State of Illinois

Department of Healthcare and Family Services

PRIMARY CARE PROVIDER HANDBOOK

1-877-912-1999

www.illinoishealthconnect.com

Illinois Health Connect is administered by:

July 2011

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I. Important Telephone Numbers

General Contact Information

- Illinois Health Connect Enrollee and Provider Helpdesk: 1-877-912-1999
  TTY: 1-866-565-8577
  Fax: 1-847-995-1021
  Provider Relations Fax: 1-847-995-0827

- Illinois Health Connect Helpline Hours: Monday-Friday 8:00 AM-7:00 PM

- Illinois Health Connect Website: www.illinoishealthconnect.com

- Illinois Health Connect Mailing Address: Illinois Health Connect
  1375 E. Woodfield Road
  Suite 600
  Schaumburg, IL 60173-5418

- Illinois Nurse Helpline: 1-877-912-1999
  TTY: 1-800-571-8419

- Illinois Nurse Helpline Hours: Monday-Friday 7:00 PM-8:00 AM
  Saturday-Sunday All day (24 hours)

- HFS Provider Helpdesk: 1-800-842-1461

- HFS Billing Questions: 1-217-782-5565

Provider Support

Advisory Subcommittees
Call Illinois Health Connect (IHC) for more information about subcommittees, meeting dates, times, and locations. 1-877-912-1999

Continuity of Care
Call IHC for assistance in coordinating care for your Illinois Health Connect enrollees. 1-877-912-1999

Division of Specialized Care (DSCC)
Call DSCC for more information. 1-800-322-3722

Enrollee Eligibility Verification
Call IHC for more information. 1-877-912-1999
Or go online: Medical Electronic Data Interchange (MEDI) System
www.myhfs.illinois.gov

Recipient Eligibility Verification (REV)
www.hfs.illinois.gov/rev

Family Case Management
Contact DHS for more information about Family Case Management. 1-217-785-5900

Fraud and Abuse
To report suspected fraud and abuse committed by any HFS Medical Program participant, enrollee or any entity providing services to HFS Medical Program participants. 1-800-843-6154 TTY: 1-800-447-6404

Healthy Kids
Call IHC for more questions on the EPSDT program. 1-877-912-1999

Identifying HFS Medical Program Specialists
Call IHC for help in finding a Specialist. 1-877-912-1999

Illinois Client Enrollment Broker
Contact ICEB for more information on the delivery systems in the Voluntary Managed Care Counties, the call is free or go online. 1-877-912-8880 TTY: 1-866-565-8576 www.illinoisceb.com

Illinois Health Connect Client Helpline
Participants can call IHC for assistance in picking a PCP, enrolling, help with scheduling appointments and to answer questions. 1-877-912-1999

Illinois Health Connect Provider Helpdesk
Call IHC for more information on enrollee outreach, education, appointment scheduling, answers to questions, to talk to a provider service representative, training specialist quality assurance nurse or medical director. 1-877-912-1999

Illinois Nurse Helpline
Enrollees who cannot reach their PCPs after-hours or on weekends can call this helpline for information. 1-877-912-1999

Immunization Registry
ICARE (Formerly TOTS) 217-785-1455
Contact the Illinois Department of Public Health for more information or go online. www.idph.state.il.us

Panel Process and Provider Panel Roster
Call IHC for more information on how to change panel limits, or on the monthly PCP Panel Roster. 1-877-912-1999

Prior Authorization of Services Requirements *(Including Medical Services and Pharmacy Services)*
Prior Pharmacy Approval 1-800-252-8942
Drug Search Engine to determine need for pharmacy prior approval available at www.hfs.illinois.gov/pharmacy
Click on “Search for Prior Approval Status by Drug”
Prior Approval Fax 1-217-524-7264
DME Prior Approval (Equipment, No Pharmacy) 1-217-782-5565

Provider Education
Call IHC for more information on provider education, including information on monthly webinars, Clinical Resources, and questions about Illinois Health Connect. 1-877-912-1999

Provider Materials
Call IHC to request brochures or other materials about Illinois Health Connect. 1-877-912-1999

Provider Profiles
Call IHC for more information on the semi-annual provider profiles. 1-877-912-1999

Referral Resource Database
Call IHC to identify medical professionals and community-based agencies that can help address enrollees' medical and other (e.g. WIC, transportation) needs. 1-877-912-1999

Register Referrals
The preferred method of registering referrals is by going to www.illinoishealthconnect.com/providerportal.aspx. Contact IHC to register a referral via telephone or fax, or for more information on the referral process. 1-877-912-1999
Fax: 1-412-318-2740

Translation and Interpretation Assistance
Call IHC for assistance with translation or interpretation services, or for more information. 1-877-912-1999
TTY: 1-866-565-8577

Or use the Illinois Relay Service 711 www.illinoisrelay711.com/index.htm

Vaccines for Children Plus Program
Contact DPH for more information. 1-800-526-4372
or 1-217-785-1455
Or go online: www.illinoisaap.org/vfc.htm#join
In Chicago – 1-312-746-6358
or 1-312-746-6050

Women's Health Services
Contact IHC for more information 1-877-912-1999
Or go online: www.illinoishealthywomen.com

II. Foreword

Under Illinois Health Connect, most people with an HFS medical card or All Kids medical card will select a Primary Care Provider (PCP) to manage their care, provide immunizations and other primary and preventive health care services, provide referrals for additional care when needed and help avoid unnecessary emergency room visits and hospitalizations.

This handbook was written and developed to support Illinois Health Connect PCPs in their service to Illinois Health Connect enrollees. The handbook has been divided into topic areas relevant to Illinois Health Connect PCPs, as indicated in the Table of Contents. If you have any questions or comments regarding Illinois Health Connect, please contact us at:

Illinois Health Connect
1375 E. Woodfield Road
Suite 600
Schaumburg, IL 60173

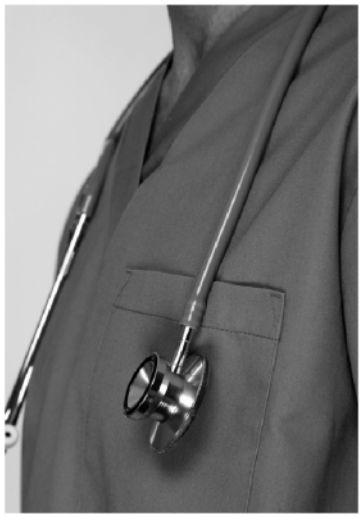
Telephone: **1-877-912-1999**
TTY: **1-866-565-8577**
Fax: **1-847-995-1021**

III. Illinois Health Connect: Program Overview

Illinois Health Connect is Illinois' Primary Care Case Management Program (PCCM). Illinois Health Connect is administered under the Illinois Department of Healthcare and Family Services (HFS), operates in all counties in the State of Illinois. Illinois Health Connect is a health plan that is available to most people covered by a HFS medical card including All Kids.

The Illinois Health Connect program enables enrollees to choose their own Primary Care Providers(PCPs), while receiving the advantages of care coordination, and case management services.
The goals of Illinois Health Connect are to:

- Improve the quality of health care and increase the utilization of primary and preventive care
- Reduce the usage of the emergency room for routine medical care
- Improve access to care through the availability of a provider network and expansion of providers
- Provide the most appropriate and cost-effective level of care



HFS will reimburse Illinois Health Connect PCPs based on current reimbursement practices for a specific provider type. PCPs, other than FQHCs, ERCs and RHCs, who participate in IHC are eligible for enhanced rates for selected primary and preventive care services. Illinois Health Connect enrolled PCPs are provided a monthly care management fee for each enrollee listed on their panel whether or not they provide services to the client that month. PCPs have daily access to panel rosters through the IHC provider portal accessed through the MEDI system. Providers can also request a monthly mailed copy of their panel roster.

The Department contracts with Automated Health Systems (AHS) to administer the Illinois Health Connect Program. Under Illinois Health Connect, AHS provides comprehensive outreach, education, enrollment, and ongoing support services to Illinois Health Connect providers and participants. The Illinois Health Connect program focuses on:

- Promotion of the patient-physician relationship to improve the quality of healthcare for members
- Increase primary and preventative healthcare services that support continuity of care services
- Improve access to care through the availability of the provider network
- Reduce unnecessary emergency room visits and hospitalizations with the establishment of a medical home, eliminating fragmented care
- Providing better coordination and continuity of care

IV. Illinois Health Connect: Program Summary

A. PCP Support

Automated Health Systems has primary responsibility for administering Illinois Health Connect. In Illinois Health Connect most people with an HFS or All Kids medical card will have a medical home with a Primary Care Provider. Illinois Health Connect offers providers support in their efforts to maintain and improve Illinois Health Connect enrollees' health. The Illinois Health Connect Provider Helpdesk (1-877-912-1999) and field representatives offer provider support available via the telephone and in the field.

Illinois Health Connect:

- Assists PCPs in enrolling in Illinois Health Connect
- Helps PCPs reach out to their Illinois Health Connect enrollees to educate them about recommended pediatric & adult preventive care and assist them in seeking timely services
- Distributes semi-annual provider profiles to support quality assurance efforts and particularly identify children & adults who have not received recommended preventive care
- Maintains relevant information and resources via the Illinois Health Connect website
- Assigns a regional provider services representative to each PCP to provide face-to-face or telephone assistance, training, troubleshooting, and other requested support
- Operates the toll-free Illinois Health Connect Helpdesk for providers, to field questions and requests for assistance during regular business hours
- Operates the toll-free Illinois Health Connect Helpdesk for participants, to provide care coordination for enrollees and assist participants in finding a PCP
- Operates the toll-free Illinois Nurse Helpline for enrollees who cannot reach their PCPs after-hours or on weekends, Enrollees can call this helpline for information
- Assists providers and enrollees in identifying medical professionals and community-based agencies that can help address enrollees' medical and other needs
- Assists with billing or payment questions

B. Illinois Health Connect Helpline

The Illinois Health Connect Helpline supplements providers' work with enrollees by providing outreach and education activities designed to ensure adherence with recommended preventive service schedules.

The Illinois Health Connect Client Helpline provides:

- Care coordination/referrals
- Specialty care referral
- Enrollee education and follow-up
- Appointment scheduling
- Referrals for pregnant women
- Information on childhood wellness and immunizations
- Promotion of HFS initiatives and resources (e.g., smoking cessation)

C. Care Management Fee

PCPs enrolled in Illinois Health Connect receive a monthly care management fee. The monthly care management fee is paid to Illinois Health Connect PCPs on a capitated basis for each client whose care they are responsible to manage. The fees are::

- $2.00 per child (under 21)
- $3.00 per adults
- $4.00 per senior or adult with disabilities

This care management fee will be paid monthly, even if the client does not utilize a service that month. PCPs will continue to receive reimbursement from HFS for their services using an enhanced fee schedule which includes an add-on for certain preventive and primary care codes and applies to both children and adult care. PCPs will continue to receive reimbursement from HFS for their services using the current established rate. The HFS fee schedule can be located at: www.hfs.illinois.gov/feeschedule/

D. Enhanced Maternal and Child Health Rates

PCPs, other than FQHC, ERCs or RHCs, automatically qualify for the enhanced maternal and child health rates. Information concerning enhanced maternal and child health rates begins on page 22 of this handbook.

E. Advisory Subcommittees

Illinois Health Connect has established subcommittees to serve as the communication vehicle between the Illinois Department of Healthcare and Family Services, Automated Health Systems, and members of the provider and participant communities. These subcommittees include the Quality Management, Provider Network, Behavioral and Mental Health, and Respiratory Illness subcommittees. The advisory subcommittees meet via teleconference quarterly. All PCPs are welcome to participate and give feedback about improving patient care and developing HFS policies.

For more information about the subcommittees' purpose and function, meeting dates, times and locations please check www.illinoishealthconnect.com or call the Illinois Health Connect Provider Helpdesk at **1-877-912-1999.**

Illinois Health Connect: General Requirements

A. Provider Enrollment

Providers Eligible to be PCPs (must meet PCP Requirements):

- Physicians, primarily General Practitioners, Internists, Pediatricians, Family Physicians, as well as OB/GYNs, and other Specialists
- Federally Qualified Health Centers (FQHCs),Rural Health Clinics (RHCs) and other clinics including certain specified hospitals and Cook County Bureau of Health Services
- Certified local health departments (PT052)
- School-Based /Link Clinics
- Nurse Practitioners and Physician Assistants, upon review and approval of the Illinois Health Connect Medical Director. An additional form completion is required.
- Other qualified health professionals as authorized by HFS

PCPs must agree to provide medically necessary care in a timely manner with a focus on the provision of quality primary and preventive health care services that support continuity of care initiatives and avoid unnecessary emergency room visits and hospitalizations.

To enroll, providers must complete and submit the IHC PCP Agreement and Attachment (see Appendix A) and:

- Enroll with HFS as a "Participating Provider" with HFS as one of the allowed provider types. Providers who are not enrolled with HFS as Participating Provider should refer to the HFS website at www.hfs.illinois.qov/enrollment/ for the appropriate enrollment forms, or contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999.
- Maintain hospital admitting and/or delivery privileges or arrangements for admission or for APNs maintain a collaborative agreement with a physician who has hospital admitting privileges.
- Make medically necessary referrals to HFS enrolled providers, including specialists, as needed.
- Provide direct access to enrollees to a person who is qualified to make medical decisions through an answering service/paging mechanism or other approved arrangement for coverage twenty-four hours a day, seven days a week. Automatic referral to hospital ER does not qualify.
- Maintain office hours of at least 24 hours/week (solo practice) or 32 hours/week (group) per location of service.
- Agree to maintain appointment standards:
  - Routine, preventive care available within five weeks from request, but within 2 weeks for infants less than 6 months, from the date of request for such care
  - Urgent care appointments not deemed emergency medical conditions triaged and , if deemed necessary, provided within 24 hours
  - Appointments for enrollee problems or complaints not deemed serious available with 3 weeks from the date of request for such care
  - Initial prenatal appointments without expressed problems: 1st trimester within 2 weeks, 2nd trimester within 1 week, 3rd trimester within 3 days
  - Upon notification of Enrollee hospitalization or ER visit, follow-up appointment available within 7 days of discharge

- Agree to provide and coordinate Maternal and Child Health Services (if providing services to pregnant women and children)
- Perform periodic preventive health screenings (EPSDT) and primary pediatric care as needed in accordance with established standards of care
- Perform risk assessments for pregnant women and children and provide obstetrical care or delivery services
- Schedule, or coordinate with a case manager to schedule, diagnostic consultation and specialty visits and communicate with the case management entity
- Provide equal access to medical care for clients in cooperation with the Department or its designated case management entity.(From the MCH agreement)
- Communicate with the case management entity.(From the MCH agreement)
- Agree to institute a symptom-based action plan of care to be shared with Enrollees with chronic diseases
- PCPs must comply with federal and state laws and regulations including 42 CFR Part 438 Managed Care. This specific Code of Federal Regulations can be located at: www.access.gpo.gov/nara/cfr/waisidx 02/42cfr438 02.html
- Provide direct access to enrollees through an answering service/paging mechanism or other approved arrangement for coverage twenty-four hours a day, seven days a week (24/7). Automatic referral to hospital ER does not qualify. When medically appropriate, PCPs will consider honoring an enrollee's request for referrals and second opinions.
- Meet other requirements as detailed in the PCP Agreement

B. Affiliations

IHC PCPs may “affiliate” with each other. This means that a “care-sharing” arrangement exists. This is most often established between partners in the same group but affiliations can also be created between practitioners who routinely provide cross-coverage for each other. For example, physicians who routinely alternate call on weekends can affiliate. This is a medical relationship which involves a care-sharing arrangement while maintaining continuity of care. The registration must be completed in the IHC system in order for these affiliations to be recognized for claims submittal. NO referrals are needed between providers who are affiliated with each other.

As a part of the application process, to register one or more affiliations with IHC, there is an affiliation form (or spreadsheet for mass affiliation requests) to be completed through your PSR or the Help Desk. This process includes the signature of both parties involved in an affiliation, certifying that a “care-sharing” agreement is an effect. After initial PCP enrollment, additional affiliations can be requested or ended any time. Once the form is submitted to IHC, the affiliation will be registered as beginning on the date it is entered. Please allow a few days for this process to take effect. From the beginning date forward all claims submitted for cross covering will be covered. Services provided prior to the affiliation will still need a referral.

Once enrolled as an IHC PCP, physicians (provider type 10) can verify existing affiliations by reviewing their Location of Service Information on the IHC Provider Portal. Other provider types should contact the IHC Provider Helpdesk at 1-877-912-1999. To establish a new affiliation following enrollment, contact your Provider Service Representative or the IHC Provider Helpdesk at 1-877-912-1999 for instructions and to obtain the proper materials.

C. Approval

PCP enrollment in the Illinois Health Connect program is complete only after IHC has reviewed and approved the application of the PCP. IHC will send a welcome letter confirming enrollment and assign a unique Illinois Health Connect Number to each PCP.

D. PCP Panel Information

- An individual PCP is allowed to accept up to 1,800 Illinois Health Connect enrollees. This is dependent on the FTE (full-time equivalency) for that provider at that location.
- A group PCP site is allowed to accept a maximum of 1,800 Illinois Health Connect enrollees per full time equivalent provider. If the PCP utilizes and supervises a nurse practitioner, midwife or physician assistant the panel size may be increased an additional 900 per full-time nurse practitioner, midwife and/or physician assistant. A PCP may request an exception to the 1,800 per individual PCP limit by submitting a written request to IHC. Exceptions are granted on a case-by-case basis.
- PCPs may limit the size of their enrollee panel from 1-1800.
- PCPs may designate their panel specifications when enrolling in Illinois Health Connect, including:

  Auto-assignment of enrollees: The PCP may choose whether or not to accept auto-assignment of enrollees. Auto-assignment will be determined by several factors including: existing provider and participant relationship based on HFS claims data; geographic location of the participant and the PCP; family members' PCP assignments; provider specialty; special needs of the participant, if known; capacity limits set by IHC and limits set by the provider; and eligibility of provider for auto-assignment.

  New enrollees: The PCP may designate if new enrollees are being accepted in their practice, or if they will accept existing patients only. IHC's definition of existing patient is an enrollee that has a paid Medicaid claim with that provider in the last 3 years.

  Age or gender restrictions of enrollees: The PCP may designate if there are any age or gender restrictions in their practice.

  County restrictions: The PCP may choose to apply county restrictions to his/her panel.

  Pregnant women and newborns: The PCP may designate if they are willing to accept pregnant women and/or newborns on their panel. IHC's definition of a newborn is an enrollee age birth-91 days old. Also, acceptance of newborns means that both new and existing patients can be added to the panel.
- For questions about the PCP panel process or to change your panel information and restrictions, contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999 or your assigned Provider Service Representative (PSR).

E. Eligible Populations

As of May 2010, the current eligible IHC population is approximately 2.0 million and includes most recipients of a HFS or All Kids Medical Card:

- Children in the current All Kids Program and the expanded All Kids Program
- Parents in the FamilyCare Program
- Moms and Babies Program
- Adults with disabilities and the Elderly

F. Excluded Populations from Mandatory Enrollment in IHC

Some HFS (Medicaid) clients are excluded from the IHC program and do not have to select a PCP:

- People who receive Medicare
- Children under age 21 who get Supplemental Security Income (SSI)
- Children in foster care and children who get Subsidized Guardianship or Adoption Assistance from DCFS (Department of Children and Family Services)
- Children under age 21 who are blind or who have a disability
- People who live in nursing facilities (i.e. ICF/DD; ICF/MI; State Operated)
- American Indians and Alaska Natives
- People with Spend-down
- People in Presumptive Eligibility programs
- Refugees
- People enrolled for treatment in the Health Benefits for Persons with Breast or Cervical Cancer Program
- People living in Community Integrated Living Arrangements (CILAs)
- Children under age 21 whose care is managed by the Division of Specialized Care for Children (DSCC) of the University of Illinois at Chicago
- People in the Program for All-Inclusive Care for the Elderly (PACE)
- People with high level private health insurance (third party liability)
- People enrolled in the following programs with no other medical eligibility
  - Illinois Healthy Women
  - All Kids Rebate and FamilyCare Rebate
  - Illinois Cares Rx (formerly SeniorCare/Circuit Breaker)
  - Transitional Assistance, age 19 and older
  - Emergency Medical Only
  - Hospice
  - Sexual Assault, Renal, and Hemophilia programs.
- Some people who get Home and Community-Based services, like the Community Care Program, or Community Services for Persons with Developmental Disabilities, that are not elderly or do not have a disability

While HFS encourages these clients to establish a medical home, care can be rendered by any HFS enrolled provider and the claim will not reject for lack of IHC Referral.

Important Note: All providers should verify via the MEDI system if the patient has a PCP. If MEDI does not list a PCP then the claim will not reject due to a lack of IHC referral. You should check even if you think the patient is in the excluded population. Providers should always verify that a PCP is not listed on the MEDI system.

G. Changing PCPs

1. PCP Initiated:

A Primary Care Provider may request a change in enrollee assignment in certain circumstances. Every effort will be made to honor such requests. Illinois Health Connect must follow federal guidelines that relate to Primary Care Case Management programs and can be found in 42 CFR, Part 438, Section 438.56 "Disenrollment: Requirements and Limitations." Any standards established by the PCP for patient reassignment must be practice-wide and apply to **all** patients, regardless of payer, such as:

- The patient's continued enrollment seriously impairs the PCP's ability to provide services to either the enrollee or other enrollees
- The patient refuses to comply with the suggested treatment plan
- The patient disagrees with the treatment plan
- The patient requires treatment or services more readily available through another PCP
- The patient violates office policy as applied to all patients
- The patient commits fraud or other misrepresentation
- The patient makes threats or physical acts constituting battery to the PCP or staff

A PCP **may not** request enrollee reassignments due to a change in an enrollee's health status, utilization of medical services or diminished mental capacity or uncooperative or disruptive behavior resulting from the enrollee's special needs except when continued assignment seriously impairs the PCP's ability to furnish services to the particular enrollee or other enrollees.

All requests for disenrollment must be submitted in writing to the Illinois Health Connect Medical Director for review. This should be done on the "Provider Initiated Request for Client Reassignment" form that can be found on the IHC website at www.illinoishealthconnect.com or by calling the Provider Helpdesk at 1-877-912-1999. To ask a question or discuss a specific situation, please call the IHC Medical Director at 1-888-912-9120 ext. 2218. The PCP and the enrollee will be notified in writing within 30 days. The request may be faxed to the IHC Medical Director at 1-847-995-1021.

Note: The provider who wishes to reassign the enrollee must specify if the enrollee is to be reassigned from other affiliated providers such as all practitioners in the same group practice due to reasons indicated.

If for some reason the PCP decides to allow the patient back into the practice, a letter of reinstatement needs to be submitted to the IHC Medical Director. The letter should include the patient's name and recipient ID number; as well as all providers that the restriction should be removed from. Once this is processed, the PCP will receive notification via telephone that the restriction is reversed. At that time, the provider will need to notify the patient that if the patient wishes to have this provider again as his or her PCP, then the patient will need to contact the Illinois Health Connect Client Helpline at 1-877-912-1999 (TTY: 1-866-565-8577) for reassignment. IHC will not automatically reassign the patient back to the PCP.

2. Enrollee Initiated:

Under the Illinois Health Connect guidelines, enrollees may change their PCP selection once every calendar month for any reason unless the enrollee is in the Recipient Restriction Program (RRP). Enrollees may change PCP more often than once per month for cause. IHC and the Department will evaluate these requests on a case-by-case basis. Enrollees who wish to change their PCP must contact the Illinois Health Connect Client Helpline at **1-877-912-1999, TTY: 1-866-565-8577. The call is free.**

The request to change PCPs will be completed within 24-48 hours of the date the PCP change request is received. However, if an enrollee chooses to change to a PCP who has a restricted panel, the panel restriction process is initiated where IHC faxes a request to the PCP to authorize enrollment. It takes 24-48 hours for the enrollment to be effective once the returned request has been entered.

Same day PCP change referrals are entered when an Enrollee calls the IHC Client Helpline and requests to change to a PCP who has an open panel. Same day PCP change referrals are not entered for clients who change PCPs via the mail, website, or for PCP changes done or as a result of the panel restriction process.

In counties where the Voluntary Managed Care Program operates, an Illinois Health Connect enrollee may request disenrollment from Illinois Health Connect and enrollment in one of the managed care organizations available to the enrollee, or a participant in one of the managed care organizations may request enrollment in the Illinois Health Connect program. A request to change between Illinois Health Connect and the Voluntary Managed Care Program may take up to 45 days to complete.

Enrollees in counties where the Voluntary Managed Care Program operates who wish to change their health plan enrollment in the Illinois Health Connect program or Voluntary Managed Care Program must contact the Illinois Client Enrollment Broker at 1-877-912-8880, (TTY: 1-866-565-8576). The call is free. Enrollees wanting to change their PCP only and not their health plan, should contact their health plan directly.

3. Department Initiated – Recipient Restriction Program (RRP):

Enrollees that request frequent changes of PCP may be referred to the Recipient Restriction Program for consideration of participation. The RRP is a program operated by the HFS Office of the Inspector General that identifies those individuals who overuse medical or pharmacy services in excess of need or in such a manner to constitute an abuse of the program. Abusive enrollees are locked-in to one physician or pharmacy or both and have their case managed for 12 or 24 months in an effort to curb the abusive patterns. Information about the RRP can be found in the HFS Provider Handbook Chapter 100 at 106 through 106.2 located at www.hfs.illinois.gov/assets/021103chap100.pdf.

4. Department Initiated – PCP Termination:

If the Department of Healthcare and Family Services cancels the participation of a PCP in the Illinois Health Connect program for any reason, affected enrollees will be assigned to another PCP and given the opportunity to change the PCP. If the assigned PCP is not the PCP the enrollee would like, the enrollee can call the IHC Client Helpline to choose a new PCP.

H. PCP Re-Assignment for Enrollees Who Lose and Regain Eligibility

The Department will assign enrollees who lose HFS Medical Program eligibility and regain it within 60 days to their previously assigned PCP, as long as the eligibility status and geographical residence of the enrollee are still valid for participation in Illinois Health Connect and that PCP is still available. IHC will send a notice to these enrollees within 5 calendar days. The notice will inform enrollees that they have been re-enrolled in Illinois Health Connect and assigned to their previous PCP or new PCP and that he/she can change his/her PCP assignment by contacting IHC.

I. Enrollee Selection of a Specialist as a PCP

An enrollee may request a specialist to serve as his/her PCP on a case-by-case basis if the specialist has agreed to meet all PCP requirements. If the specialist is not yet enrolled as a PCP, IHC will do the following:

- Upon the enrollee's request, IHC will ask the enrollee if he/she has discussed with the specialist his/her willingness to serve as a PCP. If not, IHC will contact the specialist to determine whether he/she wishes to participate as a PCP in the Illinois Health Connect program.

If the enrollee indicates he/she has determined that the specialist is willing to serve as the PCP, IHC will contact and inform the specialist about the requirements for the Illinois Health Connect program and procedures for enrolling as a PCP, including that the provider will require referrals for all IHC recipients not on his/her panel whether it is for primary care or specialty care.

- IHC will explain to the enrollee that until the specialist is enrolled as a PCP, the enrollee must either select or be auto-assigned to a currently enrolled PCP.
- The specialist must review and agree to the requirements of the Illinois Health Connect Primary Care Provider Agreement.
- The specialist must complete and sign the Illinois Health Connect Primary Care Provider Agreement.
- If approved, IHC will then change the enrollee's PCP to the specialist.

J. Voluntary Disenrollment of Illinois Health Connect PCPs

A PCP may voluntarily disenroll from the Illinois Health Connect Program at any time by notifying the Department and IHC in writing of his/her intent to discontinue participation in the Illinois Health Connect Program.

This notification must be received at least 45 calendar days prior to the proposed termination. The PCP should continue to deliver or refer enrollees to services until they are reassigned to another Illinois Health Connect provider. IHC will reassign enrollees as soon as possible after the receipt of the written notification indicating the PCP's decision to discontinue participation in the Illinois Health Connect Program and/or the HFS Medical Assistance Program.

K. Involuntary Disenrollment of Illinois Health Connect PCPs

Involuntary disenrollment of a PCP may occur if HFS determines that the Illinois Health Connect PCP:

- Is terminated from the HFS Medical Assistance program or by any professional licensing agency
- Does not adhere to conditions of the Illinois Health Connect Program and the Illinois Health Connect Primary Care Provider Agreement Refuses to comply with requests for corrective action related to the PCP's practices, policies, or standards.

L. Nondiscrimination Policy

The PCP may not discriminate against individuals eligible to enroll on the basis of health status, need for health care, race, color, national origin, or disability and will not use any policy or practice that has the effect of discriminating.

M. PCP Relocation

If a PCP intends to move to a new office setting, he or she must:

- Complete all necessary HFS required change forms; and
- Notify HFS and IHC in writing of his or her intent to move to a new office setting at least 45 days prior to the proposed move.

N. Marketing Restrictions

Marketing means any communication from a PCP to a potential enrollee that can be interpreted as intended to influence the individual to enroll with that entity or either to not enroll in, or to disenroll from, another PCP or health care delivery system.

Marketing is allowed with the following restrictions:

- PCPs shall not engage in marketing practices that could mislead, confuse or defraud potential enrollees or misrepresent the PCP or HFS
- PCPs shall not discriminate against potential enrollees on the basis of health status or need for health care
- PCPs shall not distribute any marketing materials regarding the Primary Care Case Management (PCCM) Program without HFS prior approval
- PCPs shall not imply that the PCP is endorsed by HFS or the federal government
- PCPs shall not engage in cold-call or door-to-door marketing. Cold-call is defined as any unsolicited personal contact by a PCP for the purpose of marketing. This includes unsolicited telephone contact, contact at the individual's residence and other type of contact made without the individual's consent.
- PCPs are allowed to notify current patients of their participation in IHC so that patients can choose the provider as his/her PCP.

O. Continuity of Care

When enrollees transition from one service delivery system to another [i.e., Voluntary Managed Care to Illinois Health Connect, or Illinois Health Connect to Voluntary Managed Care], PCPs, with the assistance of IHC, shall work to ensure continuity of care for those individuals. The sharing of information between service providers is of the utmost importance in ensuring that appropriate services continue to be provided as the enrollee transitions between programs. Such information includes medical records (as appropriate and in accordance with HIPAA regulations), and current treatment plans. Providers may also contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999 for assistance.

P. Coordination of Care

As outlined in the Illinois Health Connect Primary Care Provider Agreement, the PCP must coordinate, monitor and provide primary health care services to all enrollees who choose or are assigned to the PCP's panel (including those who transfer to Illinois Health Connect from other health delivery systems). The PCP will make referrals for specialty care and other services, when medically necessary.

- The PCP agrees to coordinate the delivery of primary care services with any specialist, case manager, or provider involved with the enrollee, including but not limited to, consultations and referrals.
- When medically appropriate, the PCP will honor an enrollee's request for referrals and second opinions.
- The PCP will advise enrollees if a requested service is not covered by HFS, or requires prior authorization (i.e., beyond the scope or duration of an already covered service).
- The PCP will make a referral to another HFS provider if the PCP cannot provide a service because it is beyond the scope of the PCP's practice. If the need for such service is of a type or duration that would impede the PCP's ability to provide comprehensive care, the enrollee can be reassigned to a new PCP who is able to provide comprehensive care.
- The PCP will advise the enrollee when a referral is indicated, assist the enrollee with choosing a specialist from available HFS Medical Program enrolled providers and either schedule the referral appointment or provide contact information to the enrollee to schedule the appointment. The PCP may contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999 for assistance in identifying HFS Medical Program specialists. The PCP will give the enrollee the specialist's name, address, and telephone number. The PCP will record each referral in the enrollee's medical record.
- The PCP will coordinate with IHC to participate in and coordinate care for panel enrollees.

For assistance with coordinating care for your Illinois Health Connect enrollees, please call the Illinois Health Connect Helpdesk at **1-877-912-1999** to speak with a provider service representative.

Q. Referral Policies and Authorization Procedures

The Department of Healthcare and Family Services implemented Phase 1 of the Illinois Health Connect Referral System by geographic region:

Northwest region:	October 1, 2009
Collar counties:	December 1, 2009
Cook county:	February 1, 2010
Central & Southern regions:	April 1, 2010

Phase I of the Illinois Health Connect Referral System was implemented to continue the ongoing efforts to connect Illinois Health Connect patients with their medical homes. By doing so, the patient's Primary Care Provider (PCP) becomes familiar with their medical needs and ensures they receive the necessary preventive and primary care, including immunizations and screening, thus improving the quality of care for the patient through better coordination and management of services by the PCP.

Phase I requires patients to be seen by their own PCP or a physician or clinic affiliated with their PCP. Affiliations must be registered in the IHC system. Once a provider is affiliated in the system, NO referrals are necessary between providers after the date of affiliation. Any Date of Service (DOS) prior to the affiliation will still require a referral. PCPs seeing patients enrolled in Illinois Health Connect but not enrolled on their panel, or on an affiliated PCP's panel, on the date of service must obtain a referral from the patient's PCP in order to be reimbursed by HFS for services provided. It is the responsibility of the rendering provider to obtain the referral. It is not the responsibility of the patient to obtain the referral. The option of issuing a referral for care is entirely the decision of the current IHC PCP. PCPs are able to submit referrals for their Illinois Health Connect patients to see other PCPs through the Illinois Health Connect Provider Portal via the secure MEDI system and directly with Illinois Health Connect via fax and phone. **Non IHC PCPs including Specialists will not require a referral.**

All services by PCPs for Illinois Health Connect patients not enrolled on their panel, or on an affiliated PCP's panel, require a referral to be registered in the Illinois Health Connect Referral System by the patient's PCP in order to be reimbursed for services provided. A patient's assigned PCP is not required to submit a referral to IHC for services provided by another IHC PCP. Submitting referrals to IHC for services rendered by another IHC PCP is at the discretion of the patient's PCP. PCPs seeing IHC patients who are not enrolled with them for their medical home on the date of service assume all risk of non-payment if no referral is obtained and registered with IHC. The Department strongly encourages all PCPs to utilize their panel rosters or to check PCP assignments in the Department's MEDI system (assignments are updated daily) to ensure a patient is enrolled with them for their IHC medical home on the date of service. The billing PCP's remittance advice will have an error code of G11 with the message “IHC PCP referral required.” The G11 error code identifies that a referral is required, and will not reimbursed from the Department. Providers **CANNOT** bill the client for services not reimbursed by the Department where the PCP received an error code of G11. Once the office accepts the client as a Medicaid patient and bills the Department for services provided, the provider cannot bill the client for services. This is stated in the HFS Handbook Chapter 100 section 114.

PCPs should continue to encourage patients seeking services in their office, but not enrolled on their panel or on an affiliated PCP's panel on the date of service, to see their IHC PCP first. Reinforcement by PCPs of the medical home concept will encourage Illinois Health Connect enrollees to access services available with their PCP and build upon the foundation of the medical home, resulting in better coordination and continuity of care for these patients.

To register a referral with IHC authorizing another IHC PCP to submit a claim for services rendered to your patient or to verify that a referral has been registered to allow you to submit a claim for services rendered to a patient who is not currently linked to you:

- Log the referral in the Illinois Health Connect referral system (www.illinoishealthconnect.com/). While it is recommended that referrals be logged via the Illinois Health Connect Provider Portal, providers may also telephone or fax them to the Illinois Health Connect Care Coordination Unit (Telephone: **1-877-912-1999** or Fax: **1-412-318-2740**). A referral form is also available on the Illinois Health Connect website. Providers can search the IHC Portal database, or call the Care Coordination Unit or Provider Relations Helpdesk to verify the status of a referral.

- Referrals will require basic information such as the PCP name and identification number, enrollee information, referred provider information, reason for the referral and the date range of the referral.
- Referrals made by Illinois Health Connect PCPs may be post dated up to 60 days after the date of service.

Note: If the rendering provider needs assistance in identifying who the assigned (referring) provider is, the rendering provider should contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999.

Services that **DO NOT REQUIRE** a referral include:

- Services provided to newborns up to 91 days after birth
- Family Planning and Obstetrical and Gynecological (OB/GYN) services
- Physicians not enrolled as an IHC provider
- Shots/Immunizations
- Emergency Room
- Emergency and Non-Emergency Transportation
- Pharmaceuticals
- Home Health Care
- Dental Services
- Vision/Optometrist Services
- Speech, Occupational and Physical Therapy
- Mental Health and Substance Abuse services provided by Department of Human Services Community Mental Health Service Providers (provider type 36) and Department of Human Services Alcoholism and Substance Abuse Service Providers (provider type 75) and Psychiatrists.
- Outpatient Ancillary Services (radiology, pathology, lab, anesthesia)
- Services to treat sexually transmitted diseases and tuberculosis
- Early Intervention Services
- Lead Screening and Epidemiological Services
- Hospital Services
- Medical Equipment and Supplies
- Services provided by:
  - School-based/linked clinics for children under age 21
  - School-based clinics through Local Education Authorities for children under age 21
  - Local health departments
  - Mobile vans, with HFS approval
  - FQHC homeless sites and migrant health centers
  - Emergency Department Diversion Centers, with HFS approval

Services that **DO REQUIRE** a referral include:
IHC PCPs seeing patients enrolled in IHC but not enrolled on their panel, or an affiliated PCP's panel on the date of service, must obtain a referral from the patients IHC PCP in order to be reimbursed by HFS for services provided.

R. Appeals and Fair Hearing Information for Enrollees

An enrollee may appeal an action the Department takes that they feel was wrong. When an enrollee appeals an action, they are requesting a fair hearing. During a fair hearing, a fair hearing officer, representative from the Department, and the Illinois Health Connect enrollee with a complaint, discuss the complaint. The fair hearing officer will reach a verdict on a resolution.

An enrollee can file an appeal if the Department:

- Denies his/her application,
- Stops his/her benefits (coverage),
- Says that he/she will start to get fewer benefits, or
- Changes his/her co-payments.

An enrollee can also appeal if he/she thinks the Department made a mistake about any decision. An appeal must be filed within 60 days of when the enrollee is notified of the action. An enrollee may not get a fair hearing if the action happened because of a change in the law.

How to Make an Appeal To make an appeal and ask for a fair hearing, the enrollee can call **1-800-435-0774 (TTY: 1-877-734-7429).** Hours are from 8:30 AM to 4:45 PM Monday through Friday.

S. Fraud and Abuse/False Claims and Statements

HFS has established a hotline to report suspected fraud and abuse committed by any HFS Medical Program participant, enrollee or any entity providing services to HFS Medical Program participants. The hotline number is 1-800-843-6154 and operates between the hours of 8:00AM and 5:30PM, Monday through Friday. Voicemail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer. TTY: 1-800-447-6404. The call is free.

Suspected fraud and abuse may also be reported via the State website at www.state.il.us/agency/oig/reportfraud.asp

Information reported via the website can also be done anonymously. The website contains additional information on reporting fraud and abuse.

T. Translation and Interpretation Requirements

Under Title VI of the Civil Rights Act of 1964, providers and agencies that receive federal funds have an obligation to provide language assistance in order to make services accessible to Limited English Proficient persons. HFS Medical Program providers are required to offer and provide access to interpreter services in languages regularly encountered within their geographical area to all of their patients, including those who are enrolled in Illinois Health Connect.

Additionally, the Department of Healthcare and Family Services is committed to ensuring that enrollees who have sign language needs have access to the HFS Medical Program services for which they are entitled. The federal law that provides for such access, The Americans with Disabilities Act (ADA), applies to health care providers whose offices are considered public accommodations. HFS Medical Program enrolled providers are obligated under the ADA to provide or arrange for sign language services for enrollees who are hearing impaired, when needed to access medical services. For more information, providers or consumers may contact the Illinois Deaf and Hard of Hearing Commission toll-free at 1-877-455-3323 or locally at 1-217-557-4489. The Commission also has a website, www.idhhc.state.il.us , where providers or consumers can access their Interpreter Directory.

It is the responsibility of the PCP to notify enrollees of the availability of oral and written language services at no cost to the enrollee. A PCP may not request or require the use of family members (including children) and/or friends as an interpreter.

PCPs may contact the Illinois Health Connect Provider Helpdesk at **1-877-912-1999** for assistance in locating information on agencies that assist enrollees, both children and adults, needing translation/interpretation services.

The following information must be provided at the time of the request:

- Enrollee's name
- Enrollee's HFS ID number
- Medical provider (doctor) name, address, and telephone number
- Date and time of medical appointment
- Language preference or preferred sign language preference

Additional Telephone Numbers

For more information on arranging translation and/or interpretation services for enrollees, please call:

- **Illinois Health Connect Provider Helpdesk: 1-877-912-1999**
- **TTY: 1-866-565-8577**
- **Illinois Relay Service: 711** (Go to www.illinoisrelay711.com/index.htm for more information.)
- **Title VI Website:** www.usdoj.gov/crt/cor/coord/titlevistat.htm

U. Emergency Services and Emergency Care

All PCPs must educate their enrollees on the proper use of the emergency department.

When an Illinois Health Connect enrollee presents to a hospital emergency department, the emergency department will determine if the condition/situation is a true emergency. PCPs should not use the emergency department as their PCP backup unless an agreement to provide after-hours triage has been made. The PCP or its after- hours coverage provider will assess the enrollee's non-emergent symptoms and advise the enrollee and make arrangements to examine/treat the enrollee as necessary.

An emergency admission is an admission to a hospital for a condition in which immediate medical care is necessary to prevent death, serious impairment, or significant deterioration of the health of the patient. An emergency medical condition is described as a condition manifesting with acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:

- Placing the health of the individual (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction to any bodily organ or part

Emergency services are Direct Access; therefore, in Illinois Health Connect, enrollees DO NOT NEED A REFERRAL from their PCP for emergency services. Enrollees can use any emergency provider/hospital.

VI. Provider Education and Support

A. Provider Education

Automated Health Systems provides ongoing education and support to Illinois Health Connect providers. Provider education includes how to use the referral system, billing, administrative processes, covered services, targeted areas of quality improvement, and administrative changes.

IHC Provider Services Representatives, Quality Assurance Nurses, and training specialists are based regionally throughout the state. Both Provider Service Representatives and Quality Assurance Nurses will meet face-to-face with providers to address issues, concerns, and answer questions, in order to ensure providers and office staff are kept up-to-date on HFS policies and the Illinois Health Connect Program.

In addition to on-site training, IHC offers monthly webinars that provide an opportunity for providers to receive general updates on recent policy changes or disseminate other important information. IHC also offers a web-based library Clinical Resources that address concerns such as common health problems, health literacy, and considerations for working with special needs enrollees.

For more information concerning webinars or Clinical Resources, contact IHC at 1-877-912-1999 or visit the website at www.illinoishealthonnect.com and click on the links for Clinical Resources and Provider Education.

B. Illinois Health Connect Provider Helpdesk (1-877-912-1999)

The Illinois Health Connect Provider Helpdesk assists PCPs with:

- Provider enrollment or changes to a PCP panel
- Verifying patients on a PCP's panel
- Getting answers to questions about Illinois Health Connect

C. Specialty Resource Database

Providers can also call the Illinois Health Connect Provider Helpdesk to access the Specialty Resource Database. This tool assists providers and enrollees in identifying medical professionals and community-based agencies that can help address enrollees' medical and other (e.g., WIC, transportation) needs.

The HFS Medical Program provides payment for a broad range of diagnostic, therapeutic, and rehabilitation services provided by physicians, hospital clinics, community health centers, rural health centers, specialty clinics such as drug and alcohol clinics, psychiatric clinics and psychiatric partial hospitalization facilities. Where possible, these enrolled providers should be used when referrals are needed for further diagnosis and treatment. IHC will assist PCPs with referrals to these resources.

D. Illinois Health Connect Program Website

The Illinois Health Connect Program website is a one-stop-shop for providers and enrollees to get resources, materials, and information like provider notices, informational notices, educational webinar information and quality tools. Potential enrollees are able to join Illinois Health Connect, search for providers, find out who's my PCP, and select a PCP online at www.illinoishealthconnect.com.

E. IHC Provider Portal

By going through the secure HFS MEDI system website, providers are able to use the IHC provider portal, to enroll as an Illinois Health Connect PCP, review their panels, see their provider profiles, make/verify referrals, and more.

F. Illinois Nurse Helpline

The Illinois Nurse Helpline provides back-up support to enrollees who cannot reach their PCPs after-hours or on weekends as a means of minimizing unnecessary emergency department use and reconnecting enrollees to their PCPs. The Illinois Nurse Helpline utilizes the McKesson Solutions' Care Enhance Nurse Advice Patient Assessment System. The web-based system is based on 455 clinical algorithms divided into five modules: adult, mental health, pediatrics, seniors, and women's health.

HFS Medical Program participants may contact the Illinois Nurse Helpline Monday-Friday, 7 p.m. - 8 a.m. (CST) and 24 hours per day on Saturday and Sunday.

The Illinois Nurse Helpline telephone number is: **1-877-912-1999,** (TTY: 1-866-565-8577).

G. Panel Rosters

Panel rosters inform providers of enrollees that are assigned to them and include specific information about when an enrollee in their panel is due for a lead screening, well child screening, or adult preventive services (e.g., mammogram) based on claims data.

Upon request, PCPs will be trained by IHC on how to use the Panel Roster reports to actively outreach and schedule their enrollees who are due for preventive services such as well-child exams. A sample Illinois Health Connect Panel Roster is included in Appendix B.

As of December 1, 2008, Illinois Health Connect no longer routinely mails monthly Panel Rosters to each PCP. To continue receiving a mailed Panel Roster, please contact the Provider Helpdesk at 1-877-913-1999. Electronic Panel Rosters are available online through HFS' Medical Electronic Data Interchange (MEDI) System linking to the IHC provider portal and are updated daily. MEDI also provides up-to-date eligibility information, including IHC PCP information, for all HFS clients. Access to MEDI requires registration. Assistance with MEDI registration is available:

1. www.myhfs.illinois.gov/training/guides.html and click on “Introducing the MEDI System.”

2. Information guide on MEDI enrollment is posted on the IHC website under Provider Information at www.illinoishealthconnect.com

3. Calling your IHC Provider Service Field Representative or the IHC Provider Services Helpdesk at 1-877-912-1999.

H. Quality Assurance Tools

One of the primary goals of Illinois Health Connect is to support the work of the medical home physicians and other providers and to provide quality assurance tools to the medical home. The IHC provider portal gives provider's access to several of these quality tools, which include the following:

1. Claims History Report

In order to assist clinicians with providing care, Illinois Health Connect will provide electronic access to a summary of the claims for any current HFS client. The Claims History contains all claims submitted to HFS for the past 2 years, including pharmacy claims, and contains at least five years for immunization claims. The immunization claims will be retained in the Claims History for seven years. Due to Illinois confidentiality laws, the Claims History does not contain claims information related to mental illness, drug and alcohol abuse treatment, domestic violence or HIV/AIDS care. The Claims History only reflects claims received by HFS so services paid by other payers are not included.

In order to protect patient confidentiality, this Claims History feature is found on the IHC Provider Portal application only accessible through the secure Medical Electronic Data Interchange (MEDI) System. Providers and their designees must be registered and have a digital certification to access MEDI to utilize the IHC Provider Portal. Once on the Provider Portal, access to the Claims History can be obtained by clicking on the "Claims History" link and providing at least three pieces of identifying information about a specific client including name, RIN, DOB or SSN. For more information or assistance in accessing this information, contact the Illinois Health Connect Provider Relations Helpdesk at 1-888-912-1999.

2. Drug Search Engine

HFS is pleased to announce that a drug search engine has been incorporated into its website that will allow providers to search for drugs by both generic and brand names to immediately determine if the drug requires prior authorization (PA). This web page also contains links to information regarding the PA process, PA forms and PA requirements so that prescribing for HFS clients can be streamlined. The web address is: http://www.hfs.illinois.gov/pharmacy/. Click on "Search for Prior Approval Status by Drug" on the left side of the page.

This search engine was developed and is maintained by the University of Illinois at Chicago College of Pharmacy (UIC). The Department would like to sincerely thank UIC for the hard work that they invested in the search engine.

I. Illinois Health Connect Provider Profiles

Provider Profiles are sent to all IHC PCP's semi-annually in the Spring and Fall. Provider Profiles will provide an overview of patient care goals to help support the PCP's quality assurance efforts. The Profiles provide a summary of each PCPs performance on several clinical indicators. The data reflected in the Provider Profiles is gathered from HFS claims data.

Provider Profiles may be obtained on the Illinois Health Connect Provider Portal through the secure login of the HFS MEDI system. It can also be obtained by contacting the IHC Provider Helpdesk at 1-877-912-1999, your IHC Provider Service Representative (PSR), or your Quality Assurance Nurse (QAN).

Quality Assurance Nurses from IHC are available to come to the PCP's office to go over the Provider Profile in detail, in addition to assisting with education and resources related to the clinical indicators.

J. Client Outreach for Preventive Care

IHC Enrollee Services has developed a Care Coordination Unit that is dedicated to educating clients about upcoming appointments. Upon clients incoming phone calls, IHC is reminding them of due appointments. IHC is conducting outbound calls to educate and encourage clients, who are due, to schedule an appointment. To further assist the client, IHC sometimes conducts three way calls to PCP offices to help eligible clients schedule EPSDT/Healthy Kids appointments. If IHC helps to schedule an appointment, an appointment reminder notice is sent to the client's home seven days prior to the scheduled appointment. During these calls, demographic information is verified to ensure accuracy for upcoming mailings such as appointment reminder notices.

IHC continually reminds clients to schedule a Healthy Kids visit. Reminders are given according to the client's date of birth and the HFS periodicity schedule. IHC also reminds adult clients annually to have an adult preventative health exam.

K. IHC Bonus Payment for High Performance Program

Beginning in calendar year 2008, PCPs who achieve benchmark performance in areas identified by HFS and in accordance with the methodology developed by IHC, HFS and provider advisory groups, can qualify to receive an annual bonus incentive payment. PCPs who do not achieve benchmark performance in the identified areas will not be financially penalized and will not qualify to receive an IHC bonus payment for that bonus period. Bonus payments for each IHC PCP will be determined by HFS. More information about the Bonus Program can be found at www.illinoishealthconnect.com under the Quality Tools section.

L. Enhanced Maternal and Child Health Rates

PCPs, other than FQHC and RHCs, automatically qualify for the enhanced Maternal and Child Health rates.

Procedure Code	Description	Base Rate	Add-on	Total
99201	E/M Office/OH Visit New Patient	$27.95	$1.60	$29.55
99202	E/M Office/OH Visit New Patient	$32.00	$1.60	$33.60
99203	E/M Office/OH New Patient	$41.60	$1.95	$43.55
99204	E/M Office New Patient OH	$66.40	$3.25	$69.65
99205	E/M Office/OH Visit New Patient	$70.85	$3.25	$74.10
99211	E/M Office/OH Visit Established Patient	$12.30	$0.58	$12.88
99212	E/M Office/OH Visit Established Patient	$24.25	$1.40	$25.65
99213	E/M Office/OH Visit Established Patient	$28.35	$18.21	$46.56
99214	E/M Office/OH Visit Established Patient	$42.50	$30.47	$72.97
99215	E/M Office/OH Visit Established Patient	$48.00	$1.95	$49.95
99381	Initial Evaluation Healthy Infant	$32.15	$59.75	$91.90
99382	Initial Evaluation Healthy Child	$32.15	$66.50	$98.65
99383	Initial Evaluation Healthy Child	$32.15	$64.45	$96.60
99384	Initial Evaluation Healthy Adolescent	$32.15	$72.81	$104.96
99385	Initial Evaluation Healthy 18-39 yrs.;	$32.15	$72.81	$104.96
99386	Initial Evaluation Healthy 40-64 yrs.;	$66.40	$38.56	$104.96
99387	Initial Evaluation Healthy 65 yrs. and greater; Preventative	$66.40	$38.56	$104.96
99391	Periodic Re-evaluation Established Infant	$32.15	$37.37	$69.52
99392	Periodic Re-evaluation Healthy Child	$32.15	$45.72	$77.87
99393	Periodic Re-evaluation Healthy Child	$32.15	$44.69	$76.84
99394	Periodic Re-evaluation Healthy Adolescent	$32.15	$52.47	$84.62
99395	Periodic Re-evaluation /Mgmt. 18-39 yrs.; Preventative	$32.15	$53.50	$85.65
99396	Periodic Re-evaluation/Mgmt. 40-64 yrs.; Preventative	$42.50	$43.15	$85.65
99397	Periodic Re-evaluation/Mgmt. 65 yrs. and greater; Preventative	$42.50	$43.15	$85.65
59409	Vaginal Delivery Only	$535.20	$389.25	$924.45
59410	OB Care/Vaginal Delivery Only Including Postpartum Care	$535.20	$389.25	$924.45
59514	Cesarean Delivery Only	$681.20	$389.25	$1,070.45
59515	Cesarean Delivery including Postpartum care	$681.20	$389.25	$1,070.45
59612	Vaginal Delivery Only, after Previous Cesarean Delivery	$535.20	$389.25	$924.45
59614	Vaginal Delivery After Previous C-Section, Including Postpartum Care	$535.20	$389.25	$924.45
59620	C Sect Delivery After Attempted Vaginal Delivery after Previous C Section	$681.20	$389.25	$1,070.45
59622	C Sect After Attempted Vaginal Delivery IV/C Sect/ Including Postpartum Care	$681.20	$389.25	$1,070.45

M. Enhanced Home-Based Services Rates & Enrollment as Home-Based PCP

Effective November/December, 2009, HFS increased reimbursement for home visits.

Procedure Code	Description	Base Rate	Add-on	Total
99341	Home Visit E/M New Patient - 20 minutes	$27.95	$8.86	$36.81
99342	Home Visit E/M New Patient - 30 minutes	$37.40	$16.23	$53.63
99343	Home Visit E/M New Patient - 45 minutes	$54.90	$31.38	$86.28
99344	Home Visit E/M New Patient - 60 minutes	$70.55	$42.78	$113.33
99345	Home Visit E/M New Patient - 75 minutes	$85.55	$50.85	$136.40
99347	Home Visit E/M Est. Patient - 15 minutes	$24.25	$11.56	$35.81
99348	Home Visit E/M Est. Patient - 25 minutes	$31.30	$22.82	$54.12
99349	Home Visit E/M Est. Patient - 40 minutes	$47.50	$31.43	$78.93
99350	Home Visit E/M Est. Patient - 60 minutes	$68.85	$41.29	$110.14

Subsequently, Illinois Health Connect has been enrolling those primary care providers that are interested in regularly providing home-based care. If you are interested in enrolling as an IHC home-based PCP, please contact your Provider Service Representative or the Provider Helpdesk at 1-877-912-1999.

N. Billing Information

Provider billing practices for HFS Medical Program covered services will not be affected by Illinois Health Connect policies unless HFS notifies providers of specific changes that relate to Illinois Health Connect. For detailed billing instructions, always refer to the Illinois Medical program Provider handbook and billing guides, which can be found at http://www.hfs.illinois.gov/handbooks/.

O. National Provider Identifier (NPI)

HFS has implemented a mandatory reporting of the Billing Provider's NPI on all electronic, direct data entry and hard copy claim submittals. The department will reject all claims received without a Billing Provider NPI. NPIs for Other Physician IDs, such as, Prescribing, Attending, Operating and others are a requirement.

Effective with claims received on or after October 1, 2010, HFS will require the NPI to be reported to designate the Pay-To Provider (Payee) for electronic and direct data entry. The one-digit payee code is still required to be reported on paper claim forms. This will replace the department's current requirement of reporting the one-digit payee code to designate the appropriate Pay-To Provider (Payee). The one-digit payee code is still required to be reported on paper claim forms, with the exception of the UB04. Claims received on or after October 1, 2010 that do not contain a registered Payee NPI will be denied. Any questions pertaining to NPI can be referred to the HFS Bureau of Comprehensive Health Services, Billing and Payment Section, at 1-217-782-5565, or you can contact the IHC Provider Helpdesk at 1-877-912-1999.

P. Enrollee Eligibility and IHC PCP Verification

HFS will soon be moving to a permanent annual Medical card rather than a monthly Medical card for clients. Thus, the HFS or All Kids permanent medical card will not contain the name of the enrollee's PCP. Therefore, it is necessary that PCPs check the participant's eligibility for the HFS Medical Program and enrollment in Illinois Health Connect prior to providing services. There are several avenues to check eligibility, including:

- **Medical Electronic Data Interchange (MEDI) System**
  The MEDI System available to all HFS Medical Program providers to verify eligibility of any enrollee presenting with an HFS or All Kids medical card.
  Registration on the MEDI System is required. To register you must be an approved provider with an HFS Medical Program provider identification (billing) number from HFS. Please go to the website below to view an introduction to the MEDI system and to obtain more information about how to register.

  www.myhfs.illinois.gov

  Then click on "Introduction to MEDI."

  MEDI will also include the following information:
  - Illinois Health Connect and Voluntary Managed Care enrollment status
  - Primary Care Provider name for Illinois Health Connect enrollees
  - Co-pay information
  - Panel Roster and Claims Histories through the IHC Provider Portal

- **Recipient Eligibility Verification (REV)**
  The REV system is available to enrolled HFS providers throughout the state. The REV system utilizes clearinghouses, known as REV vendors, relay electronic transactions between a provider and HFS. REV vendors have direct telecommunication line access into HFS databases. Through the REV system, vendors provide information on HFS Medical Program eligibility, Illinois Health Connect and MCO enrollment information, HFS Medical Participant restriction status, and private insurance coverage. The REV system also allows providers the ability to: submit claims electronically; check claims history; check on rejected claims; and download batches of claim information (status of claim, adjudicated figures, paid amounts, etc.).

  Providers wanting access to the REV system sign an agreement with one or more vendors and pay the REV vendors for their services. For more information on REV, please visit the REV website at: http://www.hfs.illinois.gov

- **"Who Is My PCP?"**
  The link is available via the IHC website (www.illinoishealthconnect.com) for enrollees to verify their currently assigned or selected PCP. This feature does not guarantee eligibility on the date of service, so one of the above eligibility verification options need to be used as well by the provider.

- **IHC Provider Helpdesk**
  To verify an enrollee's PCP on the date of service, or to determine who the PCP was on a previous date of service, providers can contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999. IHC generated referrals as well as referrals registered by providers can be verified as well.

Q. PCP Materials

IHC maintains brochures and other materials that may be helpful to PCPs. To request Illinois Health Connect program materials, call the Illinois Health Connect Provider Helpdesk at **1-877-912-1999.** Or, download materials online at www.illinoishealthconnect.com.

R. Cultural Sensitivity

Health disparities, defined as differences in care not attributable to medical necessity or patients' ability to access the health care delivery systems, are an increasingly recognized problem in the United States. The growing concern regarding health disparities has increased the need for culturally competent providers.

Cultural differences between PCPs and enrollees should not affect providing, accessing or receiving quality health care. PCPs should also be willing and able to recognize that harmless non-traditional treatments that are consistent with the enrollee's cultural background may be equally or more effective and appropriate for a specific enrollee, especially if used as a complement to traditional treatment and discussed with a respectful, nonjudgmental attitude.

There are many sources of help for providers who want to become culturally proficient. The AMA has directed substantial resources to helping health care professionals expand their cultural competencies, as has the American Academy of Family Physicians (AAFP). The Office of Minority Health has many excellent resources and tools to assist providers and their office staff in becoming more culturally competent: www.omhrc.gov/. As an example of the latter, please see *A Provider's Handbook on Culturally Competent Care - American Academy of Family Physicians* [www.aafp.org/x19555.xml] Berlin and Fowkes (Teaching framework for cross-cultural care: Application in Family Practice. West J Med. 1983;139(6):934-938) have suggested the following acronym, **LEARN:**

Listen with sympathy and understanding to the patient’s perception of the problem

Explain your perceptions of the problem and your strategy for treatment.

Acknowledge and discuss the differences and similarities between these perceptions.

Recommend treatment while remembering the patient’s cultural parameters.

Negotiate agreement. It is important to understand the patient’s explanatory model so that medical treatment fits in their cultural framework.

VII. Healthy Kids (EPSDT)

A. Overview

The Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) is a comprehensive child health program that provides for initial and periodic examinations and medically necessary follow-up care.

Through Illinois' EPSDT program called Healthy Kids, all children and adolescents under age 21 who are covered by the HFS Medical Program or All Kids are provided with preventive health screening services, such as, well child health examinations. There are no fees or co-payments for children's checkups, shots, lab test, or x-rays.

Enrollees under age 21 are also eligible to receive comprehensive dental health services including preventive and restorative/treatment services. Ongoing preventive dental care should begin at age one or earlier, if needed.

The EPSDT program consists of two mutually supportive, operational goals as federally required:

- assuring the availability and accessibility of required health care resources, and
- assisting program participants and their parents or guardians use them, as requested.

Through partnership with providers under the Illinois Health Connect (IHC) or MCO programs, Illinois' children are provided with a "medical home" for efficient, high quality health care and receive needed referrals for health and health-related specialty care. IHC will assist clients with scheduling a Healthy Kids checkup and will remind clients when the next Healthy Kids checkup is due.

The Healthy Kids Program guidelines are detailed in the *Handbook for Healthy Kids Services*, www.hfs.illinois.gov/assets/041404hk200.pdf. HFS will no longer print hard copies of this guide.

B. EPSDT Covered Services

The following services are covered under the preventive component of the EPSDT Program and are separately reported and billed, as appropriate. Also refer to http://www.hfs.illinois.gov/assets/021004healthykids.pdf.

C. Well Child Examination

1. **Health Screening,** which includes a comprehensive health and developmental history (including assessment of physical health, mental health [including social, emotional and behavioral issues], development and nutrition) and a comprehensive unclothed physical examination at the following ages:

Under Age One:	Birth 2 weeks 1 month 2 months 4 months 6 months 9 months	**Two to Six:**	Annually
One to Two:	12 months 15 months 18 months 24 months 30 months	**Six to Twenty-one:**	Examinations every other year or more often if medically recommended or if following acceptable medical practice standards for recommended periodicity schedule, e.g. AAP or AAFP.

Interperiodic screening such as a comprehensive pre-participation exam for sports, day-care or camp, is reimbursed as often as medically necessary in the judgment of the clinical provider or at the request of the parent.

Billing Information: Unless the provider determines otherwise appropriate to report and bill the Evaluation and Management Services CPT Code, the well child screening examination should be reported and billed using the Preventive Medicine Services CPT Code, appropriate for the status (new or established patient) and age of the individual, using the appropriate preventive diagnosis code (e.g., V20) as primary.

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2. **Developmental Screening:** According to policy of the American Academy of Pediatrics (AAP), developmental surveillance should be performed at every well-child visit as part of well-child health examination, with objective developmental screening using an HFS recognized developmental screening tool, conducted at the 9, 18, and 30-month well child visits.

   Note: Per the AAP guidelines, a developmental screen should occur at the 24-month well child visit if there is not a 30-month well child visit scheduled. Providers may choose to administer additional objective screenings.

Using standardized objective screening tools, a developmental screening should be performed during the 9, 18, and 30 month visits (HK203.5.2). Additionally, an objective developmental screening measuring a child's social-emotional development at the 4, 6-9, 18, and 30-month well child visits are also recommended. Perinatal depression screening for the mother at 2 and 6-month well child visit is also recommended using a standardized approved assessment tool. A list of developmental screening tools approved by HFS is detailed in the *Handbook for Healthy Kids Services*, which can be found at the following website: www.hfs.illinois.gov/assets/041404hk200.pdf (HK 203.5.2)

Billing Information: Report and bill an objective developmental screening using CPT 96110 or CPT 96111, depending on the instrument used to screen or assess the child's progress with developmental domains. Perinatal depression, using an objective screening instrument recognized by HFS, is reported and billed using CPT 99420 with modifier HD (pregnant/parenting women's program) under the woman's recipient number if she is post partum; using CPT 99420 with modifier HD under the child's recipient number, if the perinatal depression screening occurs during the well child visit or episodic visit for an infant (under age one); or using H1000 under the woman's recipient number when billing for depression screening, performed during the prenatal visit or during a well child visit for a pregnant young women (under 21). For more information, refer to the following website: http://www.hfs.illinois.gov/assets/112904pd.pdf

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3. **Risk Assessment:** A risk assessment (subjective, by history) should be completed for all infants and children. HFS provides reimbursement for "risk assessment" for children and pregnant women, using a recognized standardized risk assessment instrument.

Billing Information: When a standardized risk assessment instrument is utilized to identify health risks for intervention, CPT 99420 should be reported and billed. Assessing mental health or substance abuse risk using an HFS recognized risk assessment instrument, such as the Mental Health Screening or Substance Abuse Screening located in the Handbook for Healthy Kids Services is reimbursed using CPT 99420. Refer to http://www.hfs.illinois.gov/assets/072202hk200appendices.pdf

HFS recognizes the American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) questionnaire as a risk assessment for adolescents. Reimbursement will be made for completion of either the Younger Adolescent Questionnaire or the Middle-Older Adolescent Questionnaire. Refer to www.hfs.illinois.gov/assets/021004healthykids.pdf

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4. **Vision Screening: Public Act 95-0671 requires any child entering kindergarten to receive an eye examination by an optometrist or ophthalmologist.** Vision screening (subjective, by history) should be completed for all infants and children. Beginning at age 3, an objective vision screening using a standard testing method, is recommended annually for children between the ages of 3 through 6; and at 8, 10, 12, 15 and 18 years of age, according to AAP's recommendations. Refer to *Handbook for Healthy Kids Services,* HK - 203.7.1.

Billing Information: An objective vision screening is reported and billed using CPT 99172 (visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity) or CPT 99173 (screening test of visual acuity, quantitative, bilateral), as appropriate.

HFS Medical Program enrollees are entitled to all services included in the state plan for diagnosing and treating any uncovered condition. Included in this plan are vision services, including eyeglasses.

5. **Hearing Screening:** Hearing screening (subjective) is recommended as part of well child-visit. State law effective December 2002 requires all newborns receive an objective hearing screening using a standard testing methodology, such as an electro-physiological testing methodology, to acoustic emission (OAE) or automated auditory brainstem (AABR) for identifying congenital hearing loss. Objective hearing screening, using a standard testing method, is recommended for children between the ages of 4 through 6, and at 8, 10, 12, 15 and 18 years of age, according to the AAP's recommendations. Refer to *Handbook for Healthy Kids Services,* HK - 203.7.2

Billing Information: An objective hearing screening is reported and billed using CPT 92551 (screening test, pure tone, air only) or CPT 92552 (pure tone audiometry (threshold); air only, as appropriate. HFS Medical Program participants are entitled to all services included in the state plan for diagnosing and treating any uncovered condition. Included in this plan are hearing services, including hearing aids.

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6. **Oral Health Screening:** An oral screening is part of the physical examination but does not replace a referral to the dentist. Referral to a dentist for routine and periodic preventive care, beginning at age two or sooner, as needed, is recommended. HFS' Dental Administrator can assist in the referral. Enrollees can call DentaQuest of Illinois at 1-888-286-2447 customer service for referral assistance. Providers can call 1-888-281-2076 for provider service. Refer to *Handbook for Healthy Kids Services,* HK - 203.8.

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7. **Appropriate Immunizations:** Appropriate Immunizations as approved by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) shall be provided, appropriate for a child's age and health history. Refer to *Handbook for Healthy Kids Services,* HK - 203.2.

Billing Information: The CPT code specific to the childhood vaccine antigen should be used when reporting and billing the immunization. HFS will reimburse the provider an administration fee when the childhood vaccine is available through the Vaccine for Children's Program.

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8. **Laboratory Procedures** as appropriate for the individual's age and population group shall be performed. Refer to *Handbook for Healthy Kids Services,* HK 203.3.

Billing Information: A Primary Care Provider may charge only for those tests performed in the office by the staff, using the provider's equipment and supplies. Payment made by HFS for laboratory tests performed in the Primary Care Provider's office includes both the professional and technical component fees. A professional and technical payment cannot be made to the PCP unless the PCP owns the equipment and completes the test. Physicians providing laboratory services in an office setting must comply with the Clinical Laboratory Improvements Amendment (CLIA) Act. With the exception of the blood lead specimen collection, a Primary Care Provider may not charge for laboratory tests performed by an outside laboratory. Refer to Handbook for Physicians, A-222.1, http://www.hfs.illinois.gov/assets/101006 physician.pdf

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9. **Lead Toxicity Screening:** Federal mandates and HFS policy require that all children enrolled in the HFS Medical Program be considered at risk for lead poisoning and receive a screening blood lead test prior to age **12 and 24 months.** Children over age 24-months and under 72 months who have not previously had a blood lead screening test, should also receive a blood lead test..

All children enrolled in HFS' Medical Programs are expected to receive a blood lead test regardless of where they live or income level as they are considered at risk for lead poisoning. Children at highest risk should be screened on a regular basis. Children six years and older may also be screened, if medically indicated or otherwise appropriate. HFS requires that lead screening be performed in accordance with the state regulations and guidelines stipulated in the "Lead Poisoning Prevention Act" 410 ILCS 45/1 et seq., as amended.

The blood specimens for lead analysis should be sent to the Illinois Department of Public Health, Division of Laboratories, 825 North Rutledge, PO Box 19435, Springfield, Illinois 62794-9435 (217) 782-6562.

Billing Information: Blood lead screening is reported and billed using CPT Code 36415 with modifier Ul. Providers enrolled for Category of Service 30 who have the requisite equipment may bill for Clinical Laboratory Improvement Act (CLIA) waived blood lead analysis [ESA Biosciences LeadCare II Blood Lead Testing System (Whole Blood)] using the Current Procedural Terminology (CPT) Code 83655 with the QW modifier. Offices that are CLIA Certified can bill the CPT code 83655 without the QW modifier.

Providers enrolled for Category of Service 30 who send blood lead specimens to the Illinois Department of Public Health (IDPH) laboratory for analysis may bill for venous or capillary blood
lead draw. The provider who draws the specimen for IDPH to process may bill for obtaining the sample by using the CPT Code 36415 or 36416 with the U1 modifier.

Child health services that are preventive in nature such as well child screening services, childhood immunizations, lead screening, vision screening, hearing screening and objective developmental or risk screening should be accompanied with a preventive child heath diagnosis code (e.g. v202). Providers are reminded that the v is part of the diagnosis code or the diagnosis is incorrectly reported.

You can review a copy of the Provisions of the Illinois Lead Poisoning Prevention Code at: http://hfs.illinois.gov/assets/84520.pdf

For information on childhood lead poisoning, please contact the Illinois Department of Public Health (IDPH) at 217-782-0403, or visit the IDPH Web site at: www.idph.state.il.us

Providers in Chicago should contact the Chicago Department of Public Health (CDPH) at 312-746-7810, or visit the CDPH Web site at: www.cityofchicago.org/health

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10. **Anticipatory Guidance and Health Education:** Anticipatory guidance is a required component of every well-child screening and is not a separate billable service.

Health education provided to both parents or guardians and children is designed to assist them to understand what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention. Observation of parent or guardian and child interaction assists providers in identification of strengths, issues and potential risk factors that need to be taken into consideration for anticipatory guidance. Providers should include in their anticipatory guidance the importance of keeping well-child visit appointments. Providers should conduct monitoring and follow-up of children who have missed appointments and referrals and include discussion on accessing care and resolving barriers.

D. Medical Records:

Providers should refer to Chapter 100, Topic 110 for record requirements applicable to all providers. Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the individual practitioner rendering services. The record maintained by each provider is to include the essential details of the patient's condition and of each service provided. All entries must include the date and must be legible and in English. For information on implementing and using Electronic Medical Records (EMRs), please visit the following website: http://hie.illinois.gov/rec.html.

Medical records for EPSDT services must include the following, where applicable:

- Personal health, social history and family history
- Diagnostic and therapeutic orders, including medications lists
- Clinical observations, including results of treatment
- Reports of procedures, tests and results, including findings and clinical impression from screenings or assessments
- Diagnostic impressions
- Immunization records
- Allergy history
- Periodic examination record
- Growth chart
- Referral information, if any
- Health education/anticipatory guidance, age and history appropriate
- Relevant history of current illness or injury, if any, and physical findings
- Nutritional assessment
- Hospital admission and discharge, if any
- Family planning services, if any

E. Children with Chronic Conditions or with Special Health Care Needs:

For children with chronic diseases, the provider must develop and use treatment plans that are tailored to the individual child. The plan includes appropriate ongoing treatment reflecting the prevailing community standards of medical care designed to minimize further deterioration or complications of the child's health. Treatment plans should be on file with the permanent record for each child with a chronic disease.

F. EPSDT Incentives and Limitations - Payment/Reimbursement

- A claim will be considered for payment only if it is received by the Department no later than 12 months from the date on which services or items are provided. This time limit applies to both initial and resubmitted claims. Re-billed claims, as well as initial claims, received more than 12 months from the date of service will not be paid. For more information on time limits for claim submittal visit www.hfs.illinois.gov/assets/021103chap100.pdf.
- Increased reimbursement rates for selected maternal and child health services are available to physicians and Advanced Practice Nurses (APNs) who are enrolled as an IHC PCP or meet the Maternal Child Health Program criteria and sign the Department's MCH Agreement, which can be found at www.hfs.illinois.gov/enrollment
- An annual incentive payment of $30 per patient will be made to enrolled IHC PCPs, Maternal and Child Health (MCH) physicians, APNs and Federally Qualified Health Centers (FQHCs) who render all recommended well child visits during each year of a patient's life from ages 0-5. Refer to www.hfs.illinois.gov/assets/051906payment.pdf

G. Illinois Healthy Women

Illinois Healthy Women (IHW) is a free and confidential program by the Department of Healthcare and Family Services for women who do not have regular medical benefits. The IHW program covers family planning (birth control) and certain services provided at the family planning visit, such as the physical exam, pap tests, lab tests for family planning, testing and medicine for sexually transmitted infections and sterilization. The IHW Program does NOT cover other medical services, such as visits for acute illnesses. Women who are enrolled in IHW are ineligible to participate in IHC.

For more information about the Illinois Health Women program call 1-800-226-0766. If you use a TTY, call 1-877-204-1012 or visit the website at www.illinoishealthywomen.com.

VIII. Special Services for Children and Pregnant Women

The following programs are valuable resources for PCPs and eligible families to access to enhance the overall quality of care provided through Illinois Health Connect. For more information on these programs, please contact the appropriate program using the information supplied below, or contact your IHC Service Representative.

A. Women's Health Services

Family Planning Services and Obstetrical and Gynecological (OB/GYN) Services are direct access services and do not require referral from a Primary Care Provider (PCP), as outlined in the Provider Notice dated September 4, 2009 on Direct Access billing for IHC PCPs. This notice is available on the IHC and the HFS websites.

1. Family Planning Services

Family Planning Services are available to Illinois Health Connect enrollees with or without a referral from their PCP. Family Planning Services include reproductive health exam and medical history, pap test, education and counseling about family planning, birth control, lab tests, treatment and medicine for sexually transmitted infections, HIV testing, multivitamins with folic acid, and sterilization. For additional information on the HFS Medical Program requirements for sterilization, refer to Chapter 200 of the Physician's Handbook (Subchapter A223.4).

2. Pregnancy Testing

An enrollee can obtain a pregnancy test from her PCP, family planning provider, or any HFS Medical Program participating provider of obstetrical services.

3. Prenatal Care

An Illinois Health Connect enrollee does not need a referral from her PCP for prenatal care and may self refer to any HFS Medical Program participating provider of obstetrical services. The HFS Medical Program provider does not need approval from the enrollee's PCP for prenatal testing or obstetrical procedures.

4. Other Gynecological Health Services

Other gynecological health services do not require a PCP referral. If you are a PCP then you need to bill with the U5 modifier code, as outlined in the Direct Access Billing Provider Notice dated September 4, 2009. Other reproductive health services include an annual examination, pap test, mammogram, hysterectomy and termination of pregnancy. For additional information on the HFS Medical Program requirements for termination of pregnancy and hysterectomy, refer to Chapter 200 of the *Physician's Handbook* (Subchapter A210.5) at:

www.hfs.illinois.gov/handbooks/chapter200.html

OR

www.illinoishealthywomen.com

B. Family Case Management Program

All infants up to age one and women known to HFS as being pregnant who are enrolled in the HFS Medical Program, are referred to the DHS for Family Case Management Program services. HFS transmits the names of participants to Cornerstone, DHS' tracking system designed to track maternal and child health services provided by or through their provider networks.

DHS has contracts with the following types of organizations to provide family case management services:

- Local health departments
- FQHCs
- Local community-based agencies

Case management services are also provided to high-risk infants up to age two who are:

- Identified through the Illinois Department of Public Health's Adverse Pregnancy Outcome Reporting System (APORS)
- Identified as high risk children, depending on resources
- Wards of the Illinois Department of Children and Family Services (DCFS) (children to age five)

Case managers are responsible for:

- Providing face-to-face needs assessment, services and ongoing assistance to families to remove barriers to receiving ongoing preventive health care services
- Providing education about the importance of prenatal care and child health, including appropriate immunizations and screenings
- Providing referral to needed services, including the PCP

Providers are encouraged to work closely with Family Case Management staff to assist clients in receiving needed services. For more information about the Family Case Management Program, contact DHS at **217-785-5900.**

C. Vaccines for Children Plus Program

Children covered under the HFS Medical Program receive childhood vaccines made available to their providers by the Illinois Department of Public Health (IDPH), or in the City of Chicago, through the Chicago Department of Public Health (CDPH). HFS reimburses providers for the administration of those vaccines recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP). Providers may not charge for the cost of the childhood vaccine provided by the VFC Plus Program. The provider may bill the Department for the administration of the vaccine to program participants.

Participation in the VFC Plus Program requires that the provider complete a Provider Enrollment Form and a Provider Profile Form. An enrollment packet can be requested by calling: The Illinois Department of Public Health Vaccines For Children Plus Program at:

For Providers located in Chicago: 312-746-6358
http://illinoisaap.org/projects/reaching-our-goals/vfc-chicago/

For Providers statewide: 800-526-4372 or 217-785-1455
http://illinoisaap.org/projects/reaching-our-goals/vfc-plus-illinois/

Once the provider is enrolled and has completed the Provider Profile Form, IDPH or CDPH will send the provider a three-month supply of vaccines (depending on location of provider). Each quarter, the provider will be required to fill out an Accountability Form and a Vaccine Order Form to receive additional vaccines.

In Chicago: Participation in the VFC Plus Program for Chicago providers occurs through the Chicago VFC Plus Program Call: 1-312-746-5940 to enroll.

D. Immunization Database Programs

1. Immunization Registry

Illinois Health Connect is able to provide immunization history information for all immunizations where a claim was paid by HFS through the Claims History. The Claims History, which also includes a record of other medical encounters and filled prescriptions, can be accessed through HFS' MEDI system. Contact the IHC Provider Helpdesk at 1-877-912-1999 for more information.

HFS strongly encourages providers to participate in Illinois' Immunization Registry. For more information, contact IDPH at 217-785-1455 or visit www.idph.state.il.us/health/vaccine/icarefs.html.

2. I-CARE

I-CARE, or Illinois Comprehensive Automated Immunization Registry Exchange, is an immunization record-sharing computer program developed by the Illinois Department of Public Health (IDPH). The program allows public and private health care providers to share the immunization records of Illinois residents. Currently, the program contains more than 37 million immunization records. For additional information about I-CARE, please check the IDPH web site at www.idph.state.il.us/health/vaccine/icarefs.html.

Recently, IDPH began sharing I-CARE and Cornerstone immunization record data directly with the Illinois Department of Healthcare and Family Services (HFS). In turn, this data is provided by HFS to Illinois Health Connect (IHC). The Cornerstone data includes public health department immunization data and GLOBAL (Chicago Department of Public Health) data.

Immunization records that have been recorded in I-CARE and Cornerstone for services provided in 2009 will qualify for the 2009 IHC Bonus Payment Program for High Performance; the same will occur for every year following. Children receiving complete immunizations as recommended by the ACIP by age 2 years is one of the five measures eligible for bonus payments. HFS uses claims data to determine whether a service was rendered and the bonus benchmark achieved. Bonus payments will be a minimum of $20 per qualifying patient for care provided.

Reporting immunization records through I-CARE and Cornerstone will allow HFS, and subsequently, IHC, to recognize immunizations where a claim might not have been received by HFS. Examples include immunizations received through a free clinic, through private insurance before the child became enrolled in HFS, or improperly billed. In order to qualify for the 2009 bonus payments, records must have been entered by March 31, 2010. For additional information about the IHC Bonus Payment program, please check the IHC website at www.illinoishealthconnect.com under Quality Tools.

E. Early Intervention

Early Intervention (EI) is for children under 36 months of age who have disabilities, delays or are at a substantial risk of delays.

Children eligible for EI services experience delays in at least one of these areas:

- Cognitive development
- Physical development, including vision and hearing
- Language and speech development; psychosocial development
- Self-help skills
- Diagnosed with a physical or mental condition with a high probability of resulting in developmental delays
- Mother diagnosed with a major depression

Families access the Illinois Early Intervention Services System through the Child and Family Connections (CFC) office that serves their local area. Twenty-five sites are operational throughout the state. These regional offices provide:

- Service coordination
- Assistance with eligibility determination and coordinating development of the initial and annual Individualized Family Service Plans (IFSP), which list EI services needed by the child and family, including transportation for those services identified in the child's IFSP.

Health care providers are required to make a referral to Early Intervention within two working days after a child has been identified with a disability or possible developmental delay.

To obtain resource information for the nearest CFC office, refer to the *Handbook for Providers of Healthy Kids Services* or contact:

Illinois Department of Human Services office locator website
www.dhs.state.il.us/page.aspx?module=12&OfficeType=4&County=

Illinois Department of Human Services automated office locator helpline, at 1-800-323-4769, or
The Bureau of Early Intervention, at 217-782-1981
For more general information on EI: www.dhs.state.il.us/page.aspx?item=31889

Information about intervention services for children who are age three and over can be accessed through contacting the child's local school district office, or:

Illinois State Board of Education
Division of Early Childhood, at 217-524-4835

F. Division of Specialized Care for Children

The University of Illinois at Chicago administers the Division of Specialized Care for Children (DSCC), which provides care coordination for families and children with special health care needs. For more information on the Division of Specialized Care for Children please call 1-800-322-DSCC (3722).

IX. Dental Program

The Department of Healthcare Family Services (HFS) provides dental care through the HFS Medical Program. Dental services are federally mandated for children through age 20 under the provisions of EPSDT and provided through the All Kids dental program. HFS provides outreach and facilitates access to services, assuring appropriate utilization of preventive dental services and needed dental treatment services. HFS provides a more limited benefit package (treatment services) for adults and covers only those services which are needed to ensure the health of the individual.

A. Dental Covered Populations

The populations and health conditions covered in the Dental Program include:

- All children birth through age 20 for covered preventive, restorative, and treatment dental services
- All adults with full medical benefits for covered restorative and treatment dental services

B. Dental Excluded Populations

The populations excluded from the Dental program include:

- Individuals in limited benefit programs such as:
  - –Illinois Healthy Women
  - –All Kids Rebate
  - –Illinois Cares Rx (formerly Senior Care/Circuit Breaker)
  - –Illinois Department of Human Services' Service Packages A and B
  - –General Assistance Program for Adults
  - –Emergency Medical Only
  - –Sexual Assault, Renal, and Hemophilia Programs from the Department of Public Health
- Department of Corrections inmates
- Individuals with unmet spend-down status
- County Jail inmates
- Individuals in Supported Living Facilities (non-Medicaid)
- Certain Qualified Medicare Beneficiaries (non-Medicaid)
- State employees covered by the state's health purchasing program who are not otherwise included
- Individuals receiving Department of Human Services Social Services

To refer patients to a dental home, please contact DentaQuest Customer Service at: 1-888-286-2447

X. Glossary

- **Americans with Disabilities Act (ADA) of 1990:** United States Public Law 101-336 prohibiting discrimination on the basis of disability in (1) employment, (2) programs, services and activities of state and local government agencies and (3) goods, services, facilities, advantages, privileges and accommodation of places of public accommodation.

- **Automated Health Systems (AHS):** The Department of Healthcare and Family Services' contractor for the administration of Illinois Health Connect (Illinois' Primary Care Case Management program) and the Illinois Client Enrollment Broker.

- **Care Coordination:** A set of participant-centered, goal-oriented, culturally relevant, and logical steps to assure that a participant receives medical and medically related needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care coordination emphasizes prevention and continuity of care.

- **Care Management:** A process by which a primary care provider provides routine preventive and primary care to assigned enrollees, assumes responsibility for specialty care referral and is accessible 24 hours, 7 days per week. The primary care provider also assumes responsibility for coordination of care, receiving reports and profile information on assigned enrollees and functioning as a medical home.

- **Centers for Medicare & Medicaid Services (Federal CMS):** The federal agency within the U.S. Department of Health and Human Services responsible for the administration of the Medicare program and in partnership, works with the states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and the health insurance portability standards.

- **Certified Local Health Department:** Authorized under 77 III. Adm. Code Part 600. Agencies of local government that develop and administer programs and services that are aimed at maintaining a healthy community. To ensure that these efforts address a community's most important health problems and concerns, the local health department encourages residents to participate in assessing public health needs and in formulating a community health plan. It also works with other community organizations to assure that needed services and programs are available. Services and programs available through local health departments include, but are not limited to, a wide array of community health and health promotion activities, well child health clinics, immunizations, lead screenings, Family Case Management (FCM) program, communicable disease investigations, health education, health screenings, dental sealants and referrals to other agencies.

- **Client Enrollment Broker:** The entity contracted by HFS to assist potential enrollees in the counties where the Voluntary Managed Care Program operates to understand delivery system options and to assist with selection of a delivery system and primary care provider.

- **Dual Eligible:** A participant who is eligible to receive services through both the Medicare and the HFS Medical Program.

- **Early and Periodic, Screening, Diagnosis and Treatment (EPSDT):** Services provided to children under Title XIX of the Social Security Act (42 U.S.C. § 1396, et seq.) The preventive component of this program is referred to as the "Healthy Kids" program. Information regarding EPSDT can be found in HFS handbooks at http://www.hfs.illinois.gov/handbooks. The guidelines for the Healthy Kids program are located at http://www.hfs.illinois.gov/handbooks/chapter200.html#hk200

- **Early Intervention:** The program described at 325 ILCS 20/1 et seq., which authorizes the provision of services to infants and toddlers, birth through two years of age, who have a disability due to developmental delay or a physical or mental condition that has a high probability of resulting in developmental delay or being at risk of having substantial developmental delays due to a combination of serious factors.

- **Enrollee:** Any HFS Medical Program participant who is enrolled in the Illinois Health Connect Program.

- **Family Case Management (FCM) Program:** The program described at 77 III. Adm. Code 630.220. Administered by the Illinois Department of Human Services, this program contracts with local health departments, and in Cook County, other community-based organizations and Federally Qualified Health Centers to perform outreach and case management services for Medicaid infants and pregnant and post-partum women, and DCFS wards under age five.

- **Federally Qualified Health Center (FQHC):** A health center that meets the requirements of 89 IL Admin Code 140.461 (d).

- **Group Practice:** A group of physicians who share a practice and provide direct medical services to patients of any physician within that practice.

- **HFS:** The Illinois Department of Healthcare and Family Services and any successor department. HFS was formerly known as the Illinois Department of Public Aid (IDPA). In this handbook, HFS is also referred to as the Department.

- **HFS Medical Program:** The Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq.) or its successor program and Titles XIX and XXI of the Social Security Act (42 USC 1396 et seq.) and Section 12- 4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35); the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 USC 1397aa et seq.); and the All Kids program administered under 215 ILCS 170 et seq.

- **Health Insurance Portability and Accountability Act (HIPAA):** A federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPPA provides the U.S. Department of Health and Human Services with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

- **Healthy Kids:** Illinois' EPSDT program for well child screenings (preventive services)

- **Illinois Health Connect:** Illinois' Primary Care Case Management (PCCM) Program. Illinois Health Connect is a system under which a primary care provider signs an agreement with HFS to furnish care management services which include the location, coordination and monitoring of preventive and primary health care services to enrollees.

- **Illinois Nurse Helpline:** An after-hours and weekend nurse-staffed helpline where enrollees can interact with a medical professional when his/her primary care provider is not available.

- **Managed Care Organization (MCO):** An entity that is a federally Qualified Health Maintenance Organization which meets the advance directives requirements of subpart I of part 489 of 42 C.F.R. and set forth in Article V, Section 5.23 or any public or private entity that meets the advance directives requirements of subpart I of part 489 of 42 C.F.R. and set forth in Article V, Section 5.23 and is determined to meet the following conditions: (a) is organized primarily for the purpose of providing health care services, (b) makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid participants within the area served by the entity and (c) meets the solvency standards of regulations promulgated under 42 C.F.R. Part 438.

- **Medicaid:** Title XIX of the Social Security Act.

- **Office of Inspector General (OIG):** HFS' OIG has as its mission to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in the programs administered by HFS.

- **Participant:** Any individual determined eligible for the HFS Medical Program.

- **Panel:** A list of Illinois Health Connect enrollees assigned to a specific primary care provider. Also referred to as a Panel Roster.

- **Primary Care Provider (PCP):** A provider recognized by HFS who within his or her scope of practice, and in accordance with State certification/license requirements, and recognized by HFS as a provider, is responsible for providing all preventive and primary care services to his or her assigned enrollees under Illinois Health Connect.

- **Recipient Restriction Program (RRP):** A program operated by the HFS Office of the Inspector General that identifies those individuals who overuse medical or pharmacy services in excess of need or in such a manner to constitute an abuse of the program and restrict those individuals to a physician or pharmacy or both.

- **Referral:** An authorization provided by a primary care provider to enable an enrollee to seek medical care from another provider.

- **Rural Health Center (RHC):** A provider that has been designated by the Public Health Service, the U.S. Department of Health and Human Services, or the Governor of the State of Illinois, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (see Public Law 95-210) as an RHC.

- **Voluntary Managed Care (VMC):** The State's risk-based managed care program in which eligible participants can voluntarily enroll. The program operates in the following counties: Adams, Brown, Cook, Henry, Jackson, Kane, Lee, Madison, McHenry, Mercer, Perry, Pike, Randolph, Rock Island, Scott, St. Clair, Washington and Williamson.

- **WIC:** The Special Supplemental Food Program for Women, Infants and Children (WIC) administered by the Illinois Department of Human Services. DHS' mission for WIC is to improve the health and nutritional status of women, infants and children; reduce the incidence of infant mortality, premature births and low birth weight; aid in the development of children; and refer women to other health care and social service providers. WIC provides nutritional education, counseling and support; breastfeeding support; referrals to other services and coupons for nutritious food to pregnant women; breastfeeding women (up to one year); post-partum women (up to six months after giving birth); infants and children under the age of five who meet the participation requirements. Federal law requires HFS to coordinate with WIC, providing information about WIC to women and children who may qualify for the program.

Appendix A

Illinois Department of Healthcare and Family Services

Illinois Health Connect Primary Care Provider Agreement

This Agreement pertains only to the relationship between the Illinois Department of Healthcare and Family Services (HFS) and the Provider under HFS' Primary Care Case Management (PCCM) and the Maternal and Child Health (MCH) programs. This Agreement does not affect any other relationship or agreement, including the general Provider Agreement, between HFS and the Provider. For purposes of this program and this Agreement, Provider will be called a Primary Care Provider (PCP).

HFS Responsibilities

HFS, or the PCCM Program Administrator with whom HFS has a contractual relationship, agrees to:

- establish and maintain enrollment and referral tracking procedures and systems
- pay a monthly case management fee for all individuals enrolled with the PCP as of the first day of each month
- provider profiles and practice management reports to the PCP and monthly panel roster listing all patients currently linked to that medical home along with clinical indicators.
- pay enhanced rates to physicians who are enrolled as IHC PCP for delivery services, primary care office visits and screening services provided to children
- provide information to PCPs about relevant issues such as the patient enrollment and verification processes, Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services, referrals, administrative processes, covered services, and targeted areas of quality improvement, and assist PCPs in setting up a recall system by integrating relevant information into the Panel Roster distributed to Providers on a monthly basis

Participation Requirements

As a PCP in the PCCM program, I agree to provide a medical home and adhere to the following requirements for enrollees of the PCCM program and, as appropriate to my practice, children and pregnant women in HFS Medical Programs:

- provide medically necessary care in a timely manner with a focus on the provision of quality primary and preventive health care services that support continuity of care and avoid unnecessary emergency room visits and hospitalizations
- maintain hospital admitting and/or delivery privileges or arrangements for admission or for APNs maintain a collaborative agreement with a physician who has hospital admitting privileges
- make medically necessary referrals to HFS enrolled providers including specialists, as needed
- maintain office hours and access and availability requirements as required in the Attachment to this agreement
- institute a symptom-based action plan of care to be shared with Enrollees with chronic diseases including asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease

- provide direct access to enrollees through an answering service/paging mechanism or other approved arrangement for coverage twenty-four hours a day, seven days a week (24/7). Automatic referral to hospital ER does not qualify. Ensure that “sick” children and “at risk” pregnant women are treated as needed.
- MCH Services (as appropriate to my practice):
  - perform periodic preventive health screenings (EPSDT) and pediatric care as needed in accordance with established standards of care
  - perform risk assessments for pregnant women and children
  - provide obstetrical care or delivery services, as appropriate
  - schedule, diagnostic consultation and specialty visits or contact the designated case management entity to coordinate / schedule the visit as appropriate.
  - provide equal access to medical care for clients in cooperation with the Department or its designated case management entity
  - communicate with the case management entity
  - provide a Medical Home for pregnant women and children

Termination

Provider may terminate participation as a Primary Care Provider in the IHC Program upon forty-five days written notice sent by certified mail to:

Illinois Health Connect Medical Director
Automated Health Systems
1375 E. Woodfield Road, Suite 600
Schaumburg, Illinois, 60173

HFS may terminate a Provider's participation as a PCP in the PCCM and MCH programs under this Agreement upon 45 days notice if the Provider fails to maintain any of the above participation requirements. Such termination shall not be subject to HFS' rules and regulations on notice and hearing for a Provider's termination from participation in the HFS’ Medical Programs.

Agreement

I agree to comply with the participation requirements of a Primary Care Provider under the PCCM and MCH programs, as cited in this Agreement. I also certify that all information provided in my PCP Application is correct.

Printed Name:_____ IL HFS Number:_____

Signature: _____ Date: _____

Attachment to the Primary Care Provider Agreement

The following list provides the key responsibilities and standards that Primary Care Providers (PCPs) participating in Illinois' Primary Care Case Management (PCCM) are expected to generally meet, consistent with their scope of practice. HFS recognizes that lack of patient compliance can prevent PCPs from meeting some of these standards, despite the PCP's best efforts to work with the patient.

1. Comply with generally accepted medical standards for preventive and primary care services, including:
   a) Inform enrollees, in a manner that they can easily understand, of their treatment options and their right to participate in decisions regarding their health care, which includes the right to refuse treatment;
   b) Initiating and authorizing referrals for specialty care, inpatient care and other medically necessary services via the internet based system, telephone, fax or mail;
   c) Participating in or coordinating Enrollee care during and after an inpatient admission;
   d) Maintaining continuity of Enrollee care;
   e) Providing Enrollees under age 21 all required EPSDT services, including comprehensive well child services in accordance with the AAP guidelines, the State's periodicity schedule: age appropriate comprehensive physical examination; health history; mental and developmental screening, including social emotional; risk assessment; nutritional assessment; height and weight measurement; hearing and vision screening; anticipatory guidance and ensure appropriate laboratory screening including lead and referrals, as needed;
   f) Provide enrollees age 21 or older comprehensive primary care services and covered preventive services, in accordance with the recommendation of the U.S. Preventive Health Services Task Force: medically indicated physical examinations, health education, laboratory services, referrals for necessary prescriptions and other services, such as mammograms and pap smears;
   g) Provide pregnant and post partum women comprehensive perinatal services in accordance with the ACOG guidelines; and
   h) Provide or arrange for all appropriate immunizations for Enrollees.

2. Provide care to the Enrollee based on the standards of reasonable appointment availability. The PCP must satisfy the following access and availability requirements for enrollees:
   a) The PCP in an individual (solo) practice must maintain office hours of no less than 24 hours per week.
   b) The PCP participating in a group practice may have office hours less than 24 hours per week as long as their group practice office hours equal or exceed 32 hours per week.
   c) Routine, preventive care appointments available within five weeks, and within two weeks for infants under 6 months, from the date of request for such care;
   d) Urgent care appointments not deemed emergency medical conditions triaged and, if deemed necessary, provided within 24 hours;
   e) Appointments for Enrollee problems or complaints not deemed serious available within three weeks from the date of request for such care; and
   f) Initial prenatal appointments for women self-identifying as pregnant without expressed problems: first trimester within two weeks, second trimester within one week, and third trimester within three days.
   g) Upon notification of Enrollee hospitalization or ER visit, follow-up appointment available within 7 days of discharge.

3. Provide or coordinate primary and preventive health care services for enrollees in the appropriate amount, duration and scope, and assist enrollees in making only necessary emergency room visits and hospitalizations. Make medically necessary referrals to HFS enrolled specialty or other providers for services that require such referral.

4. Establish/maintain hospital admitting and/or delivery privileges or arrangements for admission and notify HFS immediately of any revocation, suspension or limitations placed upon those privileges or arrangements.

5. Upon disenrollment, transfer the Enrollee's medical record to the new PCP when requested by the new PCP and authorized by the Enrollee.

6. Set up a recall system to outreach to Enrollees who miss an appointment to reschedule the appointment, as needed.

7. Educate patients, as identified in the PCP's Panel Roster, to inform and remind them about preventive and immunization services, or preventive services missed or due, based on the periodicity schedule.

8. Not discriminate against, or use any policy or procedure that has the effect of discriminating against individuals eligible to enroll on the basis of race, color or national origin or on the basis of health status or the need for health care services.

9. PCP shall not make any assertion, written or oral; that the participant must enroll with the PCP to obtain benefits or not to lose benefits or that the Federal or State government endorses the PCP. PCP shall not conduct door-to-door, telephonic or other 'cold-call' marketing or engage in activities that could mislead, confuse, or defraud participants, or misrepresent the PCP or HFS.

10. Provide information to be used in the PCP Directory and notify Automated Health Systems of any changes in the Directory information.

11. Review and use all provider profiles provided.

12. Maintain access to the Internet, unless granted an exception by HFS or its PCCM Program Administrator.

13. Participate in the Vaccines for Children (VFC) program, or have an arrangement with a Provider that participates in the VFC program, if serving children. HFS recommends participation in the Illinois Department of Public Health Immunization Registry ICARE (formerly TOTS).

14. Coordinate care with community-based Providers, including State-certified health departments, school based/linked clinics, local education agencies (LEAs), Early Intervention, Women, Infants and Children's (WIC) program, and Family Case Management program. Such coordination could include sharing patient information.

15. Notify HFS, in writing, within thirty days of any changes in the PCP's professional staff, including Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives, that adversely affect the Providers panel limits in the IHC Program.

16. Obtain referrals for clients who are not on your panel roster, and agree not to bill client for rejected claims.

Appendix B

Please see the following pages for a sample panel roster.

Illinois Health Connect Panel Roster
March 2011

Enclosed is your panel roster for the Illinois Health Connect Program.

IMPORTANT PROVIDER NOTICE

To all Illinois Health Connect PCPs

To ensure the privacy, security, and confidentiality of Patient and Provider information for the Illinois Health Connect Program (IHC), the Department of Healthcare and Family Services (HFS), will be requiring Providers to enroll with the State's MEDI System if they wish to have online access to their IHC Panel Rosters, Patients Paid Claims History, and the ability to register and view referrals via the online IHC Referral System. The MEDI system utilizes Federally approved access protocols that allow only approved providers and their authorized staff to access sensitive patient and provider information.

This requirement is anticipated to go into effect in approximately three weeks. Once implemented, providers will no longer be able to access their patient information directly through the IHC website. We will post notices on this cover sheet and the IHC Web Site to inform you of the implementation date.

Don't wait. Enroll now! We encourage you to enroll with the MEDI System before the transition occurs. To enroll, please go to http://www.myhfs.illinois.gov/training/guides and click on "Introduction to MEDI". Once enrolled, the MEDI system will allow providers and their authorized staff to link to their IHC Panel Rosters, Patients Paid Claims History and the IHC Referral System. In addition, MEDI will provide up-to-date eligibility information, including IHC PCP information, for all HFS clients.

If you have any questions, please call the IHC Provider Services Help Desk at 1-877-912-1999 and follow the prompts for Providers. Remember, you must enroll with the MEDI system to be able to access your IHC Panel Roster, Patients Paid Claims History and to register and view referrals via the IHC Referral System.

Thank you.

88888

ILLINOIS FAMILY HEALTH CENTER
123 MAIN STREET SUITE 100
CHICAGO,IL 60634

Provider Enrollee Panel Roster
March 2011

Provider HFS Number: 8800880088000
Illinois Health Connect Number: 82000088
ILLINOIS FAMILY HEALTH CENTER (Fax (847) 888-9898)

Enrollee Information	Address/Phone	Begin Link Date / End Link Date	Disease Management Eligibility	Preventive Services	Status	Services Reported to IHC
BUSYFAMILY, LAD	5694 RAILROAD AVE.	4/29/1999		Well Child Visit: Screenings - Developmental: Vision: Lead:		
449000213 4/29/1998 - 12y (Male) 2890909000028900	CHICAGO, IL 60644 Phone: (847)850-4213					
				Last PCP Visit:		4/8/2010 Claim
BUSYFAMILY, YOUNGSTER	5694 RAILROAD AVE.	9/10/2003		Well Child Visit: Screenings - Developmental: Vision: Lead:	Due	
449000220 9/30/2002 - 8y (Male) 2890909000028900	CHICAGO, IL 60644 Phone: (847)850-4213					
				Last PCP Visit:		9/15/2010 Claim
EXAMPLE, MALE 909090909 3/20/1948 - 63y (Male) 2900250027002809	947 RIVER BLVD. GALVA, IL 61434 Phone: (309)998-0909	3/29/1981	Meets Diabetes Criteria	HbA1c Test: Last PCP Visit:		8/29/2009 Claim 12/10/2009 Claim
HAPPYFAMILY, FEMALE 101010101 1/1/1971 - 40y (Female) 2500260027002800	100 WINDWEST ROAD APT #10 CHICAGO, IL 60611 Phone: (847)123-4567	10/20/1999	Meets Diabetes Criteria	PAP Test: HbA1c Test: Last PCP Visit:	Due	12/20/2010 Claim 9/28/2010 Claim
HAPPYFAMILY, MALE 202020202 2/2/1972 - 39y (Male) 2500260027002800	100 WINDWEST ROAD APT #10 CHICAGO, IL 60611 Phone: (847)123-4567	1/12/1995	Frequent ED User			
				Last PCP Visit:		1/5/2010 Claim
ILLUSTRATION, TEENAGE	6490 NEWPORT DRIVE	4/13/2004		Well Child Visit: Screenings - Developmental: Vision: Lead:	Due Due Due	
550034501 6/8/1991 - 19y (Female) 2923090800023100	BRADFORD, IL 61421 Phone: (309)390-9008		Meets Diabetes Criteria	HbA1c Test: Last PCP Visit:		5/26/2009 Claim 7/23/2010 Claim

Provider Enrollee Panel Roster

March 2011

Provider HFS Number: 8800860088800
Illinois Health Connect Number: 82000088
ILLINOIS FAMILY HEALTH CENTER (Fax (847) 888-9898)

Enrollee Information	Address/Phone	Begin Link Date / End Link Date	Disease Management Eligibility	Preventive Services	Status	Services Reported to IHC
NEWFAMILY, BABY	350 SE 15TH AVE.	6/10/2005		Well Child Visit:		
				Screenings - Developmental:		
				Vision:		
				Lead:		
390902802	BRADFORD, IL 61421					
5/15/2005 - 5y (Female)	Phone: (309)594-0991					
2890909023495670						
				Last PCP Visit:		1/15/2011 Claim
NEWFAMILY, FATHER	350 SE 15TH AVE.	12/19/2010				
390800223	BRADFORD, IL 61421					
8/17/1981 - 29y (Male)	Phone: (309)594-0991					
2890909023495670			Meets Diabetes Criteria	HbA1c Test:		1/10/2010 Claim
				Last PCP Visit:		No Claims
NEWFAMILY, MOTHER	350 SE 15TH AVE.	12/19/2010				
390800220	BRADFORD, IL 61421			PAP Test:		00/00/0000 Claim
4/7/1982 - 28y (Female)	Phone: (309)594-0991					
2890909023495670				Last PCP Visit:		No Claims
SAMPLE, WOMAN	945 CENTER AVE APT #1	9/25/1992				
789012234	CHICAGO, IL 60611	00/00/0000		PAP Test:		00/00/0000 Claim
5/4/1960 - 50y (Female)	Phone: (847)908-4590			Mammogram:		00/00/0000 Claim
1209030299813038						
				Last PCP Visit:		2/20/2010 Claim

Provider Enrollee Panel Roster
March 2011

Questions? Call the Illinois Health Connect Provider Helpdesk at 1-877-912-1999. Hours: Monday - Friday 8 a.m. to 7 p.m.

Your panel roster provides the following information about your patients:

ENROLLEE INFORMATION: Illinois Health Connect enrollee's name (last, first, middle init) /HFS Recipient No.(RIN)/ Enrollee's birth date - age / IHC Case Number.
ADDRESS/PHONE: Enrollee's address and member telephone (if available).
BEGIN LINK DATE/END LINK DATE: PCP Linkage Information
DISEASE MANAGEMENT ELIGIBILITY: Identifies if the enrollee is eligible for Disease Management Services through Your Healthcare Plus (YHP), a voluntary program. For questions, please call 800-973-6792.
Frequent ED User: Enrollee has received services through the ED 6 or more times in the past year without a subsequent inpatient admission.

Meets Diabetes Criteria: Enrollee has had office, outpatient, hospital or ED visits in past two years with diagnosis of diabetes. Please confirm with the clinical record.
HbA1c Test: Shows date of most recent claim for HbA1c testing.
Last PCP Visit: Shows the date of the most recent visit with current PCP based on claims data.

PREVENTIVE SERVICES BY AGE: May show the following services: Well Child Visit, Developmental Screening, Vision Screening, Lead Screening, PAP test and Mammogram.

STATUS: "Due" - if eligible and due for the preventive service listed. Blank - if not eligible or is not due for the preventive service listed. The status is determined by HFS claims data. Please verify enrollee's medical records.
HFS preventive services recommendations:
Well Child Visit: ages 2 weeks, 1 mon, 2 mon, 4 mon, 6 mon, 9 mon, 12 mon, 15 mon, 18 mon, 24 mon, 3 yr, 4 yr, 5 yr, 6 yr, 8 yr, 10 yr, 12 yr, 14 yr, 16 yr, 18 yr, 20 yr
(panel roster shows "due" for all children continuously ages 0 to 18 months).
Developmental screening: between ages 0 to 12 months, between ages 12 to 24 months and between ages 24 to 36 months.
Mammogram: minimum every other year between ages 40 to 69 yrs.
Pap test: yearly between ages 21 to 64 yrs.
Lead screening: one test before age 12 months and a second test before age 24 months, if no screening done before age 24 months then screen at any time before age 6 years.
Vision screening: yearly ages 3yr through 6 yr, and then ages 8 yr, 10 yr, 12 yr, 15 yr, and 18 yr.

SERVICES REPORTED TO IHC: For each preventive service the following notations can be included:
Claim: Date of last claim paid for this service.
Scheduled: Enrollee reports a scheduled appointment or was assisted by IHC in scheduling an appointment.
Kept: Enrollee (or provider) reports that scheduled appointment was kept.

More clinical information about each enrollee can be obtained through the Claims History, which can be accessed through the HFS MEDI Provider Portal. The Claims History contains at least 4 years of immunization data, and 2 years of claims data including pharmacy claims. If you do not have access to MEDI, please contact your Illinois Health Connect Provider Service Representative or the Illinois Health Connect Provider Helpdesk at 1-877-912-1999. Additional information can be found on the Illinois Health Connect website at www.illinoishealthconnect.com under Quality Tools.

Age breakdown of enrollees:

Under 1: 0	19-20: 1
1-2: 0	21-39: 3
3-5: 1	40-49: 1
6-9: 1	50-64: 2
10-14: 1	65+ : 0
15-18: 0	Total Active: 9

	Eligible Enrollees	Due Enrollees	Percent Due
Well Child Visit:	0	0	0.00 %
Developmental Screening:	0	0	0.00 %
Vision Screening:	0	0	0.00 %
Lead Screening:	0	0	0.00 %
Mammogram:	0	0	0.00 %
Pap Test:	0	0	0.00 %