Illinois Medicaid Managed Care (MCO) Health Plans
Frequently Asked Questions

General MCO questions – plan information

Q1. How do I know what Managed Care Health Plans are in my region?
A1. HFS has a Care Coordination Expansion Map posted on their website

http://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf

HFS will be posting updates in the next 30 days that reflects additional changes in the Managed Care Plans throughout Illinois.

Q2. Is there a publically available directory of Health Plans with contact information?
A2. The most current directory can be located at the following link –

http://www.illinois.gov/hfs/SiteCollectionDocuments/ContactListAllMCEs.pdf

Additional changes will be posted by HFS as contact information is updated.

Q3. Are the Managed Care Plans in the five mandatory regions of the state required to contract with existing HFS enrolled Medicaid providers?
A3. No. There is no requirement for Medicaid MCOs to contract with all existing HFS enrolled Medicaid providers. However, Medicaid MCOs are required to demonstrate a sufficient provider network to assure appropriate access to their beneficiaries as well as ensure continuity of care. Development of networks does not require inclusion of all providers within the specified coverage region.

Q4. What client populations are excluded from the mandatory Managed Care enrollment?
A4. Excluded Populations:

- Participants eligible for Medicare Part A or enrolled in Medicare Part B
- American Indians and/or Natives of Alaska (may voluntarily enroll)
- Participants with Spend down
- All Presumptive Eligibility (temporary benefits) Categories
- Participants in the Illinois Breast and Cervical Cancer Program
- Participants with high-level private health insurance (also known as Third Party Liability or TPL)
Q5. **How are Medicaid clients notified of their enrollment options?**

A5. Medicaid clients are enrolled on a voluntary basis or by auto-assignment and will receive a letter that explains their options. A Medicaid client has the voluntary choice of selecting a provider and health plan – if the client does not make a selection within the first 60 days, a plan and a provider will be selected and the plan will advise of the client of their plan and provider. All efforts are made to assign the client to a physician who has seen the patient previously and is within close geographic proximity.

Q6. **Are clients allowed to change plans once enrolled?**

A6. After being enrolled in the plan, clients will have 90 days to choose a different plan in their region. After the 90 day change period, clients in mandatory regions are locked-in and can only change plans during their annual open enrollment period. Before that open enrollment period begins, clients will receive a reminder letter and information about their plan choices.

Q7. **What is HFS’ Illinois Client Enrollment Services?**

A7. The Illinois Client Enrollment Services is the group that handles enrollment for Medicaid clients who are required to enroll in one of the Medicaid plans operating in Illinois. Medicaid clients can find plan information as well as contracted health providers that accept Medicaid health plans at

http://enrollhfs.illinois.gov/choose/compare-plans

MCO Operational Questions

Q8. **Do all Managed Care Plans have the same claim timely filing provisions?**

A8. No. Contracted providers should consult the negotiation terms of their MCO agreements and/or the MCOs’ provider manual for specific provisions.

Q9. **Are the prior authorization requirements the same for all Managed Care Plans?**

A9. No. While MCOs may have some requirements that are the same for each plan, in many cases, there are differences in what additional requirements MCOs have for contracted providers. Contracted providers should consult the negotiated terms of their MCO agreements and/or the MCO’s provider manual for specific provisions.
Q10.  Is there a universal authorization request form for all MCOs?

A10. No. Each Medicaid MCO has their specific process, which may vary from on-line portal access to paper, to faxed authorizations to email requests. Contracted providers should always consult the negotiated terms of their MCO agreement and/or the MCO’s provider manual for specific provisions.

Q11. Are all providers required to be credentialed individually or will the HFS Medicaid provider number be sufficient to be a participating provider?

A11. The managed care plans are responsible for the credentialing and re-credentialing of their provider network. The plans must establish credentialing and re-credentialing criteria for all providers that, at a minimum, meet the HFS Medicaid participation standards. Each provider that wishes to participate in a plan’s network must work directly with the plan to meet their credentialing requirements.

Q12. Is a newborn that is Medicaid eligible required to enroll in a Managed Care Plan?

A12. Newborns will be automatically enrolled in the same plan as the mother.

Q13. Do inpatient admissions for clients that are in a Managed Care Plan require eQHealth (Peer Review Organization for IL Medicaid) review?

A13. No

MCO Reimbursement Questions:

Q14. What is the difference in reimbursement for a MCO contracted hospital vs. a non-contracted hospital?

A14. Reimbursement to a contracted hospital is based on the contractual agreement between the hospital and the MCO.

The MCO must pay to the non-contracted hospital the fee-for-service equivalent rate per the current HFS rate structure for emergency care and post-stabilization. Any other service(s) needs to be negotiated on a case-by-case basis.

Q15. Should the HFS rate reductions be applied to payments received from the MCO’s?

A15. The MCO capitation payments that are made by HFS are reduced by an amount equivalent to the rate reduction. The Managed Care Plan can choose whether or not to pass that reduction on to their providers.
Q16. When a Medicaid client is enrolled in a MCO, is HFS or the MCO responsible for paying the DSH, MPA and MHVA?

A16. DSH remains the responsibility of the state (HFS) to pay directly the hospital. Hospital specific add-on’s such as MHVA, MPA, Safety Net, Pediatric Psychiatric add-on are included in the rate development of the MCO rates and the plans are directed by HFS to pay these add-ons at the same rate as currently in place under the Fee-For Service model. Other rate adjustments, such as Trauma, Perinatal Adjusters are adjustments to the base rate, and subject to contract negotiations.

Q17. Does each Managed Care Plan have their own practitioner fee schedule or do they all follow the HFS Medicaid practitioner fee schedule?

A17. Reimbursement rates for services under Managed Care Plans are negotiated between payer and provider and are governed by the contract in place.

Q18. Are inpatient hospital claims for Managed Care clients reimbursed based on the HFS APR DRG Payment System?

A18. Managed Care Plans are not required to reimburse based on the HFS APR DRG payment methodology but most do.

Q19. Are outpatient hospital claims for Managed Care clients reimbursed based on the HFS APL/EAPG Payment System?

A19. Managed Care Plans are not required to reimburse based on the HFS EAPG Payment System but most do.

Q20. Will the reimbursement for PT, OT and ST be at the Medicaid therapy rate for everyone one of the plans?

A20. Reimbursement rates for services under Managed Care Plans are negotiated between payer and provider and are governed by the contract in place.

Q21. If a claim is denied by the Managed Care health plan, can providers bill Fee for Service Medicaid?

A21. No, Providers who have claims denied by the Managed Care Health Plan cannot bill Fee for Service Medicaid. The provider is responsible for obtaining authorization (if required by the Managed Care health plan) and billing the Managed Care health plan the client is enrolled in.