Provider Orientation

Integrated Care Program (ICP)
Family Health Plan (FHP)
Medicare-Medicaid Plan (MMP)
Managed Long Term Services and Supports (MLTSS)

11/1/2016
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 1,000 hospitals
Who is Centene Corporation?
Our Purpose

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

Focus on Individuals
Whole Health of our Members
Active Local Involvement
Fulfilling the Purpose

• Local Approach with Cultural Sensitivity
  – Quality healthcare is best delivered locally.
  – Ensures access to high quality services and resources to best serve our members.

• Clinical Interventions and Programs
  – Evidence-based, clinical outcomes that target specific conditions.
  – Provides solutions for complex health needs.
Our Products

• Integrated Care Program (ICP)
  – Available to seniors (65+) and individuals who receive medical benefits under the AABD program.

• Family Health Plan (FHP)
  – Available to pregnant women and families with children under 19. Also available to individuals with incomes up to 138% of FPL.
Our Products

• Medicare-Medicaid Plan (MMP)
  – Available to individuals who qualify for Medicare and Medicaid.

• Managed Long Terms Services and Supports (MLTSS)
  – Available to individuals who are eligible for the Medicare-Medicaid plan, but opted out and receive HCBS Waivers or reside in a LTC facility.
Integrated Care Program (ICP)
ICP Overview

• IlliniCare Health contracts with the state of Illinois to provide services to older adults, and adults with disabilities (AABD population)
• Currently serving approx. 30,000 members
• Counties Served: Boone, Cook, DuPage, Henry, Kankakee, Lake, Mercer, McHenry, Rock Island, Will, and Winnebago
• Eligibility for this mandatory program is determined by the State Client Enrollment Broker
ICP Eligibility

- Seniors (65+ years old)
- Adults (19+ years old) in the AABD population
- Must reside in one of the counties we serve

Exclusions:
- Individuals enrolled in Medicare
- Individuals with spend-down
- Individuals in the Illinois Breast and Cervical Cancer program
- Individuals with Third Party Insurance
- Individuals with presumptive eligibility
ICP ID Card

Member Name: jane doe
Medicaid ID#: XXXXXXXXXXXX  Effective Date: xx/xx/xxxx
PCP Name: john doe
PCP Number: xxx-xxx-xxxx

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact IlliniCare Health 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 Health nurse line toll-free at 866-329-4701 (TDD/TTY 866-811-2452). The nurse line is open 24 hours a day. www.IlliniCare.com

Members:
Member Services line, 24/7 Nurse Line, Dental/Vision: 866-329-4701
TDD/TTY: 866-811-2452

Our address:
PO Box 92050
Elk Grove Village, IL 60009-2050

Payer ID#: 68069
Medical Claims:
IlliniCare Health
Attn: CLAIMS
PO Box 4020
Farmington, MO 63640-4402

Providers:
IVR Eligibility inquiry – Prior Auth,
Behavioral Health: 866-329-4701
US Script Help Desk: 800-460-8988

Payer ID#: 68068
Mental Health Claims:
Cenpatico
Attn: CLAIMS
PO Box 7300
Farmington, MO 63640-3828

For Provider, claims and EFT/ERA Information via Web: www.IlliniCare.com

11/1/2016
Family Health Plan (FHP)
FHP Overview

- IlliniCare Health contracts with the state of Illinois to provide services to pregnant women, families, and individuals who qualify based on FPL.
- Currently serving approx. 158,000 members.
- Eligibility for this mandatory program is determined by the State Client Enrollment Broker.
FHP Eligibility

- Pregnant women & families with children under 19
- Individuals (19+ years old) with 138% of FPL
- Must reside in one of the counties we serve

Exclusions:
- Individuals enrolled in Medicare
- Individuals with spend-down
- Individuals in the Illinois Breast and Cervical Cancer program
- Individuals with Third Party Insurance
- Individuals with presumptive eligibility
Member Name: jane doe

Medicaid ID#: xxxxxxxxxx

Effective Date: xx/xx/xxxx

PCP Name: john doe

Program: Family Health Plan

PCP Number: xxx-xxx-xxxx

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Medicare-Medicaid Plan (MMP)

Also know as: Medicare-Medicaid Alignment Initiative (MMAI) and Duals
MMP/MMAI/Duals

• Medicare Medicaid Alignment Initiative (MMAI)
  – A special integrated demonstration supported by the Federal and State governments for the “dual eligible” population receiving both Medicare and full Medicaid medical benefits

• IlliniCare Health’s MMP
  – Provides the services included in the MMAI program
  – Coordinates care for our members
  – Eliminates the barriers between Medicare and Medicaid
MMP Overview

- IlliniCare Health contracts with the state of Illinois and the Federal government to provide services to individuals who qualify for Medicaid and Medicare
- Currently serving approx. 1,400 members
- Counties Served: Cook, DuPage, Kane, Kankakee, Lake, and Will
- Members may opt out of IlliniCare Health’s MMP on a monthly basis
MMP Overview Cont.

• IlliniCare Health is the primary payer for both Medicare and Medicaid services
• Members can opt out of MMP each month
  – If a member opts out of IlliniCare Health, Medicare will become their primary carrier/payer
• IlliniCare Health’s MMP is a demonstration program, not to be confused with Medicare Advantage
MMP Eligibility

- Adults age 21 and older
- Entitled to Medicare Parts A, B, and D; receive full Medicaid benefits
- Individuals with End Stage Renal Disease (ESRD)

Exclusions:
- Individuals enrolled in American Indian/Alaskan Natives Program
- Individuals in the Illinois Breast and Cervical Cancer Program
- Individuals in spend-down
- Individuals with Third Party Insurance
- Individuals with presumptive eligibility
MMP Objectives

• Improve the beneficiary experience in accessing care
• Promote person-centered care planning and independence in the community
• Improve quality of care
• Rebalance Long-Term Services and Supports (LTSS) to strengthen and promote the community-based systems
• Eliminate cost-shifting between Medicare and Medicaid
MMP ID Card

Member Name: Sample A 2015
Member ID: C1234567031
Health Plan (80840):
Medicaid ID: 123456703
PCP Name: Test Doctor
PCP Phone: (800) 234-2356

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to call IlliniCare Health for an ok before you get emergency care. If you are unsure if you need to go to the ER, call your PCP or Nurse Advice Toll-free at 1-877-941-0482 or TTY at 711 (Illinois Relay) 24 hours a day.

Member Service: 1-877-941-0482
Behavioral Health: 1-877-941-0482
Website: http://mmp.illincare.com
Pharmacy Help Desk: 1-855-854-0270
Send claims to: IlliniCare Health
                PO Box 4020
                Farmington, MO 63640-4402

Rx Bin: 12353
RxPCN: 6241400
Managed Long Term Services and Supports (MLTSS)
IlliniCare Health contracts with the State of Illinois to manage the Home and Community Based Service (HCBS) Waivers and Long Term Care (LTC) benefits for these members.

- Counties Served: Cook, DuPage, Kane, Kankakee, Lake, and Will

- Eligibility for this mandatory program is determined by the State Client Enrollment Broker.
MLTSS Eligibility

- Entitled to Medicare Parts A, B, and D; receive full Medicaid benefits but have **opted out of MMP**
- Receive either HCBS Waiver Services or reside in a LTC facility

**Exclusions:**
- Individuals enrolled in American Indian/Alaskan Natives Program
- Individuals in the Illinois Breast and Cervical Cancer Program
- Individuals in spend-down
- Individuals with Third Party Insurance
- Individuals with presumptive eligibility
**MLTSS ID Card**

**Member Name:** jane doe  
**Medicaid ID #:** XXXXXXXXXXXX  
**Effective Date:** xx/xx/xxxx  
**Program Name:** Managed Long Term Services and Supports

**Members:**  
Member Services line,  
24/7 Nurse Line: 844-316-7562  
TDD/TTY: 866-811-2452  
www.IlliniCare.com

**Our address:**  
PO Box 92050  
Elk Grove Village, IL 60009-2050

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Cenpatico  
Attn: CLAIMS  
PO Box 7300  
Farmington, MO 63640-3828
Clinical Models and Programs
Health Risk Screening (HRS) – Completed by new members within 30 days of enrollment

- Identifies members with unmet or ongoing needs
- HRS assesses:
  - Functional abilities
  - Physical and behavioral health conditions
  - Social, environmental, and cultural issues
  - Ability to live independently
  - And other needs that form the basis of our care plan
Medical Home Model

The Primary Care Provider (PCP) is the cornerstone of IlliniCare Health’s service delivery model.

- PCPs serve as the “medical home” for members
  - Establishes a member-provider relationship
  - Supports continuity of care
  - Eliminated redundant services
  - Ultimately improves health outcomes in a more cost effective way
Medical Home Model

• Member outreach is critical to the medical home model. It allows IlliniCare Health to:
  – Explain benefits, provide health education – including how to access care
  – Participate in community events and establish partnerships with community stakeholders to promote healthy living and preventative care
  – Identify and engage high-risk members
  – Facilitate communication across medical, dental, vision, and behavioral health specialists
Medical Home Model

- Expected outcomes:
  - Improved access to medical, behavioral, and social services
  - Improved coordination of care
  - Improved seamless transitions of care
  - Assured appropriate utilization of services
  - Improved beneficiary health outcomes
Value Added Benefits

- 24/7 Nurse Advice Line
  - Access to free health information from RNs
- MemberConnections
  - Educates members about their benefits and services
- Free Transportation
  - Free rides to and from medical appointments
- Start Smart for Your Baby
  - Education for expecting mothers
- Nurtur
  - Disease management and education for chronic conditions
- CentAccount
  - Healthy rewards program
Integrated Care Team (ICT)
Integrated Care Team

• Identifies health conditions early on
• Facilitates of communication and coordination of services across specialties
• Identifies and engage high-risk members
• Identifies barriers to adherence with current treatment plans and goals
• Created customized plan of care
• Holistic approach – links members to appropriate social, medical, and behavioral services
Integrated Care Team

- Behavioral Health Care Coordinator
- HCBS Care Coordinator
- Care Coordinator
- Program Coordinator
- Social Worker

Members
ICT Members

- Behavioral Health Care Coordinator
  - Focuses on behavioral health needs
- Care Coordinator
  - Licensed nurse focused on physical health needs
- Social Worker
  - Works with members, caregivers, and the community to setup a support system
- Program Coordinator
  - Provides team support, educates member
- HCBS Care Coordinator
  - Coordinates care for members receiving HCBS services
ICT Responsibilities

• Completes Health Risk Screenings, Health Risk Assessments, and Re-Assessments based on changes in member needs
• Collaborate with the member, caregivers, and providers to develop and implement a care plan
• Assist member with coordination of services
• Facilitate exchange of information between providers
• Maintain routine contact with member
Quality Initiatives
HEDIS Measures

- HEDIS = Healthcare Effectiveness Data and Information Set
- Developed by the National Committee for Quality Assurance (NCQA)
- Standardized performance measures
- Measure the quality of health care services provided by IlliniCare
- Rates calculated on claims/encounter data
HEDIS Goals

- Health Risk Screening within 90 days
- Annual PCP visit
- Annual dental visit
- Annual flu vaccine
- Comprehensive diabetes care (HbA1c, ACE/ARB, etc.)
- Colorectal cancer screening
- Breast cancer screening

- Cervical cancer screening
- Adult BMI assessment
- Congestive heart failure care (ACE/ARB, beta, etc.)
- Coronary artery disease care (cholesterol, beta, etc.)
- Hospital admissions due to UTIs and bacterial pneumonia
- LTC – stage II pressure ulcers
Core HEDIS Goals

- Annual Ambulatory of Preventative Care PCP Visit
- Follow-up with Provider within 14 days of Inpatient Discharge
- Follow-up with Provider within 14 days of ED Visit
- Follow-up with Behavioral Health Provider within 7 days of BH Inpatient Discharge
- Diabetes Care
  - HbA1c Testing, Retinal Eye Exam, Microalbuminuria Testing, Statin Therapy, ACE/ARB Therapy
- Antidepressant Medication Management
  - Acute Phase: At least 84 days (12 weeks) of continuous medication
  - Continuation Phase: At least 180 days (6 months) of continuous medication
FHP Core HEDIS Goals

- Well Child Visits – Visit with PCP annually
  - Once a month: First 15 months
  - Once a year: 3, 4, 5, and 6 years
- Childhood Immunization Status
- Developmental Screenings – First 3 years
- Prenatal and Postnatal Care
  - Timeliness of prenatal care and postnatal follow-up
MMP Quality Oversight

- Both the Centers for Medicare and Medicaid Service (CMS) and the State monitor the MMAI through:
  - HEDIS measures
  - Adequacy of provider network
  - Claims payment and data transfers
  - Service authorization and delivery
  - Participant direction
  - Critical incident reporting and follow-up
  - Review of care plans
  - Provider credentialing standards
  - Health assessments performed
A Quality Coordinator will contact with your office within the next 2 weeks to arrange a date to further discuss your quality measures and any other quality concerns you may have.
Prior Authorization
Prior Auth. Requirements

- Prior Auth. required for:
  - In-patient admissions
  - Some out-patient surgeries
  - High-tech radiological services (NIA: www.radmd.com)
  - Ancillary Services: Orthotics & prosthetics, DME over $500 or over the HFS allowed amount, Home Health Care services
  - Biopharmaceutical medications
  - All out-of-network non-emergency services and providers
Prior Auth. Requirements

- Some in-network specialist require prior auth.:
  - Chiropractors: Required after the 12th visit
    - Limited to the manual manipulation of the spine
    - Members 20 years old or younger
  - Podiatrists: Required after the 3rd visit in a calendar year
  - Pain Management Specialists
    - Certain medications require authorization
Utilization Management

• Send authorizations to:
  – Inpatient Services: 877-650-6937 (fax)
  – Concurrent Review: 877-668-2071 (fax)
  – Outpatient Services: 877-779-5234 (fax)
  – OB Notification: 866-681-5152 (fax)
  – Utilization Management: 866-329-4701 (phone)
Utilization Management

• Authorizations NOT required for:
  – Emergency / Observation / Urgent Care Services
  – Dialysis at participating facilities
  – Physical therapy / Speech therapy / Occupational therapy
    • Prior authorization may be required after 6 visits
  – Routine office labs, x-rays, mammograms, ultrasounds (non-OB), PCP visits, par specialist visits, immunizations, and EKGs
  – Routine non-surgical outpatient services
Billing and Claims
Centene Claims

• Timely and accurate ICP and FHP clean claims payment within **7-10** days of receipt
• Timely and accurate MMP clean claims payment within **14** days of receipt
• 75% of claims paid within 7-10 days of receipt
• 99% of claims paid within 30 days
MMP Claims Submission

- Medicare Instance
  1. Submit claim through Provider Portal, paper claim, or Clearinghouse. All claims go through EDI processes.
  2. EDI will lookup member to verify dual eligibility and flag claim.
  3. Route to Medicare Instance and process as primary.
  4. Medicare claims is paid through Claims Payable process.
MMP Claims Submission

• Medicaid Instance

1. Original claim data will be store for Inbound Claim.
2. Add the Medicare COB data.
3. Process in Medicaid or CBH Instance as secondary, depending on the payer ID.
4. EOP/EOB will reflect the Medicare and Medicaid claim numbers.
Balance Billing

• Medicare and Medicaid providers are prohibited from balance billing members for covered services

  – This rule applies to IlliniCare Health members enrolled in the following plans:
    • ICP
    • FHP
    • MLTSS
    • MMP

1. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997
2. Section 1128B(d)(1) of the Social Security Act, as modified by Section 4704 of the Balanced Budget Act of 1997
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.
  – Any claim disputes / reconsiderations must be received within 180 days of the DOS or date of discharge, whichever is later.
  – 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)
Paper Claims

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

Mental Health Claims
Cenpatico
Attn: Claims
PO Box 7300
Farmington, MO 63640-3828

Provider Claim Disputes
IlliniCare Health
PO Box 3000
Farmington, MO 63640-3800
Through IlliniCare Health’s provider website, you can access:

- Provider manual
- Billing manual
- Provider directory
- Quick reference guides
- Benefits summaries for consumers
- Online forms
- Secure Provider Portal
Secure Provider Portal

- Through the secure Provider Portal, providers and their support staff can:
  - Verify eligibility and benefits
  - Submit and check the status of claims
  - Submit authorizations for services
  - Review payment history
  - Securely contact IlliniCare Health

- Registration is free and easy – www.IlliniCare.com
Electronic Clearinghouses

• Providers can participate in IlliniCare Health’s Electronic Claims Filing Program

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<tr>
<th>EDI Partner</th>
<th>Medical Payer ID#</th>
<th>Behavioral Health Payer ID #</th>
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<tbody>
<tr>
<td>Availity</td>
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<td>SSI</td>
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<tr>
<td>Trizetto Provider Solutions, LLC (formerly Gateway)</td>
<td>68066</td>
<td>68068</td>
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</table>
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
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<td></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>Pharmacy: 866-399-0928</td>
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# Vendor Information

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<th>MLTSS</th>
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<tr>
<td>Cenpatico Behavioral Health</td>
<td>866-329-4701</td>
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<td>844-316-7562</td>
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<tr>
<td></td>
<td>Fax: 866-399-0929</td>
<td>Fax: 866-399-0929</td>
<td>Fax: 866-399-0929</td>
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<tr>
<td>Dental Health and Wellness Dental Services</td>
<td>855-586-1416</td>
<td>855-586-1416</td>
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<tr>
<td>OptiCare Vision Services</td>
<td>800-465-6972</td>
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<td>866-329-4701</td>
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<td>US Script Pharmacy</td>
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<td>Nursewise 24/7 Nurse Advice Line</td>
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<td>Nurtur Disease Management</td>
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