IAMHP

ILLINOIS ASSOCIATION OF MEDICAID HEALTH PLANS

Special Needs Children

2021 Health Plans

HealthChoice Illinois-Statewide

- Aetna Better Health
- Blue Cross Blue Shield Community Health Plans
- CountyCare
- Meridian Health
- Molina

MMAI-Statewide

- Aetna Better Health
- Blue Cross Blue Shield Community Health Plans
- Humana
- MeridianComplete
- Molina

YouthCare- Statewide

- Meridian (Name displays asYouthCare)

Populations Covered

Special Needs Children

Special Needs Children populations include children under the age of twenty-one (21) and:

1. receive-Supplemental Security Income (SSI); or
2. are classified as disabled; or
3. Medicaid children receiving care coordination services through the University of Illinois at Chicago's Division of Specialized Care for Children (DSCC). This is known as the CORE program.

DCFS Children

The Illinois Department of Children and Family Services (DCFS) populations include children who either are:

- Effective 4-1-20under the legal custody or guardianship of DCFS (Current Youth in Care); or

- Effective 2-1-20 were formerly under the legal care of DCFS and are receiving assistance through Title IV-E (Former Youth in Care)

Former Youth in Care includes:

- Families who have achieved unification within a year
- Youth who have emancipated
- Families who achieved permanency via adoption
- Families who achieved permanency via guardianship:

Special Needs Populations & Services **excluded** from managed care enrollment:

- Medically Fragile Technology Dependent (MFTD) waiver individuals
- Individuals receiving services through the Nursing and Personal Care Services Program (NPCS)
- DD waiver/LTC services

IMPACT

Registering in IMPACT

- Registration in IMPACT
  - https://www.illinois.gov/hfs/impact/Pages/ProviderEnrollment.aspx will directly affect how a provider is reimbursed by a health plan
  - Submit all applicable provider type(s) and specialties
  - Taxonomy number(s) and NPI(s) must match the ones listed on claims and rosters to ensure payment.
  - Multiple provider types need to register separately with separate and unique NPIs

Medicaid Managed Care Information

Medicaid MCO Characteristics

- Defined Benefit Package: At least equal to FFS
- Network Capacity Standards
- Mandated Provider Trainings & Policies
- Robust Fraud, Waste & Abuse Standards
- Care Coordination
  - Defined staffing ratios
  - Defined contact standards

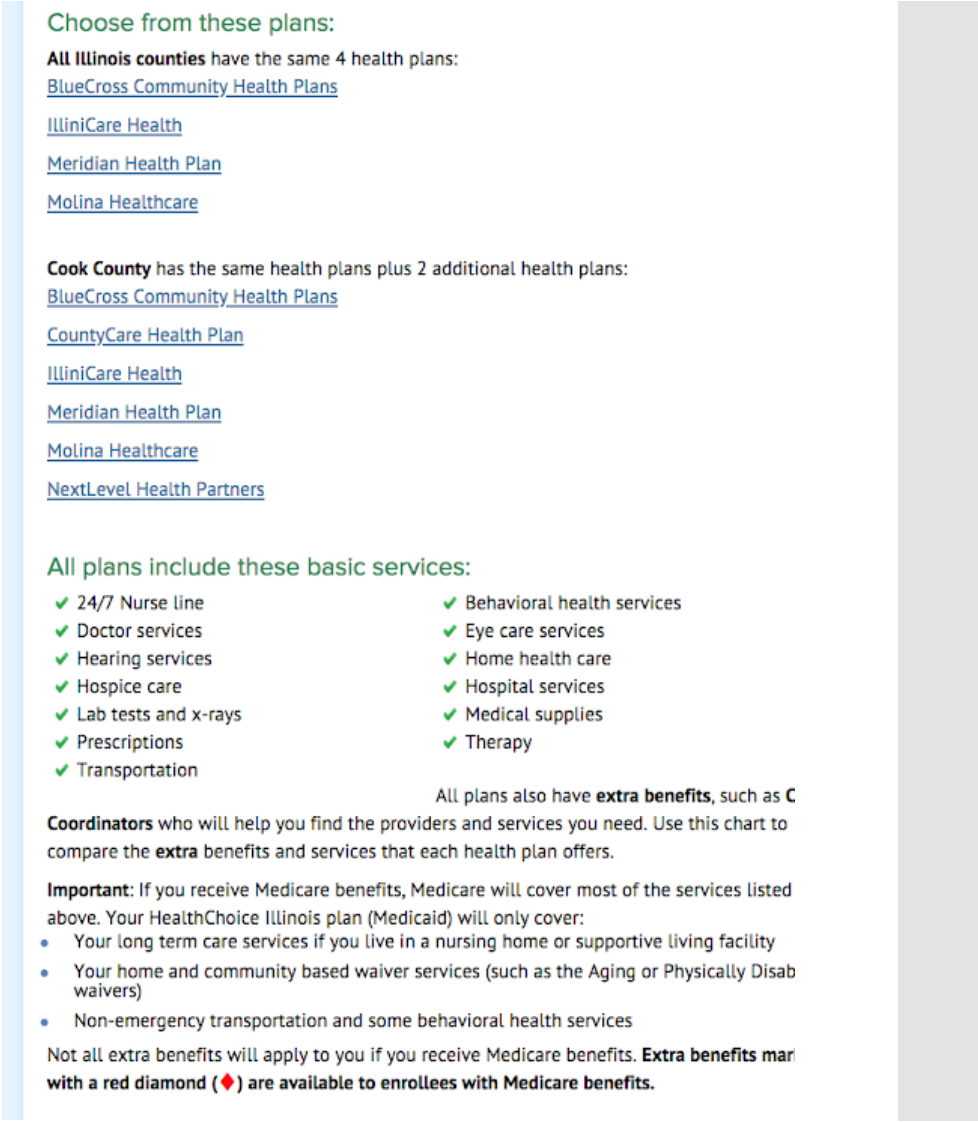
How to Enroll?

Call Illinois Client Enrollment Services at 1-877-912-8880 to enroll in a health plan.

You can, enroll online (http://enrollhfs.illinois.gov/) or call 1-877-912-8880. The hours are Monday through Friday 8 a.m. – 6 p.m.

https://enrollhfs.illinois.gov/node/13 This takes you to enrollment material. Would IAMHP consider moving the comparison chart information on the right, along with this link, to a new slide?

Call HFS' Health Benefit Hotline at 1-866-226-0768 to find out which health plan a child is enrolled.



Choose from these plans:

All Illinois counties have the same 4 health plans:

BlueCross Community Health Plans

IlliniCare Health

Meridian Health Plan

Molina Healthcare

Cook County has the same health plans plus 2 additional health plans:

BlueCross Community Health Plans

CountyCare Health Plan

IlliniCare Health

Meridian Health Plan

Molina Healthcare

NextLevel Health Partners

All plans include these basic services:

- ✔ 24/7 Nurse line
- ✔ Doctor services
- ✔ Hearing services
- ✔ Hospice care
- ✔ Lab tests and x-rays
- ✔ Prescriptions
- ✔ Transportation
- ✔ Behavioral health services
- ✔ Eye care services
- ✔ Home health care
- ✔ Hospital services
- ✔ Medical supplies
- ✔ Therapy

All plans also have **extra benefits**, such as **C**

Coordinators who will help you find the providers and services you need. Use this chart to compare the **extra** benefits and services that each health plan offers.

Important: If you receive Medicare benefits, Medicare will cover most of the services listed above. Your HealthChoice Illinois plan (Medicaid) will only cover:

- Your long term care services if you live in a nursing home or supportive living facility
- Your home and community based waiver services (such as the Aging or Physically Disab waivers)
- Non-emergency transportation and some behavioral health services

Not all extra benefits will apply to you if you receive Medicare benefits. **Extra benefits mar with a red diamond (♦) are available to enrollees with Medicare benefits.**

How will providers know which MCO patients are enrolled in?

MCO Plan Code can be found here

Eligibility Results

Retain Inquiry | New Inquiry | Print Everything

Transaction Audit Number:		Recipient Name:	
Recipient Number:		Recipient SSN:	
Recipient Date of Birth:		Recipient Sex:	
Provider Number:		Provider Name:	
County Code:		Case Name:	
Case Address:		City - State - Zip:	
Begin Date:		End Date:	
NPI Number:		Renewal Due Date:	

Coverage Detail Expand Hide

For the date(s) of service entered, the client is eligible for medical benefits.

Case Type: MEDICAID ELIGIBLE, FULL COVERAGE

Begin Date	End Date	System Date
12/01/2019	12/31/2019	01/05/2018

Service Type(s):OCCUPATIONAL THERAPY - SPEECH THERAPY - SKILLED NURSING CARE - SUBSTANCE ABUSE - VISION (OPTOMETRY) - PSYCHOTHERAPY - PSYCHIATRIC-INPATIENT - PSYCHIATRIC-OUTPATIENT - CARDIAC REHABILITATION - PEDIATRIC - MENTAL HEALTH - URGENT CARE - MEDICAL CARE - DURABLE MEDICAL EQUIPMENT PURCHASE - AMBULATORY SERVICE CENTER FACILITY - DURABLE MEDICAL EQUIPMENT RENTAL - SURGICAL - SECOND SURGICAL OPINION - HEALTH BENEFIT PLAN COVERAGE - DENTAL CARE - DIAGNOSTIC X-RAY - ORAL SURGERY - HOME HEALTH CARE - HOSPICE - HOSPITAL - HOSPITAL INPATIENT SERVICES - DIAGNOSTIC LAB - HOSPITAL OUTPATIENT SERVICES - HOSPITAL EMERGENCY ACCIDENT - EMERGENCY ROOM VISIT - HOSPITAL AMBULATORY SURGICAL - RADIATION THERAPY - MRI/CAT SCAN - NEWBORN CARE - WELL BABY CARE - ANESTHESIA - DIAGNOSTIC MEDICAL - DIALYSIS - CHEMOTHERAPY - SURGICAL ASSISTANCE - IMMUNIZATIONS - FAMILY PLANNING - EMERGENCY SERVICES - PHARMACY - BRAND NAME RX DRUGS - GENERIC RX DRUGS - PODIATRY - PROFESSIONAL (PHYSICIAN) VISIT OFFICE -

Special Information: Title XIX.

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For the date(s) of service entered, the client is eligible for limited medical benefits. Additional information available below or refer to the Provider Handbook for program specific coverage limitations.

Case Type:

Begin Date	End Date	System Date
12/01/2019	12/31/2019	01/11/2019

Service Type(s):HEALTH BENEFIT PLAN COVERAGE -

Special Information: State Funded. Coverage is limited to IL Department of Human Services Programs. Services under this coverage are billed directly to HFS. If you have any questions about DHS Social Services cases, please send inquiry via email to: DHS.ERIN@ILLINOIS.GOV

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Managed Care Organization Expand Hide

Plan Code:	59	Site Name:	NEXTLEVEL HEALTH PARTNERS MMCP
Exclusion Code:	6	Organization Name:	N L MERGER SUB INC MMCP
Site Number:	001	Organization Phone:	8448079734
Begin Date:	12/01/2019	Street:	3019 W HARRISON ST
End Date:	12/31/2019	City - State - Zip:	CHICAGO, IL 60612

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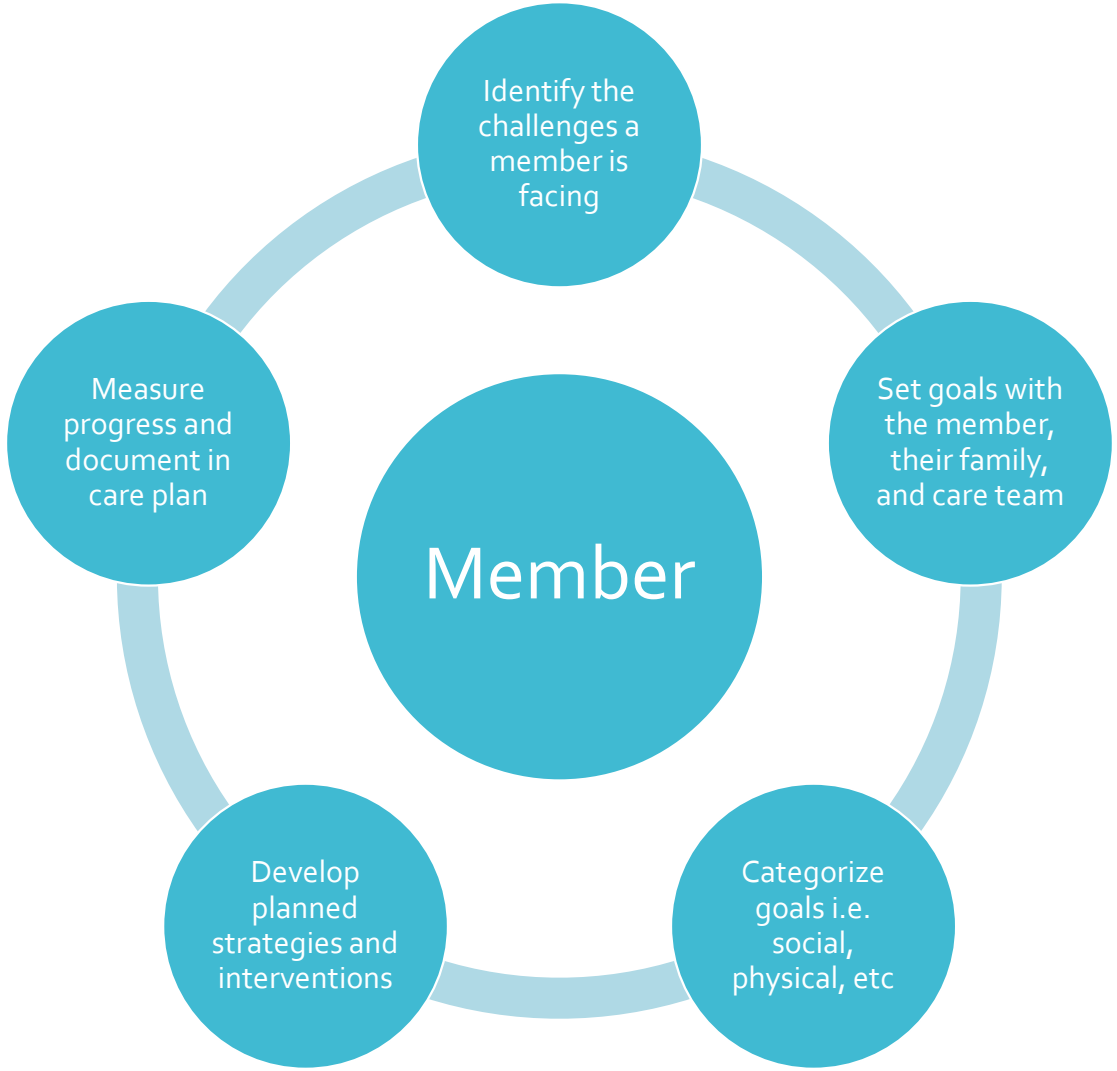
Care Coordination

- The purpose of care coordination is to support families and ease the navigation of health care to ensure a seamless process
- All children defined as a Special Needs Child will receive all care coordination provided by either a:
  - Medicaid Managed Care Organization; or,
  - a delegated or contracted community-based organization such as DSCC.
- In the event of an issue with a contracted entity a provider can always call the assigned MCO
- Care coordinators are required to have training and experience servicing the population
- The ratios, care plans and engagement are regularly monitored by HFS and their external quality review organization
- Care Coordinators are assigned to members based on risk. However, any member can request care coordination services.

Responsibilities of a care coordinator

- Speaking with the family to find out primary concerns or goals to be addressed
- Sending out the invitation
- Securing a conference call/ in-person meeting location
- Using clinical skills to facilitate an evidence-based conversation of goals
- Making sure the member and family's concerns are met and the family understands the information presented
- Addressing any areas the health plan is able to cover (benefits)
- Summarizing the meeting and confirming responsible parties for any action items for follow-up
- Documenting a record of the meeting
- Escalating any potential risks as needed to leadership or appropriate entity
- Advocating, above all, for the family and supporting the family to advocate for themselves.

Care Coordination Model #1



Interdisciplinary Care Team

1) The member/family – they are the leader and driver of the team and care plan
2) All members of the treatment team and support system (caregivers, extended family, school personnel), including but not limited to:

- Nurses
- Pharmacists
- Nutritionists
- Social workers
- Therapist
- Psychologist
- Educators
- Primary Care Physicians
- Specialists

Obtaining services for a member

- Prior Authorization may be necessary for services or products for a member.
- For home modification services providers and members should work closely with the Member's care coordinator to ensure a seamless process.
- For therapy services, such as PT/OT/ST, appropriate medical professionals should order services and seek appropriate PAs as necessary. A care coordinator or health plan team member can assist if finding an appropriate therapist is difficult.
- Medical professionals can also order DME supplies for members. A care coordinator or health plan team member can assist if necessary.

Obtaining services for a member: New/Newer Services

- Medicaid Health Plans follow HFS policies for benefit coverage including but not limited to:
  - Effective date of coverage
  - Type of providers able to bill the service
  - Registered providers in IMPACT
  - Billing forms/codes (if there is a difference it will be noted in the IAMHP billing guide)
  - Benefit limits or population limitations
- If a new or newer service does not have policies in place for the fee-for-service Medicaid program it is likely it will not be operational in the managed care plans either.

Prior Authorization

- Prior Authorization may be necessary when there are changes to the care plan or after the 180-day continuity of care transition period.
- It is recommended that provider utilize portals and request prior authorizations electronically.
- MCOs are responsible for reviewing prior authorization requests.
- To find out more information about prior authorization requirements and procedures for each Managed care organization please visit the link below:
  - https://iamhp.net/resource-center-preauthorization

Member Appeals

FOR MEMBERS:

1. Members have appeal rights. There are described in the member handbook that all members receive when they enroll with their health plan.
2. Appeals that are upheld by the MCO can be referred by the member to the next level – HFS State Fair Hearings.
3. In Illinois Medicaid, the doctor can always appeal on behalf of the member.

Provider Disputes

FOR PROVIDERS:

1. Providers also have the right to file a complaint or dispute with an MCO
2. It is important to note these are regulated process that are over seen and monitored by HFS
3. It is important to note, that even if there is a delegated model, providers can always reach out to the MCO
4. For more information on provider disputes, please refer to the IAMHP Billing Guide.

MCO Resources

IAMHP developed a Comprehensive Billing Guide.

- Find online at iamhp.net/providers
- General billing guides for:
  - General claim submission information
  - Claim disposition
  - Etc.

Applies to contracted providers for HealthChoice Illinois only

- May differ from traditional commercial billing
- Billing for MMAI services may follow different guidance

IAMHP Tools and Resources

Point of Contact

Escalation Guides can be found here: https://iamhp.net/resources/Documents/Special%20Needs%20Children%20Escalation%20Guide%2002-05-21.pdf

IAMHP Key Contacts

https://iamhp.net/provider-contacts

Key Contacts for Providers

To find the contact you are looking for, simply navigate to that page using the link provided. **IAMHP no longer maintains a printed directory.**

By Topic Area

- Children's Services
- Community Mental Health
- Dental
- Durable Medical Equipment
- Federally Qualified Health Centers (FQHC)
- Home Health
- Hospice
- Hospitals
- Long Term Care
- Mental Health
- Methadone Treatment
- Pharmacy / Pharmaceuticals
- Physicians
- Public Health Departments
- Redetermination Point Person
- Substance Use Disorder

Report a Contact Change

Help us keep this information up-to-date. Notify our team using the form below if you see any inaccuracies.

Your Role in Requesting a Change *

- ○ I am a Directory User who believes a listing is incorrect
- ○ I am an Organization Designee who needs to report a change

Requested Change *

- ☐ Remove a Contact (This person is no longer the contact, but there is no replacement yet)
- ☐ Add Contact (New person, but not replacing anyone)
- ☐ Replace Contact (Remove this person and replace them with someone else)
- ☐ Other

Please describe the change in detail below.

If you are adding a new contact, we need to know:

- Their name
- Their title
- Organization (if different from yours)
- Their phone number
- Their email address
- Their areas of responsibility / committees / topics that they should be listed under

Change Needed *

Prior Authorization Links

- Find out more information about prior authorization requirements and procedures for each Managed care organization.
  - https://iamhp.net/resource-center-preauthorization

IAMHP Website – Info for Providers

In addition to the Key Contacts and Billing Guides, the Info for Providers section also includes links to Provider Manuals and Prior Authorization links

Regular updates to reflect any URL changes, document updates, etc.

IAMHP always welcomes suggestions, so please don't hesitate to share what additional information we can collect from the health plans and post to our site.

Samantha Olds Frey, Chief Executive Officer

samantha@iamhpteam.org

IAMHP Contact Information