Illinois Medicaid MCO Transformation

- Illinois Medicaid MCO Transformation
- IHA Education Series
- November 13, 2017
- CountyCare
- Presenters:
  - Gerald Kiplinger, Director of Operations, CountyCare
  - Allison Hoffman, Senior Director, Member Services and Provider Relations
  - Kayla Dunning, Marketing Director
  - Laura Merrick, Senior Product Manager, MHN
  - Tina Spector, Vice President of Clinical Integration, MHN
AGENDA

CountyCare Overview
Billing Instructions
Claims Adjudication
Reimbursement Methodology
Provider Portal
Provider Claims Disputes
Utilization Review
Issue Escalation
Website
Discharge Planning
Care Management
AGENDA
CountyCare Overview
Billing Instructions
Claims Adjudication
Reimbursement Methodology
Provider Portal
Provider Claims Disputes
Utilization Review
Issue Escalation
Website
Discharge Planning
Care Management
About CountyCare

• Established October 2012 under CMS 1115 Waiver to Early Enroll ACA-eligible Adults Into Care
  ○ Take advantage of Medicaid expansion under ACA
  ○ Mitigate threat of mandatory Medicaid managed care implementation in Chicago

• Obtained Health Plan Status July 1, 2014
  ○ Allowed for expansion to serve all Medicaid beneficiaries – including Family Health Plan & Seniors and Persons with Disabilities – living in Cook County

• Provider “Owned and Operated” Health Plan
Over 150,000 People Reached to Initiate an Application
- About 50% of estimated eligible beneficiaries in Cook County

Over 100,000 Individuals Approved for Coverage

Broad Network of Providers Geographically Disbursed Throughout Cook County
- Over 138 primary care access points
  - All safety net Federally Qualified Health Centers (FQHCs) and American Indian Health Services
- 35+ community hospitals; 6 academic medical centers
- Hundreds of additional ancillary providers

Landmark Enrollment Initiative at Cook County Jail
- Accounts for 4% membership in Year 1
CountyCare Today

- One of the Largest Medicaid Health Plans in IL
- ~300,000 lives
  - 23% ACA Adults
  - 73% Family Health Plan Members
  - 4% Seniors & Persons with Disabilities
- Age Group:
  - < 19 y/o = 53%
  - 19-39 y/o = 23%
  - 40+ y/o = 24%
- 27% live in Suburban Cook County
CountyCare’s Guiding Principles

- Improved Quality and Outcomes
- Technology
- Enrollees
- Community
- Provider-Owned and Led
- Integrated Behavioral Health Care
- Innovation
- Partnerships and Investments
Key Initiatives

- **Provider-led Care Coordination**
  - Three partnering Care Management Entities
  - Specific carve-outs for highest needs members (kids and LTSS members)
- **Integration of Behavioral Health Services**
  - Elimination of BH Benefits Manager
  - Integrated care coordination, UM and claims
  - BH Consortium of IL, LLC
Key Initiatives

- **Addressing Social Determinants**
  - Housing Instability
  - Food Insecurity

- **Leveraging Technology**
  - Real-time Admit/Discharge/Transfer alerts for all CountyCare members
  - Acute care (ED and inpatient), community care (CMHCs) and corrections
Key Initiatives

• Partnering with CCHHS on Key Investments
  ○ BH provider capacity (C4, HSI)
  ○ CCHHS Community Triage Center
  ○ Transportation fleet
  ○ Behavioral Health Consortium of IL, LLC
  ○ Behavioral Health Learning Collaborative
  ○ eConsult
### Strategic Partners

<table>
<thead>
<tr>
<th>Scope of Work</th>
<th>Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Office Operations (TPA Services), Utilization Management, Member and Provider Services</td>
<td>evolent health</td>
</tr>
<tr>
<td>Care Management</td>
<td>CCHHS</td>
</tr>
<tr>
<td></td>
<td>MHN ACO</td>
</tr>
<tr>
<td></td>
<td>LA RABIDA Care Coordination</td>
</tr>
<tr>
<td></td>
<td>Independent Living Systems</td>
</tr>
<tr>
<td>Pharmacy Benefits Management</td>
<td>OPTUMRx</td>
</tr>
<tr>
<td>Dental Benefits Management</td>
<td>DentaQuest</td>
</tr>
<tr>
<td>Vision Benefits Management</td>
<td>EyeQuest</td>
</tr>
<tr>
<td>Transportation Benefits Management</td>
<td>First Transit</td>
</tr>
<tr>
<td>Children’s Mental Health Crisis Line Services</td>
<td>Chrysalis Consulting Group</td>
</tr>
</tbody>
</table>
Billing Instructions

- CountyCare accepts electronic CMS-1500 and UB-04 claims, frequency 7 and 8 claims. Enhancement work is being done to accept electronic COB information.
- CountyCare adheres to all HFS guidelines, including FFS, APL and non-APL, ED and Obs services.
- Configuration monitors the HFS website for billing updates and new provider notices. New rules are configured into the system.
- If configuration is not completed until after the date the new rules went into effect, a recalculation is done on all claims post the effective date.
- Known system issues are communicated on the website.
Reimbursement Methodology

• CountyCare follows EAPG/APR-DRG methodology on all inpatient (non-per diem) and outpatient claims.

• Once an update to EAPG/APR-DRG reimbursement is released, our pricing system (PCI) is updated.

• If pricing is not completed until after the date the new rules went into effect, a recalculation is done on all claims post the effective date.
Provider Claim Disputes

• Three ways a provider can dispute their claim denial/underpayment:

1. Call into Customer Service at 312-864-8200, where an OCI (Open Claim Issue) ticket is opened to Claims.

2. Written appeal, with additional information to support why they believe the claim should be paid. Written appeals are reviewed by the Claims team. CountyCare ATTN: Appeals, P.O. Box 3727, Corpus Christi, TX 78463

3. Work with the PR Representative who will work with Claims to investigate issues. You can find your PR Representative on www.countycare.com or find them through Customer Service at 312-864-8200.

• Following Claims investigation, a decision may be reversed and paid, or denied again. A new EOB is sent with a new remark code (AP or APPA). Any claims denied inappropriately will be reprocessed.
Provider Portal

• The CountyCare Provider Portal allows providers to:
  ○ check member eligibility and benefits,
  ○ check status of claims and payment history
  ○ request authorizations,
  ○ View your PCP panel
  ○ and communicate with CountyCare staff.

• CountyCare’s contracted providers and their office staff have the opportunity to register for our secure provider website in just four easy steps.

• It’s simple and secure!

• http://www.countycare.com/providers/portal
Medical Management

- Requests may be submitted by Provider Portal, telephone or fax.
- All out-of-network services require prior authorization, with the exception of Emergency Care and Family Planning Services.
- Prior authorization should be requested at least seven (7) calendar days before the requested service delivery date.
- Turnaround Times
  - Urgent TAT: one day
  - Standard TAT: three business days

- [www.countycare.com/providers/prior-authorizations](http://www.countycare.com/providers/prior-authorizations)
Medical Management

- CountyCare uses the InterQual Criteria sets
- All denials are made by a medical director
- All member appeal decisions are made by a same/similar specialty match provider.
- Behavioral health prior authorizations and appeals are made by a behavioral health medical director.
Provider Relations

• All providers are assigned to a Provider Relations Representative. Their job is to assist with escalated issues, educate on new processes and programs, provide roster, panel, and claim reports, and help providers improve the quality of care and service they provide to members.

• A list of the PR Representatives can be found at:

• [http://www.countycare.com/resources](http://www.countycare.com/resources)
## Provider Relations

<table>
<thead>
<tr>
<th>Where</th>
<th>PROVIDER SERVICES HOTLINE</th>
<th>PROVIDER PORTAL</th>
<th>YOUR PROVIDER RELATIONS REPRESENTATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When</strong></td>
<td>M- F: 8:30AM - 8:00PM CT</td>
<td>24 hours a day</td>
<td>M- F: 8:30AM - 5:00PM CT, as needed</td>
</tr>
<tr>
<td><strong>How</strong></td>
<td>M- F: 8:30AM - 8:00PM CT</td>
<td>7 days a week</td>
<td>Via phone information outlined below</td>
</tr>
<tr>
<td><strong>For What?</strong></td>
<td>Phone: 312-864-8200</td>
<td>Details: <a href="http://www.countycare.com/providers/portal">http://www.countycare.com/providers/portal</a></td>
<td>(find your rep by checking below and on the next sheets!)</td>
</tr>
<tr>
<td><strong>For What?</strong></td>
<td>Phone (TF): 855-444-1661</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax: 312-548-9940</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Live Representative Service
- Check Member Eligibility
- Check Member Benefits
- Check Claims Status
- Claims Reconsiderations
- Request Authorization
- Check Provider Status (also on public website)
- Report Critical Incident
- File Appeals, Grievance
- 24 Hour Nurse Hotline
- And more!

### Self Service - No Wait!
- **Submit Authorizations**
- Check Authorization Status
- View Member Eligibility
- Check Claims Status
- View EOPs
- View Panel Rosters
- Important Documents and Forms

### Anything you cannot receive assistance on via Call Center Provider Reps or Portal
- To discuss escalated Issues, Concerns, Questions
- Requests for Training on CountyCare (Plan, Benefits, Systems (portal), Processes, etc)
- **NOT** to check eligibility, claims status, request Auth, etc
For Providers

Thank you for being a part of the CountyCare provider network. Here, you can view a claims status, connect with your care manager, access pre-authorizations and much more.

Have a question? Call us at 312-864-8200, option 6.
Medical Home Network (MHN) is a not-for-profit organization established in 2009 by the Comer Family Foundation following an HMA report the foundation commissioned to better understand inequities in healthcare for the Medicaid population living in Chicago’s South and Southwest Sides.

2009 Report’s Key Findings

Coverage did not always equal access

The population was underserved and extremely poor

Patient’s relationships with their medical homes were tenuous

Many opportunities existed to improve access, coordinate care and reduce costs
Integrating Disparate Entities Across the Delivery System to Enhance Patient Care, Value & Outcomes

MHN ACO Providers

- 9 FQHCs
- 3 Hospital Systems
- 86 Medical Homes
- 375 PCPs
- 150 Care Managers
- 1,200 Specialists
- 5 Hospitals
MHN ACO Practice Transformation

Program Tenets

✓ Patient-centered, Practice-level care management

✓ Integrated Care Team (ICT) includes care managers employed by and embedded in ACO sites

✓ Whole patient care that manages physical health as well as social, mental, and community issues that impact the health and medical care of the enrollee population

✓ Workforce development which includes extensive training and a Care Coordination Certification

✓ Coordinated care management across the healthcare ecosystem
Practice-Level vs. Centralized Care Management

**Practice-level Care Management**
- Builds on established patient relationships
- Requires structure and oversight
- Drives shared incentives and alignment

**Centralized Care Management**
- Challenged engaging patients
- Challenged engaging PCPs
- Limited access to EMR data

---

© Copyright 2017 MHNU Corporation, All Rights Reserved, Used with Permission
MHN Care Management: Workforce to Support the Care Team

Practices employ Care Management team members who are fully integrated into clinic care teams

**Care Manager**
- Licensed
- **Lead for CRA/Care Plan**
  - Goal Setting
  - Medication Reconciliation
  - Disease Management Education
  - Transitions of Care
  - Behavioral Health Referral
  - Specialist Referral Coordination
  - Care Team Communication

**Care Coordinator**
- Unlicensed
- HRA Administration
- Low-intensity social needs referrals
- Assist with coordination needs (appointments, housing, food resources, and transportation)
- Disease Management Education as delegated
- Coach patient how to effectively communicate with PCP and care team
MHN Model of Care: Driving Care Transformation via Risk-Focused Patient Management

- Identify & Stratify
- Engage & Connect Mod and High Risk
- Plan & Support
- Follow Up & Reassess Risk
- Transition to Low Risk
- Reevaluation in Response to Triggers

- Health Risk Assessment (HRA)
- Comprehensive Risk Assessment (CRA)
- Medication Reconciliation
- Care Plan
- Reassessment
Key Stats Are Significant for Partnerships Across the Continuum

Key Stats:
- Health Risk Assessment (HRA) Completion-87.6%
- Comprehensive Risk Assessment (CRA) Completion-82.6%
- Care Plan Completion-82.2%
- 50% of ED patients and 44% of inpatients are completing PCP visits within 7 days of discharge

Significance:
- Sharing of information is optimal
- Transitions of Care is effective
## Transitions of Care

### Hospitals and Clinics Work in Unison

<table>
<thead>
<tr>
<th>At Admission</th>
<th>During Inpatient Stay</th>
<th>Discharge Preparation</th>
<th>Post Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic Care Manager</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure communication with hospital CM within 2 business days of admit</td>
<td>Contact patient over phone</td>
<td>Discharge discussion with hospital CM to include (follow script)</td>
<td>Review discharge summary/instructions</td>
</tr>
<tr>
<td>- Hospital CM should call within 1 day (if not, call the hospital)</td>
<td>- Complete missing CM documents</td>
<td>- Discharge plans/issues</td>
<td>Update care plan and medication reconciliation with new information obtained from hospital care manager</td>
</tr>
<tr>
<td>- Review patient info with hospital CM</td>
<td>- Obtain patient availability for 7 days follow up</td>
<td>- New goals for patient (update care plan)</td>
<td>Follow-up call to patient within 2 business days (follow script)</td>
</tr>
<tr>
<td>- Reason for admit</td>
<td>- Initiate patient engagement with the Medical Home (or delegate to Clinic Care Coordinator)</td>
<td>- Patient preferences</td>
<td>- Complete CTM-3</td>
</tr>
<tr>
<td>- Brief historical handoff</td>
<td>Reassess Risk and document in MHNCConnect</td>
<td>- Notable changes</td>
<td>- Talk with non-compliant patients</td>
</tr>
<tr>
<td>- Ensure HRA completed</td>
<td>Ongoing communication with hospital CM</td>
<td></td>
<td>Reassess risk (if needed)</td>
</tr>
<tr>
<td>- Exchange patient contact info</td>
<td>- New goals, new findings</td>
<td>Weekly check-in for 4 weeks (follow script)</td>
<td></td>
</tr>
<tr>
<td><strong>Send patient info to hospital</strong></td>
<td>- Anticipated discharge plan</td>
<td>Document all the above in MHNCconnect.</td>
<td></td>
</tr>
<tr>
<td>- CM documents</td>
<td>Facilitate call between PCP and hospital team if requested</td>
<td>Complete bundle checklist in MHNCConnect.</td>
<td></td>
</tr>
<tr>
<td>- Disease specific information</td>
<td>Arrange for patient care conference if needed, with inpatient counterparts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish communication schedule with hospital CM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notify PCP/care team of admission and document</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Care Manager</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit patient face-to-face</td>
<td>Complete face-to-face visit with patient</td>
<td>Consult with hospital medical team to understand plan of care</td>
<td></td>
</tr>
<tr>
<td>- Identify reason for admit/factors that lead to admit</td>
<td>- Establish medical home/PCP importance</td>
<td>Meet with patient</td>
<td></td>
</tr>
<tr>
<td>- Verify patient contact info</td>
<td>- Assist with HRA completion (if requested by MH)</td>
<td>- Explain discharge plan</td>
<td></td>
</tr>
<tr>
<td>Call medical home CM to review patient information.</td>
<td>Fax completed HRA to medical home</td>
<td>- Review care needs</td>
<td></td>
</tr>
<tr>
<td>Receive patient documentation via fax from medical home</td>
<td>Share patient info received from medical home with inpatient care team (hospitalists, residents, SW, pham, etc.)</td>
<td>- Review meds</td>
<td></td>
</tr>
<tr>
<td>Set communication schedule with medical home CM including expected LOS</td>
<td>Monitor patient progress and continuously communicate with medical home CM</td>
<td>- Reinforce follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Call between hospital and PCP if requested; request medical home CM to arrange</td>
<td>Communicate with MH (follow script)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Discharge plans/issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- New goals for patient (update care plan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient preferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Notable changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obtain patient availability for 7 day follow up and transportation needs (communicate to medical home CM)</td>
<td>Fax discharge documents</td>
<td></td>
</tr>
</tbody>
</table>

ัก Transitions are seamless for the patient across the continuum of care
MHN Technology Solution Drives Operational Programs: Collaboration and Connectivity Across the Continuum

High Value Hospitals

Community Health Resources

Medical Homes & Primary Care Members & Care Management

Health Information Exchanges (public & private)

Health Plan


Complex Care Management

Behavioral Health Network

PCP & Specialist Communication

Patient Engagement

© Copyright 2017 MHNU Corporation, All Rights Reserved, Used with Permission
Hospitals & Emergency Rooms

Advocate Christ
  • Hope Children's
Advocate Trinity
Advocate South Suburban
Cook County Health & Hospital Systems
  • Stroger
  • Provident
  • Oak Forest
Ingalls Memorial
La Rabida Children’s
Loretto
Mercy Medical Center
Rush University Medical Center
Saint Anthony
Sinai Health System
  • Sinai Hospital
  • Holy Cross
  • Schwab Rehabilitation
University of Illinois Chicago
University of Chicago Medicine
  • Comer Children’s
Presence St. Mary & Elizabeth

St. Bernard’s
Hartgrove
Riveredge
Norwegian American
Lurie Children’s

FQHC and PCP offices

Access
American Indian Health Service
Alivio
Asian Human Services
Aunt Martha’s Youth Service
Beloved Comm Family Wellness
CCHHS ACHN
CCHHS CORE Center
Chicago Family
Christian Comm Health
Circle Family Health
Community Nurse Health
Esperanza
Erie Family
Family Christian
Friend Family
Heartland Health Centers
Heartland Health Outreach
Holy Cross Clinic
Howard Brown
La Rabida Clinic
Lawndale Christian
Mercy Family
Mile Square
Near North Service Corp
PCC Comm Wellness
PrimeCare Comm Health
Rush U. Med Group
St. Anthony Clinics
Sinai Medical Group
TCA Health

IN DEVELOPMENT

LIVE

FUTURE
Thank You!
Provider Manual

CountyCare’s Provider Manual is available to guide providers on all aspects of the plan. The manual is an excellent resource for information on:

- Member Eligibility
- Member Benefits
- Quality Improvement Program
- Prior Authorization and Utilization Management
- Rights and Responsibilities for Members and Providers
- Fraud, Waste and Abuse and Critical Incidents
- Provider Complaints, Member Grievances and Member Appeals

Managed Care Manual for Medicaid Providers
Prior Authorizations

Medical Services Prior Authorizations
For faster turn-around-time and easier tracking- submit your Medical Prior Authorization request via the CountyCare Provider Portal! Click here to Login or find out more information

Call 312-864-8200 711 TTD/TTY Option 4

Or fax either the Inpatient Prior Authorization Form or Outpatient Prior Authorization Form to the following numbers:

Inpatient Medical Prior Authorization Form: 1-800-856-9434  
Outpatient Medical Prior Authorization Form: 1-866-209-3703

> Learn More

Behavioral Health Services Prior Authorizations
For faster turn-around-time and easier tracking- submit your Medical Prior Authorization request via the CountyCare Provider Portal! Click here to Login or find out more information

Call 312-864-8200 711 TTD/TTY Option 4
Claims Projects

Please review the reports for details around current or recently completed Claims and Configuration projects CountyCare is working on. The report outlines project description, impacted providers, expected resolution, current status, and expected ETA, when this is known. If you have any questions about the projects on this report, please contact your Provider Relations Representative.

- CountyCare Claims - Configuration Project Updates 11-2-17
- CountyCare Claims - Configuration Project Updates 8-15-17
- CountyCare Claims - Configuration Project Updates 7-15-17
- CountyCare Claims - Configuration Project Updates 6-1-17
- CountyCare Claims - Configuration Project Updates 5-1-17
Billing Guidelines, Tips, Reference Guides

See below for links to claims and billing guidelines specific to provider types, services, updated HFS guidance, and more.

- CountyCare Provider Billing Manual
- CountyCare Billing Guidelines FOHC-RHC-ERC Providers
- CountyCare Billing Guidelines for DASA Providers
- CountyCare Billing Guidelines for Community Mental Health Providers
- CountyCare Claim Remark Code LookUp - Reference
- CountyCare Corrected or Voided Claims Resubmission Guidance
- CountyCare Duplicate Claims Guidance
- CountyCare Transportation Billing Guidelines
- EAPG Pricing Billing Guidelines – IAMHP Provider Memo
- General Acute Care and Children’s Hospitals Billing Guidelines - IAMHP Provider Memo
- Physician Assistant Billing Guidelines – IAMHP Provider Memo
- Provider Appeal Instructions
- Provider Guidelines for Billing CountyCare Members
- IAMHP (IL Association of Medicaid Health Plans) - Info For Providers (Resources and Key contacts)
Welcome to CountyCare FHN/CCAi Providers!

We are excited to have you as part of our network, and we look forward to working with you to provide quality care for our CountyCare members.

- **Seamless Transition:** Our #1 goal is the seamless transition of members to CountyCare as their new health plan. To that end CountyCare has agreed to accept assignment of FHN and CCAI provider contracts, including specialists and ancillary providers to maintain, wherever possible, the PCP-member relationship to ensure consistency of services and member experience.
- **Current CountyCare Providers:** Your FHN members will be transitioned to CountyCare under the terms of your agreement with CountyCare.
- **Not Currently a CountyCare Provider:** Your current agreement has been assigned to CountyCare in accordance with your FHN provider agreement and will be active with CountyCare effective November 1, 2017.
- **Contracting Questions:** Email CountyCareContracting@cookcountyhhs.org
- **Medical Group Providers:** If you are part of a group practice or IPA, your group contract has been assigned from FHN to CountyCare and will be active November 1, 2017.
Resources

As a member or provider, you may be looking for important forms, documents or other information about CountyCare. The links below will bring you to a page where you can read and download the information you need, when you need it.

Resources are organized for members, for providers and for information related to prior authorizations.

Search Resources

Member Resources
- Advance Directive/Power of Attorney
- Annual Member Notice
- Behavioral Health Brochure
- Behavioral Health Fact Sheet

Provider Resources
- Behavioral Health Brochure
- Behavioral Health Fact Sheet
- Contracts and Letter of Agreement Requests
- CountyCare Claim Remark Code

Prior Auth Resources
- Dental
- Durable Medical Equipment
- General (Including Behavioral Health)
- Inpatient Behavioral Health