Long Term Care Orientation

HealthChoice Illinois (Medicaid)
Medicare-Medicaid Plan (MMP)

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 1,000 hospitals
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

• HealthChoice Illinois (Medicaid)
  – Medicaid program available statewide. Includes Service Package I and II.

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

Medicaid

2/21/2018
Overview

- IlliniCare Health contracts with the State of Illinois to provide services to the Medicaid population.
- This is a statewide program – all Illinois counties are included in this program.
- Eligibility for this mandatory program is determined by the Illinois Client Enrollment Services.
Eligibility

- Seniors (65+ years old)
- Adults (19+ years old) in the AABD population
- Pregnant women and families with children under the age of 19
- Individuals age 19-64 who qualify based on FPL

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
ID Card

HealthChoice Illinois

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

RXBIN: 004336
RXPCN: MCA1DADV
RXGROUP: RX5437

MEMBERS
Member Services, Behavioral Health, Dental, Transportation, 24/7 Nurse Advice Line:
866-322-4701
TTY: 711
www.IlliniCare.com

PROVIDERS
24/7 Eligibility and Prior Auth Check:
866-322-4701
Enovle Pharmacy Solutions Help Desk:
844-276-1408

Payer ID #: 68069
Claim and EFT/ERA information on www.IlliniCare.com

Mailing Address
IlliniCare Health
PO Box 32050
Elk Grove Village, IL 60009-32050

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

2/21/2018
Medicare-Medicaid Plan (MMP)

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

2/21/2018
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
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
Overview

- 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
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
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
ID Card

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.illinicare.com
Pharmacy Help Desk: 1-855-854-0270
Send claims to: IlliniCare Health
PO Box 4020
Farmington, MO 63640-4402
Member Identification and Risk Stratification

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
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 & SNFist Program
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

Members

- Behavioral Health Care Coordinator
- HCBS Care Coordinator
- Care Coordinator
- Program Coordinator
- Social Worker
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
ICT Integration with LTC

- ICT conducts face-to-face HRAs in LTC facilities
- ICT collaborates with LTC facilities to:
  - Identify and address care gaps and opportunities
  - Develop, share, and collaborate on members’ comprehensive Care Plans
  - Assist with member care coordination (primary contact)
  - Identify and assist with timely transitions
  - Collaborate with facilities to reduce avoidable utilization
  - Coordinate prospective care needs
  - Plan timely discharge coordination and post-hospitalization services
SNFist Program

This program identifies opportunities for improvement in care transitions of older adults and chronically ill patients to post-acute environments utilizing care coordination partnerships of hospitalist programs and SNFist programs.
Overall Goal: Enhance and coordinate care transitions of older adults and chronically ill patient to post-acute settings.

How do we achieve this goal?
- Reduce hospital length of stay
- Reduce the frequency of potentially avoidable hospital (PAH) admissions and readmissions
- Reduce unnecessary ED utilization
- Improve patient health outcomes
- Improve the process of transitioning between inpatient hospitals, post-acute facilities and home settings
- Reduce overall health care spending.
SNFist Program Services

- Regularly scheduled daily on-site hours in facilities with high numbers of IlliniCare Health members
- Oversight/follow-up through a multidisciplinary team of physicians, certified nurse practitioners and clinical nurse specialists
- Consistent providers for continuity of care
- Comprehensive assessments
- Daily interventions
- Individual patient visits (based on need)
- Communication with other physicians and caregivers, ancillary services providers, and family
- Monitoring of services to ensure compliance with all regulations and standards
- Round-the-clock coverage 7 days a week is provided (based on need)
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
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
Prior Authorization Requirements

• Prior Auth required for:
  – Sub-acute stays
  – Custodial care
  – Rehabilitative services
  – New admissions

• Request authorizations by contacting us:
  – By phone: 866-329-4701
  – By fax: 877-941-0483
MMP – Skilled Care

- Medicare Part A (hospital insurance) covers skilled nursing care in a skilled nursing facility (SNF) under certain conditions for a limited time.
- Medicare-covered services include:
  - Semi-private room
  - Meals
  - Skilled nursing care
  - Physical and occupational therapy
  - Speech-language pathology services
  - Medical social services
  - Medications
  - Medical supplies and equipment used in the facility
  - Ambulance transportation
Billing and Claims
Claims

• Timely and accurate Medicaid 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
LTC Claims

• Submit charges on UB-04

• Bill types:
  – 212: 1st claim
  – 213: Interim continuing claim
  – 214: Interim last claim
  – 217: Replacement of prior claim
LTC Claims

• Revenue codes for sub-acute care:
  – 0191 sub-acute care – Level I UB04 Revenue Code
  – 0192 sub-acute care – Level II UB04 Revenue Code
  – 0193 sub-acute care – Level III UB04 Revenue Code
  – 0194 sub-acute care – Level IV UB04 Revenue Code
  – 0199 other sub-acute care UB04 Revenue Code
  – 019X sub-acute care UB04 Revenue Code

• Revenue codes for custodial care:
  – 0120 or 0190 general classification UB04 Revenue Code
  – Other revenue codes that are appropriate for custodial care

• Revenue codes for Bed Hold:
  – 185 – Nursing Home (for hospitalization)
  – 183 – Therapeutic Leave
MMP LTC Claims

• Submit one claim for both Medicare and Medicaid
• Coverage for skilled nursing is up to 100 days
• If there is a break in care that last for more than 30 days, a new 3-day hospital stay is required to qualify for additional SNF care
  – The new hospital stay doesn’t need to be for the same condition
• If there is a break in care that lasts for more than 60 days, this end the current benefit period and renews the SHF benefits.
Therapy Services Claims

- HealthChoice Illinois (Medicaid)
  - Therapy services are covered in the per diem rate
  - Services are covered ONLY if rendered and billed by an entity other than the LTC facility
  - Must be deemed medically necessary
Therapy Services Claims

- MMP
  - If therapy services are considered a Part B service, then therapy claims should be billed to IlliniCare Health.
    - Services must be pre-authorized and are subject to service limitations.
    - If this is not a Part B service, or if Part B has been exhausted, LTC facilities will not be reimbursed for therapy.
    - Services are covered ONLY if rendered and billed by an entity other than the LTC facility and deemed medically necessary.
Oxygen Billing

• **Submit a 1500 claim form NOT an UB-04**
  
  – LTC facilities are responsible for providing the 1\textsuperscript{st} tank of oxygen on a monthly basis and are not allowed to bill for the 1\textsuperscript{st} tank.
  
  – LTC facilities must be registered as a DME provider type 63 with the State
  
  – Oxygen claims must be billed separately from the room and board claim
  
  – Oxygen claim must be submitted on a professional 1500 claim form
Hospice Billing

• Authorization must be obtained by the hospice provider
• Inpatient hospice is handled as pass-through by the hospice provider
• IlliniCare Health will pay 95% of the LTC facility’s per diem rate, and the hospice agency is responsible for paying the LTC facility
  – This agreement is negotiated between the hospice agency and the LTC facility, IlliniCare Health is not involved
Room and Board Claims

- Deny: R & B days do not equal coverage period.
  - Dates billed must match the number of units.
  - Report bed holds on a separate line of service
    - Revenue code – Bed Hold
      - 185 – nursing home (for hospitalization)
      - 18X
    - Bed holds must be reported even though not reimbursed per the SMART Act 2012
- Claim must be corrected and resubmitted within 180 days of the DOS
# Room and Board Claims

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## BED HOLDS

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## DISCHARGE

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<td>30</td>
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</table>
Patient Credit File

All IlliniCare Health members should be on the monthly Patient Credit File (PCF)

- IlliniCare Health can only pay claims for members on the PCF
- All custodial care claims refer to the PCF to deduct member funds accordingly
- When a claim is denied because the member is not on the CPF
  - The claim does not need to be resubmitted
  - The claim will be paid as soon as the member appears on the PCF
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.
**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.
  - A “request for reconsideration” must be submitted before a claim dispute. Reconsideration requests 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 the 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.
Claims Services

• 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
www.IlliniCare.com

• 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

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:

Login

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.

Provider Registration Video

Provider Registration PDF
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

<table>
<thead>
<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>
<td>68066</td>
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<td>Emdeon</td>
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<td>Trizetto Provider Solutions, LLC (formerly Gateway)</td>
<td>68066</td>
<td>68068</td>
</tr>
</tbody>
</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
Abuse, Neglect, and 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.
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

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