Home and Community Based Services

Orientation

2/21/2018
Who is IlliniCare Health?

• Parent Company: Centene Corporation
  – 30+ years of experience

• IlliniCare Health Provides:
  – Medical, behavioral health, pharmacy, dental and vision benefits as one entity with a single care plan

• Employees are local and have market knowledge

• Integrated Care Team understands the communities we serve and their resources
Who is Centene Corporation?

- Headquartered in St. Louis, MO
- Employs approximately 13,400 individuals
- Serves over 4.1 million managed care members
- Currently operates health plans in 23 states
- Contract with over 90,000 physicians and more than 1000 hospitals
Centene’s Philosophy

Local Approach
• Quality healthcare is best delivered locally.
• Enables us to ensure accessible, high quality, and culturally sensitive healthcare services to our consumers.
• Care Coordination model utilizes integrated programs by a local staff.

Care Coordination / Service Delivery
• Promote a medical home for each consumer (a PCP)
• Partner with trusted providers such as yourselves
• Ensures consumers receive the right care, in the right place, at the right time.
Our Purpose

Transforming the health of the community, one person at a time.

Focus on Individuals
Whole Health of our Members
Active Local Involvement
Service Package II

- IlliniCare Health will manage the following services as part of Service Package II:
  - Home and Community Based Services (HCBS) – also known as waiver services
  - Long Term Care (LTC) - Custodial Care
  - Supportive Living Facilities (SLF)

- Home and Community Based Services:
  - Adult Day Service
  - Adult Day Service Transportation
  - Behavioral Services
  - Day Habilitation
  - Home Delivered Meals
  - Home Health Aide
  - Home Modifications/Assistive Equipment
  - Home Care Aide
  - Nursing, Intermittent/Skilled
  - Physical/Occupational/Speech therapy
  - Personal Emergency Response System
  - Individual Provider
  - Respite Care
  - Specialized medical equipment and supplies
  - Vocational Services
  - Cognitive Behavioral Therapy
Who is Eligible?

- Members eligible to receive Medicaid approved waiver services
- Must reside in one of the covered counties listed during the initial roll-out date:
  - Cook
  - Du Page
  - Lake
  - Kane
  - Kankakee
  - Boone
  - McHenry
  - Winnebago
  - Rock Island
  - Henry
  - Kankakee

- Exclusions:
  - Participants with Spend-down
  - Participants in the Illinois Breast and Cervical Cancer Program
  - Participants with Third Party Insurance
  - Participants with presumptive eligibility
Remains the same as the Recipient ID #

Member Name: jane doe
Medicaid ID#: XXXXXXXXXX    Effective Date:

PCP Name: john doe
PCP Number: xxx-xxx-xxxx

Rx: US Script
BIN: 008019

Open Access Plan: members are able to seek care from any contracted PCP

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact IlliniCare for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or IlliniCare nurse line toll-free at 1-855-444-1661 (TDD/TTY 1-866-811-2452). The nurse line is open 24 hours a day. Our address: 999 Oakmont Plaza Dr, Suite 400, Westmont, IL 60559
Waiver Services

• Enables members to live independently in the community with the assistance of Home and Community Based Service Providers.

• Service Package II Waivers:
  - **Elderly Waiver**: For individuals 60 years and older that live in the community.
  - **Persons with Disabilities Waiver**: For individuals that have a physical disability.
  - **Persons with HIV/AIDS Waiver**: For individuals that have been diagnosed with HIV or AIDS.
  - **Persons with Brain Injury Waiver**: For individuals with an acquired injury to the brain.
Eligibility

- Eligibility will be determined by government agencies
  - Department on Aging (DOA)
  - Division of Rehabilitation Services (DRS)

- Determination of Need (DON) tool assesses the member’s:
  - Ability to perform the activities of daily living
  - Mental acuity
  - Level of impairment
  - Level of unmet need

- Member’s assessment will determine type and frequency of services that member is eligible to receive.
  - Member has choice to receive services
Care Coordination

• Illinicare Health is responsible for coordinating care for members
  – Collaborate with the member, caregivers, and providers to develop and implement a mutually agreed upon care plan
  – Assist member with the coordination of services
  – Facilitate exchange of information between service providers
  – Maintain routine contact with member

• Continuity of Care
  – Services will remain unchanged for a set period of time
    • Services can only be changed if approval is received by the member

• Care Transitions
  – Health plans, HFS and state agencies work together on any member transitions
  – Transition process in place to ensure continuity of care
Purpose and Usage:

- Clear communication to Provider on the total Units/Hours per month to be utilized
- Enhanced clarification on specific tasks/needs members have with frequency and duration guidelines
- Allows for flexibility in order to meet the member’s needs as they change/vary from month to month
PURPOSE AND USAGE:

- Schedule allows for addition/modification of time spent on certain tasks in order to meet member’s overall care needs.

- If services are not provided on scheduled days for any reason, it is the expectation those hours will be added to alternative days during the calendar month to accommodate member within reason.

![Service Request to Provider](image)
PURPOSE AND USAGE:

- Formalized process to ensure services are being provided. A way to aid in performance review.

- Will be flexible in the way in which to obtain the information. If provider has a system in place that identifies the needs we are seeking, we will accept that system.

- Will allow us to meet our requirement per the state-clear expectation that IlliniCare obtains information on member services/barriers, etc.
PURPOSE AND USAGE: (continued)

- A consistent and formalized way to communicate issues. (change in condition, refusal of services, out of town, member not home)

- Change in plan based on member’s needs.

- Trends in utilization, trends in members behavior of utilization.
Prior Authorizations

ALL Home and Community Based Services require prior authorization prior to delivery of service.

New Services:
- Services will be based on the member’s care plan.
- HCBS Care Coordinator will be in contact with both the member and provider.
- Once services are approved, prior authorization will be entered into the system by HCBS Care Coordinator.
- HCBS Care Coordinator will contact service providers with a prior authorization number, confirming service can now take place.

Existing Services:
- Services that are currently in place for the member will remain for a set period of time.
- HCBS Care Coordinator will enter prior authorizations for each service into the system.
- Providers will receive a notice from IlliniCare explaining the transition process, and members we currently show have services with that provider.
- If you have questions regarding if a service is authorized for the member, contact the HCBS care coordination team at (866) 329-4701 ext. 47733 or email HCBS@centene.com
Billing Overview

- All services must be billed to IlliniCare using a CMS 1500 form.

  - Claims can be submitted electronically or on a red CMS 1500 claim form.
  - Must be completed using computer software or a typewriter.
  - All claims must be submitted within 180 days from the date of service.
  - Claims must be submitted after services have been rendered.
  - Claims must be submitted to the following address:
    IlliniCare Health Plan
    ATTN: Claims Department
    P.O. Box 4020
    Farmington, MO 63640-4402
Supportive Living Facilities (SLF)
IlliniCare Health pays for services within the SLF, but does not pay for room and board.

The following services are included in the global rate:

- Nursing services
- Personal care
- Medication administration
- Laundry
- Housekeeping
- Maintenance
- Social and recreational programming
- Ancillary Services
- 24 hour response/security staff
- Health Promotion and exercise
- Emergency call system
- Daily Checks
- Quality assurance plan
- Management of resident funds, if applicable
**IlliniCare Health Integration with SLFs**

- Collaborate with Facilities to:
  - Identify and address care gaps and opportunities
  - Develop, share, and collaborate on members’ comprehensive Care Plans
  - Primary one stop partner for assistance with member care coordination, including physical health, mental health, and psychosocial needs

- Assessments:
  - Initial interview and assessment
  - Comprehensive Resident Assessment (RAI)
    - Conducted by SLF, Reviewed by IlliniCare Health
  - Long Term Care Assessment
  - Service Plan
  - Semi-Annual Evaluation
Medical Overview

• Medical Providers on-site at SLF
  – Must be an in-network provider
  – Prior authorization required for all out-of-network services (except emergency services and family planning)

• Medical Home
  – For all non-emergent services, direct member to Primary Care Physician

• Integrated Care Team
  – Assist in coordinating care for member:
    • Setting up appointments
    • Finding community resources
    • Finding in-network providers

• Transportation
  – Transportation services are available for members to get to/from appointments
Billing Overview - SLF

- All providers required to bill on medical claim forms
- Supportive Living Facilities can be submitted electronically or on a red CMS 1500 form
- All SLF will be using the same procedure code: T2033
- If there is a temporary absence, use T2033, with modifier U1
- Members must be on patient credit file in order for claim to process
- Claims must be submitted after services have been rendered
Patient Credit File

• All Supportive Living Facility claims refer to the patient credit file to deduct member funds accordingly

• If member is not on the patient credit file, claim will deny
  – Ex code on the explanation of Payment (EOP): Hf
  – Description: “DENY:Mbr not currently on the PT Credit File- will reconsider once on file”
  – **Claim does NOT need to be resubmitted**
  – IlliniCare Health will compare monthly patient credit file against previously denied
  – Claims will be paid as soon as member appears on patient credit file
Long Term Care (LTC)
Authorizations

- Authorizations are required for the following:
  - Sub-acute stays
  - Rehabilitative services
  - New admissions
- Custodial Care
  - Prior authorization is required
  - For those members currently residing in a facility when Service Package II rolls out, authorizations should already be on file for those members
  - Required Information:
    - Member Name
    - Member DOB
    - Admission Date
    - Discharge Date
Claims

• Submit charges on UB-04 claims form
  – Bill Types
    • 212- 1st claim
    • 213- Interim continuing claim
    • 214- Interim last claim
    • 217- Replacement of prior claim
  – Revenues codes- Custodial Care
    • 0120 or 0190 general classification UB04 Rev Code
    • Other revenue codes that are appropriate for custodial care being provided not to include the sub-acute revenue codes indicated above
  – Revenue codes- Bed Holds
    • 0120 or 0190 general classification UB04 Rev Code
    • Other revenue codes that are appropriate for custodial care being provided not to include the sub-acute revenue codes indicated above
Patient Credit File

• All custodial Care claims refer to the patient credit file to deduct member funds accordingly
• If member is not on the patient credit file, claim will deny
  – Ex code on the Explanation of Payment (EOP): Hf
  – Description: “DENY:Mbr not currently on PT Credit File – will reconsider once on file.”
  – Claim does NOT need to be resubmitted
  – IlliniCare will compare monthly patient credit file against previously denied claims
  – Claims will be paid as soon as member appears on patient credit file
Provider Value
What Centene Brings to Providers

- Timely and accurate ICP and FHP claims payment (clean claims) processed within 7-10 days of receipt
- Timely and accurate MMAI Claims (clean claims) are processed within 14 days of receipt
  - Coordination of Benefit
  - First and Second Pass Steps
- 75% of claims are paid within 7-10 days of receipt
- 99% of claims are paid within 30 days
- Local dedicated resources: LTC Integrated Care Team
- Education of providers and support staff through orientations
- Provider participation on health plan committees and boards
- Electronic and web-based tools for administrative functions
Web-Based Tools

Through our main website providers can access:

- Provider newsletters
- Provider and Billing Manuals
- Provider Directory
- Announcements
- Quick Reference Guides
- Benefit Summaries for Consumers
- Updated to the State’s Medicaid Program
- Online Forms
IlliniCare Health’s Home Page

Logon to [www.illinicare.com](http://www.illinicare.com) and become a registered provider.
Secure Web Portal

• On our secure portal providers can:
  – Verify eligibility and benefits
  – Submit and check status of claims
  – Review payment history
  – Secure contact us

There is no waiting, no on-hold music, no time limits. Registration is free and easy.
Electronic Submission

• Required Fields:
  – Member’s Name
  – Member’s DOB
  – Member ID Number
  – Date of Services
  – CPT/HCPC Code - Provided by IlliniCare Health
  – Diagnosis Code – provided by IlliniCare
  – Days/Units
  – Total Charges
  – Tax ID Number
  – Medicaid Number / NPI Number
Provider Log in Page

The Tools You Need Now!
Our site has been designed to help you get your job done.

Check Eligibility
Find out if a member is eligible for service.

Authorize Services
See if the service you provide is reimbursable.

Manage Claims
Submit or track your claims and get paid fast.

Login
User Name (Email)
name@domain.com
Password

Forgot Password / Unlock Account

Need To Create An Account?
Registration is fast and simple, give it a try.

Create An Account

How to Register
Our registration process is quick and simple. Please click the button to learn how to register.
Claim Services

• Timely Filing Guidelines:
  – 180 days from the date on which services or items are provided. This time limit applies to both initial and resubmitted claims.
  – Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid.
  – A “request for reconsideration” must be submitted before a claim dispute. Reconsideration request must be received within 180 days of the DOS or the date of discharge, whichever is later. Claim disputes must be received within 90 days of paid date, not to exceed 1 year from DOS.
  – When IlliniCare Health is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer.

See the provider manual or billing manual for more detailed information about claims and billing.
Providers can file claims three ways:

1. Paper claims
2. Secure Provider Portal
3. Electronic Clearinghouses (EDI partners)
Claims Submission

IlliniCare Health
Attn: Claims
PO Box 4020
Farmington, MO 63640-4402

Provider Portal: Provider.IlliniCare.com

IlliniCare Health Payer ID # 68069
Claims Payments

• EFT and ERA through PaySpan Health
  – IlliniCare Health partners with PaySpan Health to deliver electronic payments (EFTs) and remittance advices (ERAs)
  – **FREE** to IlliniCare Health participating providers
  – Electronic deposits for your claim payments
  – Electronic remittance advice presented online
  – HIPAA compliant

• Register at [www.PaySpanHealth.com](http://www.PaySpanHealth.com) or call PaySpan at 877-331-7154
Claims Payments

• Provider Benefits with PaySpan Health
  – Reduce accounting expenses
  – Improve cash flow
  – Maintain control over bank accounts
  – Match payments to advice quickly
  – Manage multiple payers
Claims Inquiries/Disputes

• In order to track and process your claims concerns you will need to be assigned a Case Number before an issue will be considered for additional or escalated review.

• Case Numbers will be assigned by calling Member and Provider Services at (866)329-4701. You can expect an action regarding your concern within 30 days.

• If you choose to follow up on your case, please contact Member and Provider Services at the above number and provide them with your Case Number. They will then be able to check on the progress of your Case.

Unsuccessful requests for reconsiderations may be disputed via the submission of a Provider Claim Dispute Form (available online) to:

IlliniCare Health
PO Box 3000
Farmington, MO 63640-3800
Contact Us

• Provider Services/Claims
  – 866-329-4701

• Waiver Services Authorizations
  – 866-329-4701 ext.47733
  – HCBS@Centene.com

• LTC Authorizations
  – 866-329-4701 ext. 47914
  – Fax: 877-941-0483
Abuse, Neglect & Fraud
Abuse and Neglect

- **Abuse**: causing and physical, sexual or mental injury to an individual, including exploitation of the individual’s financial resources.

- **Neglect**: failure to provide adequate medical care, personal care or maintenance, which causes:
  - Pain, injury or emotional distress
  - An individual to have maladaptive behavior
  - Deterioration of physical or mental condition
  - Puts the individual’s health or safety at risk
  - Possible injury, harm or death
Types of Abuse

• **Physical Abuse.** Non-accidental and inappropriate contact with an individual that causes bodily harm.

• **Mental Abuse.** The use of demeaning, intimidating or threatening words, signs, gestures or other actions that results in emotional distress or maladaptive behavior.

• **Sexual Abuse.** Any sexual behavior, sexual contact or intimate physical contact, including coercion or encouragement of an individual to engage in sexual activity that results in sexual contact, intimate physical contact, sexual behavior or intimate physical behavior.

• **Financial Abuse.** Using an individual’s financial resources without consent. Including improper use of guardianship or power of attorney.
Signs of Abuse & Neglect

• Physical Abuse:
  – Injury not cared for
  – Injury that is inconsistent with its explanation
  – Cuts, puncture wounds, burns, bruises, welts
  – Dehydration or malnutrition without illness-related cause
  – Soiled clothing or bed
  – Lack of necessities such as food, water or utilities

• Mental Abuse
  – Fear
  – Anxiety, agitation
  – Anger
  – Isolation, withdrawal
  – Depression
  – Resignation
  – Hesitation to talk openly
  – Ambivalence
  – Contradictory statements
  – Implausible stories

These signs are not necessarily proof of abuse or neglect. But they may be clues that a problem exists.
Signs of Abuse & Neglect

• Abuse by Caregiver:
  – Prevents member from speaking or seeing others
  – Anger, indifference, or aggressiveness towards members
  – Lack of affection
  – Conflicting accounts of incidents
  – Talk of member as a burden
  – History of substance abuse, mental illness, or violence

• Financial Abuse
  – Sudden changes in bank account
  – Unexplained withdrawal of money
  – Adding additional names on bank account
  – Unapproved withdrawals of money
  – Unpaid bills despite having enough money

These signs are not necessarily proof of abuse or neglect. But they may be clues that a problem exists.
Reporting Abuse & Neglect

• You must report abuse and neglect when:
  – You witness any type of abuse or neglect
  – You are told of any type of abuse or neglect
  – You suspect an incident of abuse or neglect

• Reporting requirements:
  – Report the incident within four (4) hours of discovery
  – Must report to the Office of the Inspector General
    • Any allegation of abuse or neglect by an employee, community agency, provider, or facility
    • Any injury or death that occurs when abuse or neglect may be suspected
Reporting Abuse & Neglect

Office of Inspector General: 800-368-1463

IlliniCare Health Provider Services: 866-329-4701

Department on Aging: 866-800-1409

Senior Help Line: 800-252-8966

Department of Public Health: 800-252-4343
Fraud

- **Fraud**: to knowingly get benefits or payments to which you are not entitled. This could be a provider or member.
  - A lie on an application
  - Using someone else’s ID card
  - A provider billing for services that were not given
  - Double billing
  - Submission of false document
  - Usage abuse of transportation
Reporting Fraud

IlliniCare Health Provider Services: 866-329-4701

Fraud and Abuse Hotline: 866-685-8664

Online at Office of Inspector General:

http://www.state.il.us/agency/oig/reportfraud.asp
Our Responsibilities

- IlliniCare Health is required to report any instance of abuse, neglect or fraud
- All employees are trained on:
  - Types of abuse and neglect
  - Types of fraud
  - How to report abuse, fraud and neglect
- IlliniCare Health employees are required to:
  - Discuss instance of abuse, neglect or fraud with their direct supervisor
  - Report the instance to the Office of the Inspector General
  - Document the instance in the member’s file
  - If applicable, discuss the instance with the member’s PCP
## Contact Information

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<tr>
<th>HealthChoice Illinois (Medicaid)</th>
<th>Medicare-Medicaid Plan (MMP)</th>
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<tbody>
<tr>
<td>IlliniCare Health</td>
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<tr>
<td>999 Oakmont Plaza Drive, Westmont, IL 60099</td>
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<td><strong>Member &amp; Provider Services</strong></td>
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<tr>
<td>Telephone: 866-329-4701</td>
<td>Telephone: 877-941-0482</td>
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<td>(eligibility, claims, authorizations, transportation, etc.)</td>
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<tr>
<td>Authorization Fax: 877-779-5234</td>
<td>Authorization Fax: 844-409-5557</td>
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Questions?