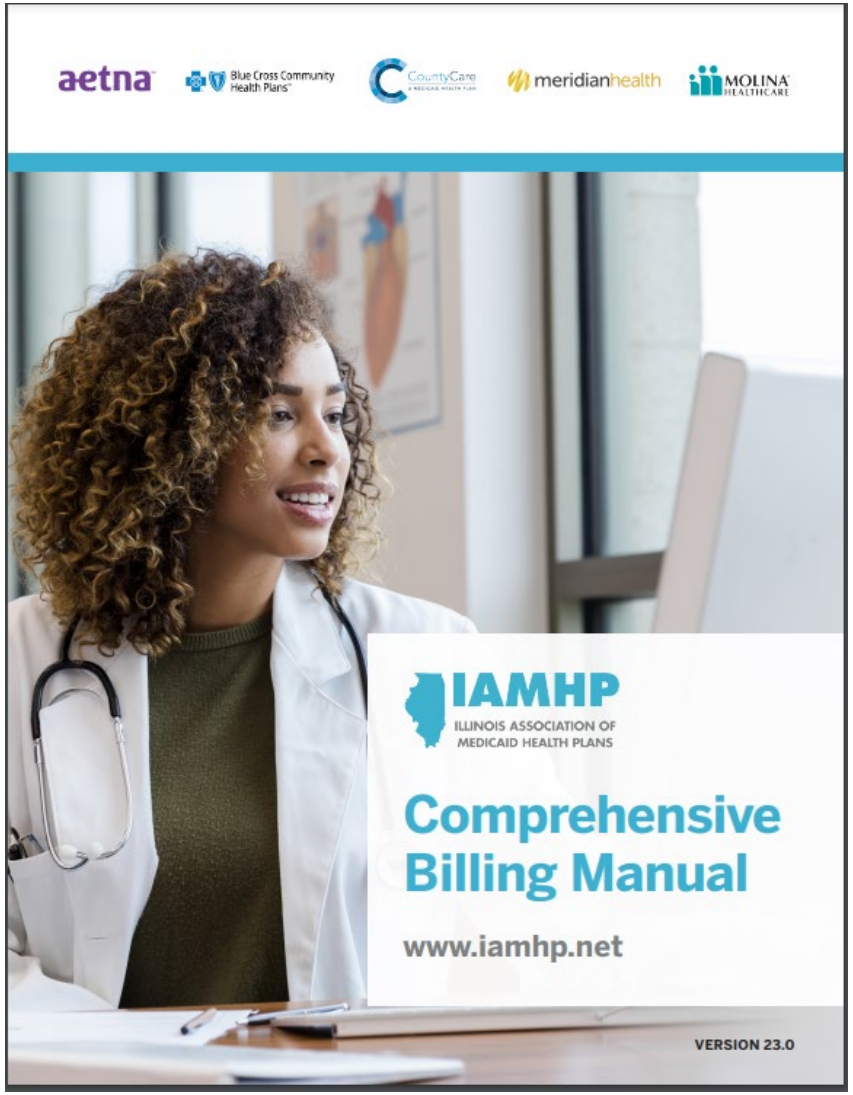
Claims Corner

IAMHP billing manual



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

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

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

Verifying member eligibility

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

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

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

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

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

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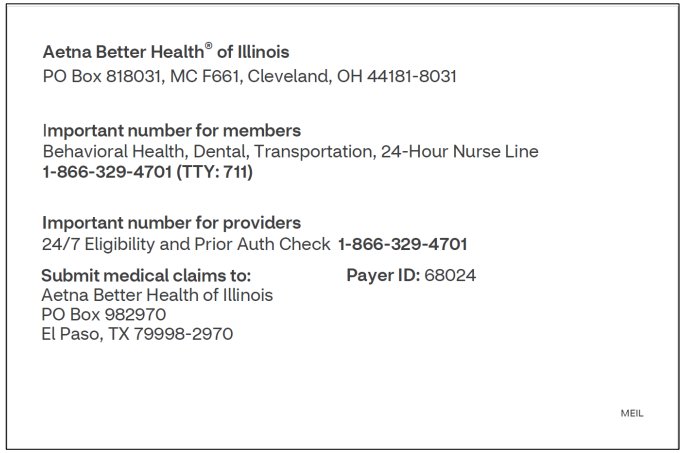
Member ID cards

The member ID card contains the following information:

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

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



Roster/demographic submissions

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

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

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

Prior authorizations

A prior authorization request may be initiated by:

- Submitting the request via the 24/7 Secure Provider Web Portal **AetnaBetterHealth.com/Illinois-Medicaid**
- Fax the request form to 1-877-779-5234 for Physical Health or 1-844-528-3453 for Behavioral Health
- Through our toll-free number **1-866-329-4701**

✓ Please remember that Emergency Services do not require prior authorization

✓ Submit Authorization requests within 7 (seven) days prior to elective procedures

✓ Submit Authorization requests within one business day of urgent/emergent admission

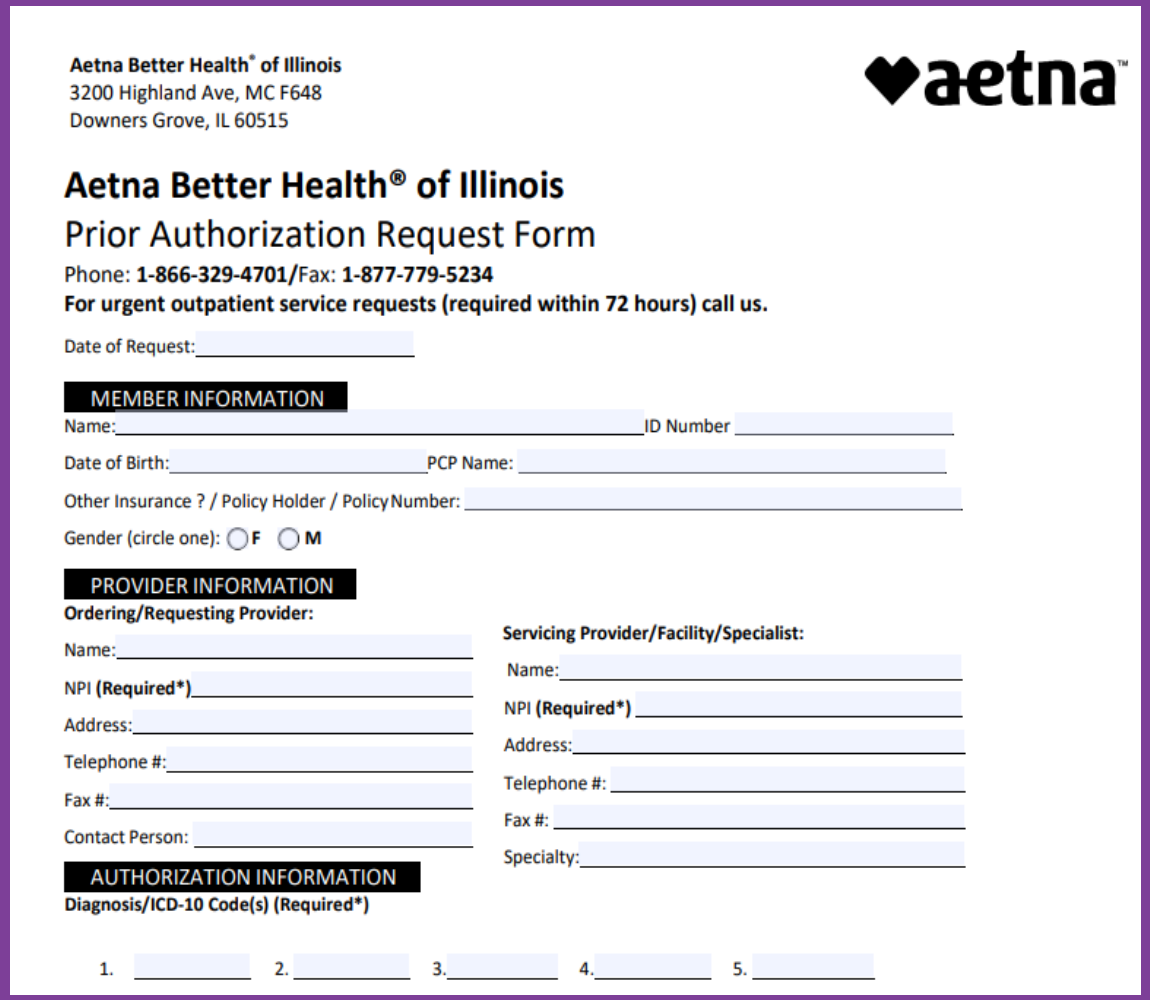
✓ Turnaround times for processing requests are as follows:
- Standard – 96 hours
- Urgent – 48 hours
- Urgent Concurrent – 3 calendar days

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

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

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

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



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

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Aetna Better Health® of Illinois

Prior Authorization Request Form

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

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

Date of Request: _____

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____ PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): ◯ F ◯ M

PROVIDER INFORMATION

Ordering/Requesting Provider:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Person: _____

Servicing Provider/Facility/Specialist:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

AUTHORIZATION INFORMATION

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

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

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Billing & claims payment

For claim submission:
Electronic claims submission through clearinghouse:

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

Submit paper claims to:

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

Check run twice a week

- ❑ Wednesday will be 1ST check run, with a Saturday paid date
- ❑ Friday will be a 2ND check run, with a Tuesday paid date.
- ❑ Paper remits and checks will generally be mailed on Mondays and Wednesdays.

ERA:

- Remittance advices are available within the Availity provider portal.
- Electronic 835's and ERA come from Change Healthcare

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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)

We've partnered with Change Healthcare to introduce the **new EFT/ERA Registration Services (EERS).**

It's a **better, more streamlined way** for our providers to access payment services.

Benefits

EERS is a standardized method of electronic payment and remittance that expedites the payee enrollment and verification process.

Providers can use the Change Healthcare tool to **manage EFT and ERA enrollments with multiple payers on a single platform.**

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, visit **https://payerenrollservices.com/**.

Itemized bill process

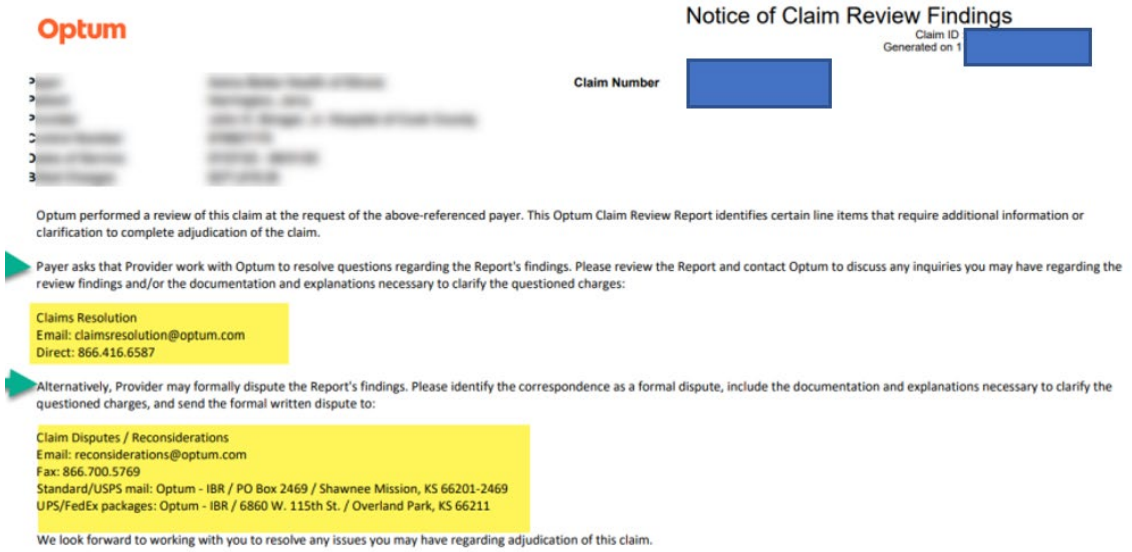
High-dollar inpatient DRG claims at or exceeding an expected reimbursement of $25K require an itemized bill.

There are three ways to submit an itemized bill:

1. Submit the Itemized Bill electronically via the EDI Dispute Process
2. Following electronic claims submission, upload the Itemized Bill via the Availity portal
3. When mailing via claim reconsideration, include a copy of the claim form, attach the Itemized Bill, and mail directly to Aetna Better Health of Illinois, PO Box 982970, El Paso, TX 79998-2970

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

SAMPLE OPTUM NOTICE



Optum

Notice of Claim Review Findings

Claim ID
Generated on 1

Claim Number

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

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

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

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

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

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

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Provider disputes (resubmissions/reconsiderations)

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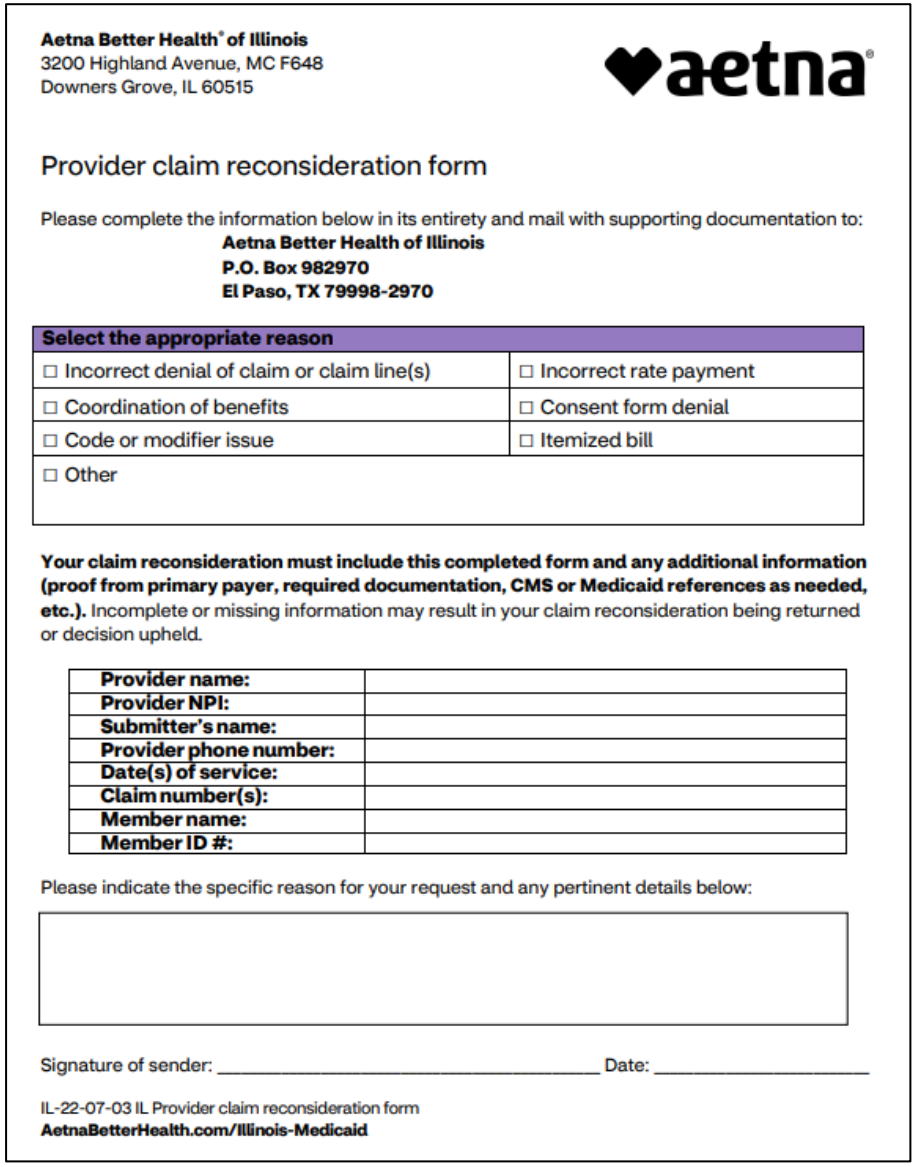
Provider claim reconsideration form

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



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

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Provider claim reconsideration form

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

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

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

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

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

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

Signature of sender: _____ Date: _____

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

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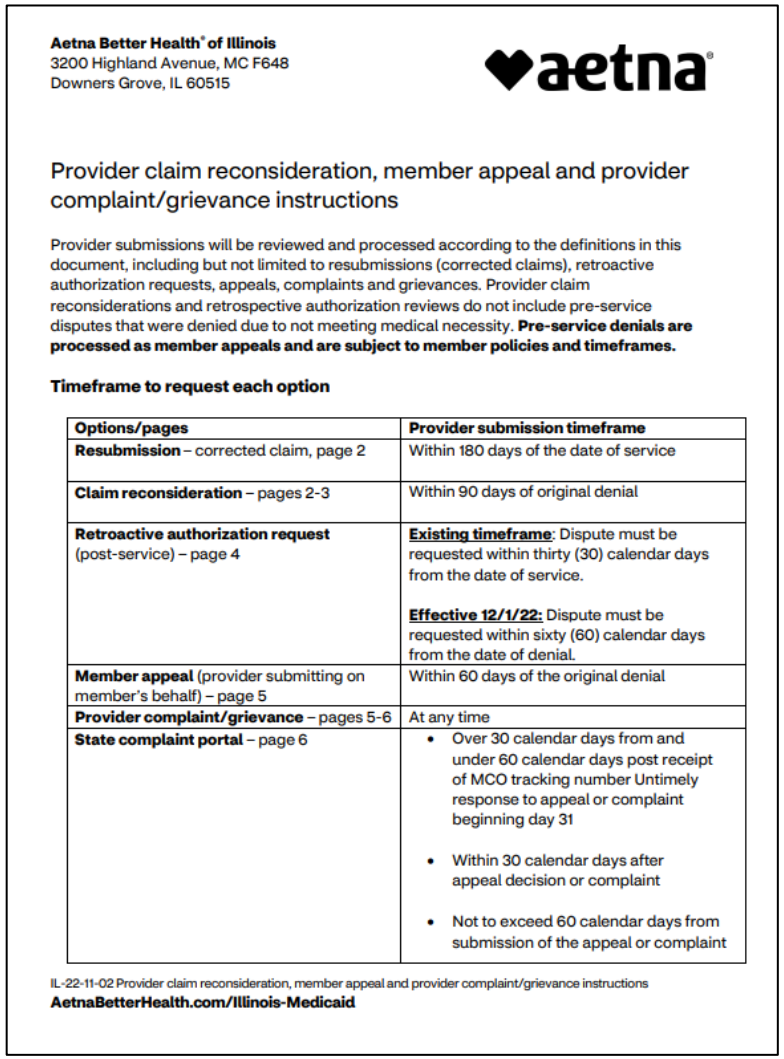
Instructions for claim reconsideration, member appeal and provider complaint/grievance

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



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Downers Grove, IL 60515

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

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

Timeframe to request each option

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

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

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

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

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

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

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

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Recoupments

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

Provider notification will include:

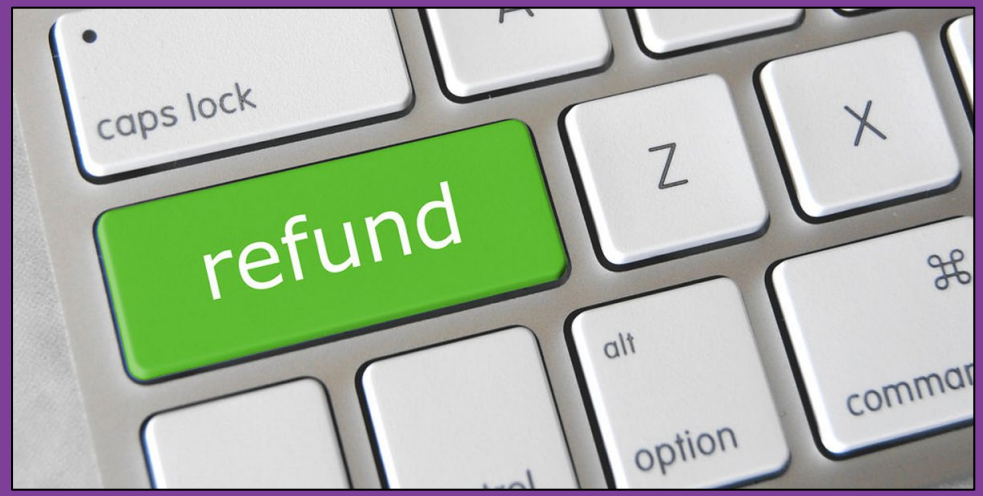
- Impacted claims
- Member's name
- Date of service

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

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

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

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



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Provider escalations

Provider Experience escalation process

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Provider complaints (also known as a grievance)

Aetna Better Health has established a provider complaint process that expedites the timely and effective resolution of complaints 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 complaints about any matter other than an appeal. Possible subject of complaints 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. Complaints 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 complaint 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 complaints

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

HFS requirements for submitting a state complaint

- The new provider dispute resolution process requires providers to first use the MCO internal dispute process before submitting a complaint to HFS.
- Disputes submitted to the Aetna internal dispute resolution process may be submitted to the new HFS Complaint Resolution Portal:
    1. No sooner than 30 days after submitting to the Aetna's internal process and
    2. No later than 60 days after submitting to the Aetna’s internal process.
        If HFS determines a complaint was submitted sooner than 30 days or later than 60 days after submitting the dispute to the Aetna’s internal process, the complaint will be immediately closed.
    3. Claim numbers should be used as a tracking number
        Any changes will be updated by the health plan

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

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Quality management

Introduction to HEDIS®

Healthcare Effectiveness Data and Information Set

We believe quality is everyone's responsibility

HEDIS® measures focus on prevention, screenings and overall improvement of health

HEDIS® - Healthcare Effectiveness Data and Information Set

- A set of more than 96 performance measures in the managed care industry, which is developed and maintained by the National Committee for Quality Assurance (NCQA)
- A widely used measurement tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service

HEDIS performance data is used to identify opportunity for improvement, monitor the success of quality improvement initiatives, track improvement and provide impactful health care planning.

- HEDIS measures rates by race, ethnicity, gender and age. This will help identify best practices, populations needing improvement and inform the need of quality interventions
- As you partner with our plan for the care of our members, we want to work closely with your team to improve clinical quality outcomes and reward you for closing gaps in care. Improving care can make a meaningful difference in your patient's health and wellness. And, it can improve your HEDIS scores.

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

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HEDIS® reporting cycle

Measurement year

The year in which the HEDIS® services are completed

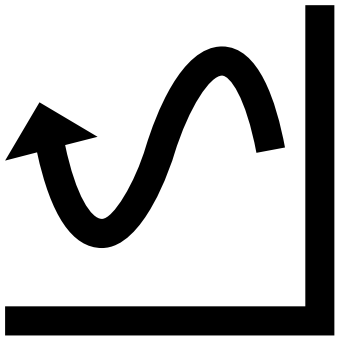
2024 measurement year

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

HEDIS® hits* may be captured using **administrative data** (claims, pharmacy, or supplemental data)

Though individual measure requirements may vary, providers typically have until the end of the measurement year to complete HEDIS® services for their members

**"HEDIS hits" or "numerator compliant" members refers to members who have closed a care gap for the measure*



Reporting year

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

2025 reporting year

Though services must be completed in 2023, a retrospective review of the services will continue from **January to April of 2024**

- This is what most providers and health plans recognize as "**HEDIS® Hybrid season**"
- HEDIS® hits may be captured using **hybrid data** a combination of administrative data and medical record review

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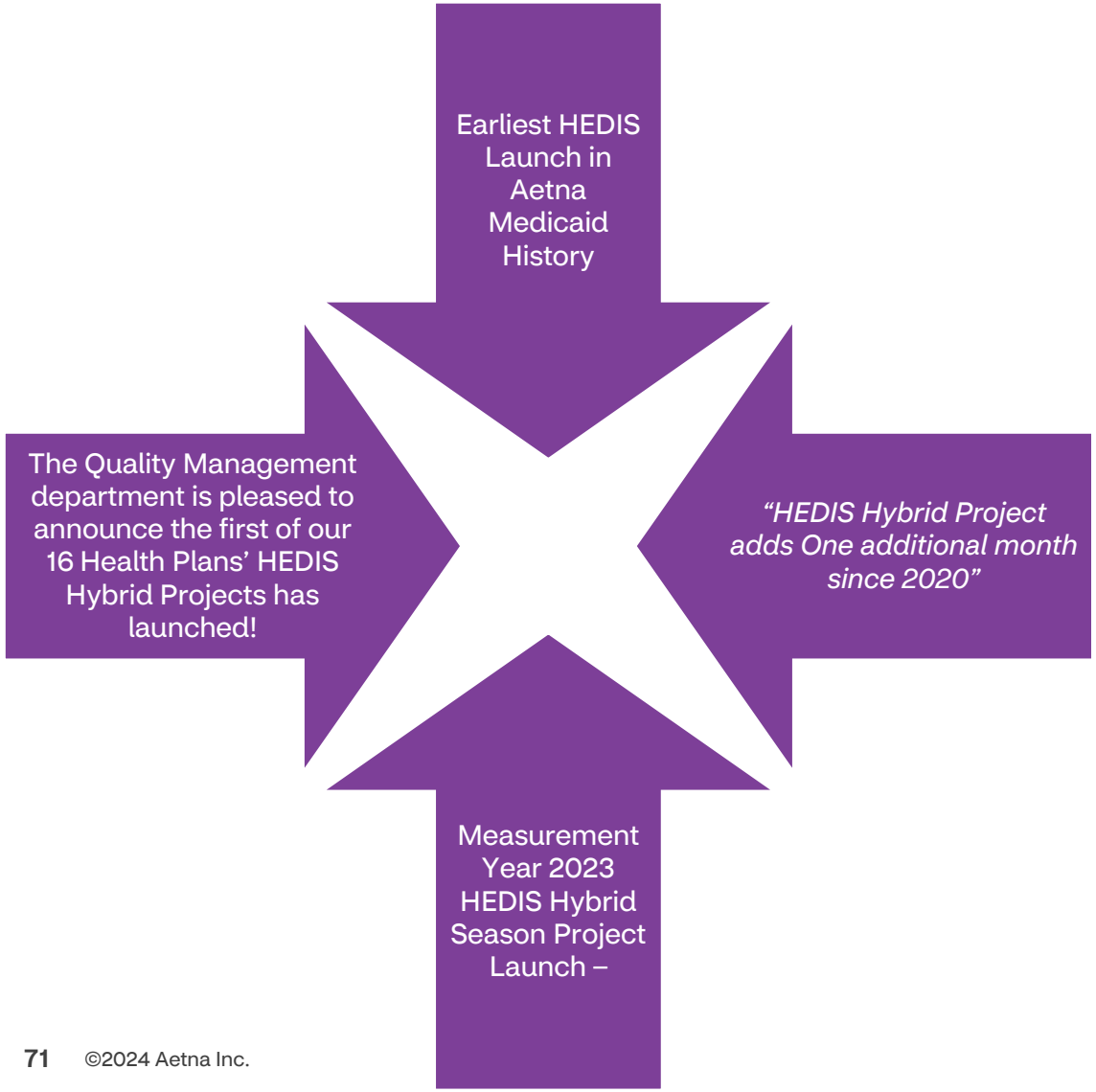
MY2023 HEDIS Hybrid Project

Quality improvement strategy



This landmark HEDIS Hybrid Project Launch enables the longest possible time for Medical Record Collection to increase our HEDIS Hybrid measure performance, directly impacting P4P and Health Plan Star Rankings.

With this January 16th initial launch and the extension of our "pencils down" date to the final day, May 3rd this year, more than one additional month has been added to the Legacy Aetna Medicaid HEDIS Hybrid Season length, 16 weeks vs. 12 Weeks or less in 2020 and prior.

In addition, based on outreach to peers across the industry, we are two full weeks ahead of our competitors in many of our markets and equal to or ahead in the remainder.

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Measuring health plan quality

HEDIS® - Healthcare Effectiveness Information Data Set

- **96 standardized, population-based measures in 6 domains**
- Covering 190m enrolled health plan members nationwide
- Illinois Health Choice contract requires reporting on 38 HEDIS® measures and sub measures (6 non-HEDIS®).
- Reported annually for prior calendar year, benchmarked nationally by NCQA
- Make improvements to quality of care and services
- Award accreditation status to health plans that assists customers in selecting health plans and providers

CAHPS® - Consumer Assessment of Health Care Providers and Systems

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

NCQA health plan ratings and summary score

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

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

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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2024 P4P
Pay for Performance overview

2024 Pay for Performance measures, targets and payment tiers

Measure	Submeasure	33rd Percentile	50th Percentile	75th Percentile	Tier 1 33rd	Tier 2 50th	Tier 3 75th+
Adult access to primary care	AAP	69.59%	72.91%	78.08%	$10	$10	$20
Breast Cancer Screening	BCS	48.06%	52.20%	58.35%	$25	$25	$50
Blood Pressure Control for Patients with Diabetes	BPD	59.85%	63.99%	70.07%	$25	$25	$50
Cervical Cancer Screening	CCS	53.37%	57.11%	61.80%	$25	$25	$50
Childhood Immunization Status (Combo 10)	CIS	26.76%	30.90%	37.64%	$50	$50	$100
Controlling High Blood Pressure	CBP	57.66%	61.31%	67.27%	$25	$25	$50
Follow-Up After ED Visit for Alcohol	FUA (30-Day: 18+)	31.27%	36.67%	42.55%	$40	$40	$80
Follow-Up After ED Visit for Alcohol	FUA (7-Day: 18+)	20.04%	24.62%	30.26%	$40	$40	$80
Follow-Up After ED Visit for Mental Illness	FUM (30-Day: 6-17)	61.20%	69.57%	77.41%	$40	$40	$80
Follow-Up After ED Visit for Mental Illness	FUM (7-Day: 6-17)	43.27%	51.39%	62.96%	$75	$75	$150
Follow-Up After Hospitalization for Mental Illness	FUH (30-Day: 18-64)	45.49%	50.89%	61.31%	$40	$40	$80
Follow-Up After Hospitalization for Mental Illness	FUH (7-Day: 18-64)	26.22%	29.48%	39.46%	$75	$75	$150
Follow-Up After Hospitalization for Mental Illness	FUH (30-Day: 6-17)	65.96%	71.93%	77.47%	$40	$40	$80
Follow-Up After Hospitalization for Mental Illness	FUH (7-Day: 6-17)	41.28%	46.27%	54.04%	$75	$75	$150
Hemoglobin A1c<8	HBD	49.39%	52.31%	57.18%	$25	$25	$50
Immunizations for Adolescents (Combo 2)	IMA	30.66%	34.31%	40.88%	$35	$35	$70
Pharmacotherapy for Opioid Use Disorder	POD	23.38%	28.49%	33.85%	$25	$25	$50
Postpartum Care	PPC	75.18%	78.10%	82%	$25	$25	$50
Timeliness of Prenatal Care	TOPC	81.75%	84.23%	88.33%	$25	$25	$50
Well-Child Visits 3-11 Years	WCV 3-11	52.40%	55.66%	62.89%	$10	$10	$20
Well-Child Visits 12-17 Years	WCV 12-17	45.57%	49.20%	56.32%	$10	$10	$20
Well-Child Visits 18-21 Years	WCV 18-21	21.72%	24.02%	29.23%	$10	$10	$20
Well-Child Visits 0-14 Months	W15 6+	55.21%	58.38%	63.34%	$15	$15	$30
Well-Child Visits 15-30 Months	W30	63.73%	66.76%	71.35%	$15	$15	$30

2024 Pay for Performance Program

Eligibility

PCPs who see at least 50% of member panel has been retired, In 2024, participating providers with a member panel of 100 or more are eligible. Incentive earning now begin in each measure by reaching the 33rd percentile for gap closure performance.

P4P targets and benchmarks

Providers will receive financial incentives for completing services on several HEDIS® measures. For 2024, there are three tiers of payment:

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

❖ ***Payments will be made in Q3 2024 for services rendered in 2024***

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Partnership bonuses

Partnership bonuses

Health Risk Survey (HRS) completion

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

Data exchange

- Providers with more than a thousand members will receive a one-time $1,000 bonus for a new supplemental data source (SDS) approved by September 1, 2024.

Notification of Pregnancy

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

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

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

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

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Supplemental Data Exchange (SDS)

Supplemental Data Exchange (SDS)

Questions?

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

ABHILQUALITYOUTREACH@AETNA.com

New 2024 Program

- Providers with more than a thousand members will receive a one-time $1000 bonus for new Supplemental Data Sources approved/submitted by 9/1/24.

SDS -Supplemental data exchange

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

Goal

- Help providers meet pay-for-performance (P4P) goals

Set-up guide

- The guide can be emailed to you upon request

Data sharing requirements

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

New Supplemental Data Sources

- All new supplemental data sources - all documentation must be received no later than 8/18/2024 for final approval by 9/1/2024.

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Availity Reporting

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Quality

Availity Quality Care Gaps Report

Background

- **Medical coding is essential to closing quality gaps and ensuring you receive credit** for the services you provide to members
- We found that **not all claims include full documentation of CPT codes for visits**, resulting in a missed opportunity to close quality gaps and receive corresponding incentive payments
- The **Quality Care Gaps report is now live in Availity** and updated monthly; the report empowers you to:
  - See members assigned to you care with open care gaps
  - Identify claims that need additional coding to close gaps
  - See your potential pay-for-performance (P4P) earnings from correcting submitted claims

Opportunity

- By correcting claims, you can **close HEDIS® gaps and receive incentive payments** for care already provided
- The focus will be on measures **Diabetes (A1C), Blood Pressure (CBP) and Childhood Immunizations (CIS)**. Examples include:
  - Claims that have an A1c test performed but no result
  - Claims that show multiple PCP visits but no BP codes
  - Claims that show a well child visit but no CIS measure code
- Our Quality team will review your report during monthly Quality meetings
- Our Provider Relations team will work with you to assist with filing corrected claims
- We'll provide training sessions, tip sheets and other educational materials

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Quality gaps in care overview

Measure Key	Total Members With Open Quality Gaps	Minimum P4P Payout Per Measure	Maximum P4P Payout Per Measure	Total Minimum P4P Payout Per Measure	Total Maximum P4P Payout Per Measure
A1C	429	$30	$50	$12,870	$21,450
CIS	278	$50	$70	$13,900	$19,460
IMA	109	$50	$70	$5,450	$7,630

Measure Key	Total Members With Open Quality Gaps	Minimum P4P Payout Per Measure	Maximum P4P Payout Per Measure	Total Minimum P4P Payout Per Measure	Total Maximum P4P Payout Per Measure
BCS	1178	$15	$25	$17,670	$29,450
CBP	12	$30	$50	$360	$600
CCS	4651	$7.5	$15	$34,882.5	$69,765
CDC	633	$30	$50	$18,990	$31,650
CIS	325	$50	$70	$16,250	$22,750
IMA	349	$50	$70	$17,450	$24,430
PPC	142	$30	$75	$4,260	$10,650
W30	441	$10	$30	$4,410	$13,230

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Group-level P4Q reports

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Aetna Better Health of Illinois P4Q Report - Provider Group Performance

Percent of Panel Seen = 24.98% (Eligible for Payout >= 50%)

Provider Group	Measure Key	Submeasure Key	Measure Description	NCQA 50%ile	NCQA 75%ile	Provider Numerator	Provider Denominator	Provider Rate	Plan Rate	Provider Tier	Tier 1 <50th	Tier 2 50th-75th	Tier 3 75th+
Provider Group	BCS	BCS	Breast Cancer Screening	50.95%	56.52%	144	426	33.80%	40.11%	<50th	$15.00	$20	$25
Provider Group	CBPB	CBP	Controlling High Blood Pressure	59.85%	65.10%	136	524	25.95%	20.71%	<50th	$30.00	$40	$50
Provider Group	CCS		Cervical Cancer Screening	57.64%	62.53%	1,087	2,580	42.13%	41.07%	<50th	$7.50	$10	$15
Provider Group	CDCB	HBA1C8	Hemoglobin A1c<8	50.12%	54.26%	89	438	20.32%	16.41%	<50th	$30.00	$40	$50
Provider Group	CIS	CO3	Childhood Immunization Status – Combo 3	63.26%	68.86%	57	135	42.22%	53.19%	<50th	$50.00	$60	$70
Provider Group	FUA	A18D30	Follow-Up After ED Visit for Alcohol – 30 day	21.53%	26.07%	18	80	22.50%	31.35%	50th-75th	$30.00	$50	$80
Provider Group	FUA	A18D7	Follow-Up After ED Visit for Alcohol 7 day	13.72%	17.37%	14	80	17.50%	22.51%	75th+	$30.00	$50	$80
Provider Group	FUH	617_7DAY	Follow-Up After Hospitalization for Mental	47.65%	56.13%	6	22	27.27%	38.05%	<50th	$30.00	$50	$80
Provider Group	FUH	1864_30DAY	Follow-Up After Hospitalization for Mental	53.31%	62.06%	28	92	30.43%	40.80%	<50th	$30.00	$50	$80
Provider Group	FUH	1864_7DAY	Follow-Up After Hospitalization for Mental	32.03%	41.67%	15	92	16.30%	23.97%	<50th	$30.00	$50	$80
Provider Group	FUH	617_30DAY	Follow-Up After Hospitalization for Mental	71.36%	79.15%	16	22	72.73%	61.08%	50th-75th	$30.00	$50	$80
Provider Group	FUM	6TO17D30	Follow-Up After ED Visit for Mental Illness –	67.79%	76.87%	6	9	66.67%	70.76%	<50th	$50.00	$60	$75
Provider Group	FUM	6TO17D7	Follow-Up After ED Visit for Mental Illness – 7	50.00%	64.39%	5	9	55.56%	64.62%	50th-75th	$75.00	$125	$150
Provider Group	IMA	CO2	Immunizations for Adolescents – Combo 2	35.04%	41.12%	46	216	21.30%	22.92%	<50th	$50.00	$60	$70
Provider Group	PPC	TOPC	Timeliness of Prenatal Care	85.40%	88.86%	59	81	72.84%	79.49%	<50th	$20.00	$30	$40
Provider Group	PPC	PPC	Postpartum Care	77.37%	81.27%	52	81	64.20%	65.36%	<50th	$30.00	$50	$75
Provider Group	W30	15TO30MTH	Well Child Visits 15-30 Mos	65.83%	72.24%	73	151	48.34%	58.29%	<50th	$10.00	$20	$30

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Health equity

Equity strategy

Addressing social, economic and health disparity

Working with trusted community partners to identify and invest in community social care gaps that affect access to hypertension and depression screening and care for members

Providing culturally responsive patient education and care management

- Connecting members to culturally- relevant care to support them in identifying and managing hypertension and depression
- Working with trusted faith and community partners to improve member access to hypertension and depression education, resources and care

Empowering providers

- Provider training in culturally responsive best practices
- Physician detailing to support in-network providers with identifying and closing gaps in care for members with hypertension and symptoms of depression
- Improving access to culturally responsive PH and BH screening and care

Addressing social barriers to care

- Employing trained social workers to assess the social barriers members face in managing their hypertension and accessing depression screening and care
- Expanding community health worker workforce to connect members to culturally relevant resources within their communities to address social needs
- Providing closed-loop referrals to community-based care to assure member needs are met

Implementing data-informed strategies

- Development of a mapping tool to target interventions. The tool will map enterprise assets and geographic hotspot locations for uncontrolled blood pressure, lack of depression screening and poor maternal health outcomes by race and ethnicity
- Using quality metric (HEDIS) performance reporting by demographic categories and geography through visual tools and maps

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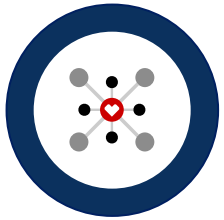
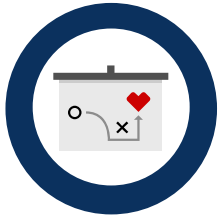
Measuring business unit health equity impact is critical to realizing our health equity strategy

Health equity pillars



Empower our people

Measure what matters



Take bold actions

How the BUA enables the pillars

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

Intended BUA outcomes

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

Successful deployment of the BUA will enable Aetna to:

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

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

KEY CONSIDERATIONS

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

FIVE PHASES

Goal 1: Establish health equity as a strategic priority

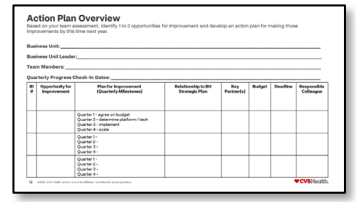
Goal 2: Measure, monitor and review health equity performance

Goal 3: Empower team members to advance health equity

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

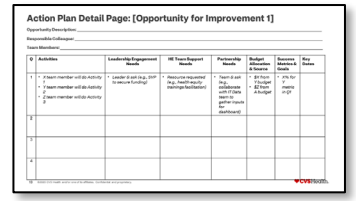
Goal 5: Meaningfully engage underserved communities as partners and leaders to improve health equity

OUTPUTS & RESOURCES

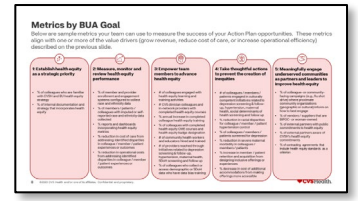


Action Plan Overview

Action Plan Best Practices



Action Plan Detail



Action Plan Metrics

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

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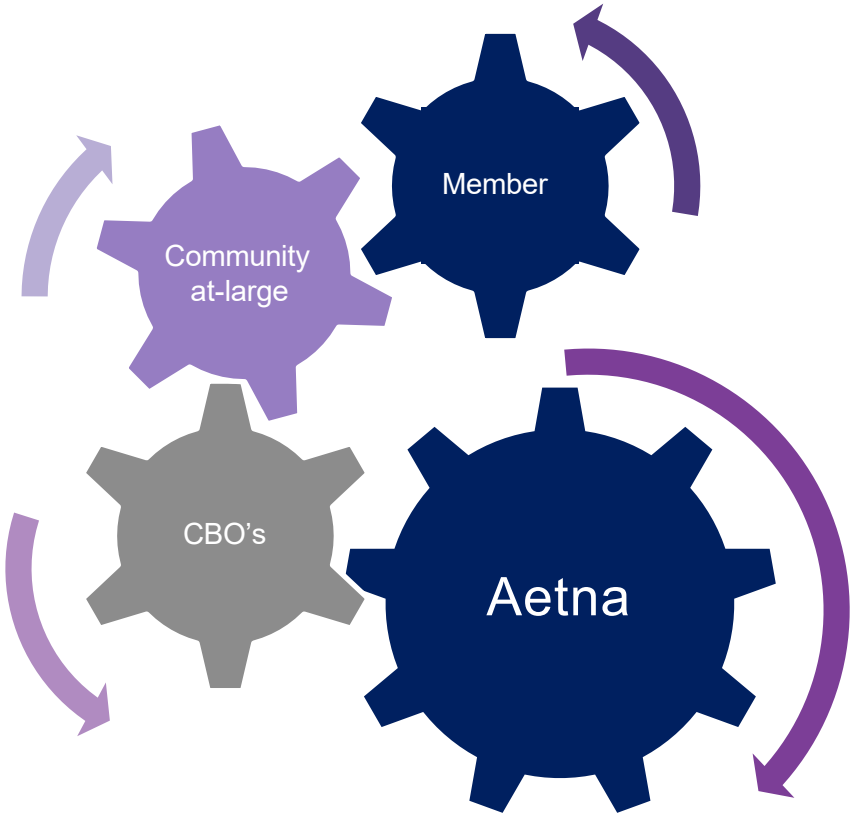
Anticipated stakeholder outcomes

Member

- Increased engagement
- Increased satisfaction
- Decreased ED visits & readmissions
- Improved HEDIS scores
- Better health outcomes

Community-based orgs

- Faith-based organizations
- City/county health departments
- Food banks/pantries
- Homeless/housing agencies
- Employment agencies
- School systems
- Domestic violence shelters



Community at-large

- Providers
- Hospital systems
- Universities
- State & local leaders

Aetna/CVS

- Lower costs
- Retain current business
- Win new RFPs

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Compliance and mandated training

Cultural, Linguistic & Disability Access Requirements & Services

Appointment standards

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

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

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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

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

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

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

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

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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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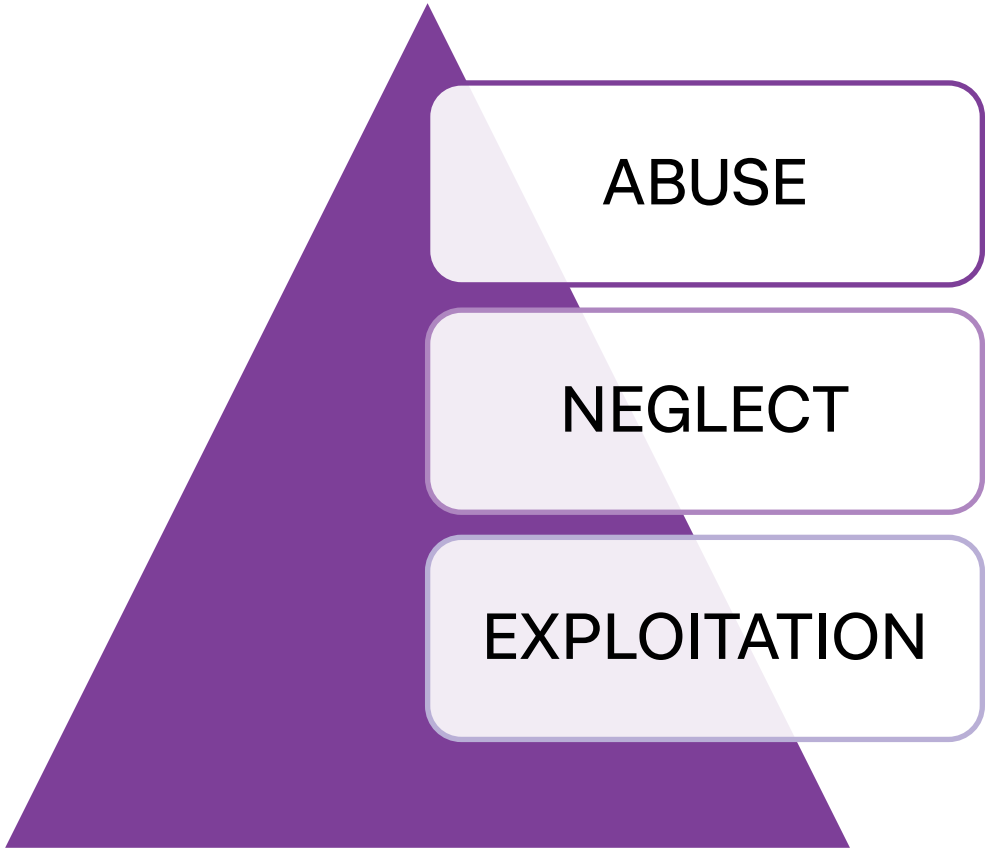
Critical incidents | Spot the signs

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 satisfaction survey

Aetna Better Health® of Illinois utilize provider satisfaction surveys results to identify how well we are meeting our providers' expectations.

- Provider satisfaction surveys are distributed annually by our vendor SPH Analytics
- Helps to identify Plan strengths and opportunities
- Distributed by mail, phone and electronically
- Assists in implementing interventions to bridge the gap in areas of opportunities

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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)**

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Vendors and partners

Aetna Better Health® of Illinois subcontracts the following services:

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

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

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

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

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

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

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Thank you!

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