Downstate Long Term Care Forum Questions and Answers
March 11, 2015

1Q: Why would it take close to 2 years to get a person approved for Medicaid? Why is there not a set amount of time that the state has to approve someone for Medicaid; such as 2 months?

1A: Determinations for eligibility are based on financial and non-financial factors. The goal is to process an application in under 90 days, but each applicant's circumstances will factor into the length of time required to process an application. For example, a resource review by the Office of Inspector General (OIG) may result in an application taking longer to process**.**

2Q: We have several facilities that are attaching the required 3654 information and supporting documents to their ABE applications upon submission and then receiving letters later on that the 3654 information is still needed and never received. This has created a lot of extra work for our Business Office Staff in trying to complete the application process for Macon County LTC. Are you aware of this issue and if so how is it being resolved?

2A: Form HFS 3654, Additional Financial Information for Long Term Care Applicants, transmitted as attachments to the Application for benefit Eligibility (ABE) applications are sometimes being sent as one sided documents rather than two sided causing the Department of Human Services (DHS) office to have to request additional paperwork.

3Q: Why is it taking so long for approved LTC applicants to be entered into the REV system by Macon LTC?

3A: Several factors determine the length of time it takes for the DHS office to process an admission entered into Medicaid Electronic Data Interchange (MEDI)/EDI Vendors (formerly referred to as REV). With few exceptions, admissions are worked oldest to newest. Some areas of the state were able to maintain a higher level of currency than others prior to the transition to the Macon LTC Hub. Those that were further behind are being caught up so that the remaining work from across the state can be completed in order by the date of submission. However, other factors such as spend downs, OIG referrals, penalty periods, resource reductions, appeals, and customer requests for extensions are additional factors which may slow the process on any individual case.

4Q: As a LTC facility that has hundreds of thousands of dollars in unpaid balances due to pending Medicaid applications, what access do we have to verification that a resident has submitted an application to DHS?

4A: Applications submitted through ABE have a tracking number assigned to them. If designated as an Authorized Representative, information regarding the status of an application can be verified through ABE or through the DHS Helpline (800) 843-6154.

5Q: How do we get the information submitted in more timely fashion? Why do the different departments not communicate with each other?

5A: Sending information to the correct centralized LTC hub will assist in the timely processing of information. Information for Regions 1 & 2 (those above Interstate 80 + Kankakee County) should be sent to Medical Field Operations (MFO) office at DHS.MFOInfo@illinois.gov. Information for Regions 3, 4, & 5 (those counties below Interstate 80) should be sent to DHS.MaconLTC@illinois.gov for will aid this timely process. The Departments of Human Services and Healthcare and Family Services continue to communicate with each other often.

6Q: Are nursing home patients on public aid still allowed to keep their Medicare Supplement Policies?

6A: Long standing federal regulations in the Social Security Act (SSA) preclude a Medigap policy being sold to a dual-eligible client. If the Medigap policy was obtained prior to the client being Medicaid- eligible the policy may be retained. Until HFS makes a determination regarding policies sold in violation of the SSA any current policies may be retained. No new policies should be written for dual-eligible clients. This was addressed in a LTC Provider Notice dated 1/22/2015- Medicare Co-Insurance Policies Not Allowed for Dual Eligible Individuals.

7Q: Where should changes to a resident's income be reported to?

7A: All income changes, as well as other changes in resident status, should be reported to DHS through MEDI/EDI vendors. Income verification documents should be sent hard copy to the appropriate LTC office and include the Transaction Audit Number (TAN) assigned when submitted electronically. A method to electronically transmit income verification documents is under development.

8Q: Does Macon have a specific goal as to how long it takes to get a new application approved assuming all paper work is submitted with the application?

8A: It is the Department's goal to complete applications within 90 days understanding that some may take longer depending on extension requests, spend downs, OIG referrals, penalty periods, resource reductions, and appeals.

9Q: How should residents in a nursing home applying for public aid answer the question on the application, "Does anyone applying have a high cost medical condition." Just what does that mean?

9A: "Does anyone have a high cost medical condition" is intended to identify customers who have or have access to private health insurance that may be eligible for the Health Insurance Premium Payment (HIPP) Program. HIPP decisions are made to determine the cost effectiveness of the State paying the cost of private insurance (often COBRA benefits) versus the cost of covering their anticipated expenses on a Medicaid card. This program is limited to specific high cost conditions. It does not apply to certain categories of assistance including residents of long term care facilities.

10Q: Question M on the Medical Benefits application - Did anyone applying receive any medical services during the 3 months before the month of this application? We were told that means being in a nursing home. So if you don't mark this question yes, the state will not back date your application to cover the cost of the nursing home, is this correct?

10A: "Did anyone applying receive any medical services during the past 3 months before the month of this application" applies to both long term care months and community months. This lets the DHS worker know if backdating is being requested and if there are medical bills during those times that may need to be paid or factored into the ongoing calculations. Marking this question as yes when appropriate, is the best way to ensure that backdating is considered.

11Q: How do I reach my LTC caseworker when she will not return phone calls, emails, faxes?

11A: Under the new task based system implemented by the Department, there is no longer a specific caseworker assigned to a county or facility, rather groups of 15 – 20 workers dedicated to specific types of work. In the Macon County hub, there are additionally six caseworkers assigned to answer phones calls daily. These workers field questions from a specific geographic area. The phone number to reach these workers directly (217)362-6515 option 2. If they are on another call, it will go to their voice mail and they will attempt to return the call within two business days.

Another way to reach the office is through email at DHS.MaconLTC@illinois.gov. Another caseworker and all of the supervisors return the email inquiries. The length of time the response takes is relative to several factors such as, but not limited to, the number of customers included in the request; if another DHS office or OIG is involved; if we have authorization to disclose information; etc.

12Q: Why is it taking an unreasonable amount of time to process admits, even when using the MEDI system?

12A: Although admits submitted in MEDI are received by DHS office the day after submitted transaction, the caseworker must process into the system. Delays include back log, eligibility determination, income, verification, etc. The new DHS LTC hubs are part of a process to streamline both applications and admissions. The number of outstanding transactions has been reduced and delays will continue to shorten.

13Q: Need more training on ABE and more training on MEDI?

13A: An 8/27/2014 ABE training and video of the 9/24/2014 ABE training has been posted on the HFS Web site for your reference.

For questions related to MEDI, the provider should call the LTC Billing Unit staff at (217)782-0545 and can be trained over the phone.

14Q: Please tell me why many of my redeterminations and new admits are coming through with incorrect calculations of resident liability from the Macon County office and how and when this will be fixed. It creates more work for me entering incorrect information, emailing corrected calculations back, and then having to reenter new information when it is received. This also creates problems for family members who get stressed out over money they don't have and can't pay. I just received the final decisions on a husband and wife case that goes back to 2012. Wife came in first on a spousal app and husband came in about a year later. When the calculations were completed in January 2015 we were told the husband had a pension withdrawal that was not allowed and so there is money owed to the facility back to

2012. There is no way to recoup this pension withdrawal at this date so how is the facility supposed to get paid for the months from 2012, 2013, and 2014 that now in 2015 have balances owing? Over 2 years to finalize apps is not acceptable. It leaves the facility with no way to get paid for these amounts.

14A: It is difficult to address concerns regarding budgeting without having case specifics. Sometimes the previous office inaccurately applied policy. When this is discovered, the Department is required to amend the calculations. Sometimes, deductions such as insurance premiums are not reported on a redetermination and the previous county did not code it on the case prior to the transfer to the Macon Hub. The previous county worker may have had knowledge of it and had a control set at their desk to allow it. Because it was not reported and never coded, the Macon Hub did not use it. When the DHS worker makes a mistake it should be fixed. In the Macon Hub, many new caseworkers have been hired over the past year. They are all on different waves of a learning curve which does sometimes lead to mistakes. The Department appreciates the identification of errors or issues when they arise in order to correct and to increase accuracy in the future.

15Q: Where can I find/locate the published rules the DHFS-Bureau of Health Finance uses to formulate their decisions regarding allowable capital equipment?

15A: For capital equipment information on capital rate calculations can be found in 89 Ill Adm Code 140.570-140.574. LTC facilities submit annual Cost Reports to the Bureau of Health Finance which are used to identify Capitol and Support Costs. Details regarding Capitol rate calculations maybe found at 89 Ill Adm Code 140.570-140.574. The Nursing Home Rate Calculation Handbook may be found on the HFS Website.

16Q: For MMAI & LTC, is there any cross-checking going to be done comparing the mailing address to the residents actual LTC facility address? Have had an instance where mail goes to family in Chicago area & resident lives in LTC in Central IL. Resident was assigned to MMAI company that does not do business in our county. Still trying to get straightened out & resident is now deceased.

16A: All correspondences go to the address on file for the resident unless otherwise indicated by a POA/Guardian, or Authorized Representative. The current system only allows for one (1) address. Facilities are encouraged to inform families or responsible parties who wish to continue to receive DHS/HFS correspondence of their responsibility to follow up on the mailings. If family or other responsible party is not willing or able to do so the client may instruct DHS to change the address on file to the facility.

17Q: We need more information on who to contact if we have questions regarding IDPA applications and their status?

17A: Questions can be directed to the workers which are assigned to inquiries at:
For Regions 1 & 2 - phone inquiries can be made to (312)793-8000 or email DHS.MFOInfo@illinois.gov .
For Region 3, 4, & 5 – phone inquiries can be made to (217)362-6515 option 2 or email DHS.MaconLTC@illinois.gov .

18Q: Will they be implementing a system where facilities can log into and see application status?

18A: Programmers are reviewing the processes and software available to allow for this capability. Currently the DHS Help Desk (800)842-6154 may be able to assist authorized representatives in checking the status of a pending application.

19Q: Families have received notices of needing more information, we have helped fax it over for them and then they receive a denial stating they did not participate in gathering information, can you explain this?

19A: Cases can be denied for failure to provide verifications for several reasons. Here are some examples: (1) The verification was supplied after the due date and after the application was denied. In this case, the application will be reviewed for a possible re-opened. (2) The verification that is submitted does not completely cover the requested information. For instance, a portion of the contract for a pre-paid burial fund is sent but it does not include the breakdown of merchandise or services. Even after another attempt by the worker to obtain what is needed, the breakdown is not provided.

All verifications requested must be received to make an eligibility determination. If most, but not all, of the requested verifications were received, the application cannot be re-opened.

20Q: With the local DHS office over a year behind in changes, when will these be caught up to correct payments from the state?

20A: At the request of the LTC industry, the primary focus of DHS has been to catch up the backlog of applications and admissions; however, some changes are still being made. The change backlog will be addressed when the older applications and admissions have been brought more current.

21Q: In the past we would contact local DHS with all the corrections that needed to be done after we received the prepayment report, how do we get these corrections done now?

21A: Submission of changes through MEDI/EDI (formerly sent by Form 1156) is the first step in getting a change done. Supporting documentation for that requested change with should be sent to the appropriate LTC Hub with the TAN referenced on it that was provided after the submission of the information into MEDI/EDI.

22Q: How can we help a resident whose family fails to complete the redetermination and is dropped from Medicaid. We have quite a few residents that have been dropped and have yet to be put back on. Facility is receiving no money for these residents and has a difficult time getting family to comply.

22A: There is a 90 day reinstatement window for cases that have been cancelled for not returning a redetermination. During this time, the facility will need to work with the family to get needed items in to MAX IL or attempt to become the authorized representative so that the designated person at the facility can complete the process needed to get the case reinstated and re-admitted. If you have no success with either, as a facility you will need to follow your business processes regarding continuation of care.

23Q: We recently had the spouse of one of our residents admitted and who had been eligible for spousal impoverishment. We notified the local DHS office that she had been admitted thinking that she would now be ineligible and would need to be paying her spouse's social security to the facility. Can we get clarification on Spousal Impoverishment?

23A: All changes including spousal impoverishment should be submitted electronically through MEDI/EDI vendor. It would be helpful if in the comments section of the admission of the former community spouse, mention could be made of the need to review the diversion on spouse's case. For cases still in need of correction, please contact at the appropriate LTC hub.

24Q: I would like to hear more about rumored Medicaid cuts that can be expected with the new administration?

24A: Due to the budget cuts proposed by the Governor, the Department has reduced the reimbursement rates of Nursing Facilities, Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities by 12.6% for the last two months of State Fiscal Year 2015. Until the Fiscal Year 2016 budget is finalized, there is no information available for rates beginning July 1, 2015.

25Q: Liability Adjustments dating back to January of 2014. Previously submitted to Randolph County Office and now submitted to Macon County. What is the timeline for getting these completed?

25A: If the liability adjustments are changes that were submitted via Form 1156s, they will be worked in the order of receipt. At the request of the LTC industry, the primary focus to date has been to catch up the backlogs of applications and admissions statewide first.

26Q: Could consideration be made to increase the file size of the ABE attachments? The largest file size I have been able to attach is 5 pages. When one has a document of more than 5 pages, it has to be split. It would speed the process if more pages could be included in a file for the attachments?

26A: The Department is currently reviewing this process and is working to increase this capability.

27Q: Why is the LTC portion of the Medi only available from 8 to 5 Monday through Friday? When the other areas of the Medi are available 24/7? Could a consideration be made to have the LTC portion available longer than 8 - 5 Monday through Friday?

27A: MEDI is only available during HFS working business hours due to system maintenance and compiling data for report creation. Shared system transaction processing occurs during the evenings and weekends. IT system updates and maintenance schedules do not allow access outside of these times.

28Q: When a resident has a dentist or doctor bill that is not covered by Medicaid, how does one enter that on the MEDI so that DHS Macon would consider allowing the bill and changing the monthly patient liability for the month? I see no where to enter these bills. Would the bill be faxed with an 1156 to the DHS office? How long would it take to approve this bill?

28A: Providers would submit a change in income via MEDI/EDI vendor and send a copy of supporting bill to DHS referencing the accepted TAN or sending a copy of printed transaction with supporting documentation to appropriate DHS LTC hub.

29Q: Patient Income Credit amounts are not changed or corrected timely. How can this process be fixed or clarified to result in quick corrections for the benefit of the Resident/Responsible Party, the LTC facility, and HFS? Some accounts have many months that need addressed, information has been submitted, but facility is told it will take many months to have time to look at the account.

29A: Changes that were submitted electronically through MEDI/EDI vendor will be worked in the order of receipt. At the request of the LTC industry, the primary focus to date is to bring more current the backlogs of applications and admissions statewide.

30Q: Address and provide training and process for Pre-Admission Screening.

30A: The Department will discuss with the Department of Aging the possibility of a training session on the Pre-Admission Screening.

31Q: Patient Credit files being sent to Molina and Health Alliance, when and how is this being done, and what if the patient credit changes after claims have been sent and paid, is a new file sent? So that if corrected claim it sent they now have changed amount.

31A: Each month HFS sends the Managed Care Organizations (MCOs) a patient credit file. The file is a rolling 12 months worth of information of LTC admits and patient credit for the recipients in their plan. The patient credit file will be sent to the MCO the month following the month that the LTC admit has been authorized for payment.

32Q: What do we do when Medicaid pending people are denied after 18 months of being pending and have no funds to pay? What do we do if the resident passes away before their case is finalized and can't be approved because they are missing the 3654 and no one has the info to complete? Please review the hardship waiver process and forms.

32A: An individual (such as a guardian, executor, or administrator) must be approved by a court to represent the resident or his/her estate. The Department will review each hardship waiver case by case. Form HFS 3654 is required for all LTC applications. If the information is not available due to the circumstances mentioned, the form may still be submitted with a signature.

33Q: Will there be a decrease in the State reimbursement rate for Supportive Living Programs?

33A: Due to budget cuts proposed by the Governor the Department has reduced Nursing Facility, Supportive Living Facility, and Specialized Mental Health Rehabilitation Facility reimbursement rates by 12.6% for the last two months of State Fiscal Year 2015.

34Q: When is Macon County going to be caught up for processing MEDI admits into the system?

34A: The Macon County hub is near being caught up with admits transitioned to us from 2014 and before from other Regions.

35Q: Why are we doing MEDI admits before RIN#'s assigned. Caseworkers are unable to find and I have to spend extra time giving the information after the fact, another time delay in receiving funds.

35A: The DHS worker is able to search for an admission transaction using the Provider Number, RIN, or TAN number. The TAN that is provided to the facility after submission in MEDI/REV is the best identifier of the admission and was developed for tracking purposes. The admission (or change) in question can be located quickly by a DHS worker if the facility provides the TAN.

Only one of the three fields identified as "Required" on the MEDI/EDI Vendor fields (RIN/SSN/CASE NUMBER) must be completed to transmit the admission. Timely submission of the admission means payment will begin date of admission (if eligible) instead of a penalty due to not submitting admissions timely. This was addressed in two recent provider notices dated 12/12/2014 and 3/17/2015. In order to ensure timely submittal of an admission, the option to enter the admission prior to a RIN assignment for a new applicant has been available for years.

36Q: Why do I not receive DPA 2299 or recipient eligibility inquiry with newly approved cases from "the hub" - I receive them on any admits thru Sangamon county. They are an excellent tool to ensure we (facility/DHS) have the same figures.

36A: There is no requirement to send Form 2299. Facilities should be using Form HFS 2500 LTC/SLF Resource Calculation and pre-payment reports to ensure the facility and DHS have the same figures.

37Q: What is the purpose of not having designated caseworker any more - I never have a point of contact and some of my inquiries through the generic email are routed to the wrong individual, which causes further delay.

37A: The Department made the decision move to a task based system. This allows all cases to be attended by groups of workers rather than one person. One of the advantages of this system is that all work is done based upon the date of submission which makes it much more equitable than if done by just one worker. In the past, a facility may have been assigned a seasoned, fast worker while another facility may have had a new or slower worker assigned to them. In addition, when there was one worker assigned to the facility, worker vacations, leaves of absences, and retirement could at times leave the customers cases unattended for weeks or months. In the task based system, one person's absence has minimal effect because there are other workers to keep the workflow going.

38Q: Why am I getting follow up requests several months after the information submitted? Also, when I have done a REDE for the Link card with local caseworker, she does a rede on the financial at the same time as she has all the necessary information (or requests anything else she may need)- but have had to do duplicate redes on several residents - seems a waste of resources.

38A: Many REDEs across the State have been out of compliance for some time. MAX IL was developed to capture the out of date redeterminations to bring them current, in addition to the ones that were current to keep them up to date. Because of the coordination of the two facets of the project, some residents may be receiving more than one redetermination form. The catch up REDE and current REDE may be weeks or months apart, but both are required to get the case back to an annual review status. Another reason for receiving multiple REDE forms is that due to the recent conversion of cases to the LTC Hubs and the assignment of a new case number, the MAX IL system released duplicate forms on cases that had already been sent based on the former case number and then again on the new case number without recognizing they were the same customer.

39Q: Will rede paperwork ever be sent to the facility (or approved rep) rather than the resident who has memory issues and does not do anything with it?

39A: Customer notices are to go to the facilities. Due to the multiple waves of newly hired caseworkers over the past twelve months and the many layers of learning curves they are on, this has not always happened. We have worked and continue to work to address the issue and believe that it has been resolved.

40Q: Is it necessary to spend $11.75 to send a link card to the facility from Decatur? Prior to the hub, they were mailed regular mail will be glad to email when received for their records?

40A: Link cards are to be mailed in a manner that allows tracking in case of loss or theft. The regular mail system does not accommodate this.

41Q: Is there any consideration being made to sending application processing back to the local offices since Macon County seems to have been overwhelmed?

41A: The Macon Hub will continue to provide services to Downstate Illinois. Since its conception in December 2013, many of the over 90 staff hired in staggered phases, came without previous LTC knowledge and experience. They have been trained on policy, multiple computer systems, and have been able to bring more current the innumerable backlogs of work from various counties including thousands of redeterminations, new applications, case reinstatements, and admission processing. The Department understands that counties that had an available LTC caseworker are feeling frustration as the completion of their work has slowed. However, counties that have not been assigned an LTC caseworker for an extended period of time have been pleased to see the progress that has been made.

42Q: What is the expected time for pending patients to be approved medicaid?

42A: As we get closer to eliminating the backlog statewide, our goal is to complete applications within a 90 day period.

43Q: What is the current estimated time for an approval?

43A: While it is the goal to approve Medicaid and process an admission on most cases within a 90 day period, variables such as referral to OIG, customer requests for extensions, appeals, penalty periods, spendowns, and resource reductions may result in a longer process on any case.

44Q: Are all offices fully transitioned to their corresponding HUB?

44A: There are a few offices which continue to maintain LTC work. These offices are in Adams, Christian, Hancock, Jersey, Mid-Illinois, Montgomery, Morgan, and Sangamon Counties.

44Q: What is the process for distribution of SNAP cards for SLF residents?

44A: Upon approval of SNAP benefits, a pin pack is mailed to the SLP. Cases handled by the Macon LTC hub will have the SNAP card mailed to the facility.

45Q: Are entering adjustments still being deferred until annual recertification or upon receipt?

45A: Some changes are being completed; however, the primary focus of the hub is to eliminate the backlog of Applications and Admits at the request of the LTC industry.

46Q: What is the appeal process for payment under SLF Program due to lack of timely notification from HFS?

46A: Questions on billing and payment should be directed to HFS Billing Unit at (217)782-0545. Procedures for payment disputes or payment review can be found 89 Ill Adm Code 140.20.

47Q: What is the process for redetermination when a form is not received?

47A: Contact IMRP for a lost/not received form at (855)458-4945 or TTY: (855)694-5458.

48Q: What are the steps for provider payment from claims to payment?

48A: Currently, payment to providers (claim) begins upon authorization for LTC payment by the DHS caseworker by processing the admission in MEDI. Once the admission has been processed, the resident will appear on the facility's pre-payment report. Claims are generated on a monthly basis by BLTC within 30 days of the service month. The claims are then transmitted (vouchered) to the Comptroller and will be scheduled for payment.

49Q: How long will it be before the state will no longer issue any provider payments?

49A: Payments to providers from HFS will continue as long as individuals are enrolled in fee-for-service. At this time there is not projected end date.

50Q: How does the state view the transition to managed care as it relates to SLP's who receive expedite payments??

50A: SLP residents enrolled in Managed Care will typically receive payment quicker than those eligible for expedited payment.

51Q: When entering an application in the ABE system, I have registered as a Community Partner, why am I only allowed to enter 1 application within a 30 day period? Is Community Partner the best choice for a billing person who enters all applications for the families/facility?

51A: Register the client and setting up an individual account and passcode for each person. A different account is needed for each person. A webinar http://www2.illinois.gov/hfs/SiteCollectionDocuments/082714ltcwebinar.pdf and video http://multimedia.illinois.gov/hfs/hfs-abe-2014.html have been posted on the HFS Web site for your reference.

52Q: For residents who did not keep bank records (and bank statements did not provide a copy of the check or deposit slip with the bank statement) and their credit union does not keep records past 60 days, how are the residents supposed to verify checks or deposits > or = $1000?

52A: Banks and credit unions are required to keep records for several years. Depending upon the institution, they may charge a fee for access to past records but the records are accessible. If a customer is trying to verify what a deposit or withdrawal was for, they should be providing supporting documentation such as an award letter, bill or verification of transfer to another account.

53Q: Several facilities have had "recoupments" - takebacks due to corrections to service categories (LOC) in MEDI. However, the original claims were not paid. What is the state's process for reconciling these accounts? What is the plan to ensure this stops occurring?

53A: An LTC admission transaction must approved on the system before provider can send changes through MEDI. LTC adjustments can only occur on a vouchered claim but with payment delays sometimes adjustments are processed prior to initial payment being issued by Comptroller. However, credit adjustment amounts are recovered from future payment vouchers and for the most part vouchers are paid in order. A provider may see a voucher that the recovery of posted credits is offsetting payable claims before receiving original payment but the payable claims on the recovery voucher would not have been paid until after the original payment if they had not been used to satisfy the posted liability.

54Q: Several cases over 1 year old are still not being worked. What is the plan and the timeline to ensure these are priority and resolved by the end of the second quarter 2015?

55A: OIG and DHS are processing applications and admissions in the priority of oldest to newest. It is not likely the resolution will occur by the end of second quarter 2015. Providers can check the monthly Long Term Care report on HFS Website for applications and admissions pending. http://www2.illinois.gov/hfs/SiteCollectionDocuments/LTCReportStatus.pdf

56Q: OIG cases seem to take several months to complete before transferring to caseworkers. What are the barriers that prevent these cases from being review in a more timely manner?

56A: Each case has a unique set of circumstances. The complexity and the availability of the requested documentation will factor in the length of time required for the OIG to complete the review.

57Q: Accessibility to caseworkers is lacking. How do you propose, in a service-related industry, to improve service and overall performance?

57A: All incoming items are assigned to groups of 15 - 20 workers rather than one worker being assigned to a specific facility. Any of these workers are available to answer questions and address concerns. Access to a caseworker for assistance is available by two main routes phone or email. Regions 1 & 2 (those above Interstate 80 and Kankakee County) will go to Medical Field Operations (MFO) office at (312)793-8000 or DHS.MFOInfo@illinois.gov . Regions 3, 4, and 5 (those below Interstate 80) will go to the Macon LTC Unit at (217)362-6515 option 2 or DHS.MaconLTC@illinois.gov. A caseworker will answer the call and assist. However, if the worker is already with another caller, a voicemail can be left and the call will be returned. Having groups of workers whose primary function is to respond to inquiries provides the most efficient customer service to all.

58Q: When will the state provide on-line remittance information on MEDI (not REV) or provide them electronically?

58A: On-line remittance advices are currently available on MEDI under the IEC link for registered payees and are available in X12 format. If they need assistance with registering as a payee or cannot see their remits they need to contact the MEDI Help desk. REV vendors have a version of claims history that they make available to their providers. MEDI supplies a HIPAA compliant claim status response 277 to a 276 claim status request in addition to the 835 remit.

59Q: If we have concerns with a caseworker not returning calls, who can we contact?

59A: Contact for Regions 1 & 2 (those above Interstate 80 and Kankakee County) is the Medical Field Operations (MFO) office at DHS.MFOInfo@illinois.gov. Contact for Region 3, 4, & 5 (those below Interstate 80) for the Macon LTC Unit is DHS.MaconLTC@illinois.gov.

60Q: Best practice process by which SLF waiver members are notified to enroll in a MCO?

60A: For individuals that are newly approved for Medicaid, who reside in a region where managed care is mandatory, and for which nothing would exclude them from enrolling (eg. comprehensive insurance or spenddown), an enrollment packet will be sent to them. The individual, or their authorized representative, will need to contact the Illinois Client Enrollment Services at (877) 912-8880 to complete the enrollment process.

61Q: Why do we have so many duplicated request for info when all info was attached to the application at time of submission?

61A: Requests for items already submitted are generally the result of poor quality of the document making it difficult or impossible to read; a two sided document being sent as one sided so that half of the information is missing; or additional information is needed based upon what was received.

62Q: How long is it taking to process new admits?

62A: As of March 2015, the Macon County hub is close to completing 2014 admits that are ready to work. This includes applications which are no longer pending at OIG, cases in which the penalty period is over, spenddown has been met, or the resource reduction is complete.

Please refer to the HFS Website for updated information regarding pending applications and admissions. http://www2.illinois.gov/hfs/SiteCollectionDocuments/LTCReportStatus.pdf

63Q: When is IDPA going to be caught up with income changes?

63A: After the backlog of applications and admissions are current, the DHS caseworkers will begin to work the backlog of changes.

64Q: Why isn't the state using D8 and D9 codes to alert facilities of cancellations instead of just ending service dates? What do we do when a case is approved in LTC, but the eligibly segments do not get updated. Best way to communicate to get corrections.

64A: There was a system error that allowed the caseworkers to enter LTC admits on system when there was not eligibility to cover admit span. This has recently been corrected. Caseworkers have been working those recipients (approx 1200) that were reported by LTC Billing Unit as having an eligibility issue. The LTC Billing Unit routinely reports missing and ended eligibility for processed LTC admits. It is extremely important that providers regularly check recipient eligibility and for MCO billing. The Department will be implementing the provision of the requirement of Public Act 98-0104 to submit a monthly bill. Informational Notices will be released through the HFS website which will provide additional guidance. Once implemented, a pre-payment report will no longer be generated. Providers' notification of an eligibility issue will be in the form of a rejected claim to the provider.

65Q: Transition from Regional Offices to Medical Field Office. Removing assigned caseworkers from our facilities.

65A: Concerns about specific caseworkers can be sent to Local Office Administrators in Medical Field Operations (MFO) or Macon LTC hubs. Mr. Willie States is MFO Administrator DHS.MFOInfo@illinois.gov. and Ms. Anne Bradley is Macon LTC Administrator DHS.MaconLTC@illinois.gov.

66Q: How can SNFs better communicate with counties/caseworkers to better serve the needs of the resident?

66A: Providing information to the correct office: Regions 1 and 2 (above Interstate 80 and Kankakee County) DHS.MFOInfo@illinois.gov or Regions 3, 4, or 5 (below Interstate 80) DHS.MaconLTC@illinois.gov

67Q: What is the state's fiscal plan to come in line with budget and pay their vendors more timely?

67A: FY 16 budget was still pending at the time of publication of this document. The Departments will implement changes as directed by the Legislature and Medical Assistance Program Administrators.

68Q: Families have received notices of needing more information, we have helped fax it over for them and then they receive a denial stating they did not participate in gathering information. Can you explain this?

68A: If you believe a denial notice is received in error after assisting the family in submitting the information, please contact the appropriate LTC office to resolve the problem. If still unresolved, an option is to file a timely appeal.

69Q: Looking for more info on how to best manage problem cases. How to know when it is best to Appeal or re-apply. What to do when redes end in a significant changing of benefit. How to handle lost cases between old caseworkers and new hub?

69A: If a case has been canceled due to failure to return the redetermination form, there is a 90-day timeframe in which the case can be reinstated provided the form and all necessary information has been returned that is needed to determine eligibility. An appeal may not be necessary in this case. Failure to respond or provide the necessary documentation within the specified timeframe will require the individual to reapply for benefits.

If a case has been canceled for other reasons, the individual has a limited time period to file an appeal. Please refer to the instruction provided on the cancelation notice when filing an appeal.

70Q: Discuss transition to replacement plans such as Molina and Health Alliance and what it means to providers. Contact lists for assistance.

70A: The contact list of the MCOs:
http://www2.illinois.gov/hfs/SiteCollectionDocuments/ContactListAllMCEs.pdf

71Q: Can you please go over entering an application for Spousal Impoverishment cases so we know we are entering them the best way possible?

71A: When completing the ABE application, enter 2 for "How many are in the home" and include the information about the spouse plus the spouse's income and resources.