IlliniCare Health

WHO WE ARE

IlliniCare Health provides:

Medical
Behavioral Health
Pharmacy
Dental
Vision

Our parent company, Centene Corporation, has 30+ years of experience

IlliniCare Health employees are local and have market knowledge

- Our Integrated Care Teams understand the communities we serve and the resources available within those communities
Centene Corporate

OUR PARENT COMPANY

WHO WE ARE

St. Louis based company founded in Wisconsin in 1984

31,500 employees

#66 on the Fortune 500 list

#4 Fortune’s Fastest Growing Companies (2015)

WHAT WE DO

28 states (including IL) with government sponsored healthcare programs & implementations

Medicaid (23 states)
Exchanges (13 States)
Medicare (12 States)
Correctional (8 States)

2 international markets

12.2 million members
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 Our Purpose

OUR FOCUS

• Local approach with cultural sensitivity
  • Quality healthcare is best delivered locally
  • Access to high quality services and resources to best serve our members

• Clinical interventions and programs
  • Evidence-based clinical outcomes that target specific conditions
  • Solutions for complex health needs
Our Products

HEALTH CHOICE ILLINOIS

• Medicaid program available statewide. Includes Service Package I and II.

MEDICARE – MEDICAID ALIGNMENT INITIATIVE

• Demonstration available in Cook and collar counties. Also known as the Medicare-Medicaid Plan (MMP) or Duals.

AMBETTER INSURED BY CELTIC

• Insurance for purchase on the Health Insurance Marketplace. Available in Cook and DuPage counties.
HealthChoice Illinois

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.
**HealthChoice Illinois**

**ELIGIBILITY**

- Eligibility is determined by Illinois Client Enrollment Services (ICES).
  - 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
Medicare-Medicaid Plan
DUALS

Medicare-Medicaid Alignment Initiative
MMP/Duals/MMAI

OVERVIEW

• Illinois’ 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 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
MEMBER 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
Ambetter Insured by Celtic

OVERVIEW

• Ambetter is a certified Qualified Health Plan issuer on the Health Insurance Marketplace.

• Ambetter health insurance plans are designed to deliver high quality, locally-based healthcare services to our members. Plans are designed to have:
  • Affordable premiums that keep out-of-pocket costs down
  • Maximized Advance Premium Tax Credits (APTCs) / cost-sharing reductions
  • Low deductibles & copays for highly subsidized members
  • An exclusive provider network with strong discounts with select providers
Value Added Benefits

• **24/7 Nurse Advice Line**
  • Access to free health information from RNs.

• **MemberConnections®**
  • Connects members to providers, community resources, and health education.

• **Free Transportation**
  • Free rides to and from medical appointments.

• **Start Smart for Your Baby®**
  • Education and support for expecting and new mothers.

• **Disease Management**
  • Support and education for complex and/or chronic conditions.

• **CentAccount® / Medicare Rewards Program / My Health Pays®**
  • Rewards for completing healthy behaviors.
Clinical Models and Programs
Identification and Stratification

HEALTH RISK SCREENING

- HRS is completed by new members within 30 days of enrollment to identify members with unmet or ongoing needs.

- Each HRS assesses a members’:
  - Functional abilities
  - Physical and behavioral health conditions
  - Social, environmental, and cultural issues
  - Ability to live independently
  - And other needs that form the basis of the 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
  - Eliminates redundant services
  - Ultimately improves health outcomes in a more cost effective way
Medical Home Model
MEMBER OUTREACH

• Member outreach is critical to the success of the medical home model. Through member outreach, IlliniCare Health is able to:
  • Explain benefits and provide health education – including how to access care
  • Establish partnerships with community stakeholders to promote health living and preventive 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 transitions of care
• Increased appropriate utilization of services
• Improved member health outcomes
# Appointment Standards

<table>
<thead>
<tr>
<th>Category</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>Immediately</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
<td>Within three (3) weeks</td>
</tr>
<tr>
<td>Routine Preventive Care</td>
<td>Within five (5) weeks</td>
</tr>
<tr>
<td></td>
<td>For infants under six (6) months: Within two (2) weeks</td>
</tr>
<tr>
<td>Pregnant Woman Visits</td>
<td>1st Trimester: 2 week</td>
</tr>
<tr>
<td></td>
<td>2nd Trimester: 1 week</td>
</tr>
<tr>
<td></td>
<td>3rd Trimester: 3 days</td>
</tr>
<tr>
<td>Post-Discharge Follow-Up</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Office Wait Times</td>
<td>Not to exceed 1 hour</td>
</tr>
<tr>
<td>After Hours</td>
<td>24/7 coverage (voicemail only not acceptable)</td>
</tr>
</tbody>
</table>

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.
Integrated Care Team
Integrated Care Team
ICT

- IlliniCare Health’s ICT:
  - Identifies health conditions early on
  - Facilitates communication and coordination of services across specialties
  - Identifies and engages high-risk members
  - Identifies barriers to adherence with treatment plans and goals
  - Creates customized plans of care
  - Takes a holistic approach – links members to appropriate social, medical, and behavioral services and supports.
Integrated Care Team

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

Member
Integrated Care Team
RESPONSIBILITIES

- Complete Health Risk Screenings, Health Risk Assessments, and Reassessments based on the member’s needs
- Collaborate with the member, caregivers, and providers to develop and implement a care plan
- Assist the member with coordination of services
- Facilitate exchange of information between providers
- Maintain contact with the member
Quality Initiatives

HEDIS

A Quality Coordinator will contact your office to arrange a date to further discuss your quality measures and any other quality concerns you may have.
HEDIS

Healthcare Effectiveness Data and Information Set

- Developed by the National Committee for Quality Assurance (NCQA)
- Standardized performance measures
- Measures the quality of healthcare services provided by IlliniCare Health
- HEDIS rates are calculated from claims and encounter data
Core HEDIS Goals

- Adult BMI assessment
- Annual dental visit
- Annual flu vaccine
- Annual PCP preventive visit
- 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
- Breast cancer screening
- Cervical cancer screening
- Childhood Immunization Status
- Colorectal cancer screening
- Comprehensive diabetes care (HbA1c, ACE/ARB, etc.)
- Congestive heart failure care (ACE/ARB, beta, etc.)
- Coronary artery disease care (cholesterol, beta, etc.)
- Developmental Screenings – First 3 years
- Diabetes Care
  - HbA1c Testing, Retinal Eye Exam, Microalbuminuria Testing, Statin Therapy, ACE/ARB Therapy
Core HEDIS Goals

- 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
- Health Risk Screening within 90 days
- Hospital admissions due to UTIs and bacterial pneumonia
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- LTC – stage II pressure ulcers
- Prenatal and Postpartum Care
  - Timeliness of prenatal care and postnatal follow-up
- Well Child Visits – Visit with PCP annually
  - Once a month: First 15 months
  - Once a year: 3, 4, 5, and 6 years
MMP Quality Oversight

Both CMS and the State of IL monitor MMP through:

• HEDIS measures
• Adequacy of provider network
• Claims payment and data transfers
• Services authorization and delivery
• Participant direction
• Critical incident reporting and follow-up
• Review of care plans
• Provider credentialing standards
• Health assessments performed
Prior Authorization
UTILIZATION MANAGEMENT
Prior Auth. Requirements

- Prior authorization is required for:
  - Inpatient admission
  - Some outpatient surgeries
  - High-tech radiological services
  - Biopharmaceutical medications
  - All out-of-network non-emergency services and providers

- Starting 1/1/2018 requests for authorizations will be reviewed and decided on within 4 days.
  - Can be extended for an additional 4 days.
ASC Procedure Prior Auth.
POLICY CHANGE EFFECTIVE AUGUST 1, 2018

• 35 surgical procedure codes will require prior authorization when scheduled in a hospital setting

• Ambulatory Surgery Center(s) are the preferred location for scheduling and will NOT require prior authorization

• Applies to in-network providers

• Authorization requests should be faxed to the dedicated line: 866-724-4487

• The updated ASC Steerage Policy is located on IlliniCare.com
Prior Auth. Check Tool

1. Go to IlliniCare.com

2. Click “For Providers”

3. Select “Prior Auth Check”

4. Choose the product you are submitting prior auth for:
   - Ambetter
   - Medicaid
   - Medicare-Medicaid
Prior Auth. Check Tool

5. Fill out the form.

6. If “yes” is selected for any question, you will get a prompt saying prior auth. is needed.

7. If “no” is selected for all questions, you will be prompted to enter a CPT code.
   - This will tell you if prior auth. is needed for that code.
Utilization Management

- **Call** in authorizations to:
  - MMP: 877-941-0482
  - Ambetter: 855-745-5507

- **Fax** authorizations to:
  - HealthChoice Illinois:
    - Medical: 877-779-5234
    - BH: 844-528-3453
  - MMP: 844-409-5557
  - Ambetter: 844-311-3746
Prior Auth. on Provider Portal

1. All processed prior auth. requests submitted within the last 90 days will display on the “Authorizations” tab in the provider portal.
   - Status, auth. ID, member name, date range for services, diagnosis, auth. type, and service are listed.

2. Click the “Error” button to view prior auth. requests. This displays the auth. number and the auth. ID (the confirmation number when submitting a request on the provider portal).
Prior Auth. on Provider Portal

1. To view a prior auth. request, enter the auth. or confirmation number in the field and click “Search”.

2. The prior auth. request will display the status, auth. number, member name, services date range, diagnosis, auth. type, and service.

3. To view details of a prior auth. request, click the auth. number. You can view attached documents submitted with the request by clicking “View”.
Prior Auth. on Provider Portal

Create an authorization request:

1. Enter the member’s last name or member ID and DOB. Check eligibility. Click on the member’s name to open the overview.

2. Select the “Authorizations” tab.

3. Displays prior auth. requests previously submitted, or create a new prior auth. request.
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 of receipt.
Claims Submission
TIMELY FILING GUIDELINES

• **180 days from the date on which the services or items are provided.**
  - Applies to both initial and submitted claims.

• A “request for reconsideration” must be submitted before a claim dispute. Requests for Reconsideration must be received within 90 days of the original determination or Explanation of Payment (EOP).

• 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.
Claims Submission

- Providers can file claims three ways:
  
  - Paper claims
  - Provider Portal
  - Electronic Clearinghouse (EDI partners)
Claims Submission

PAPER CLAIMS

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

MMP
IlliniCare Health
Attn: Claims
PO Box 4020
Farmington, MO 63640-3822

Ambetter
Ambetter
Attn: Claims
PO Box 5010
Farmington, MO 63640-5010
Claims Submission

PROVIDER PORTAL

• Submit claims electronically on the secure Provider Portal.

• Go to Provider.IlliniCare.com to access the provider portal.
Claims Submission
ELECTRONIC CLEARINGHOUSES

• IlliniCare Health Payer ID # 68069

• EDI partners include:
  • Availity
  • Emdeon
  • Smart Data Solutions
  • SSI
  • Trizetto Provider Solutions
Claims Payment
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 [PaySpanHealth.com](http://PaySpanHealth.com) or call **877-331-7154**.
Cultural and Linguistic Competency
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 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.
Linguistic Competency

• IlliniCare Health 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.
Fraud, Waste, and Abuse

FWA
Fraud, Waste, and Abuse

- **Fraud**: Fraud is 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.

- **Waste**: 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.

- **Abuse**: This includes 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

TYPES

• Abuse
  • Physical Abuse
  • Sexual Abuse
  • Mental Abuse

• Neglect

• Exploitation
Signs of Critical Incidents

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 EXPLOITATION

• 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
Reporting Critical Incidents

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
Provider Resources
IlliniCare.com

- Through IlliniCare Health’s website, you can access:
  - Provider manual
  - Billing manual
  - Provider directory
  - Quick reference guides
  - Benefits summaries for members
  - Online forms
  - Secure Provider Portal
Contact Information

HEALTH CHOICE ILLINOIS

- Phone: 866-329-4701
- TTY: 711
- Medical Auth. Fax: 877-779-5234
- BH Auth Fax: 844-528-3453

- Mailing Address:
  IlliniCare Health
  PO Box 92050
  Elk Grove Village, IL 60009-2050
Contact Information

MMP

• Phone: 877-941-0482

• TTY: 711

• Auth. Fax: 844-409-5557

• Mailing Address:
  IlliniCare Health
  PO Box 92050
  Elk Grove Village, IL 60009-2050
Contact Information

AMBETTER

- Phone: 855-745-5507
- TTY: 866-565-8576
- Auth. Fax: 844-311-3746

- Mailing Address:
  IlliniCare Health
  PO Box 92050
  Elk Grove Village, IL 60009-2050
1-866-329-4701
(TDD/TTY: 711)
Monday-Friday 8 a.m. to 5 p.m.
IlliniCare.com