Illinois Medicaid Managed Care Toolkit for School Health Centers

EverThrive Illinois
Champions for Healthy Communities

Formerly Illinois Maternal & Child Health Coalition

INDEX

INTRODUCTION

This toolkit was developed by EverThrive Illinois and the Illinois School-Based Health Alliance (ISBHA) to support Illinois school health centers (SHCs) with the transition to Medicaid managed care. The toolkit includes background information and a catalogued list of definitions, contacts, ideas, and resource links to help SHCs more readily access SHC-specific Medicaid managed care information in one place. As appropriate, we've included dates and links to original sources. Please note that much of this information is subject to change. While we will do our best to update the toolkit, wherever we provide a link to a source, we recommend that you take the time to verify.

This toolkit is part of a larger policy collaborative effort, sponsored by the national School Based Health Alliance, seeking to ensure that SHCs are integrated into new and emerging financial models. We thank the national School-Based Health Alliance for their support for this project. We also thank our partners at the Illinois Department of Healthcare and Family Services, the Illinois Department of Public Health, the ISBHA's Steering Committee members, the various health plans and the Illinois Association of Medicaid Health Plans for their feedback.

BACKGROUND

Following the State's Medicaid reform law and the federal Affordable Care Act, the Illinois Department of Healthcare and Family Services (HFS) transitioned over 2 million participants into managed care health plans. They concentrated their efforts in five mandatory managed care regions: Rockford, Central Illinois, Metro East, Quad Cities, and Greater Chicago (Cook and Collar Counties). In these regions, HFS contracted with private health plans to manage the care of Medicaid patients to improve quality of care and control cost.

For Medicaid enrollees, this shift meant that instead of accessing care from any provider accepting Medicaid, they now had to choose a managed care health plan. Each health plan has a network of providers that enrollees can then access.

For Medicaid providers, this shift meant that providers now needed to begin to integrate themselves into the various managed care health plan networks. SHCs are an integral part of the State's healthcare safety net and this transition to managed care has had significant operational and business implications for them. While historically, SHCs have been able to bill HFS directly for services rendered to Medicaid patients, with this shift, all SHCs located in mandatory managed care regions have had to change their insurance verification, care coordination, and billing practices to work directly with the various managed care health plans serving their regions.

The subsequent sections outline definitions and helpful information as SHCs continue to integrate themselves into the Medicaid managed care landscape.

DEFINITIONS

Managed Care Entities (MCEs) are health insurance plans that seek to control cost and improve quality of care. In Illinois there are four different types of MCEs: Accountable Care Entity (ACE), Care Coordination Entity (CCE), Managed Care Organization (MCO), and Managed Care Community Network (MCCN).

Accountable Care Entity (ACE): ACEs are provider-based organizations that coordinate care for their Medicaid enrollees. Providers bill the Illinois Department of Healthcare and Family Services (HFS) for Medicaid covered services. ACEs are transitioning their memberships to partner MCOs or MCCNs, with all transitions being completed by July 1, 2016.

Care Coordination Entity (CCE): CCEs are provider-based organizations that coordinate care for their Medicaid enrollees. Providers bill the Illinois Department of Healthcare and Family Services (HFS) for Medicaid covered services. CCEs are transitioning their memberships to partner MCOs or MCCNs, with all transitions being completed by July 1, 2016.

Managed Care Organization (MCO): A Managed Care Organization (MCO) is a traditional insurance-based Health Maintenance Organization paid on a full-risk capitated basis to cover almost all Medicaid services. Providers bill MCO's directly for enrollee services.

Managed Care Community Network (MCCN): A provider-owned and governed entity that operates like MCOs on a full-risk capitated basis. Providers bill MCCN's directly for enrollee services.

HFS CONTRACTING & REIMBURSEMENT EXPECTATIONS

What expectations does HFS have of SHCs and Medicaid managed care health plans with regards to contracting and reimbursement?

Medicaid managed care health plans will continue to reimburse SHCs for services rendered to their members, irrespective of contracting status, until **September 30th, 2016**.

Effective **October 1st, 2016**, SHCs without a contract are not guaranteed payment by health plans for services rendered to their members.

If the contract has not been executed as a result of delays on the health plan's part, SHCs should inform representatives from IDPH and the ISBHA. Type 56 SHCs encountering unique challenges should also keep IDPH and ISBHA representatives abreast of issues. IDPH and the ISBHA will elevate issues to HFS and health plans as needed.

After October 1st 2016, all newly certified SHCs will receive a 3-month contracting grace period, effective their certification date.

CONTRACT LANGUAGE BETWEEN HFS AND MEDICAID MANAGED CARE HEALTH PLANS

What does the contract language between HFS and Medicaid managed care health plans state?

HFS has established explicit contracting and billing expectations in their contract language with Medicaid managed care health plans. Their contract reads:

> **5.11.1 School-Based Health Centers.** Contractor shall offer contracts to all of the school health centers recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a referral as a condition of payment for school health center services. Contractor shall accept claims from non-Affiliated Providers of school health center services outside of its Contracting Area. Contractor shall make payment to non-Affiliated Providers of such services according to the Department's applicable Medicaid fee-for-service reimbursement schedule. Contractor may require school health centers to follow Contractor's protocols for communication regarding services.

PRIOR AUTHORIZATION

Do SHCs have to have prior authorization from a student's PCP to receive reimbursement?

Per HFS' contract language, health plans will not require prior authorization from contracted SHCs:

> **Contractor shall not require prior authorization or a referral as a condition of payment for school health center services.**

BILLING BY SITE

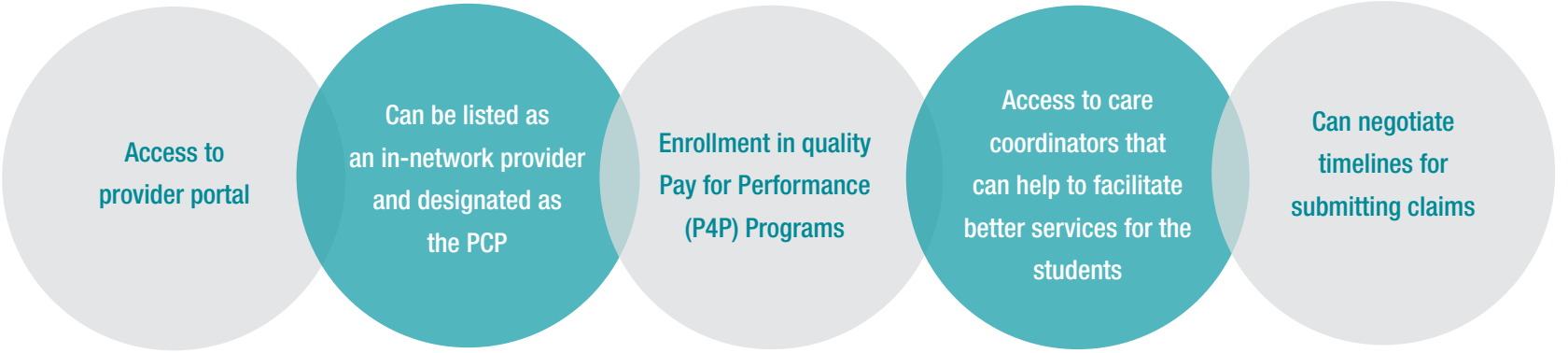
Do SHCs have to bill by individual provider or can they continue to bill by site (i.e. facility) as they've historically done with HFS?

Contracted SHCs may bill Medicaid managed care health plans by site. HFS has determined that they are not required to bill by individual provider.

BENEFITS OF CONTRACTING

Beyond reimbursement for services rendered, why should SHCs contract with Medicaid managed care health plans?

Contracting is the first step to strengthening relationships with health plans and furthering care coordination for SHC patients.



1. Access to provider portal

Contracting gives you access to more information. Health plans typically have a provider portal. This portal provides additional member information that only those providers contracted directly with the plan can access. Health plans have a lot of clinical and quality data that they can share with their providers to assist with patient care. In addition, you will typically be assigned a provider relations representative who acts as your liaison to work out issues or concerns directly.

2. Can be listed as an in-network provider and designated as the PCP

Health plans list their in-network providers on their promotional materials, including their website. Being listed as an in-network provider enhances SHC visibility and may help minimize members' concerns over whether services rendered at the SHC will be covered by their insurance. Contracting will ensure that you can continue to see your current patients without interruption and be assigned as their PCP. In addition, being designated as a PCP furthers a SHCs ability to bill for services rendered.

BENEFITS OF CONTRACTING

CONTINUED

3. Enrollment in quality Pay for Performance (P4P) Programs

Contracting may enable you to secure more payments. Medicaid is shifting away from the traditional fee-for-service model. Health plans are bearing full risk for their members and are financially incentivized to meet quality benchmarks. As such, health plans are able and eager to develop quality P4P programs with their contracted providers. A quality P4P program sets forth quality metrics that providers must meet in order to qualify for incentive or bonus payments.

4. Access to care coordinators that can help to facilitate better services for the students (e.g. transportation, specialists, etc.)

Contracting improves care coordination. Health plans want to ensure that members have access to non-medical and specialist services that impact health outcomes. To this end, they offer care coordination services that can help remove barriers and connect members to services. As a contracted provider, you are able to access care coordinators and connect students to additional services. Health plan care coordinators offer an added layer of support and resources for your patients.

5. Can negotiate timelines for submitting claims

As you develop a contract with a health plan, you are able to negotiate the terms of your contract. That includes, negotiating the timelines for submitting and re-submitting claims. As a non-contracted provider, you must adhere to the health plan's standard non-affiliated provider timelines and will only get paid the minimum non-participating payment schedule.

MAP OF MANAGED CARE ENTITY (MCE) SERVICE AREAS

The Illinois Department of Healthcare and Family Services (HFS) has released a Care Coordination Map that outlines which MCEs are providing care in each region of Illinois:
http://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf

The below table also provides information as of April 2016:

Medicaid Health Plan	Operating in the following Regions under the Family Health Plan (FHP) Program
1 Aetna Better Health	Greater Chicago and Rockford
2 Blue Cross/Blue Shield	Greater Chicago
3 CountyCare	Greater Chicago Cook County only
4 Family Health Network	Greater Chicago
5 Harmony	Greater Chicago and Metro East and the following 5 Illinois counties: Jackson, Perry, Randolph, Washington, Williamson
6 Health Alliance	Central Illinois, Quad Cities, Rockford
7 IlliniCare	Greater Chicago, Rockford, Quad Cities
8 Meridian	Greater Chicago, Central Illinois (Stark, Knox, Peoria, Tazewell and McLean counties only), Metro East, Quad Cities, Rockford, and the following 10 Illinois counties: Adams, Brown, DeKalb, Henderson, Lee, Livingston, Pike, Scott, Warren, Woodford
9 Molina	Greater Chicago (Cook County only), Central Illinois, Metro East
10 Next Level	Greater Chicago (Cook County only)

Please note: 3 health plans contract with HFS for other care coordination programs and do not participate in Family Health Plan (FHP) - and therefore are not required to follow the SHC established criteria: Humana, CIGNA/HealthSpring, and Community Care Alliance of Illinois.

LIST OF DENTAL AND VISION VENDORS FOR EACH MANAGED CARE ENTITY (MCE):

Medicaid Health Plan	Dental Vendor	Vision Vendor
1 Aetna Better Health	DentaQuest	March Vision
2 Blue Cross/Blue Shield	DentaQuest	Davis Vision
3 CountyCare	DentaQuest	OptiCare Vision EyeQuest
4 Family Health Network	DentaQuest	National Vision Administrators VisionQuest
5 Harmony	Liberty	Premiere Vision
6 Health Alliance	DentaQuest	*Currently provided through the health plan*
7 IlliniCare	DentaQuest	OptiCare Vision
8 Meridian	Liberty	Classic Optical
9 Molina	Avesis	March Vision
10 Next Level	*Currently provided through the health plan*	OptiCare Vision

THE FOLLOWING IS A LIST OF PROVIDER REPRESENTATIVES FOR MANAGED CARE ORGANIZATIONS (MCOS)* AND MANAGED CARE COMMUNITY NETWORKS (MCCNS)**:

Please note, the below information is subject to change. To ensure you have the most up to date contact information, please consult the Managed Care Entity (MCE) webpage.

The following Medicaid health plans operate under the Family Health Plan (FHP) Program and are contracting with SHCs. The health plans have identified the following dedicated contacts to assist SHCs with contracting and billing processes. We have also provided general provider services contact information for each health plan:

1 Aetna Better Health*

a. Michelle Mittleman-Horner
Director, Network Management
e: Mittleman-HornerM@aetna.com
p: 312-821-0604

b. Provider Services:
866-212-2851, press 2

2 BlueCross BlueShield of Illinois*

a. Tishika Townsend
Director, Government Programs
e: tishika_townsend@bcbsil.com
p: 312-653-4915 (office)
p: 312-218-8002 (cell)
f: 312-729-8726 (fax)

b. Provider Services:
888-657-1211, language choice, press 1

3 CountyCare**

a. Jeanne Klein
Manager Provider Relations
e: jklein2@cookcountyhhs.org
p: 312-864-0947

b. Provider Services:
312-864-8200, press 3

4 Family Health Network**

a. Marcia Moore
Senior Manager, Contracting
e: mmoore@myfhn.com
p: 312-605-9851

b. Provider Services:
888-346-4968, press 5

5 Harmony Health Plan*

a. Karen Amazigo
e: Karen.Amazigo@wellcare.com
p: 312-516-4941
f: 312-630-2022 (fax)

b. Provider Services:
800-608-8158, press 2

6 Health Alliance Medical Plan*

a. Maxine Wallner
Director of Provider Networking
e: Maxine.Wallner@healthalliance.org
p: 217-337-8117

b. Provider Services:
800-851-3379, press 3

Beginning on 12/31/16 Health Alliance will no longer participate in the Medicaid Managed Care Family Health Plan (FHP).

7 IlliniCare Health Plan*

a. Dave Hepp
Director of Provider Contracting
e: martin.d.hepp@Illinicare.com
p: 312-260-5472
f: 855-254-1792

b. Provider Services:
866-329-4701, say "provider"

8 Meridian Health Plan of Illinois*

a. Derek Punzalan
Director of Network Development
e: Derek.Punzalan@mhplan.com
p: 312-980-2371

b. Provider Services:
866-606-3700, press 2

c. Provider Services:
888-773-2647, press 2

THE FOLLOWING IS A LIST OF PROVIDER REPRESENTATIVES FOR MANAGED CARE ORGANIZATIONS (MCOS)* AND MANAGED CARE COMMUNITY NETWORKS (MCCNS)**:

CONTINUED

9 Molina Healthcare*

a. Tracy Pacheco
Director Provider Services
e: tracy.pacheco@MolinaHealthCare.com
p: 630-203-3949

b. Michael Manade
Director, Provider Contracting
e: michael.manade@molinahealthcare.com
p: 630-203-3900 x 162201

c. Provider Services:
855-766-5462, press 1

d. Provider Services:
855-866-5462

10 NextLevel Health**

a. Michelle Gilliam
Director of Provider Services
e: Michelle.gilliam@nlhpartners.com
p: 773-657-8362

b. Provider Services:
844-807-9734, language choice, then press 2 for provider services

The following three health plans contract with HFS for other care coordination programs, but do not currently participate in Family Health Plan (FHP) Program. Therefore, they are not required to follow the established SHC contracting criteria and are not offering contracts to SHCs:

1 Cigna HealthSpring of Illinois*

a. 866-487-4331, press language choice, then 3

b. 866-486-6065

2 Community Care Alliance of Illinois**

a. 866-871-2305, press 5

3 Humana Health Plan*

a. 800-626-2741

THE FOLLOWING IS A LIST OF PROVIDER REPRESENTATIVES FOR ACCOUNTABLE CARE ENTITIES (ACES)* OR CARE COORDINATION ENTITIES (CCES)** THAT ARE TRANSITIONING TO MANAGED CARE ORGANIZATIONS (MCOS) OR MANAGED CARE COMMUNITY NETWORKS (MCCNS) (SEE APPENDIX A):

All ACEs and CCEs will transition their membership to partner MCOs or MCCNs by July 1, 2016. After ACE and CCE members transition to MCOs or MCCNs, providers must bill the MCO or MCCN directly in order to receive payments. There is additional contact information in the HFS notice for individuals with questions regarding the transitions.

The list below outlines the remaining ACEs and CCEs in Illinois, the MCO or MCCN that they are transitioning to, and the date of transition. If the ACE or CCE has already transitioned, please reference the above MCO/MCCN contact information for provider representative information.

Please note, due to the upcoming transitions, the below information is subject to change frequently. To ensure you have the most up to date contact information, please consult the MCE webpage.

4 Advocate Accountable Care* Transition Partner and Date TBA a. 800-3-ADVOCATE (23862283) b. 855-260-0996	**5 Be Well Partners in Health**** Transitioning to Cigna Healthspring of Illinois; Date TBA a. 866-537-9695	**6 Better Health Network*** Transitioning to Molina Healthcare; Date TBA a. 844-410-CARE (2273)	**7 Community Care Partners*** Transitioning partner and date TBA a. 888-977-2447, press 3
8 HealthCura* Transitioned to BlueCross BlueShield of Illinois on 12/1/2015	**9 Illinois Partnership for Health*** Transitioned to Health Alliance on 11/1/2015	**10 Loyola Family Care*** Transitioned to Molina Healthcare on 1/1/2016	**11 Lurie Children's Hospital of Chicago**** Transitioned to multiple MCOs
12 MyCare Chicago * Transitioned to Molina Healthcare on 1/1/2016	**13 Next Level Health Illinois**** Transitioned to NextLevel Health (MCCN) on 1/1/2016	**14 Precedence Care Coordination**** Transitioning to Health Alliance; Date TBA a. 855-342-0996 b. 309-779-3066	**15 SmartPlan Choice*** Transition Partner and Date TBA a. 844-254-CARE (2273)
16 Together4Health** Transitioned to multiple MCOs	**17 UI Health Plus*** Transitioned to BlueCross BlueShield of Illinois on 1/1/2016		

LINK TO HFS PROVIDER HANDBOOKS

The following is a link to the Illinois Department of Healthcare and Family Services (HFS) website where you can find the HFS Handbooks for Providers of Medical Services:
http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx

The following is a link to the Illinois Department of Healthcare and Family Services (HFS) Managed Care Manual for Medical Providers:
http://www.illinois.gov/hfs/SiteCollectionDocuments/MCOManual.pdf

LINK OF HFS PROVIDER NOTICES

The Illinois Department of Healthcare and Family Services (HFS) releases Provider Notices that contain important information for providers of medical services and for those seeking reimbursement from billing claims. Relevant Provider Notices that have been released during 2016 are listed in the Appendix. To view all previously released HFS Provider Notices and to subscribe to receive email notifications of future notices, visit HFS' website:
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx.

LIST OF STANDARD TIMELINES FOR BILLING MCES

How quickly should I bill to ensure reimbursement? Will my claims "time-out"?

The following are standard claim submission timelines when not contracted with a Managed Care Entity (MCE), which usually fall between 90 and 180 days. If you do have a contract, your contract is the best place to find your specific billing timeline. Please note, some MCEs distinguish between the number of days the provider has for the initial claim submission and subsequent re-submissions, should the claim be rejected. If for whatever reason your claim is rejected and you are in the process of re-submitting or re-negotiating, the initial claim submission timeline does not apply. Instead, an MCE may outline additional timeline requirements for handling re-submissions. If the MCE does not explicitly provide a timeline for re-submissions, please contact the MCEs designated SHC representative or general provider representative for more information. Finally, the information outlined below is subject to change. This summary is meant to provide a general overview. To ensure you have the most up to date timelines, please consult the MCE webpage.

The following is a list of standard billing timelines for Managed Care Organizations (MCOs)* and Managed Care Community Networks (MCCNs):**

1 **Aetna Better Health***

a. New Claim Submissions– Claims must be filed on a valid claim form within 90 days from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.

b. Claim Resubmission – Claim resubmissions must be filed within 180 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

*Information from the Aetna Better Health Integrated Care Program/Family Health Plan Provider Handbook, accessed January 6, 2016.

The following is a list of standard billing timelines for Managed Care Organizations (MCOs)* and Managed Care Community Networks (MCCNs)**:

Continued

2 Blue Cross/Blue Shield of Illinois*

a. Providers are required to submit all claims eligible for reimbursement within 180 days from the date of service. FHP may, at its sole discretion, deny payment for any such fee for service claim(s) received after 180 days from the date of service.

*Information from BCBS Community Family Health Plan Provider Manual, accessed May 6, 2016. This manual is password protected; contracted providers receive a password from BCBS for access.

3 CountyCare**

a. Original claims must be submitted to CountyCare Health Plan within 180 calendar days from the date services were rendered or compensable items were provided. All corrected claims, requests for reconsideration or claim disputes must be received within 365 calendar days from the date of notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 365 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:
   - Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
   - Mechanical or administrative delays or errors byCountyCare Health Plan or the Illinois Department of Health and Family Services (HFS).

*Information from CountyCare Health Plan Billing Manual, accessed January 6, 2016.

4 Family Health Network**

a. Unless otherwise stated in the provider agreement, providers must submit their claims within one hundred and twenty (120) days of the date of service or discharge date or ninety (90) days from the primary insurance payment date, whichever is later.

*Information from Practitioner and Provider Manual, accessed May 6, 2016.

5 Harmony Health Plan*

a. Unless otherwise stated in the Agreement, the Provider must submit claims (initial, corrected and voided) within three (3) months from the date of outpatient service or discharge date or three (3) months from the primary insurance payment date (whichever is later).

*Information from Harmony Medicaid Provider Manual, accessed January 6, 2016.

The following is a list of standard billing timelines for Managed Care Organizations (MCOs)* and Managed Care Community Networks (MCCNs):**

Continued

6 Health Alliance Medical Plan*

a. Health Alliance requires claims to be submitted within 90 calendar days of the date of service. Exceptunder rare circumstances, Health Alliance processes all claims within 30 days of receipt. If you have not received a payment or communication from Health Alliance for a claim within 45 days after the date of submission, please follow up with our Customer Service Department to verify the claim's status.

b. If you receive notification that we require more documentation for a claim, you must follow up with Health Alliance within 45 days from the date of the notification or the claim will be denied.

*Information from Health Alliance Medicaid Provider Manual, accessed January 6, 2016.

7 IlliniCare Health Plan*

a. Original claims must be submitted to IlliniCare Health within 180 calendar days from the date services were rendered or compensable items were provided. The filing limit may be extended where the eligibility has been retroactively received by IlliniCare Health up to a maximum of 180 calendar days. When IlliniCare Health is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

b. All corrected claims, requests for reconsideration or claim disputes must be received within 45 calendar days from the date of notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 45 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance.

*Information from IlliniCare Health Billing Manual, accessed January 6, 2016.

8 Meridian Health Plan of Illinois*

a. Providers have 365 days from the date of service to submit a claim. A claim can be resubmitted or adjusted so long as it is submitted within 365 days from the last date of adjudication. If a claim is submitted for a second time and denied within that year, providers have up to one year from the last adjudication date to make corrections, however it cannot exceed two years from the date of service. No claim will be paid past two years from the date of service.

b. There are two exceptions to the timely filing guideline, which include:
   - Retroactive eligibility: These claims must be accompanied by a Notice of Decision and received within 365 days of the notice date and reimbursed under a retrospective payment system
   - Third-party related delays: These claims must be accompanied by a third-party liability (TPL) explanation of benefits and also received within 365 days of the TPL process date

*Information from Meridian Health Plan Provider Claims Manual, accessed January 6, 2016.

The following is a list of standard billing timelines for Managed Care Organizations (MCOs)* and Managed Care Community Networks (MCCNs)**:

Continued

9 Molina Healthcare*

a. Providers must submit claims to Molina Healthcare within 180 calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits, provider must submit claims to Molina Healthcare within 90 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Molina Health care within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.

*Information from Molina Healthcare Medicaid Provider Manual, accessed January 6, 2016.

10 NextLevel Health**

Providers must submit all claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by NextLevel Health up to a maximum of 180 days. All claim requests for reconsideration, corrected claims or claim disputes must be received within 180 calendar days from the date of notification of payment or denial is issued.

*Information from NextLevel Health Provider Manual, accessed March 25, 2016.

The following is a list of Accountable Care Entities (ACEs)* and Community Care Entities (CCEs)** that may continue to have enrollees until July 1, 2016:

11 Advocate Accountable Care*

12 Be Well Partners in Health**

13 Better Health Network*

14 Community Care Partners*

15 Precedence Care Coordination**

16 SmartPlan Choice*

In this case, providers bill the Illinois Department of Healthcare and Family Services (HFS) directly. HFS' policy on standard billing timelines is as follows:

a. A claim will be considered for payment only if it is received by the department no later than 180 days from the date on which services or items are provided. This time limit applies to both initial and resubmitted claims. Re-billed claims, as well as initial claims, received more than 180 days from the date of service will not be paid.

*Information from HFS Informational Notice, Dated July 23, 2012, accessed January 6, 2016.

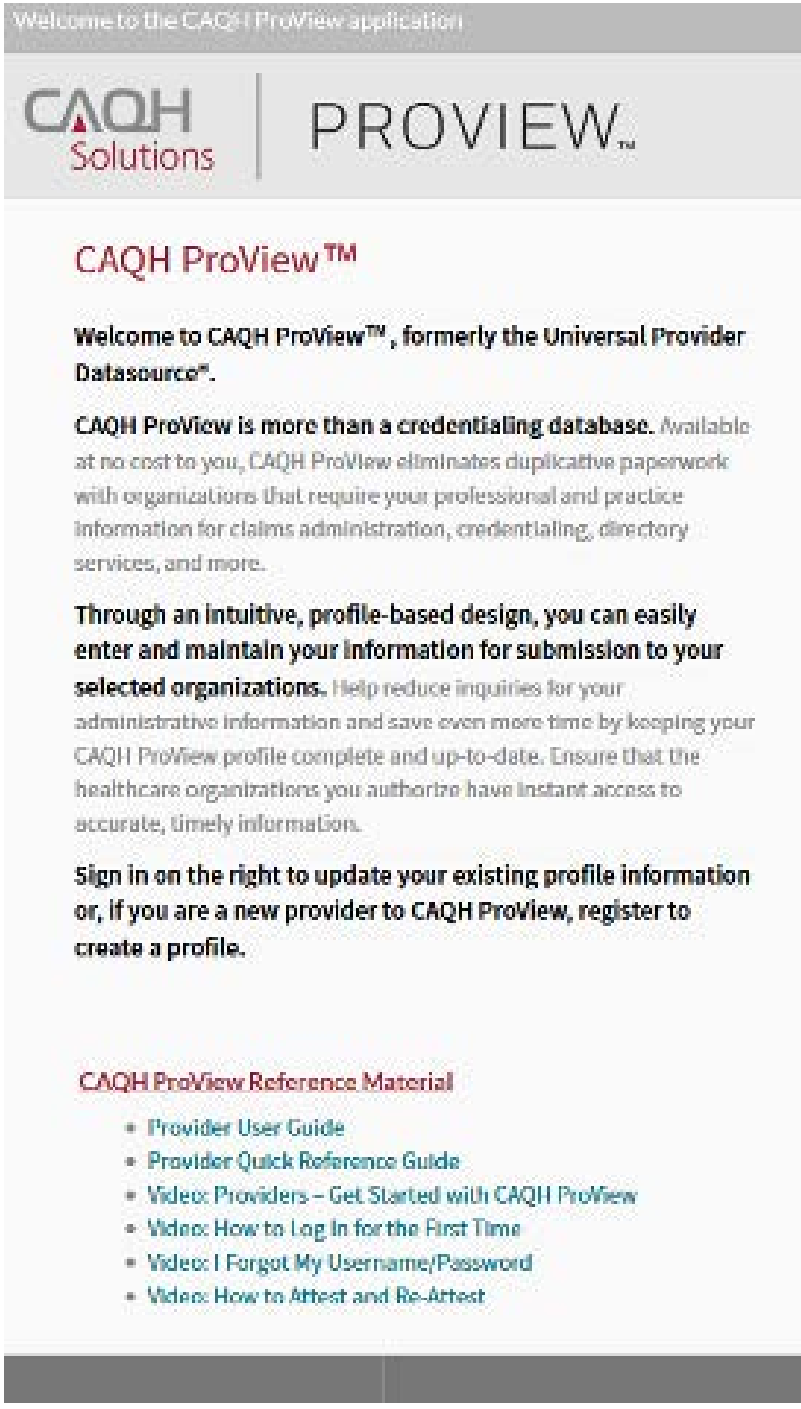
Please Note: After the ACE or CCE has transitioned to an MCO or MCCN, providers will need to bill the MCO or MCCN directly in order to receive payments.

PROVIDER CREDENTIALING DATABASE: CAQH PROVIEW

One aspect that has proved time consuming for many school health centers (SHCs) when contracting with Medicaid health plans is the credentialing process for providers.

CAQH ProView simplifies this process by streamlining the electronic data collection of provider data used in credentialing, free-of-charge to health care providers. After the data (education, training, licensing, etc.) is entered into the CAQH ProView system by providers, it can be authorized to be shared with and accessed by multiple Medicaid health plans. The result is the submission of one standard credentialing application to a single source instead of individual credentialing applications for each health plan, saving time and paperwork.

For more information on CAQH Proview and to register online, visit their webpage: http://proview.caqh.org/pr



SITE VISIT AND MARKETING POWERPOINT

It is always a great idea to market your SHC to managed care health plans. Whether you have no relationship with a particular health plan or are simply looking to strengthen an existing relationship, we recommend that you schedule a site visit with representatives from the health plan. Consider preparing for and scheduling time for the following activities:

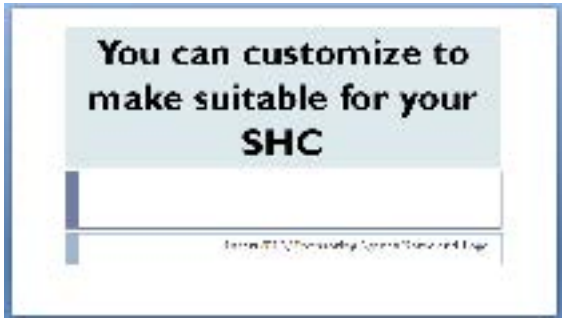
- Facility tour
- Meetings with key organizational leaders and staff
- With appropriate consents and planning, meetings with student users, school partners, community champions
- Presentation of marketing PowerPoint (sample PPTs included)

If you are unable to schedule a site visit to present your PowerPoint in person, email it. While seeing the SHC in action may be most impactful, sending them a nicely developed PowerPoint will still help paint a clearer picture of what distinguishes your SHC as a provider.

Below are two sample marketing PowerPoints developed by Insuring Sources, Inc. through an individual technical assistance opportunity provided to two local SHCs, Kankakee SHCs and Rush SHCs. We have also developed a PowerPoint template that SHCs can use as a starting point for their own marketing PowerPoint.

Kankakee SHCs

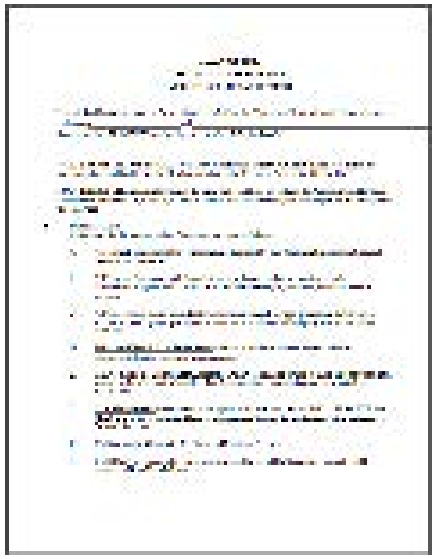
Rush SHCs



Fill-In Template

SAMPLE CONTRACT LANGUAGE

Below are two sample contracts drafted by two different health plans accompanied by a sample review of each contract. These contracts and review documents have been de-identified and are meant to help give SHCs a general sense for standard contracts and their interpretation.



Sample Contract 1

Review of Sample Contract 1

Sample Contract 2

Review of Sample Contract 2

OPPORTUNITIES

Medicaid managed care health plans are interested in collaborating with SHCs to improve health outcomes for children and adolescents. Since they are expected to meet quality metrics (e.g. HEDIS), they are particularly interested in partnering with providers that can meet and exceed these metrics. They understand that SHCs are especially well positioned to address the needs of children and adolescents and help them exceed these quality metrics. Therefore, your ability to show your outcomes using data is critical.

They are also interested in innovation that helps improve long-term health outcomes and reduce healthcare costs. In many ways, SHCs serve as early examples of innovators in care coordination and comprehensive healthcare within the larger healthcare system. As the relationship between Medicaid health plans and SHCs continues to evolve from focusing on discrete operational issues to envisioning, planning for, and implementing new models of care, SHCs are in a position to secure additional resources. For example, health plans want to understand how they can support you in increasing access to behavioral health and other services that impact social determinants of health and traditional Medicaid has historically not been able to reimburse. To this end, the Illinois School-Based Health Alliance has launched a Behavioral Health Workgroup that is working on identifying challenges and opportunities related to financing behavioral health services in SHCs. We encourage interested SHC staff to contact us at CAHI@everthriveil.org. This is just one example of the type of opportunities that lie ahead. We encourage SHCs to continue moving these conversations forward in your interactions with health plans and also partner with us to innovate and drive quality for children and adolescents throughout Illinois.

APPENDIX - 2016 HFS PROVIDER NOTICES

Appendix A

HFS Provider Notice issued 01/04/16: Care Coordination Health Plan Transitions for Medicaid Participants in ACEs and CCEs
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160104a.aspx

Appendix B

HFS Provider Notice issued 01/19/2016: Managed Care Manual
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160119a.aspx

Appendix C

HFS Provider Notice issued 03/15/2016: IMPACT Provider Revalidation-Due Date Extensions
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160315a.aspx

Appendix D

HFS Provider Notice issued 03/18/2016: Publication of Notices on Healthcare and Family Services (HFS) Website
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160318b.aspx

Appendix E

HFS Provider Notice issued 04/29/2016: Coding for Emergency Contraceptive Pills (ECPs).
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160429a.aspx

Appendix F

HFS Provider Notice Issued 05/04/2016: New Guide – How to Get a Medical Card and a Primary Care Provider (PCP) for Your Baby
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160504a.aspx

Appendix G

HFS Provider Notice Issued 05/13/2016: Illinois Medicaid Program Advanced Cloud Technology (IMPACT) Provider Type Selections
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513a.aspx