Frequently Asked Questions
For Long Term Care Facility Administrators & Providers

The Department of Healthcare and Family Services (HFS) began the new Integrated Care Program (ICP) May 1, 2011. This program replaces Illinois Health Connect for individuals in the Aid to Aged, Blind and Disabled (AABD) population. The department has contracted with two health care plans - Aetna Better Health and IlliniCare Health Plan - to deliver health care benefits to those enrolled in the program.

ICP serves older adults and adults with disabilities who are eligible for Medicaid but not Medicare. The service area for ICP includes the following counties:

- Suburban Cook (those areas with ZIP codes that do not begin with 606)
- DuPage
- Kane
- Kankakee
- Lake
- Will

The department began mailing enrollment packets during March, and 3,000 packets will be sent each week over the next few months.

ICP will be implemented in three phases, called Service Packages. Service Package I began May 1, 2011, and includes all of the standard Medicaid medical services, such as Primary Care Provider (PCP) services and specialist care, emergency care, laboratory and x-rays, behavioral health, pharmacy, etc. Also included in Service Package I is the first 90 days of service after admission to a nursing facility. Service Package I applies to all individuals (older adults and adults with disabilities) who are eligible for ICP whether they reside in the community or in a Long Term Care (LTC) facility.

Service Packages II and III will begin approximately one year later, and expand ICP coverage to include LTC services, including those in nursing facilities or in Home and Community-Based Services (HCBS) waivers.

We have created this list of questions and answers to assist LTC staff who may have questions about ICP. If you have additional questions that are not addressed below – or if you would like to become part of the department's ongoing ICP stakeholder meetings, please contact:

Illinois Department of Healthcare and Family Services
Bureau of Managed Care
217-524-7478

Eligibility and Enrollment

1. ***Q: Is enrollment in ICP mandatory?***

   A: Yes. Enrollment packets will be rolled out over the next few months so that enrollees in ICP, including LTC residents, can choose their health plan. If eligible residents do not select one of the two health plans, Aetna Better Health or IlliniCare Health Plan, the department will auto-assign residents into one of the two plans.

2. ***Q: If residents in a facility receive Medicaid funding, will this new program affect residents of that facility during Service Package I?***

   A: Yes. Under Service Package I, the two health plans will be responsible for medical care for those people who are eligible for **Medicaid only** and do not have Medicare, even those who live in LTC facilities. Except for the first 90 days of stay in a nursing facility, facilities will continue to receive payment from the department for services provided by the facility under its Medicaid rate until the implementation of Service Package II.

3. ***Q: What is the age limit for this program? When a person turns 65 and becomes eligible for Medicare is he/she no longer eligible for ICP?***

   A: All AABD clients age 19 and older that are **not Medicare eligible** living in Suburban Cook, DuPage, Kankakee, Kane, Lake and Will counties will be eligible for ICP. Clients who do not qualify for Medicare at the age of 65 will remain in the program. Clients who become enrolled in Medicare will be disenrolled from ICP.

4. ***Q: Will facilities be notified which health plan their residents selected?***

   A: Facilities may obtain that information from the department's Medical Electronic Data Interchange system (MEDI).

5. ***Q: Will the health plan notify nursing facilities as to when to bill the health plan for the first 90 days?***

   A: No. Upon admission of a resident, a facility should inquire about coverage just as they would check for any financial coverage.

6. ***Q: Will the health plan perform any type of assessment prior to admission to a nursing facility?***

   A: No. A facility continues to be responsible for ensuring that a pre-admission screening assessment is conducted as required and according to current policy.

7. ***Q: Do residents contact their Department of Human Services (DHS) caseworkers to enroll?***

   A: There is no need for residents to contact their DHS caseworkers to enroll in ICP. Enrollment is handled through the Illinois Client Enrollment Broker.

8. ***Q: How does a new resident who is being admitted to an LTC facility apply for Medicaid?***

   A: There is no change to the current process of applying for medical assistance. Additionally, facilities continue to be responsible for admitting residents and making any changes in status to the department's Recipient Data Base through the use of the Medical Electronic Data Interchange (MEDI) or Recipient Eligibility Verification (REV) systems.

   No one is enrolled into ICP until medical eligibility is approved. Once a person is determined to be eligible for Medicaid, he/she will be sent an enrollment packet and then has 60 days to choose a PCP and a health plan.

9. ***Q: How do facilities handle cases that are backdated?***

   A: There is no backdating of ICP enrollment. Enrollment is always prospective. The department will pay for services provided during a medical eligibility period not covered under ICP.

10. ***Q: How do facilities handle residents who have Medicaid applications that have been pending for several months or have gone through several appeals?***

    A: No one will be invited to enroll in ICP until found to be Medicaid eligible. When Medicaid eligibility is approved, the resident will be sent an enrollment packet and then has 60 days to choose a PCP and health plan.

11. ***Q: When residents cross from one zone to another (for example, a county where ICP is offered to a county where it is not offered –or the reverse), how soon after they come to the facility do they enroll or disenroll? If they cross over in the middle of the month, does coverage begin or end immediately?***

    A: When a resident moves to a new address, the department recognizes the address and category of eligibility and determines the resident is eligible for ICP. He/she will then be sent an enrollment package. Enrollment with the health plan is prospective and begins the first day of the following calendar month. If a resident loses ICP because he/she no longer resides in the county where ICP is offered, he/she will be disenrolled by the department. Enrollment with the ICP health plan will last through a calendar month.

Services and Referrals

12. ***Q: What medical care benefits are covered under Service Package I?***

    A: A few of the major services covered in Service Package I include all physician care, including PCP and specialist care, hospital care, pharmacy, laboratory, x-ray, transportation, therapies and dental. For nursing facility services, Service Package I includes the first 90 days after admission to a nursing facility. It does *not* include LTC payments currently covered through nursing facilities (after the first 90 days), Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or HCBS waivers.

13. ***Q: Is it possible for LTC facilities to contract for any Service Package I services, such as oxygen or transportation?***

    A: Services provided outside the medical per diem rate may be separately reimbursable by the health plan. LTC facilities should contact the health plans directly to find out about specific services. All contracted services must still meet medical necessity requirements established by the individual health plans' Prior Authorization units.

14. ***Q: What if a client already has services (such as medical equipment and supplies) prior approved by the department during the enrollment process?***

    A: Both health plans are committed to providing continuity of care for new clients, and they plan to make sure the transition process is timely and without disruption. Both Aetna Better Health and IlliniCare Health Plan will honor all previous service prior authorizations for up to 90 days following initial enrollment in their plans.

15. ***Q: Who refers clients to LTC facilities? The current process has the hospital referring clients directly to the facility. Will the hospital now refer clients to the health plan who in turn will refer clients to the facility?***

    A: In ICP, both health plans will provide care coordination to their members through their respective Integrated Care Teams. The hospital will work with the client's care coordinator from the health plan to determine the best possible outcome for the client and if necessary, refer them to an LTC facility.

16. ***Q: How much of a role in the resident's care will the health plan be responsible for? Will facilities need to get referrals or prior authorization for doctor visits, tests and hospitalizations?***

    A: Referrals or authorization for provider services should be obtained from the resident's health plan. Each health plan maintains a unique set of requirements relative to referrals and authorizations. Facilities will need to work with the patient's health plan on what the criteria is for obtaining a referral. In addition, the PCP should be familiar with or know the procedures for obtaining a referral or authorization with the resident's respective health plans.

17. ***Q: Do the first 90 days apply only to an enrollee's first admission to a nursing facility or does it apply each time an enrollee is admitted to a nursing facility?***

    A: The health plan will be required to pay the first 90 days of **each** nursing facility admission if there is at least 60 days between a nursing facility admission date and the most recent nursing facility discharge date.

18. ***Q: If an enrollee is admitted to a hospital from a nursing facility during the first 90 days, do the remaining 90 days continue to apply upon readmission to the nursing facility from the hospital?***

    A: Yes.

Providers and Health Plans

19. Q: Can physicians, dentists, and pharmacists who currently come into the facility continue to provide care?

A: Now and during the 90-day transition period the health plans are working to contract with all providers who are currently providing care to the AABD population. After the 90-day transition period, in most cases, providers will need to be contracted with the health plan the resident has selected to continue to provide care to that resident. Providers should contact the health plans directly to obtain a contract. The plans have provided the following contact information for providers:

Staci Chambers
Senior Network Manager
Aetna Better Health
1-866-827-2710
E-mail Staci Chambers

Melissa Dannenberg
Director Network Development
IlliniCare Health Plan
312-576-9983
E-mail Melissa Dannenberg

20. Q: How do providers know if a resident is enrolled in ICP?

A: Providers can check the Medical Electronic Data Interchange (MEDI) System to determine if a person is enrolled. Under the 'Managed Care Organization Information' section, those enrolled in ICP will have a plan code of '23' (Aetna Better Health) or '24' (IlliniCare Health Plan) and an exclusion code of '7'.

21. Q: Do the health plans contract with facilities that provide medically necessary transportation through their use of facility vans?

A: Yes. The health plans have a subcontracted relationship with a transportation broker; facilities interested in offering transportation services should contract with that transportation broker. Aetna Better Health has contracted with Medical Transportation Management (MTM) and IlliniCare Health Plan has contracted with First Transit to provide non-emergency transportation to its members. Please contact the health plans directly if your facility is interested in this type of contract.

Billing

22. Q: For Service Package II, is it true that the health plans and not the state will be paying the long term care per diem (room and board) for the* Medicaid only *members in my facility? If so, will the facility need a contract and will the health plans pay the facilities in the same way and same amount as the state?

A: You will need to sign a contract with the health plans. The LTC per diem will be covered by the health plans in Service Package II. The health plan will reach out to LTC facilities after Service Package I is implemented to begin planning for implementing Service Package II.

23. Q: LTC facilities currently do not bill the department monthly; the system generates a pre-bill automatically. Will individual bills be sent out to the health plans monthly or can facilities continue to list bill?

A: The facility will need to work with each health plan to understand and adapt to that plan's billing process.

24. Q: Will facilities still be responsible for collecting the resident's portion of the cost or will that become the responsibility of the health plan?

A: The facility will remain responsible for collecting the resident's portion of the cost. This cost will be factored into the health plans' reimbursements by HFS.

25. Q: Will the health plan pay for additional services provided at a skilled nursing facility (SNF) that Medicaid does not currently cover (for example, higher acuity residents being released from a hospital)?

A: The facility should work with the health plan to determine additional services and negotiate a rate. The plan may cover more services than HFS covers.