

Illinois Medicaid Managed Care Toolkit for School-Based Health Centers



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INTRODUCTION

This toolkit was developed by EverThrive Illinois to support Illinois school-based health centers (SBHCs) with the transition to Medicaid managed care. The original toolkit was released in 2016, and this updated version was released in the spring of 2019. This updated version contains additional information that reflects the recent changes we've seen to the Medicaid managed care landscape in Illinois. The toolkit includes background information and a cataloged list of definitions, contacts, ideas, and resource links to help SBHCs more readily access SBHC-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 originated from a larger policy collaborative effort, sponsored by the national School-Based Health Alliance, seeking to ensure that SBHCs across the nation 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 Illinois School-Based Health Alliance (ISBHA) Steering Committee members, the various health plans, the Illinois Association of Medicaid Health Plans, and, of course, SBHCs across Illinois 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 in 2015. 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.

As of January 1, 2018, Illinois expanded their Medicaid managed care program to cover all counties in Illinois. With this expansion, HFS changed the name of their Medicaid managed care program to HealthChoice Illinois. HealthChoice Illinois is now mandatory in all Illinois counties. The goal of the new program was to reduce the number of Medicaid managed care plans in Illinois, expand Medicaid to the entire state, and relieve administrative burden on providers. Instead of the 12 Medicaid managed care health plans that existed in 2015, there are now four Medicaid managed care health plans statewide, with two additional health plans that serve Cook County only. Additionally, due to the statewide expansion, HealthChoice Illinois will reach approximately 80% of Medicaid enrollees in the State.

For Medicaid enrollees, the shift to managed care 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.

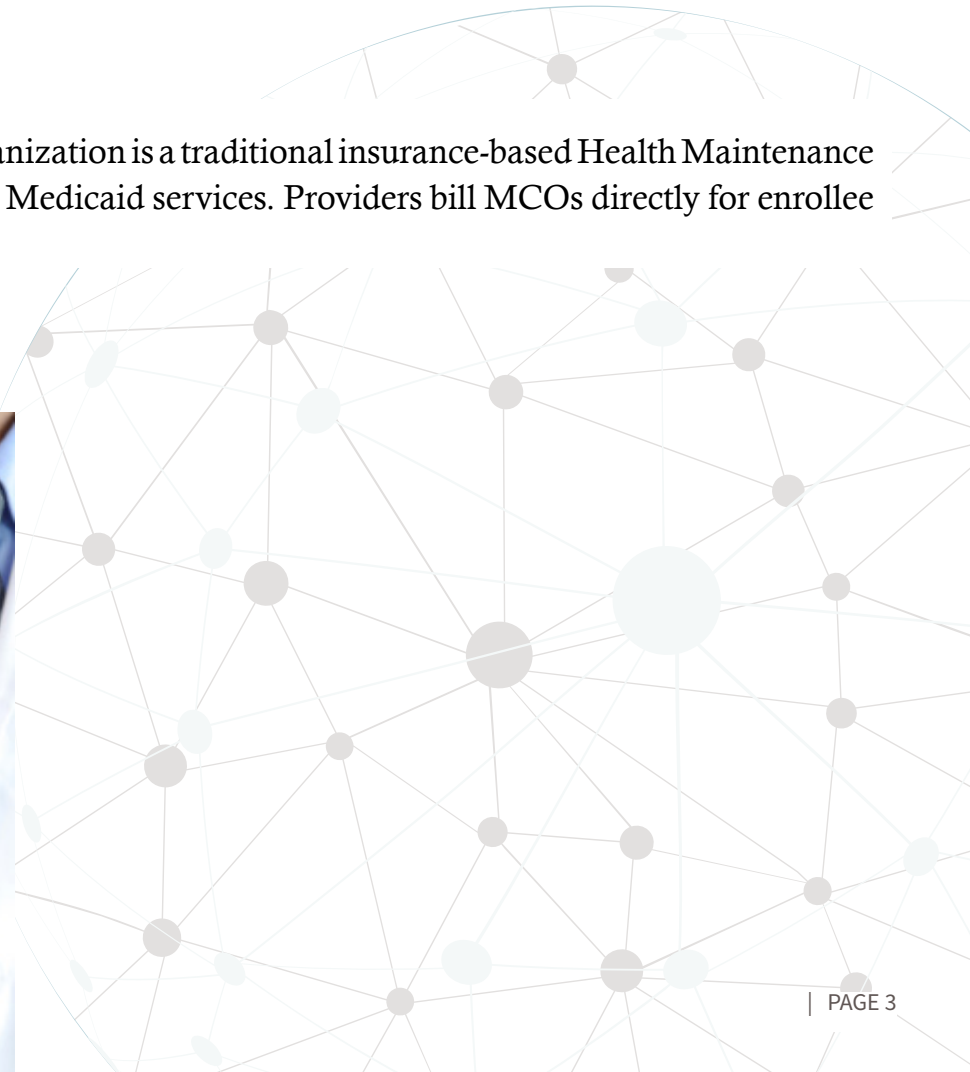
For Medicaid providers, this shift meant that providers now needed to integrate themselves into the various managed care health plan networks. SBHCs are an integral part of the State's health care safety net and this transition to managed care has had significant operational and business implications. Before the shift to Medicaid managed care, SBHCs billed HFS directly for services rendered to Medicaid patients. With this shift, all SBHCs 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 SBHCs continue to integrate themselves into the Medicaid managed care landscape.

DEFINITIONS

Managed Care Entities (MCEs): Managed Care Entities are health insurance plans that seek to control cost and improve quality of care. There used to be multiple types of MCEs in Illinois, but there is now only one main type of MCE: Managed Care Organizations (MCOs).

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



CONTRACTING

HFS CONTRACTING & REIMBURSEMENT EXPECTATIONS

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

While SBHCs are free to choose which health plans to contract with, effective October 1, 2016, SBHCs not contracted with Medicaid managed care health plans are not guaranteed payment for services rendered to their members.

After October 1, 2016, all newly certified SBHCs will receive a 3-month contracting grace period, effective on their certification date. SBHCs seeking certification are encouraged to start the contracting process early so that the center is well positioned to receive payments when the clinic opens to patients.



CONTRACT LANGUAGE BETWEEN HFS & MEDICAID MANAGED CARE HEALTH PLANS

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

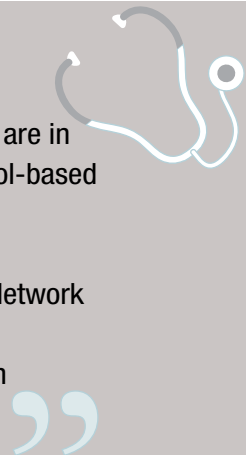
HFS has established explicit contracting and billing expectations in their model contract language with Medicaid managed care health plans. Each plan negotiates their contract with HFS, though contract language is not understood to be drastically different, and most health plans agree to the model contract language. The information on SBHCs in the model contract reads:



5.20.2.1 School-based health centers.

5.20.2.1.1 Contractor shall offer contracts to all 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-based health center services provided by those school-based health centers with which Contractor has contracts.

5.20.2.1.2 For Illinois school-based health centers outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of school-based health center services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require school-based health centers to follow Contractor's protocols for communication regarding services rendered in order to further care coordination.



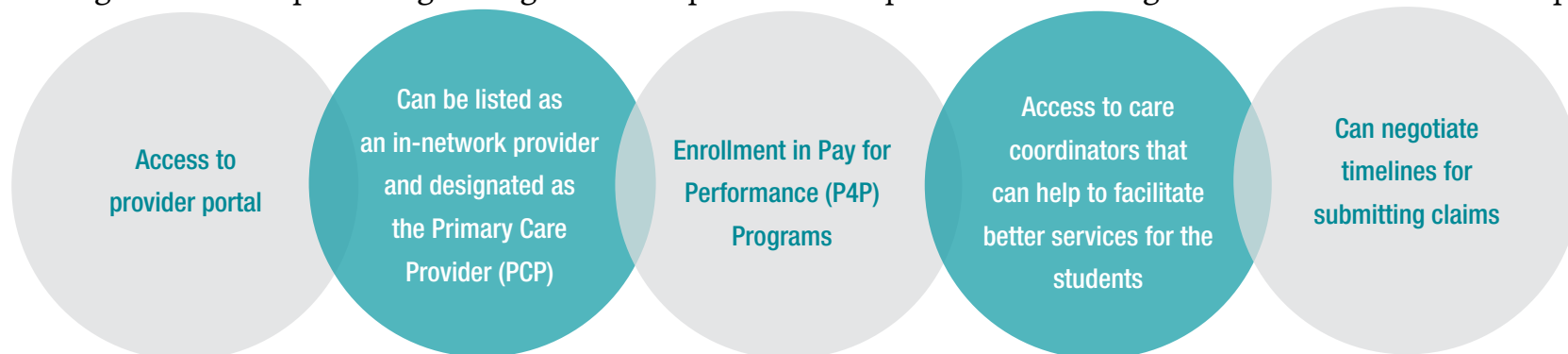
For the most up to date model contract language, [please visit HFS' Care Coordination webpage](#) and select "Model Contract" on the right-hand panel.

[2018 Model Contract Language](#)

BENEFITS OF CONTRACTING

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

Contracting is the first step to strengthening relationships with health plans and furthering care coordination for SBHC 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 SBHC visibility and may help minimize members' concerns over whether services rendered at the SBHC 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 Primary Care Provider (PCP). In addition, being designated as a PCP furthers a SBHC's ability to bill for services rendered.

BENEFITS OF CONTRACTING

CONTINUED

3. Enrollment in 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 P4P programs with their contracted providers. A 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 can negotiate the terms of your contract. That includes negotiating the timelines for submitting and re-submitting claims.

During the 3-month contracting grace period for newly established SBHCs, 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. After the grace period, SBHCs are not guaranteed payment for timely claims when no contract is in place.

PRIOR AUTHORIZATION

Do SBHCs have to have prior authorization from a student's Primary Care Provider (PCP) to receive reimbursement?

Per HFS' contract language, health plans will not require prior authorization from **contracted** SBHCs: "Contractor shall not require prior authorization or a referral as a condition of payment for school health center services." There is no age restriction in the model contract language related to prior authorization for SBHCs.

BILLING BY SITE

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

EXPLANATION OF BENEFITS (EOB) INFORMATION

An Explanation of Benefits, or EOB, is a written statement sent by a health insurance company or MCO to their members explaining what medical treatments and/or services were paid for on their behalf. According to two state laws, Medicaid MCOs are required to protect patient confidentiality for sensitive services by not sharing information about a patient's use of these services unless specifically requested by the patient. This means that an EOB document or any other written or electronic communication will not be sent to the patient, their relatives, or their household members when that patient is provided a sensitive service, UNLESS requested by that patient.

Who do these laws apply to?

These laws apply to all MCO patients, including minors. These laws do not impact MCO communications with subcontractors or providers and do not apply to private health insurers.

What services qualify as “sensitive services”?

Sensitive services include any service related to mental health, reproductive health, family planning, sexually transmitted infections or sexually transmitted diseases (STI/STD), domestic violence, sexual assault, or substance use.

How do providers bill MCOs for sensitive services?

SBHC providers bill for sensitive services the same way they bill for all other services. It is the MCO's responsibility to ensure that EOBs are suppressed for sensitive services, not the providers. HFS and the MCOs worked together to establish a list of specific billing codes that are categorized as sensitive to ensure patient confidentiality while allowing providers to continue billing for sensitive services.

EXPLANATION OF BENEFITS (EOB) INFORMATION

CONTINUED

Does this apply to online portals?

Electronic communications are included under this law, and sensitive service information should not be shared with anyone other than the patient through electronic portals.

Further questions?

For questions regarding internal protocols to protect the privacy of this information or to review the list of specific billing codes that qualify as sensitive health services, contact the specific health plan.

If an EOB was accidentally sent that included sensitive service information, please contact the specific health plan.

[Read the law 305 ILCS 5/5-30\(i\)](#)



HEALTH PLAN INFORMATION

MAP OF MANAGED CARE ORGANIZATION (MCO) SERVICE AREAS

The Illinois Department of Healthcare and Family Services (HFS) has released [this Care Coordination Map that outlines which MCOs are providing care in each region of Illinois.](#)

The below table also provides information as of May 2019:

Medicaid Health Plan	Operating in the following regions under the Family Health Plan (FHP) Program
1 Blue Cross/Blue Shield	Statewide
2 IlliniCare	Statewide
3 Meridian	Statewide
4 Molina	Statewide
5 CountyCare	Greater Chicago Cook County only
6 Next Level	Greater Chicago Cook County only

LIST OF VENDORS FOR EACH MANAGED CARE ORGANIZATION (MCO)

Each Medicaid MCO has preferred vendors for transportation, Pharmacy Benefit Manager (PBM), behavioral health, dental, vision, and eyeglass services.

Plan	Transportation	PBM	Behavioral Health	Dental	Vision	Eyeglasses
Blue Cross/Blue Shield	Logisticare	Prime Therapeutics	Chrysalis (Crisis Call services only) CARES	DentaQuest	Davis Vision	Davis Vision
CountyCare	First Transit	MedImpact	CountyCare Member Services	DentaQuest	EyeQuest	EyeQuest
IlliniCare	Logisticare (IlliniCare Member Services)	Envolve Pharmacy Solutions	Chrysalis (Crisis Call services only)	IlliniCare Member Services	IlliniCare Member Services	IlliniCare Member Services
Meridian	MTM	Meridian Rx	Chrysalis (Crisis Call services only)	DentaQuest	Meridian Network (non-delegated)	Meridian Network (non-delegated)
Molina	Secure Transportation	CVS Caremark	Molina Member Services	Avesis	March Vision	March Vision
Next Level	PAL Transportation, SCR Medical, Catch a Ride	Envolve Pharmacy Solutions	Chrysalis (Crisis Call services only)	Liberty Dental	Envolve Vision	Envolve Vision

For contact information for each vendor, and for the most up to date list, please visit [HFS' Care Coordination webpage](#) and select "MCO Subcontractors" on the right-hand panel.

[MCO Subcontractor Contact List \(as of 04/01/2019\)](#)

LIST OF SBHC PROVIDER REPRESENTATIVES FOR MANAGED CARE ORGANIZATIONS

Please note, the below information is subject to change. To ensure you have the most up to date contact information, please consult the individual health plan webpage.

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

1 BlueCross BlueShield of Illinois

- a. Tishika Townsend
Director, Government Programs
e: tishika_townsend@bcbsil.com
p: 312-653-4915 (office)
- b. Provider Services:
877-860-2837

2 CountyCare

- a. Brian Barrett
Manager of Provider Contracting
e: brian.barrett@cookcountyhhs.org
p: 312-864-1180
- b. Provider Services:
312-466-2920
- c. Provider Services:
855-444-1661

3 IlliniCare Health Plan

- a. Melissa Powell
Senior Manager, Contracting & Network Development
e: melissa.s.powell@llinicare.com
p: 312-260-5368
- b. Provider Services:
866-329-4701, TTY: 711

4 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, TTY: 711

5 Molina Healthcare

- a. Mike Welton
Manager, Provider Network Relations
e: michael.welton@molinahealthcare.com
p: 630-203-3900 x 163982
- b. Michael Manade
Manager, Provider Network Relations
e: michael.manade@molinahealthcare.com
p: 630-203-3900 x 162201
- c. Provider Services:
855-866-5462

6 NextLevel Health

- a. Theodore Dixon
Vice President of Provider Network Services
e: theodore.dixon@nlhpartners.com
p: 312-300-5780
- b. Dianne Glenn
Director of Strategic Community and Provider Partnerships
e: Diane.glenn@nlhpartners.com
p: 312-300-5780 x110
- c. Provider Services:
844-807-9734

LIST OF STANDARD TIMELINES FOR BILLING MCOS

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 Organization (MCO), 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 that some MCOs 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 MCO may outline additional timeline requirements for handling re-submissions. If the MCO does not explicitly provide a timeline for re-submissions, please contact the MCO’s designated SBHC 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 individual health plan webpage.

The following is a list of standard billing timelines for Managed Care Organizations (MCOs):

1 [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. BCBS may, at its sole discretion, deny payment for any such fee for service claim(s) received after 180 days from the date of service.

Providers may dispute a claims payment decision by requesting a claims review. Providers may contact BCBSIL at 877-860-2837 regarding claims appeal questions. Providers are required to notify BCBSIL in writing within 60 days of receipt of payment or such shorter time frame as required by applicable Law. Unless the provider disputes BCBSIL payment within the time frame indicated above, prior payment of the disputed claim(s) shall be considered final payment in full and will not be further reviewed by BCBSIL.

*Information from the [BCBS Community Health Plans Provider Manual](#), accessed May 13, 2019. This manual is password protected; contracted providers receive a password from BCBS for access.

LIST OF STANDARD TIMELINES FOR BILLING MCOS

CONTINUED

2 [CountyCare](#)

- a. Providers must submit all claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where provider or member eligibility has been retroactively received by CountyCare. When CountyCare is the secondary payer, claims must be received within 180 calendar days of the final determination of the primary payer. All claim requests for reconsideration, corrected claims or claim disputes must be received within 60 calendar days from the date of notification of payment or denial is issued.

*Information from [CountyCare Provider Manual](#), accessed May 13, 2019.

3 [IlliniCare Health Plan](#)

- a. To be eligible for reimbursement, providers must file claims within a qualifying time limit. A claim will be considered for payment only if it is received by IlliniCare Health 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. Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid.
- b. Any request for reconsiderations must be received within 180 days of the DOS or date of discharge, whichever is later. Claim disputes must be received within 90 days of paid date, not to exceed 1 year from DOS.
- c. When IlliniCare Health is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer.

*Information from [IlliniCare Health Billing Manual](#), accessed May 13, 2019.

4 [Meridian Health Plan of Illinois](#)

- a. In-network providers have 365 days from the date of service to submit an initial claim and 120 days from the last remittance date to resubmit the claim if the claim is initially received within the one-year timeframe. 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:
 - i. 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
 - ii. 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 May 13, 2019.

LIST OF STANDARD TIMELINES FOR BILLING MCOS

CONTINUED

5 [Molina Healthcare](#)

- a. Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by a provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, provider must submit Claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and provider hereby waives any right to payment.

*Information from [Molina Healthcare Medicaid Provider Manual](#), accessed May 13, 2019.

6 [NextLevel Health](#)

- a. Providers must submit all claims and encounters within the timeframe established in their Agreement with NextLevel Health, which is generally 180 calendar days from the date of service. The filing limit may be extended where eligibility has been retroactively received by NextLevel Health up to a maximum of 120 days, or where a specific program specifies an extended timely filing period by HFS. All claim requests for reconsideration, corrected claims, or claim disputes must be received within 90 calendar days from the date of notification of payment or denial is issued.

*Information from [NextLevel Health Provider Manual](#), accessed May 13, 2019.

What if I still have questions?

The Illinois Association of Medicaid Health Plans (IAMHP) recently released their Comprehensive Billing Manual. The Manual serves as a one-stop resource for all claims policies and procedures for each MCO. However, the Manual is a general guide, and for any MCO-specific questions or clarifications, it is best to contact the plan directly.

The Manual will be updated quarterly, so please be sure to visit [IAMHP's website](#) for the most recent version. To ensure you have the most up to date timelines, please consult the individual health plan webpage.

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES (HFS) INFORMATION

MANAGE MY CASE

The State of Illinois' Application for Benefits Eligibility (ABE) offers 'Manage My Case' (MMC) as an online portal to help patients and providers manage benefits online. This is a valuable resource for individuals enrolled or enrolling in Medicaid, as it allows them to do the following:

- Check the status of an application
- Renew or redetermine benefits
- Apply for additional benefits
- Report changes – income, household members, expenses or new address
- Upload documents
- View notices
- View and reschedule upcoming appointments
- File and manage appeals
- See case history and benefit details
- Access correspondence

MANAGE MY CASE

CONTINUED

To set up MMC, an individual must have a Social Security Number and an established credit history. To enroll in MMC, follow the steps below:

- 1 Go to <http://ABE.Illinois.gov>
- 2 Click on the green “Manage My Case” button
 - a. Enter the ABE User ID and Password
 - b. If the user does not have an ABE account, they should click ‘Create an ABE account’ to register. NOTE: It is very important that individuals write down their username and password so that they can access their account in the future
- 3 After logging in, select ‘Link your account’
 - a. Enter user’s date of birth and Social Security Number or Individual ID number. This one-time process will link the user’s ABE account to their benefit case information
 - b. On this page, users will also be able to choose the way notices are sent (either electronic only, or both paper and electronic)
- 4 When the user links their case to their ABE account, they will be asked to answer a few questions to confirm their identity. If successful, they will be directed to MMC.
 - a. If unsuccessful, the user will be asked to contact the identity verification help desk to continue the application. When they call, they will be given a code to enter into ABE
- 5 Once the user has successfully linked their case and completed the Identity Proofing, the Case Summary page displays. The user will only need to link their case and complete Identity Proofing one time. After that, when the user logs on to ABE and clicks “Manage My Case” from the ABE Homepage, they will be brought directly to the Case Summary page. This page links users to a lot of the Manage My Case features. Learn more about how to access these features through the [ABE User Guide](#).



For more information, you can also refer to the [ABE Customer Support Page](#). If you're calling client enrollment services, an MCO, or any other department at HFS or DHS on behalf of a patient, it is best to note the time of the call, the number you call from, the first and last name of the person you spoke with, and the department that they're under. If you are transferred to someone new, remember to collect the same information (who, title, time).

LINK TO HFS PROVIDER HANDBOOKS

[Illinois Department of Healthcare and Family Services website - HFS Handbooks for Providers of Medical Services](#)

[Illinois Department of Healthcare and Family Services website - Managed Care Manual for Medical Providers](#)

LINK TO HFS PROVIDER NOTICES

The Illinois Department of Healthcare and Family Services releases Provider Notices that contain important information for providers of medical services and for those seeking reimbursement from billing claims. [View all previously released HFS Provider Notices and subscribe to receive email notifications of future notices on the HFS website.](#)

FILING MANAGED CARE PROVIDER COMPLAINTS

HFS has developed a provider portal that allows providers to report issues they're experiencing with health plans in an electronic and secure format. HFS will work with the provider and health plan to answer questions promptly and to ensure fair resolution of disputes.

How do providers submit a complaint?

Providers must first ensure that the complaint has been reviewed by the MCO in question before sending it to HFS; otherwise HFS will close the complaint without review. Only one form per MCO should be completed. If there are several members, dates of service, claims, authorizations, etc. affected by the same problem for the same MCO, the provider should upload an attachment with the information into a single complaint. An upload template can be found through the [HFS Managed Care Provider Complaints webpage](#).

Can private health information be uploaded on the portal?

Yes, private health information can be securely uploaded with specific member details by including the member's name, HFS 9-digit recipient identification number, and date of service.

How long will it take to hear back after submitting a complaint?

HFS requests that providers allow 2 business days for a reply to an urgent complaint (e.g. immediate prescription needs or access to care needs) and 15 business days for all other complaints.

*Provider complaints regarding the resolution of Medicaid Fee-for-Service issues should continue to be directed to HFS at 877-782-5565.

PROVIDER CREDENTIALING

REGISTERING IN IMPACT

Before the rollout of HealthChoice Illinois in 2018, providers needed to go through the credentialing process with each health plan individually. Medicaid providers now only need to register with [HFS' Illinois Medicaid Program Advanced Cloud Technology \(IMPACT\) website](#) in order to be credentialed with each health plan. This single and simplified credentialing process is meant to relieve the cumbersome process of credentialing with each health plan individually.

Please note that this is only applicable for Medicaid providers and does not apply to providers of commercial insurance or Medicare providers.

Additionally, credentialing does not equate to a contractual agreement with the health plans to provide services, and providers and plans will still need to enter into contractual agreements to be considered an eligible provider.

Finally, although providers will be credentialed through IMPACT, the system does not capture all the information that health plans need from providers. Providers may still need to provide individual information, such as office hours, to each of the MCOs.

Illinois Association of Medicaid Health Plans (IAMHP), in conjunction with HFS and the Illinois Health and Hospital Association (IHA), has created a standardized enrollment template that captures the necessary information for each health plan. An informational notice on the standardized contracting and payment process template, as well as the universal IAMHP roster template, can be found by visiting the [IAMHP Resource Center](#) and downloading the forms from the right-hand panel (accessed May 10, 2019).

RESOURCES

SITE VISIT AND MARKETING POWERPOINT

It is always a great idea to market your SBHC 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 SBHC in action may be most impactful, sending them a nicely developed PowerPoint will still help paint a clearer picture of what distinguishes your SBHC as a provider.

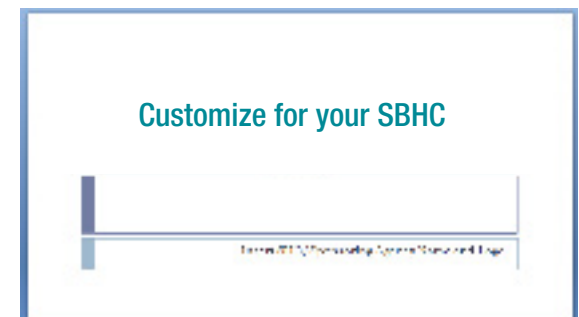
Below are two sample marketing PowerPoints developed by Insuring Sources, Inc. through an individual technical assistance opportunity provided to two local SBHCs, Kankakee SBHCs and Rush SBHCs. We have also developed a PowerPoint template that SBHCs can use as a starting point for their own marketing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



Kankakee SBHCs



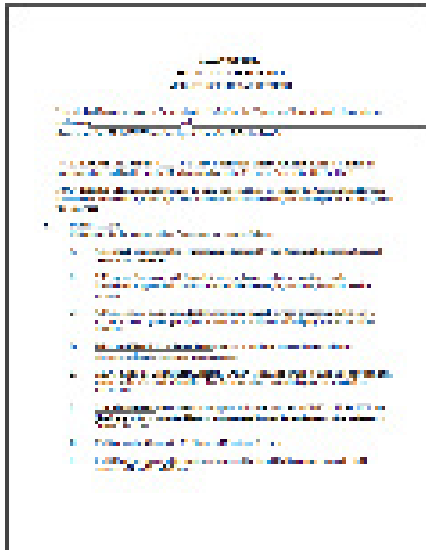
Rush SBHCs



Fill-In Template

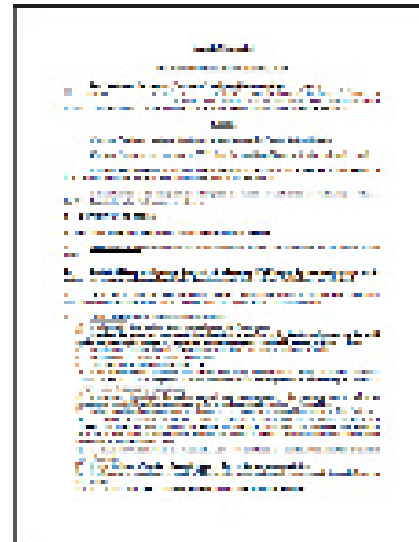
SAMPLE CONTRACT LANGUAGE

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 SBHCs 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 health plans are interested in collaborating with SBHCs 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 SBHCs 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 health care costs. In many ways, SBHCs serve as early examples of innovators in care coordination and comprehensive health care within the larger health care system. As the relationship between Medicaid health plans and SBHCs continues to evolve from focusing on discrete operational issues to envisioning, planning for, and implementing new models of care, SBHCs are positioned to secure additional resources.

EVERTHRIVE IL'S INNOVATIVE REIMBURSEMENT MODEL PROJECT

In 2017, EverThrive IL launched an innovative reimbursement model project that aims to identify challenges and opportunities to better sustain and enhance SBHC services through new reimbursement models within Medicaid managed care. As we gathered data and information from SBHCs, and engaged in conversations with key stakeholders, we identified the following challenges and opportunities for SBHCs looking to partner with Medicaid MCOs.

EVERTHRIVE IL'S INNOVATIVE REIMBURSEMENT MODEL PROJECT

CONTINUED

Challenges

- **Patient volume:** We found that patient volumes vary significantly by SBHC, and in every case, do not meet the customary visit per provider FTE totals seen in non-SBHCs. This makes it hard to articulate to health plans the cost savings of an individual SBHC.
- **Primary Care Physician (PCP) assignment:** While some SBHCs do function as the PCP for their patients, many SBHCs do not serve this role. Given that most performance-based payments for preventative services go to the patient's PCP, this presents a challenge when identifying alternative payment models.

Opportunities

- **Chronic illness:** Chronic illnesses (e.g. diabetes and asthma), when left unmanaged, cost the health care system a large amount of money. SBHC's ability to manage chronic conditions in schools is a valuable service for the health plans that helps reduce long-term health care costs.
- **Avoidable utilization of emergency department (ED) for acute or sub-acute visits:** Similarly, unnecessary ED utilization is one of the highest drivers of health care costs. As a model proven to reduce ED visits and hospitalizations, SBHCs are well positioned to save the health plans money by intervening before a patient needs to utilize the ED.
- **Health plan premium withhold for preventative services:** By providing primary and acute care, as well as behavioral health services, SBHCs keep young people healthy and prevent them from developing more costly health conditions. SBHCs are well positioned to capitalize on payments that health plans receive when they meet their preventative service metrics that are set forth by the State.

EVERTHRIVE IL'S INNOVATIVE REIMBURSEMENT MODEL PROJECT

CONTINUED

Alternative SBHC Reimbursement Models

Given these challenges and opportunities, we have identified three potential models that aim to increase revenue, and ultimately sustainability, of SBHC services:

1. **Engagement of school-aged children with their primary care providers:** SBHCs would serve a care coordination role, helping to establish familiarity between the PCP, patient, and parent or guardian. The SBHC could then negotiate rates with the health plans and receive incentive payments for improved health outcomes, such as: closing care gaps, ensuring members receive their PCP visits, and reducing the number of subsequent ED visits from members
2. **Using telehealth to expand the impact of the SBHC to neighboring schools:** With the SBHC acting as the hub, and the surrounding schools acting as the spokes, SBHCs can use telehealth to expand their reach and capitalize on additional visits
3. **Detecting and managing depression in high school populations:** Low rates of primary care utilization amongst adolescents often results in undetected mental health issues. By successfully screening and connecting those in need with services, SBHCs would be increasing their behavioral health service utilization. Additionally, SBHCs could possibly create a pay-for-performance arrangement with health plans to provide screens and reduce scores.

As we work to implement one or two of these models as a pilot project in the upcoming year, we'll be sure to inform the SBHC field on opportunities to become involved and share lessons learned.

INTEGRATED HEALTH HOMES

Another opportunity for SBHCs to capitalize on care coordination innovation comes from the newly established Integrated Health Homes (IHH) program for Illinois' Medicaid population. Starting in 2020, each eligible Medicaid member will be linked to an IHH, and the IHHs will be responsible for care coordination for members across their physical, behavioral, and social care needs. IHHs will be paid PMPM, as well as receive outcomes-based payments on specific quality measures. Any provider, including a SBHC, is eligible to become a part of an IHH. HFS is currently working on finalizing what the IHH model will look like in Illinois. You can find more information on IHHs on the [HFS Integrated Health Homes webpage](#), and we'll be sure to share more information with the field as it becomes available.

CONNECT WITH US

SBHCs that are interested in learning more about our innovative reimbursement project, IHHs, or exploring innovative partnerships between SBHCs and Medicaid MCOs, should reach out to [Kristen Nuyen at knuyen@everthriveil.org](mailto:knuyen@everthriveil.org).

