

Q&A from DHS Webinar on HealthChoice Illinois, 3/22/2018

Important note for DMH and DASA Providers:

Please review the latest HFS provider notices released on March 28 and March 29, respectively.

- (<https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn180328a.aspx>)
- (<https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn180329c.aspx>)

There was a recent change in the MCO implementation schedule for expansion counties that will affect a small segment of the Illinois Medicaid population.

Please [subscribe to HFS provider notices](#) for updates on the implementation schedule.

1. Will the PowerPoint be made available for providers to download?
2. Currently we bill HFS directly for Rule 132 Services that are provided to any dual eligible member who is NOT enrolled in and MCS or an MMAI or MLTSS. Are these Medicare/Medicaid clients who currently we bill directly to HFS for MRO services the ones that are going to be automatically enrolled in these MCOs, or will it be the Medicaid only?

RESPONSE: Health Plans will cover Rule 132 services for clients who are enrolled in MMAI or HealthChoice Illinois.

3. Previously, the Medicare/Medicaid had the option of opting out of managed care (the MMAIs). Is this option now going away? Will they now be in MCO's like the Medicaid only clients?

RESPONSE: MMAI policy has not changed with the implementation of HealthChoice Illinois. Clients can still opt out of MMAI. In the six collar counties (Lake, Kane, DuPage, Cook, Will and Kankakee), an individual receiving long term supports and services (LTSS) who opts out of MMAI will be required to join HealthChoice Illinois for LTSS services. Behavioral health is included in that service package.

4. How will we know who is being enrolled (e.g., which area of the city/state) and at what time? Are we just supposed to keep checking the MEDI system every day/week/month to see if someone's insurance has changed? Will anyone consider notifying providers of these changes instead of just the clients themselves? Most of our clients will throw out mail they get from HFS or from an insurance company and so waiting/hoping that they tell us is not going to happen. Since HFS knows which clients are billed from which agency for Rule 132, is there any way that a report can be generated showing the clients who will no longer be eligible for billing to HFS due to their being changed to an MCO?

RESPONSE: Providers need to check clients' eligibility using MEDI or a third-party system when providing services. Eligibility can change, so a check should be performed prior to providing services.

5. Are these changes just for Rule 132, or are they also for dual eligible who will now have to get medical services via an MCO, even though their DD waiver services will still be billed to DHS and

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not through the MCO?

RESPONSE: Please clarify the changes that are being referenced.

6. Can DMH help us provider agencies identify who is being switched?

RESPONSE: Providers should check eligibility to identify members who are enrolled in managed care.

7. Please explain better the issue of how credentialing is being done through IMPACT.

RESPONSE: When providers register and are approved in IMPACT, they are credentialed with all the health plans. In addition to credentialing through IMPACT, providers will need to contract with each plan individually. Health plans should not be asking for duplicative information that providers make available through their IMPACT registration, but they can request additional information.

8. We have come across a couple of clients who have Medicare and been assigned an MCO. One has a Medicare effective date of 04/01/2018 which Medi did not show-provided the information to update Medi but they left the MCO as active. It is our understanding that dual eligible are not included-how should these clients rectify this issue? Who do they contact? They wish to have Medicare and traditional Medicaid.

RESPONSE: A recent change in the MCO implementation schedule for expansion counties will affect a small segment of the Illinois Medicaid population. Please see provider notices listed at the beginning of this document.

9. Who loads the plans and associate PCPs for the plan on the website-HFS, the MCO or a combination of both? Many of the plans are not showing PCPs that we know there are contracts in place. Clients want to see what their PCP is listed.

RESPONSE: Providers contract with health plans and the health plans send a file to Illinois Client Enrollment Services (ICES). ICES then updates the website (enrollHFS.illinois.gov). The file is sent from the health plans to the ICES once per week. The health plans are responsible for updating their own websites.

10. Currently SASS clients are not showing up on the MEDI website with any MCO information starting 4/1. Medi is just showing regular Medicaid still. When is this information going to show on the Medi site?

RESPONSE: Please note that not all Medicaid recipients will be enrolled in managed care. Certain populations, such as special needs children, are not scheduled for enrollment until later this year, and approximately 20% of the Medicaid population will be excluded from managed care altogether. If you are aware of individuals who, according to the implementation schedule, should be enrolled already but are not, please send specific examples.

11. If agency is not contracted with all 5 plans, is there still guarantee of payment during the 90 day window for clients to switch plans?

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RESPONSE: Plans must offer an initial 90 day transition period for enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of the health plan's provider network. Health plans must also offer a ninety 90 day transition period for members switching from one Health Plan to another.

The 90 day transition period is applicable to all Providers, including Behavioral Health Providers and Providers of LTSS. The health plan pays for covered services at the Medicaid fee-for-service rate. Even if a provider is out of network, they are encouraged to call the health plan prior to rendering service to discuss billing and payment options.

12. At a recent meeting, I heard it was stated by a DMH staff that providers could bill either the MCO or HFS during the 90 day period after a persons' enrollment and bills would be paid. Is this true?

RESPONSE: No. During the 90 transition period referred to in Question #11, providers need to bill the MCO in which the client is enrolled, not HFS. The claim will reject if submitted to HFS.

13. If an individual is auto assigned to an MCO that doesn't have a contract with a client's psychiatric provider and that provider sees that client for a service on 4/1, who has enrolled in an MCO on 4/1, what options does that provider have for getting paid for that service?

RESPONSE: Please see answer to Question #11.

14. It was mentioned that a person can change their election during the 90 day period after their enrollment. Does this 90 days start on 4/1 or does it start on the date they made the selection with the enrollment broker?

RESPONSE: The 90 day switch period starts on the 1st day of the MCO eligibility. If a client's MCO starts on 04/01, then the client has 90 days from 04/01 to call ICES and request a health plan switch.

15. If a person changes their enrollment during the 90 day window, when does that change become effective? On the date they made the change with the enrollment broker? On 4/1? On the start of the next month?

RESPONSE: Start dates in managed care do not occur in the middle of the month; the effective date with a health plan is always the first day of the month. Depending on when the call is made, the effective date can either be the first day of the following month or the first day of the second calendar month, depending on when the call is made to ICES.

For the HealthChoice Illinois membership that includes parents, children, caregivers, ACA adults, seniors and persons with disabilities- members making a choice on or before the 18th, the MCO effective date will be the 1st day of the following month. Choices made on or after the 19th, the MCO effective date will be the 1st day of the second calendar month after the current month. (see below for MLTSS population).

For the MLTSS and MMAI population- If a client is switching from one MLTSS plan to another MLTSS plan or from one MMAI plan to another MMAI plan, the effective date will be the first

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day of the following month regardless of when the individual calls to switch. The cutoff date is the 18th and the rules are the same as described above. When a client switches from MMAI to MLTSS, the effective date will be the first day of the next month regardless of the date of the change.

16. What are provider's options in this scenario? A client needs community support services to maintain their stability. They have been auto-assigned to an MCO that hasn't yet completed the credentialing process to finalize to obtain preauthorization for services which the MCO requires, they are told that since they haven't been approved as a provider, they can't preauthorize services. Does the provider have any chance for getting paid for services it delivers?

RESPONSE: See answer to Question # 11.

17. Is completion of DMH client registration with the collaborative required for MCO clients? I've heard it said DMH's contract with the Collaborative will end on 6/30. What will be the process for reporting registrations after that date?

RESPONSE: Yes. This requirement is included in the HFS-MCO contracts.

18. What providers need to be included in IMPACT, only our licensed clinicians? Or do all MHPs and RSAs that provide services (often in a residential setting)?

RESPONSE: All Medicaid providers, regardless of the services they provide to a Medicaid recipient, are required to enroll in the IMPACT system. Yes, all licensed clinicians should be enrolled. The MHPs and RSAs can be enrolled in IMPACT but will not affect billing at this time.

19. We are in a county with the April 1, 2018 effective date. Does that mean we need all contracts in place, and all contract requirements completed by March 31, 2018, in order to successfully bill any Medicaid services starting April 1, 2018?

RESPONSE: See answer to Question #11.

20. What is the turnaround time for approval in IMPACT?

RESPONSE: The average process time to approve an IMPACT application is dependent upon the enrollment type of the application. Certain providers require more information for their enrollments and thus the review time is longer. Barring any extenuating circumstances, most IMPACT registrations can be approved within 15-45 days of submission.

21. What is the process and timeframe for data transfer from IMPACT into legacy?

RESPONSE: After an application is approved in the IMPACT system, the data is transferred to the Legacy system on a weekly basis.

22. Which system sends the provider info to the MCOs?

RESPONSE: The new MCO Provider extract file is a combination of IMPACT and Legacy data. The new MCO provider extract file will be sent to the MCOs on a weekly basis and will be a full data

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set each week.

23. Timeframe from approval in IMPACT to each MCO seeing the approval/info on their data file from HFS?

RESPONSE: MCOs should see the provider on the extract file within one to two weeks from approval in IMPACT.

24. If we have consumers who are moving from regular Medicaid to an MCO effective 4/1/18, do we need to request and have authorizations in place with the MCO on April 1st, or will services be covered/paid through a 90 day continuity of care period? MCO's have given us conflicting responses to this question. This could be for both MCO's that we are contracted with and also not contracted with.

RESPONSE: While the 90-day continuity of care clause is in effect (see #11), providers should check with health plans about the need to obtain authorizations, especially those providers not in network.

25. How do I confirm our MH agency (provider) enrollment/credentialing in IMPACT

RESPONSE: Providers will receive an e-mail from IMPACT when their enrollment is approved. They can also check status in IMPACT if they have not received an e-mail.

26. Where can I find a list of contact information for MCOs to establish contracts?

RESPONSE:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/101317ManagedCareProviderContactInformationforhealthPlanswebsitelogophone.pdf>

27. What is the process for service pre-approvals with the MCOs?

RESPONSE: Questions pertaining to pre-approval process should be directed toward the health plans.

28. Have the MCOs been notified of the credentialing process and that the IMPACT approval date is the MCO approval date for their credentialing, even if they require more information? (We are continuing to receive pushback from the MCOs about this. They want us to submit to IMPACT, wait for the provider sheet from the Legacy system, and then submit to them the same information for their credentialing. And then use their approval date as the credentialing date, which is often 60-120 days after the IMPACT approval date.)

RESPONSE: While the IMPACT approval date signifies that provider credentialing is complete, health plans may require additional information, such as detail about site accessibility and hours, before a provider is considered loaded and an effective in-network provider.

29. Will the back feed from IMPACT into the Legacy system continue? And if yes, for how long? Or will IMPACT soon send the provider sheets? (We are waiting for provider sheets to come weeks after the IMPACT approval date.)

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RESPONSE: The back feed process will continue until full core implementation of the IMPACT system. The provider information sheets are not generated until the provider's information is transferred to our Legacy system. If there is an issue with a provider's information not transferring correctly to the Legacy system, it will cause a delay in the creation of the provider information sheet. The provider information sheets are mailed out on a weekly basis via the USPS.

30. Why is there so much of a lag between the time a provider gets approved in IMPACT and the time when the MCO receives the information? Is there something that can be done to speed this time up?

RESPONSE: Since the new MCO provider extract file contains both IMPACT and Legacy data for the Medicaid providers, HFS is hopeful that this will cut down the delay.

31. If a consumer has BCBS as primary and Medicaid as secondary will they be going to an MCO?

RESPONSE: Clients who have high level third party liability will be excluded from managed care. HFS must have this TPL information in their system in order for this exclusion to occur.

32. If a consumer is Medicare/Medicaid are they going to a MCO? Some of our housing clients are getting information to sign up.

RESPONSE: See statement and links to provider notices at the beginning of this document.

33. When doing MEDI searches, the sight does not give the MCO ID number, if client does not bring in the card is there another way to the ID number in order to bill, and do we use this ID number or do we use their RIN number?

RESPONSE: MEDI does reflect the managed care plan with which the client is enrolled. If staff need help with the MEDI system, they can contact the MEDI help desk.

<https://www.illinois.gov/hfs/medicalproviders/edi/medi/Pages/default.aspx>

34. Can you explain the link to the "legacy" system? That information in IMPACT gets manually entered from IMPACT into the "legacy" system?

RESPONSE: Information from the IMPACT system is not manually entered into the Legacy system. Instead, the data is electronically transferred to the Legacy system from IMPACT once the application is approved. The data pull and file transfer take place on a weekly basis.

35. How do we get on the Expedite list?

RESPONSE: Please contact IMPACT.

<https://www.illinois.gov/hfs/impact/Pages/ContactIMPACT.aspx>

36. If there are issues with how information was entered into the legacy system from IMPACT, what is the best way to effectively get the changes made?

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RESPONSE: Providers may reach the Department at 877-782-5565 or by submitting an email request to IMPACT-Help@illinois.gov for any regarding the IMPACT or Legacy systems.

37. Which system (IMPACT or Legacy) feeds the provider file to each of the MCOs?

RESPONSE: Please see response to #30.

38. What is the timeframe from approval in IMPACT until the info shows up on the MCO provider file the state sends?

RESPONSE: Depending on the enrollment type and risk level, IMPACT applications should be approved within 15-45 days of submission. MCOs should see the provider on the extract file within one to two weeks of approval.

39. Where will the notices for DCFS children be sent? Biological parents? Agencies managing the cases? Foster parents? And then who will be responsible for choosing the plan? Or will all of these children automatically be enrolled in Illinicare as has been previously mentioned in other meetings?

RESPONSE: Information on enrollment of children receiving DCFS services is forthcoming.

40. Are all rates based on the Federally determined Medicaid rates? There is always discussion about negotiating rates, but none of the MCOs have ever been open to this.

RESPONSE: Rates are negotiated between the provider and the health plans individually.

41. Are the pay for performance only applicable to certain entities and services? We have contracts with all current MCO's and none of them have these details included. We are a community mental health center.

RESPONSE: Pay for performance (P4P) incentives in the HFS-MCO contract are between those two entities. Providers interested in value-based payments are encouraged to talk with their health plans.

42. You stated that the NAMI population is excluded from Health Choice. Does that mean that if a client has Medicare, they will not have a managed care plan?

RESPONSE: Please clarify. Is this a reference to MMAI?

43. Please define comprehensive third party insurance?

RESPONSE: Third Party Liability means that a "third party" has or may have a responsibility to pay all or part of the cost of medical care. HFS considers High level comprehensive third party insurance as insurance that covers both hospital and doctor visits.

44. If we had Molina in the past do we have to recredential?

I'm confused about the 90 day switch period. If a client wants to change does it get back dated to 4/1 or is it only effective from the date of the change. If they saw a provider who wasn't

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contracted with the MCO they were auto assigned for, would there be any way the provider would get paid?

RESPONSE: Credentialing is now done through IMPACT. Health plan switches made after a client has become active with the assigned health plan will become effective prospectively.

45. If we have a client who is moving from Medicaid to an MCO plan effective 4/1/18 do we need authorizations in place 4/1/18 or do we have the 90 day period to get these?

RESPONSE: While the 90-day continuity of care clause is in effect (see Q#11), providers should check with health plans about the need to obtain authorizations, especially those providers not in network.

46. If a client has third party as a primary and Medicaid as a secondary, will the client be enrolled in an MCO?

RESPONSE: Clients with high level third party liability are excluded from managed care.

47. Where can we find the recorded presentation?

48. For the elderly waiver, MCOs are requesting an NPI. I was under the impression that a typical IMPACT registration did not have NPIs. Is that correct?

RESPONSE: Providers of home and community based waiver services do not require an NPI. Health plans have recently been reminded of this.