

# *Manual for Medicaid Providers of Abortions and Family Planning Services*

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HEALTH MANAGEMENT ASSOCIATES

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## Enrolling as a Medicaid Provider

### To Begin the Application Process

Illinois Medicaid enrolls providers in the IMPACT system. Paper enrollment applications or updates are not accepted, and email is now the primary method for provider communication. IMPACT and the enrollment process is available at: <http://www.illinois.gov/hfs/impact/Pages/AboutIMPACT.aspx>

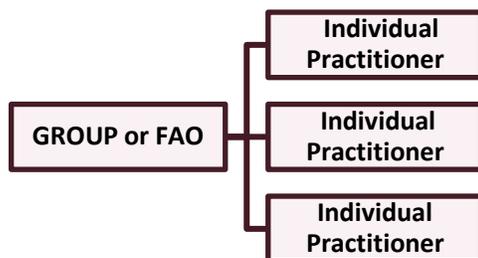
Prior to being able to complete the enrollment, anyone who needs access to the IMPACT system will need to create a user ID and Password through a single sign-on process. This process can be done anytime. To begin, go to <http://IMPACT.illinois.gov> and click on “Create New Account”.

As the first step to Medicaid provider enrollment, the system will generate a 14-digit application ID after the successful completion of the Basic Information screen. Application IDs are valid for 30 calendar days; applications must be completed and submitted to the state for review during this 30-day period or the application will be deleted. The application ID will be used to access the application before submission to the state for review and will be used to track the status of your submitted application until the application has been approved. In order to access the IMPACT provider portal, you must use an internet browser that is equivalent to Internet Explorer 8 – or a more recent browser.

### Medicaid Enrollment by a Clinic or Ambulatory Surgical Treatment Center

Abortion providers in Illinois may be able to enroll as a “Group” or as a “Facility, Agency, Organization” (FAO). Most abortion providers will qualify as a “Group” in IMPACT. [This does not apply to hospitals or hospital-based clinics, all of which already are Medicaid providers.]

The “FAO” designation will apply only to abortion providers which are Ambulatory Surgical Treatment Centers **and also have Medicare certification**. This includes Pregnancy Termination Specialty Centers in Illinois that have an Ambulatory Surgical Treatment Center license issued by the Illinois Department of Public Health; they are not considered an Ambulatory Surgical Treatment Center by IMPACT (FAO) unless they also have Medicare certification.



First, the Group or FAO should enroll as a Medicaid provider before your individual practitioners enroll as Medicaid providers (if they are not already enrolled with another medical group). Medicaid services are rendered by individual practitioners, but the Medicaid payments will be sent to the Billing Provider at

the Group/FAO’s Pay-To address. After the Group or FAO enrollment is completed and approved, then the individual practitioners will enroll and “associate” with the Group or FAO.

### Group

The Group is an organization of individual providers that provides medical or dental services. A Group provider will require a Type 2 NPI. No licensing is required for this type of organization. For enrolling in

IMPACT, a “Group” includes a corporation, partnership or LLC. A step-by-step Business Process Wizard is at: <https://www.illinois.gov/hfs/impact/Documents/IMPACTGroup.pdf>

### Facility, Agency, Organization

Any provider which is an Ambulatory Surgical Treatment Center (with Medicare certification) should enroll as a “Facility, Agency, Organization” (FAO), which is an entity that providing health care services and which has a license. An FAO includes Hospitals, Nursing Facilities, Laboratories, etc., and has a Type 2 NPI (National Provider Identifier) number associated with them; see below for more information on NPIs. A step-by-step Business Process Wizard is at:

<https://www.illinois.gov/hfs/impact/Documents/IMPACTFAO.pdf>

### National Provider Identifier (NPI)

The National Provider Identifier (NPI) number is a unique ten-digit identification number issued by the Centers for Medicare and Medicaid Services (CMS) and required by the Health Insurance Portability and Accountability Act (HIPAA) for health care providers in the United States. Providers must use their NPI to identify themselves in all HIPAA related transactions. There are two types of NPI:

NPI Type 1	NPI Type 2
<ul style="list-style-type: none"><li>• Health care providers who are individuals, including physicians, dentists, and all sole proprietors</li><li>• An individual is eligible for only one NPI</li></ul>	<ul style="list-style-type: none"><li>• Health care providers who are organizations, including physician groups, hospitals, nursing homes, etc.</li></ul>

If the abortion clinic has several NPIs but only one TIN/FEIN, there are two options:

- One enrollment including one TIN/FEIN, one NPI, a primary practice location, listing each additional location as other servicing locations **OR**
- Enter each NPI as a separate enrollment

### Site Address

You will be asked to enter your Primary Practice Location address, as well as a Correspondence address and a Pay-To address for the Primary Practice Location. Note that your group/individuals need not bill Medicaid for all services performed at this address.

**IMPACT is NPI based.** If you have one NPI for multiple locations, after you enter the Primary Location, Correspondence and Pay-To addresses, you can skip the “Add Locations” step.

### Specialty/Subspecialty

When enrolling the Group, IMPACT will ask for the Provider Type, Specialty and Subspecialty. It is recommended that you use:

- Provider type: Group
- Specialty: Clinic or Medical
- Subspecialty: No Subspecialty

## Enrollment Timeline and Commitment

All providers will be required to revalidate every 3-5 years depending on risk level or other factors determined by the Medicaid program.

The enrollment into IMPACT is not a contract – it is an opportunity to bill Medicaid as the provider wishes. Even after applying and receiving approval, the provider does not have to bill for services at all.

## Email Addresses

Each practitioner will not need a specific email address. The group's email address can be entered for each practitioner. Please note that any email address listed needs to be monitored frequently and associated to the individuals who will be acting on the provider's behalf. This is very important as email is the primary mode of communication in the IMPACT system.

## Documents to Have On Hand for IMPACT Enrollment as Group or FAO

- Information on your organization, including the Primary Practice Location address, a Correspondence Location, a Pay-To Location, office hours, whether ADA accessible, language spoken, communication preferences, telephone number, email address – and similar information on all other locations
- Contact information on each of the owners, including percent ownership, social security number, address, telephone number, relationship between each owner
- NOTE: If you are enrolling as a Not-for-Profit organization, it is recommended that you put 100% for your Corporate charitable 501(c)(3) ownership record. Then list each Board of Directors/Officers' ownership record who engage in making day to day decisions, with 0% ownership. Your managing employee can be anyone with some decision-making authority, also with 0% ownership.
- Information about each owner's ownership interest in other entities reimbursable by Medicaid or Medicare – it is required that ownership of 5% or more in any other Medicaid/Medicare entity be entered
- Specific information, including dates, of any adverse legal actions for each owner, including convictions, suspensions, revocations or exclusions – even if they were expunged or appeals are pending (note: if older lawsuits are unknown, state as such in the comments)
- Certified W-9 with the Comptroller (Rendering/Service providers do not require a certified W-9)

## Medicaid Enrollment by Individual Practitioners

### Rendering/Service Provider

This refers to the individual provider who renders services to Medicaid clients but does not submit claims directly to the state for reimbursement. Each provider must enroll separately. A step-by-step Business Process wizard is at:

<https://www.illinois.gov/hfs/impact/Documents/IMPACTTypicalRenderingService.pdf>

### Specialty/Subspecialty

In case of abortion providers, the provider type, specialty and subspecialty are likely to be:

- Physicians – Obstetrics and Gynecology – add Subspecialty or No Subspecialty

- Advanced practice nurse – Certified Nurse Practitioner – add Subspecialty or No Subspecialty
- Physician Assistant – Physician Assistants – No Subspecialty

### Billing Provider

You will be asked to “associate” with a Billing Provider, which is the provider who submits claims and/or receives payment for the individual practitioners, i.e. the abortion clinic or Ambulatory Surgical Treatment Center where the practitioner performs abortion services. You do not need to provide your own email address but can use the email address of the Billing Provider. NOTE: any email address listed needs to be monitored frequently and associated to the individuals who will be acting on the provider’s behalf. This is very important as email will be the primary mode of communication in the IMPACT system.

If a physician at your group or clinic already has a Medicaid provider number for a different medical entity the already-enrolled provider will then need to “associate” to your Group or FAO, using the Billing Provider step.

### Taxonomy Details

You will be asked to enter the correct taxonomy for your specialty from the [National Uniform Claim Committee Taxonomy Code](#) list. Choose the code that best identifies you as a provider. For example, see the taxonomy codes below. You also will be asked to list the start date for you as a provider.

- Obstetrics and Gynecology - Gynecology - 207VG0400X
- Nursing Service Providers - Women's Health Care, Ambulatory - 163WW0101X

### MCO Plan

You will be asked to “associate” with an MCO Plan. Unless you have an individual contract with an MCO, this will not be relevant for individual Rendering/Service Providers for abortion services.

### Documents to Have on Hand for IMPACT Enrollment as Rendering/Service Provider

- State professional license – number/effective date
- Board certification (MDs) or National Board Certificate (APNs and PAs) – number/effective date
- Contact information, including the NPI, for the Billing Provider
- Details of ownership - it is required that ownership of 5% or more in any other Medicaid/Medicare entity be entered
- Specific information, including dates, of any adverse legal actions, including convictions, suspensions, revocations, exclusions or monetary penalties – even if they were expunged or appeals are pending (note: if older lawsuits are unknown, state as such in the comments)

## Enrolling in Medicaid for Patients

### Covered Services

This providers manual assumes that abortion providers who become Medicaid providers for purposes of billing the state for abortion services for Medicaid-enrolled women will also bill Medicaid managed care organizations (MCOs) for a variety of family planning and other reproductive healthcare services.

Accordingly, the eligibility rules and processes described here could cover a range of populations and services.

## Eligibility Criteria

Applicants for Illinois Medicaid apply under the Public Aid Code (PAC) as certain classes or groups:

- Pregnant women of any age
- Parents or caretaker relatives raising minor children
- Single persons (age 19 through 64) – also called “ACA Adults” or adults without dependent children who became eligible for “Medicaid expansion” under the Affordable Care Act
- Children (through age 18)
- Adults (age 19 through 64) with disabilities – including those dually eligible with Medicare
- Seniors (age 65 and older)

Special provisions apply to coverage of emergency services and are not addressed here.

### Pregnant Women

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| ➤ Residence:                      | Must be Illinois resident         |
| ➤ Age:                            | Any                               |
| ➤ Citizenship/Immigration Status: | Any                               |
| ➤ SSN:                            | Not required                      |
| ➤ Income:                         | ≤213% FPL - varies by family size |
| ➤ Other:                          | Must be pregnant                  |

### Parents/Caretaker Relatives Raising Minor Children

- |                                   |                                                                                                     |
|-----------------------------------|-----------------------------------------------------------------------------------------------------|
| ➤ Residence:                      | Must be Illinois resident                                                                           |
| ➤ Age:                            | All                                                                                                 |
| ➤ Citizenship/Immigration Status: | Citizens or lawfully present not subject to 5-year bar on means-tested public benefits <sup>1</sup> |
| ➤ SSN:                            | Valid SSN or applied for                                                                            |
| ➤ Income:                         | ≤138% FPL - varies by family size                                                                   |
| ➤ Other:                          | Must be raising related minor children                                                              |

### Single Persons Over 19 Years of Age (“ACA Adult”)

- |                                   |                                                                                        |
|-----------------------------------|----------------------------------------------------------------------------------------|
| ➤ Residence:                      | Must be Illinois resident                                                              |
| ➤ Age:                            | 19-64                                                                                  |
| ➤ Citizenship/Immigration Status: | Citizens or lawfully present not subject to 5-year bar on means-tested public benefits |
| ➤ SSN:                            | Valid SSN or applied for                                                               |
| ➤ Income:                         | ≤138% FPL - varies by family size                                                      |

<sup>1</sup> Most qualified aliens entering the country on or after August 1996 are banned from receiving Federal means-tested public benefits for a period of 5 years beginning on the date of entry with a qualified alien status. Medicaid has been determined to be a federal means-tested public benefit.

### Children/Teens Under 19 Years of Age

- Residence: Must be Illinois resident
- Age: <19 years
- Citizenship/Immigration Status: Any – including undocumented children
- SSN: Valid SSN or applied for  
Not required for certain noncitizen children
- Income: ≤147% Federal Poverty Level (FPL) - varies by family size
- Other: Abortions are not funded by the State for children and teens receiving health services under other state laws: Illinois’ All Kids Share and All Kids Premium Levels 1 and 2. However, some pregnant teens eligible as children under these laws would be eligible for Public Aid Code.

### Persons with Disabilities – Including Those Who are Dually Eligible with Medicare

- Residence: Must be Illinois resident
- Age: <65
- Citizenship/Immigration Status: Citizens or lawfully present not subject to 5-year bar on **means-tested public benefits**
- SSN: Valid SSN or applied for
- Income: ≤100% FPL - varies by family size
- Resources: ≤\$2,000 single/\$3,000 couple; homestead exempted, limits on life insurance, etc.
- Other: Must have permanent disability per Social Security rule or be blind

### Summary: Different Populations Have Different Income Eligibility Requirements

Pregnant woman	Parent raising minor children up to age 19	Single Person over 19 years of age	Child (teen) under 19 years of age	Person with disability
Up to 213% Federal Poverty Level (FPL) – varies by family size	Up to 138% FPL – varies by family size	Up to 138% FPL	Up to 147% FPL – varies by family size	Up to 100% FPL – varies by family size plus limits on assets
Example of pregnant woman with 0 children: may earn up to \$3,002 monthly or \$36,019 annually	Example of mom with 2 children: may earn up to \$2,453 monthly or \$29,435 annually	Called “ACA Adult” because he/she became eligible under Medicaid expansion through Affordable Care Act	Example of child with 2 parents, 2 siblings (5 in household): family may earn up to \$3,696 monthly or \$44,352 annually	May also be “dually eligible” – both Medicare and Medicaid
		Example of 1 in household unit: may earn up to \$1,436 monthly or \$17,236 annually		Example of single disabled adult: may earn up to \$1,041 per month or \$12,490 annually + \$2,000 max. in asset

### Dollar Value of Federal Poverty Levels in Illinois for Calendar Year 2019

By law, only monthly amounts may be used to determine Medicaid eligibility. Annual numbers are not directly relevant but are provided here for general information. Annual amounts are rounded to the

nearest tenth. Illinois adjusts these dollar amounts annually after the federal Centers for Medicaid and Medicare Services updates the federal poverty level guidelines based on changes in the cost of living.

Persons in Family/ Household	Persons with disabilities	Parents/Caretakers /ACA Adults	Children/Teens	Pregnant Women
<b>Income Eligibility</b>	100% FPL	138% FPL	147% FPL	213% FPL
<b>1</b>	\$1,041/mo (~\$12,490/yr)	\$1,436/mo (~\$17,236/yr)	\$1,531/mo (~\$18,372/yr)	N/A*
<b>2</b>	\$1,409/mo (~\$16,910/yr)	\$1,945/mo (~\$23,336/yr)	\$2,072/mo (~\$24,864/yr)	\$3,002/mo (~\$36,019/yr)
<b>3</b>	\$1,778/mo (~\$21,330/yr)	\$2,453/mo (~\$29,435/yr)	\$2,613/mo (~\$31,356/yr)	\$3,786/mo (~\$45,433/yr)
<b>4</b>	\$2,146/mo (~\$25,750/yr)	\$2,961/mo (~\$35,535/yr)	\$3,155/mo (~\$37,860/yr)	\$4,571/mo (~\$54,848/yr)
<b>5</b>	\$2,515/mo (~\$30,170/yr)	\$3,470/mo (~\$41,635/yr)	\$3,696/mo (~\$44,352/yr)	\$5,355/mo (~\$64,263/yr)
<b>6</b>	\$2,883/mo (~\$34,590/yr)	\$3,978/mo (~\$47,734/yr)	\$4,238/mo (~\$50,856/yr)	\$6,140/mo (~\$73,677/yr)
<b>7</b>	\$3,251/mo (~\$39,010/yr)	\$4,486/mo (~\$53,834/yr)	\$4,780/mo (~\$57,360/yr)	\$6,924/mo (~\$83,092/yr)
<b>8</b>	\$3,619/mo (~\$43,430/yr)	\$4,994/mo (~\$59,933/yr)	\$5,322/mo (~\$62,300/yr)	\$7,709/mo (~\$92,506/yr)
<b>For each additional person, add:</b>	+368/mo	+507/mo	+542/mo	+785/mo

\*For determining a pregnant woman's income, both the fetus and woman are counted in family size

## Application Process

### Three Ways to Apply for Medicaid, Cash or SNAP (formerly Food Stamps)

#### Apply Online

- Use the [Application for Benefits Eligibility \(ABE\)](https://abe.illinois.gov/abe/access/) to apply for SNAP, cash or medical assistance.
- Refer to the [Guide to Completing an ABE Application](#).
- If you are an organization or agency that helps people access benefits, refer to the Guide to ABE for Community Partners.

#### Apply Using a Paper Application

- Download the application
  - [IL444-2378 B - Request for Cash Assistance, Medical Assistance, Supplemental Nutrition Assistance Program \(SNAP\)\(IES\)\(pdf\)](#)
  - [IL444-2378 BS Solicitud Para Asistencia Economica - Asistencia Medica - Estampillas de Comida \(SNAP\) \(IES\) \(pdf\)](#)
- Follow the directions on the form. Type in as much information as you can. If you can't answer all the questions, that's ok. You must include your name and address. You may print out the application and write on it if you prefer. You must sign the form.

- Once you've completed the application, carry, mail or fax it to your local Family Community Resource Center. Use the DHS Office Locator to locate your local office.

#### *Apply at a local Family Community Resource Center*

- Applications are taken at the DHS Family Community Resource Centers. Use the DHS Office Locator to locate the facility in your county to apply for benefits.

### **Signing the application**

Illinois regulations<sup>2</sup> require that applicants must sign their applications with some exceptions. Per the rule, children may not sign for themselves with the following exceptions.

*“(c)(3) When application is made for a non-emancipated child under the age of 18, the application must be signed by one of the following:*

- A) the child's caretaker relative with whom the child lives;*
- B) an individual with whom the child lives who intends to claim the child as a tax dependent; or*
- C) if neither subsection (c)(3)(A) or (c)(3)(B) applies, the child.”*

### **Verifying eligibility for Medicaid**

Eligibility for Medicaid, including residency and income, are verified by the state. Children's age and pregnancy are the only eligibility criteria that do not require verification – just the applicant's attestation.

### **Entities making the determination of eligibility**

State caseworkers at the Department of Human Services and Healthcare and Family Services process eligibility.

### **Earliest coverage date**

Coverage begins on the first day of the month in which the application was received by the state or, if requested, up to three months prior to the month of application, assuming the individual was eligible in each of those months.

### **Length of eligibility period**

- Pregnant women remain eligible regardless of changes in income for 60 days postpartum. Other children and adults' eligibility can change from month to month with changes in income.
- Children remain eligible for one year regardless of increases in family income. Change in age can result in a shift to a different group or loss of coverage.
- Changing residence to a different state or country results in termination.
- Every individual is required to have an annual review of all eligibility criteria.

### **Recording eligibility in the Medicaid system**

All required data must be obtained, and all verifications completed and processed by state caseworkers through the Integrated Eligibility System (IES). When eligibility is certified, information on eligible

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<sup>2</sup> 89 IAC 110.10(c)(3)

individuals is automatically transferred via electronic interface into the payment system, called the Medicaid Management Information System (MMIS).

After that full process is complete, Medicaid providers with access to HFS's Medicaid Electronic Data Interchange portal (MEDI) are able to confirm that an individual is covered and may submit billing.

## Medicaid Claiming for Abortions and Family Planning Services

### General Claiming Procedures for Surgical or Medication Abortions

As of November 1, 2019, all abortion services for both fee-for-service and managed care participants will be state-only funded. With this change, all claims, regardless of the date of service, that contain abortion procedures must be billed directly to the IL Department of Healthcare and Family Services (HFS). This applies to claims submitted for participants covered under a Medicaid managed care plan as well as traditional fee-for-service. (See pages 11 – 13 for more information on working with the Medicaid managed care plans.)

All claims must be submitted within 180 days from the date of service.

### Using the Medical Electronic Data Interchange (MEDI) System

All claims for abortion services must use the MEDI System. The MEDI System is available free of charge and provides a repository for authorization information for access to HFS' Internet applications. In order to gain access to these applications, a person must register in the MEDI system. The [MEDI Getting Started](#) page presents what is required to use these applications.

No additional hardware or special software is needed. The MEDI System is available to enrolled providers and their authorized staff, claim submitting agents and payees. During the registration process, providers and authorized personnel will be given access to specific claim formats based upon the provider's enrollment status with HFS.

This system's main purpose is to provide users with the ability to perform basic processing, including submitting claims, viewing claim status, downloading Remittance Advices, and accessing other Department information online through a web interface. Through electronic claim submission, providers receive immediate feedback on many of the required field entries. In addition, a confirmation page is available to print on each successful submission of a claim. The confirmation page displays all of the fields that were entered on the claim submission, including date of submission, time of submission and confirmation number, which can be used for tracking purposes.

### Specific Claiming Procedures and Rates for Surgical or Medication Abortions

The specific procedures for claiming (below) are valid for those providers that have enrolled in the IL Medicaid Program as a "Group" in the IMPACT enrollment system. Any abortions performed in hospitals or in Ambulatory Surgical Treatment Centers also can claim a facility fee. Under the IL Medicaid Program, an ASTC license requires Medicare certification.

**Surgical abortion:** This is a global rate reimbursement. No ancillary services are billable.

Type of Service	Procedure Code	Rate
Surgical, Induced, D & C	59840	\$660.00
Surgical, Induced, D & E	59841	\$1,600.00

**Medication abortion:** In addition to the procedure code (S0199), reimbursements for the two medications are billable.

Type of Service/Medication	Procedure Code	Rate
Medication-assisted	S0199	\$465.00
Mifepristone, 1 <sup>st</sup> pill	S0190	\$68.33
Misoprostol, 4 pills	S0191	\$1.35 per pill

**837 Professional:** Providers must identify the abortion procedure code in Loop 2400, Segment SV101. The Department will no longer require the use of specific procedure code modifiers on practitioner claims.

**837 Institutional:** Hospitals must identify the abortion procedure code in Loop 2300, Reference HI\*BG\*AH~. The Department will no longer require the use of specific condition codes on hospital claims.

## General Claiming Procedures and Rates for Family Planning Services

Family planning services for Medicaid-enrolled women and men in Illinois are reimbursable. Almost all of these patients for family planning and other reproductive healthcare services also are required to enroll in one of the Medicaid managed care health plans (MCOs).

[Section 3.1.3 of the model contract](#) between HFS and MCOs outlines the full range of services under the category of “family planning”:

- all safe, effective and clinically appropriate contraceptive methods, with emphasis on the most effective methods first. and encourage use of long-acting reversible contraceptives (LARCS), such as IUDs and implants when clinically appropriate, and consistent with FDA approved product information label;
- contraceptive methods must also include over-the-counter and prescription emergency contraception, if indicated;
- permanent methods of birth control, including tubal ligation, transcervical sterilization, and vasectomy, if clinically appropriate and desired by the patient;
- basic infertility counseling, consisting of medical/sexual history review and fertility awareness education, if indicated. (Infertility medications and procedures are not Covered Services.);
- reproductive health exam if medically necessary to determine safety and provision of contraception;
- sexually transmitted infection (STI) screenings in accordance with USPSTF A and B recommendations;
- universal HIV testing, counseling, and screening in accordance with USPSTF A and B recommendations;

- lab and screening tests that are clinically necessary for safe and prudent delivery of Family Planning and reproductive health services;
- cervical, breast and other cancer screening in accordance with USPSTFs A and B recommendations
- vaccines for preventable reproductive health in accordance with current CDC recommended immunization schedule, updated annually;
- genetic counseling and testing, if clinically indicated;
- maternity care

All practitioner fees are listed in the [Practitioner Fee Schedule](#), which is periodically updated. The following fees apply to this sample of family planning services, updated 9/11/2019:

#### *Sample of Family Planning Services*

Type of Service	Procedure Code	Rate
<b>Contraceptive management (new)</b>	99202	\$32.00
<b>IUD insertion</b>	58300	\$88.00
<b>Liletta insertion and device</b>	58300+J7297	\$88.00 + \$749.40
<b>Nexplanon insertion</b>	11981	\$88.00
<b>Nexplanon insertion and device</b>	11981+J7307	\$88.00 + \$847.90
<b>IUD removal</b>	58301	\$37.40
<b>Oral contraceptive pills</b>	S4993	\$40.95 (3 mos.)
<b>Male condoms</b>	A4267	\$0.456 each
<b>DMPA Depo-Provera – 3 mo. Injection**</b>	J1050	\$0.562 per mg

\*\* Must be billed at 150 mg (intramuscular) or 104 mg (subcutaneous)

## Presumptive Eligibility

Effective on January 29, 2020, the Illinois Department of Healthcare and Family Services adopted a final rule expanding the types of providers that may determine Medicaid presumptive eligibility for pregnant women. Under the revised rule, a provider furnishing health care that is covered under Medicaid can be considered a qualified presumptive eligibility provider.

To qualify, a provider must be enrolled as a Medicaid provider, enter into the Medicaid Presumptive Eligibility (MPE) Provider Agreement with the Department and attend Department training. Interested providers should submit a request to become an MPE provider by calling 217-524-7156 or faxing a written request to 217-524-4274. The link below outlines this process.

<https://www.illinois.gov/hfs/MedicalProviders/ProviderPrograms/Pages/MedicaidPresumptiveEligibility.aspx>

Additional information is available in the MPE Manual on the All Kids website.

<https://www.illinois.gov/hfs/MedicalPrograms/AllKids/akaa/Pages/default.aspx>

## Working with Medicaid Managed Care Organizations (MCOs)

### Illinois Managed Care Landscape

The Illinois Medicaid managed care program now covers all counties in Illinois and is called *HealthChoice Illinois*. As a *HealthChoice Illinois* member, the Medicaid-enrolled patient is able to select from a range of health plans. Contact information for each *HealthChoice Illinois* health plan is included in Appendix A.

Those women who are disabled may be dually eligible with Medicare and Medicaid. They will not be a member of *HealthChoice Illinois* but instead will be a member of a health plan that is in the *Medicare-Medicaid Alignment Initiative (MMAI)*. Contact information for each MMAI health plan is included in Appendix B.

For sake of simplicity, all *HealthChoice Illinois* and MMAI health plans are called MCOs in this handbook.

You need to contract with the MCOs because you will need to submit the claims for family planning and other reproductive healthcare services for Medicaid-enrolled teens and adults to the appropriate MCO of which your patient is a member.

### Contracting with MCOs

Enrollment in an MCO is a three-step process: contracting, credentialing and provider load.

- **Contracting.** Contact any MCO you are interested in contracting with by reaching out to the Provider Network representative on the health plan contact list (Appendix A and B).
- **Credentialing.** In addition to contracting with the MCO, providers must be credentialed by the MCO. Credentialing takes approximately thirty (30) to ninety (90) days. It is imperative for providers to submit clean documents with all applicable information when submitting their credentialing applications.
- **Provider Load.** Once a provider is credentialed, it takes thirty (30) to sixty (60) days to load provider information into the MCO's system.

You are encouraged to contract with most if not all of the MCOs to become part of their network for a range of services that your patients may need.

The contract negotiated between the Medicaid provider and the MCO dictates the relationship between the two parties, including payment provisions, provider complaint and resolution procedures and panel limitations. Once a provider has contracted successfully with an MCO, the provider is considered an Affiliated Provider.

To participate in a Medicaid MCO's network for family planning services, the provider needs a contract that includes Medicaid services and professional services. Facilities-only contracts do not cover family planning services. If you are currently holding a facility-only contract with MCOs, contact the plans regarding a professional contract so that you can bill for family planning services for Medicaid- and MMAI-enrolled women and men. These may involve new contracts or amendments to your current contracts.

MCOs are required to meet with the Affiliated Providers to explain their policies and procedures, via phone call, webinar or in the providers' offices. Provider orientation or training will include information on the MCOs utilization policies and procedures, cultural competency requirements, and billing or claims submittal information in order to be reimbursed for a service rendered. A contact person at the MCO will serve as the provider's representative.

**Useful Tip:** Be in routine contact with your MCO provider relations representative to expedite response to questions and issue resolution time.

Provider manuals are available online to all Affiliated Providers. Each MCO has a provider portal where the provider can go to learn administrative requirements.

### Sample Contracting Discussion with MCO

MCO will contract	MCO will not contract
<ul style="list-style-type: none"> <li>• <b>Provider:</b> I am from a family planning provider and would like to join your Medicaid &amp; MMAI networks</li> <li>• <b>MCO:</b> Great! Please follow our online instructions and you will receive our response in X days</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Provider:</b> I am from a family planning provider and would like to join your Medicaid &amp; MMAI networks</li> <li>• <b>MCO:</b> Our network for this type of providers are full. We are not offering any more contracts</li> <li>• <b>Provider:</b> It is my understanding that through the Medicaid program you are required to pay for the services we provide whether or not we have a contract. What is the process to submit and have claims paid as a non-participating or out-of-network provider?</li> <li>• <b>MCO:</b> I will send you a copy of our protocols so you can bill as a non-participating provider</li> </ul>

## Provider Billing

As stated, providers must bill the Medicaid MCOs for family planning services for Medicaid-enrolled women and men.

Every MCO's Enrollee ID card contains the Enrollee's HFS Recipient Identification Number (RIN). Providers MUST verify coverage and MCO enrollment through one of the HFS automated systems using the participant's Social Security Number or the participant's RIN found on either the HFS Medical Card or MCO's Enrollee ID card.

There are two options for verifying participant eligibility for Medicaid services:

- Medical Electronic Data Interchange (MEDI)

MEDI is the secure Web site for the Illinois Department of Healthcare and Family Services that allows authorized users online access to Medical Assistance Information for Medicaid Providers, among other programs. Information on access to MEDI is found here:

<https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/GettingStarted.aspx>

- Automated Voice Response System (AVRS)

For AVRS, providers should call 1-800-842-1461 and must have:

- 9-, 10- or 12-digit Medicaid Provider number;
- 9-digit Recipient Identification Number (RIN); and
- Date for which eligibility information is being sought.
- The AVRS will provide all information relating to a participant's eligibility, including MCO enrollment, and will permit up to 6 eligibility inquiries during each telephone call.

## Timely Payments

Under state law, all Medicaid claims must be submitted for payment within 180 days from the date of service.

MCOs are responsible for making payments to providers for “clean claims” for covered services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a.

NOTE: A “clean claim” is a claim from a provider for covered services that can be processed without obtaining additional information from the provider of the service or from a Third Party, except a claim submitted by or on behalf of a provider who is under investigation for fraud or abuse, or a claim that is under review for determining whether it was Medically Necessary.

## Explanation of Benefits

Explanation of Benefits (EOBs) are not sent either by HFS or the MCOs to patients who seek abortions or family planning services. Illinois law 305 ILCS 5/5-30(i) prohibits sending EOBs for “sensitive health services” which is defined in the law to include reproductive health and family planning services.

## Prior Authorizations/Services by Non-Network Providers

[Section 3.1.3 of the model contract](#) between HFS and MCOs has a specific section on “Family Planning and reproductive healthcare”. Among other provisions, it requires that:

- Contractor (the MCO) shall ensure provision of the full spectrum of Family Planning options and reproductive health services are appropriately provided within the practitioner’s scope of practice and demonstrated competence.
- Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. [“Step-failure therapy”, also known as “fail first”, is a process used by health insurance companies which requires patients to try one less expensive drug first, such as birth control pills – and if that fails and results in a pregnancy, then access to a more expensive long-acting reversible contraception.]

- Contractor shall pay for Family-Planning services ...rendered by a non-Network Provider, for which Contractor would pay if rendered by a Network Provider, at the same rate the Department would pay for such services exclusive.

**Summary: Responsibilities of MCOs**

- Must pay for all family planning and reproductive health services (except abortions, which are paid as fee-for-service directly by HFS)
- No prior authorization allowed
- No step-failure therapy allowed
- Must pay for out-of-network providers of family planning services
- No mailing of explanation of benefits to member's home
- Must have a provider grievance and appeals process

**Appendix A: Medicaid MCO Contact Information**

	<b>Blue Cross Community</b>	<b>CountyCare</b>	<b>IlliniCare</b>	<b>Meridian</b>	<b>Molina</b>	<b>NextLevel Health</b>
<b>Provider Resources</b>	<a href="https://www.bcbsil.com/provider/network/securedpage.html">https://www.bcbsil.com/provider/network/securedpage.html</a>	<a href="http://www.countycare.com/resources">http://www.countycare.com/resources</a>	<a href="https://www.illinicare.com/providers/resources/forms-resources.html">https://www.illinicare.com/providers/resources/forms-resources.html</a>	<a href="https://corp.mhplan.com/en/provider/illinois/meridianhealthplan">https://corp.mhplan.com/en/provider/illinois/meridianhealthplan</a>	<a href="https://www.molinahealthcare.com/providers/il/medicaid/manual/Pages/home.aspx">https://www.molinahealthcare.com/providers/il/medicaid/manual/Pages/home.aspx</a>	<a href="https://nextlevelhealthil.com/providers/materials-and-resources/">https://nextlevelhealthil.com/providers/materials-and-resources/</a>

**Appendix B: MMAI Only MCO Contact Information**

	<b>Aetna</b>	<b>Humana</b>
<b>Join the network</b>	<a href="https://www.aetnabetterhealth.com/illinois/providers/join-our-network">https://www.aetnabetterhealth.com/illinois/providers/join-our-network</a>	<a href="https://www.humana.com/provider/medical-resources/join-humana-network">https://www.humana.com/provider/medical-resources/join-humana-network</a>
<b>Provider Service</b>	<a href="https://www.aetnabetterhealth.com/illinois/providers/resources/services">https://www.aetnabetterhealth.com/illinois/providers/resources/services</a>	<a href="https://www.humana.com/provider/contact">https://www.humana.com/provider/contact</a>
<b>Provider Resources</b>	<a href="https://www.aetnabetterhealth.com/illinois/providers/">https://www.aetnabetterhealth.com/illinois/providers/</a>	<a href="https://www.humana.com/provider/medical-resources/medicare-medicare/illinois-medicare">https://www.humana.com/provider/medical-resources/medicare-medicare/illinois-medicare</a>