Common Questions and Answers on the IHC Client-to-PCP Assignment Process

Table of Contents:

Definitions:

HFS: Illinois Department of Healthcare and Family Services
IHC: Illinois Health Connect
PCP: Primary Care Provider
MEDI: Medical Electronic Data Interchange System

Q: Which HFS and All Kids medical card recipients are eligible to be in IHC?
A: Most HFS and All Kids medical card recipients MUST select or be assigned to an enrolled PCP.* Those populations include:

-Children in all levels of the All Kids program
-Parents in the FamilyCare program
-Moms and Babies program
-Adults with disabilities and the Elderly

If the provider is uncertain if the patient is eligible for IHC, the provider may contact the IHC Provider Help Desk at 1-877-912-1999 to verify.

*Patients who live in the following counties have the option of selecting IHC or a Managed Care Organization plan: Adams, Brown, Cook, Henry, Jackson, Kane, Lee, Madison, McHenry, Mercer, Perry, Pike, Randolph, Rock Island, Scott, St. Clair, Washington and Williamson.

Q: Which HFS and All Kids recipients are excluded from IHC?

A: Some HFS (Medicaid) clients (approximately 25%) are excluded from the IHC program and do not have to pick a PCP. ***If verifying the PCP assignment via HFS' MEDI system, and there is no PCP listed for the date of service, then the patient can be seen by any HFS provider.*** A provider may also contact the IHC Provider Help Desk to verify if a patient is excluded from IHC. IHC patients who are new to the program and are within their initial 60-day enrollment period for selecting a PCP may also appear in MEDI without a PCP. These patients may also see any HFS provider until they are linked to a PCP.

Excluded populations include:

Medicare dual eligible

Supplemental Security Income (SSI) children under age 21

American Indians/Alaska Natives (may voluntarily enroll but not mandated)

Department of Children and Family Services (DCFS) Wards and Subsidized Guardianship and Adoption Assistance children

Participants eligible through the Aid to the Aged, Blind and Disabled (AABD) program under the age of 21

Individuals residing in Nursing Facilities (including ICF/DDs, ICF/MIs and state operated facilities)

Spend-down clients (Participants who have intermittent coverage)

Some Home- and Community-Based (HCBS) Waiver Enrollees including Participants with developmental disabilities or children who are medically fragile, technology dependent

Participants residing in Department of Human Services (DHS) Community Integrated Living Arrangements (CILAs) and CILA look-alikes

Presumptively Eligible Participants

Individuals enrolled in the following limited benefits programs:

a. Illinois Healthy Women

b. All Kids and FamilyCare Rebate

c. Illinois Cares Rx, formerly known as SeniorCare/Circuit Breaker

d. DHS Social Service Package A and B

e. General and Transitional Assistance adults age 19 and older

f. Emergency Medical only

g. Hospice

h. Sexual Assault, Renal and Hemophilia programs through the Department of Public Health (DPH)

Participants with high level third-party health insurance

Participants enrolled in the Voluntary Managed Care program

Participants required to enroll in the Integrated Care program

Participants in the Program for All-Inclusive Care for the Elderly (PACE)

Participants under the control of the Department of Corrections

Participants eligible through the Health Benefits for Persons with Breast or Cervical Cancer program

Children under age 21 whose care is managed by the Division of Specialized Care for Children (DSCC) of the University of Illinois at Chicago

Refugees and Iraqi and Afghan immigrants

Participants receiving services through the Asylee or Torture Victim program

Clients in the Recipient Restriction Program (RRP) who are restricted to a particular physician. RRP clients who are only restricted to a particular pharmacy are not excluded from the PCCM program.

Always check MEDI for any patient who has a HFS or All Kids card whether it is primary or secondary coverage. Even if you believe a patient is excluded, it is necessary to verify if they have a PCP and if so who that PCP is.

Q: If a patient is eligible for IHC, what is the enrollment process like?
A: Once a patient becomes eligible for IHC (either through gaining benefits or no longer being a part of an excluded population), the patient/parent will have approximately 60 days to contact IHC to select a PCP. Throughout this 60 day period, the patient/parent will receive several mailings and outreach calls to ensure that the patient/parent actively selects his/her desired PCP. If the patient/parent does not respond to IHC's efforts, then the patient will be auto-assigned to the best fit PCP for him/her.

Q: If a patient/parent does not actively select his/her desired PCP, what factors are taken into account to auto-assign a patient to a PCP?
A: A patient can only be auto-assigned to a PCP if that PCP elects to allow patients to be auto-assigned to his/her panel of IHC patients. IHC will then take into account the following factors:

-Who the patient may have previously been linked with
-The PCP that family members (on the same case/card) are linked to
-Medicaid claims history
-Geographically closest PCP to the patient's home

Q: Why does a patient who has been seeing the provider for many years or even since birth not get auto-assigned to this provider?
A: There are several factors that may cause this. First, a client may not have a Medicaid claims history with that provider. For example, newborns may see a provider several times before HFS receives a claim for services from the provider and processes the claim. If there isn't a Medicaid claims history, the newborn may not be auto-assigned to that PCP. In addition, if a patient has recently gained HFS or All Kids eligibility, there is no patient and/or family Medicaid claims history to show the link to this provider because the services were previously paid through another insurance or private pay arrangement. Also, if a PCP has a panel roster which is at capacity, or a provider does not choose to accept auto assignments, IHC cannot auto-assign clients to the PCP.

In order to ensure a patient is assigned to the provider of their choice, it is very important to encourage patients to call IHC as soon as possible after they receive their enrollment packet so they may make an active choice of a PCP for themselves or their family.

Q: What happens if a patient loses eligibility for a period of time, and then regains it, making him/her once again eligible for IHC?
A: If the patient loses and then regains eligibility within a 60-day period, IHC will make every effort to reinstate the patient back to the PCP of his/her choice in order to maintain continuity of care. However, patient eligibility is complicated and reinstating the patient with the original PCP may not always be possible. If the patient loses eligibility for a period greater than 60 days, then the patient will have to actively select his/her PCP again (just like the initial enrollment process) or will be auto-assigned to a PCP. Therefore, it is very important to check the patient's IHC PCP at every visit. As always, the patient has the option to make a PCP selection once per calendar month.

Q: When a patient enrolls onto a PCP's panel, either during the enrollment process or when making a PCP assignment change, can the PCP see the patient right away?
A: Patients can make one active PCP change per calendar month. If the patient is eligible to make a PCP change and the patient contacts the IHC hotline and meets all of the restrictions set on the PCP's panel, then an automatic referral will be issued and the patient can see the PCP or an affiliate the same day. This <u>does not</u> apply to the following enrollments: 1. a patient enrolls via an initial enrollment form from the mailing sent by IHC; 2. the PCP has restrictions on their panel (existing patients only, not accepting pregnant women for primary care, age restrictions etc.) that necessitate the PCP to sign a restriction form; or, 3. the patient makes this selection on the IHC website. For all IHC referrals, a referral tracking number will be issued. The PCP can verify this referral in the IHC Provider Portal, which is an application on the HFS MEDI system. It can also be verified with the IHC Provider Services Help Desk.

Q: Why are there some patients that can be enrolled with a PCP right away but others must have a form signed in order to enroll?

A: If a patient does not meet one or more of the restrictions set by the PCP (i.e. existing patients only, not accepting pregnant women, etc.), then a patient will not be allowed to enroll right away. In these cases, IHC will fax a panel restriction form to the patient's desired PCP. The PCP has 30 days to send the form back, either approved or denied. If the form is not received back by the 30th day, then the form is automatically cancelled. If this is the case, then the patient will need to contact IHC to start this process again.

Once the form is received by IHC from the PCP's practice, it will be processed within a few business days. This processing will take a maximum of five days. In some cases, the change may take up to 30 days if the patient has already made another PCP selection for the month; the patient loses eligibility or his/her eligibility has changed at the time the form is returned; or, the patient's health plan change from a Managed Care Organization (MCO) to IHC will not take effect until the next month. ***It is essential that the PCP verify if the patient is on the panel before seeing him/her***. If the patient is not on the panel by the time of the visit, and the provider still wants to see the patient and be paid, then the current IHC PCP needs to register a referral within 60 days. If a referral cannot be obtained, then the provider should wait to see the patient or refer the patient back to his/her current IHC PCP. The current IHC PCP is not obligated to register a referral. The rendering provider is taking financial risk for all patients they render services to that are not on their panel and have not obtained a referral for. Patients may not be billed for services rejected by the Department as a G11 for IHC referral needed or any other rejected service code.

Q: What happens to patients when a PCP leaves a practice location or the PCP disenrolls from IHC?
A: When a provider leaves a practice location or the PCP disenrolls from IHC, the patients will be reassigned within 24-48 hours to another IHC PCP. All patients will receive a "Provider No Longer Available" letter indicating the new provider to whom they have been assigned. If the patient does not wish to see the new provider, the patient may call IHC to pick a new PCP. The client reassignment process takes into account the same factors as the enrollment auto-assignment process. In some cases, the patients may be reassigned to another PCP at the same practice or within the same medical corporation. However, those providers MUST have auto-assignments turned on in order for the patients to potentially be reassigned to another PCP at that practice. Even with auto-assignments turned on, the patient may have a better fit PCP/medical home somewhere else and be reassigned there. All of these patients have the choice to either stay with the IHC PCP that they've been reassigned to, or to contact IHC and select a new PCP of their choice.

Q: What is the IHC process like for patients who have been dismissed from the provider's practice?
A: If a PCP has dismissed a patient from their practice, the PCP should complete a "Provider Initiated Request for Client Reassignment" form and submit it with any appropriate supporting documentation. The form can be found on the IHC website or requested through an IHC

representative. Within a week after receiving the request, the IHC Medical Director will review the request to make sure that it is within the federal guidelines for Primary Care Case Management (PCCM) programs. The provider will receive an approval or denial for removal. Once approved, the Provider Services department will usually process the request within another week. At that time, the patient will be reassigned to another IHC PCP, and that PCP reassignment will take effect in 24-48 hours. The patient will receive a letter from IHC indicating that the previous PCP is no longer available for him/her, who their new reassigned PCP is, and to contact IHC with any questions or to make a different PCP selection. Until this process is completed, IHC does ask the provider to continue to provide emergency care for the patient. While IHC attempts to process these requests as quickly as possible, the provider should allow up to 30 days.

Q: What should be done if a provider looks up the patient's PCP on MEDI, determines that the IHC PCP is not the provider (or an affiliate) intended for the visit, and the patient states that he/she has already contacted IHC to switch his/her PCP?
A: Look to see if there is a referral registered in the "Provider Referral" section of the IHC Provider Portal. Or, contact the IHC Provider Help Desk to verify the change and verify there is a referral to see the patient. If there is no referral in the system, look to see if you have received a fax to add the client onto your panel. If there is no verification that the client has switched PCPs, then direct the client back to their medical home or have the client call IHC while in your office.

Q: If it is determined that a patient does not have the provider (or an affiliate) listed as his/her PCP at the time of the visit, what should the provider do?
A: Refer the patient back to his/her medical home. If the patient does not want to do that, ask him/her to contact IHC to switch the PCP assignment. If that cannot be completed on the same day of the visit (i.e. after hours, on the weekend, or patient doesn't meet PCP's restrictions), the provider can contact the current IHC PCP for a referral. The IHC PCP, however, is not obligated to provide an IHC referral. If all of these options are exhausted, and there is a written office policy for all patients (regardless of payer type) indicating a service-by-service determination of waiving their insurance, then this may be applied to HFS and All Kids patients as well. Before accepting cash for a HFS or an All Kids patient, it is advised that a PCP gets the patient/parent/guardian to acknowledge waiving HFS coverage in writing and agreeing to a specific fee for service on that date. If a PCP accepts payment from a Medicaid patient, the PCP may not bill the Department for the services.