

Member Services Toolkit for ACEs and CCEs

Installment #2: Introduction to Covered Services

Understanding Covered Services

Multiple resources must be considered in order to understand which health care services are covered within the Illinois Medicaid fee for service system. Covered services must be provided to an eligible participant by a medical provider enrolled for participation in the Illinois Medical Assistance Program. Services provided must be in full compliance with all applicable state and federal laws and regulations, including [Titles XIX and XXI of the Social Security Act](#), [Illinois' Public Aid Code](#), and the Illinois Department of Healthcare and Family Services' (HFS) [Administrative Rules](#). Services must also comply with the general provisions contained in [Chapter 100 of the HFS Provider Handbook](#), and with the specific policies and procedures contained in the [Chapter 200 series of the Handbook](#) that applies to specific types of service or types of provider. The purpose of this installment of the *Member Services Toolkit* is to help Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs) gain proficiency in using these resources to discern covered services.

HFS Provider Handbooks – A “Goldmine” of Information for Care Coordination

The *HFS Provider Handbooks* contain so much important information about covered services and authorization requirements that a staff person at one ACE described them as a “goldmine.” The *Handbooks* are available on the [HFS website](#) and offer information and guidance to providers who participate in the Illinois Medical Assistance Program. The *Handbooks* state HFS policy with sufficient instructions and guidelines to enable providers to:

- know which services provided to eligible participants are covered;
- submit proper billings for services rendered; and
- identify the proper source for inquiries when it is necessary to obtain clarification and interpretation of HFS policy and coverage.

The *HFS Provider Handbooks* are a collection of chapters, including but not limited to:

- [Chapter 100](#), the “general handbook,” contains policy, procedures and appendices applicable to *all* participating providers;
- [Chapter 200](#) handbooks contain policy, procedures and appendices applicable to the provision of a specific type of provider or category of service (e.g., *Handbook for Home Health Agencies*);
- [Chapter BC-200](#) contains information and guidance for providers who provide birth center services to participants in the HFS' Medical Programs;
- [Chapter CMH-200](#) contains general policy, procedures and appendices applicable to Screening, Assessment and Support Services provided under the Children's Mental Health Program;
- [Chapter D-200](#) contains general policy, procedures and appendices applicable to Encounter Clinic Services Providers;
- [Chapter HK-200](#) contains general policy, procedures and appendices applicable to all Healthy Kids Services Providers.

Generally speaking, each handbook follows a standard format that includes:

- a *Table of Contents* that provides a numbering system for navigating the document;
- a *Forward* that describes the purpose of the handbook;
- *Provider Participation* requirements and procedures;
- details related to *Reimbursement*, including claim submittal and payment;
- information about *Covered Services* for which payment can be made by HFS;

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- information about *Non-Covered Services* for which payment cannot be made by HFS;
- *Record Requirements* to maintain adequate records;
- And, in many cases, appendices that provide further detail.

HFS staff members take great care to adhere to this standard format in order to make sure that providers and other stakeholders are able to consistently locate the information they need.

Provider Releases and Bulletins

There are often changes to policies and covered services that must be implemented before the *Handbooks* can be updated. For this reason, it is also important to monitor [HFS Provider Releases and Bulletins](#). Releases (also referred to as notices) inform providers and billing agents of possible revisions or clarifications of medical services. Bulletins include information about general policy and procedural updates for the various provider handbooks issued by HFS. All releases and bulletins are available on the HFS website, where providers and other stakeholders can easily register for email notifications of updates.

Relevant Laws and Regulations

Illinois' Medicaid program is authorized by both federal law (Title XIX of the Social Security Act) and state law (the Illinois Public Aid Code). Additionally, some categories of eligibility for children in the All Kids program are established in Title XXI of the Social Security Act and in Illinois' Covering ALL KIDS Health Insurance Program Act. These laws, and the implementing regulations that flow from them, contain details about Illinois' medical programs that any risk-bearing managed care entity should know. The sections of Illinois' Administrative Code that are especially relevant to the topic of covered services are Title 89 [Section 140.3 Covered Services Under Medical Assistance Programs](#) and [Section 140.6 Medical Services Not Covered](#).

Some Special Considerations

- Covered services for members age 20 and under requires an understanding of Early and Periodic Screening, Diagnostic and Treatment (EPSDT). EPSDT is a very comprehensive set of benefits and services for children. These include all medically necessary diagnostic and treatment services within the federal definition of Medicaid, regardless of whether or not such services are otherwise covered for adults ages 21 and older. Plenty of detail about EPSDT can be found in the Healthy Kids Handbook [Chapter HK-200](#).
- Many mental health and substance abuse services in the Medicaid fee for service system are administered by the Illinois Department of Human Services through a network of community based providers. Future toolkit installments will provide resources for identifying, linking to, and coordinating care with those providers.
- ACEs and CCEs have established robust networks of providers who are experienced serving clients in the Medicaid fee for service system. HFS encourages and expects ACEs and CCEs to leverage the knowledge of those providers to develop expertise in the area of covered services.