



Integrated Health Homes

Provider Enrollment

IHH IMPACT Enrollment

- IMPACT website: www.illinois.gov/hfs/impact
- IMPACT Enrollment Information:
 - Enrollment type = Facility, Agency or Organization (FAO)
 - Provider type = Integrated Health Home
 - Specialty = Integrated Health Home
 - Sub-specialty = IHH-Tier A, IHH-Tier B, IHH-Tier C
- Providers must have a unique Tax ID / NPI combination for this enrollment and will be assigned a new HFS provider ID
- The IHH owner's Tax ID may be used, but remember, there is only one Pay-To address per Tax ID in IMPACT
- A new provider agreement/attestation outside of IMPACT for the IHH to submit the contracted/collaborative providers in the IHH

The BPW serves as the “Control Center” of the application

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	06/16/2015	06/16/2015	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Required			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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IHH Provider Type

Application ID: 20180829583337


Name: RHHHtest1

Add Specialty/Subspecialty

Location: 01- *

Provider Type: INTEGRATED HEALTH HOME *

Specialty: --SELECT-- *

End Date: 



Add Subspecialty

Available Subspecialties

Associated Subspecialties *



IHH Specialty

Application ID: 20180829583337

Name: RHHHtest1

Add Specialty/Subspecialty

Location: 01- *
Provider Type: INTEGRATED HEALTH HOME *
Specialty: INTEGRATED HEALTH HOME *
End Date:  ←

Add Subspecialty

Available Subspecialties

- IHH TIER A
- IHH TIER B
- IHH TIER C

Associated Subspecialties *

-



IHH SubsPECIALTIES

Application ID: 20180829583337

Name: RHHHtest1

Add Specialty/Subspecialty

Location: 01- * *

Provider Type: INTEGRATED HEALTH HOME *

Specialty: INTEGRATED HEALTH HOME *

End Date: 

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

IHH TIER B
IHH TIER C

IHH TIER A



Enrollment Checklist

Application ID: 20180829583337

Name: RHHHlest1

Do you wish to end date your enrollment? If yes, what date?	No <input type="checkbox"/>	<input type="text"/>
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	No <input type="checkbox"/>	<input type="text"/>
Are you currently excluded from any federal program? If yes, provide the program and date.	No <input type="checkbox"/>	<input type="text"/>
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	No <input type="checkbox"/>	<input type="text"/>
Have you ever had a judgment under any false claims act? If yes, list judgment and date	No <input type="checkbox"/>	<input type="text"/>
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	No <input type="checkbox"/>	<input type="text"/>
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	No <input type="checkbox"/>	<input type="text"/>
Have you ever had a program exclusion/debarment? If yes, provide program and date	No <input type="checkbox"/>	<input type="text"/>
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	No <input type="checkbox"/>	<input type="text"/>
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	No <input type="checkbox"/>	<input type="text"/>
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	No <input type="checkbox"/>	<input type="text"/>
Are you a Home Health Agency, DME, Medica, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	No <input type="checkbox"/>	<input type="text"/>
Are you planning to provide services reimbursable through DoA, DCFS, DSSC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/ODD. If yes, complete "Associate MCO Plan" step in Business Process Wizard.	No <input type="checkbox"/>	<input type="text"/>
Are you a radiologist, hospital (outpatient), Imaging Center or Independent Diagnostic Testing Facility, and are participating or wish to participate in the Breast Cancer Quality Screening Program?	No <input type="checkbox"/>	<input type="text"/>
Are you a hospital that is participating or wish to participate in the Hospital Presumptive Eligibility Program?	No <input type="checkbox"/>	<input type="text"/>
Are you a Phy, Hosp, FQHC, ERC, Meditech Clinic, RHC, Home Hlth Agency, Comm Hlth Agency, Certified Hlth Dept, or School Based/Linked Clinic, and are participating or wish to participate in the MPE Program?	No <input type="checkbox"/>	<input type="text"/>
Is your org a health plan, LTC fac or other prov approved for an ABE provider portal acct to assist individuals with eligibility for medical benefits? If yes, enter effective date of participation.	No <input type="checkbox"/>	<input type="text"/>
Are you a Pharmacy and are participating or wish to participate in the Blood Clotting Factor Hemophilia Program?	No <input type="checkbox"/>	<input type="text"/>
Are you enrolled in the Designated Family Planning Provider/Clinic Program? If yes, provide enrollment date and approving agency.	No <input type="checkbox"/>	<input type="text"/>
If this enrollment is for change of ownership (CHOW) with a new NPI, please enter the old NPI in the comment box	No <input type="checkbox"/>	<input type="text"/>
Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	Yes <input type="checkbox"/>	100,000 ABC Insurance

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Final Submission

MyInbox > Track Application > FAO Enrollment

Application ID: 20180829583337

Name: RHHHtest1

Close Next

Final Submission

Application ID: 20180829583337

EnrollmentType: Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
Δ▼	Δ▼	Δ▼	Δ▼
No Records Found!			

Terms & Conditions Page 1

Application ID: 20180829583337

Name: RHHHest1

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

In applying for enrollment as a provider of goods and services in the Illinois Medical Assistance Program ("Program") administered by the Illinois Department of Healthcare and Family Services (hereinafter referred to as Illinois Medical Assistance), the provider applying for enrollment as a provider (hereinafter referred to as "the applicant") represents, agrees, and certifies as follows:

1. The undersigned has the legal authority to execute this Agreement on the applicant's behalf.
2. The applicant understands that enrollment in the Program does not guarantee participation in Illinois Medical Assistance managed care programs, nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished to Illinois Medical Assistance during the application process on any associated form is true, accurate, and complete.
4. The applicant has disclosed the name and address of each person with an ownership or control interest in the applicant or in any subcontractor in which the applicant has direct or indirect ownership of 5 percent (5%) or more.
5. The applicant will provide proper disclosure of all criminal convictions of any person associated with the applicant's business operations, including but not limited to owners, officers or principals, and persons with management responsibility.
6. When billing for any medical goods or services, the applicant will comply with all applicable terms, conditions, policies and procedures contained in the Illinois Medical Assistance Handbooks for Providers of Medical Services, the Illinois Administrative Code, statutes, provider bulletins, and program notifications.
7. The applicant will comply with the following provisions of federal law, which state the conditions and requirements under which participation in the Program is allowed: 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 431.107.
8. Upon request, the applicant will allow authorized state or federal government agents to inspect, copy, or electronically scan any records pertaining to the delivery of goods and services to, or on behalf of, a Program recipient. These records include, but are not limited to, medical records, financial records, business records and any service contract(s) the applicant has with any billing agent/service or service bureau, billing consultant, or other health care provider.
9. The applicant will include a clause in all subcontracts related to the provision of goods and services to Program recipients that requires all subcontractors to provide state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
10. The applicant is not currently, and has not been in the past, suspended, terminated, or excluded or barred from the Program by any state or by the U.S. Department of Health and Human Services, or from any state or federal healthcare program.
11. The applicant understands that disputed claims, including overpayments, may be adjudicated by Illinois Medical Assistance.
12. The applicant shall reimburse Illinois Medical Assistance for all overpayments, and the applicant acknowledges and accepts that the Program uses random sampling, which is a reliable and acceptable method for determining extrapolated overpayments.
13. The applicant shall accept all notifications of disputed claims, overpayments, and other administrative actions involving program payments and participation by electronic mail (email) at the address provided to Illinois Medical Assistance in the executed enrollment agreement, or by mail at the physical address of record.
14. The applicant shall immediately notify Illinois Medical Assistance in writing of any change in the email address or physical address provided in the executed enrollment agreement.
15. Failure to provide Illinois Medical Assistance with changes to the email address or physical address provided in the executed enrollment agreement will constitute waiver of service of Illinois Medical Assistance notifications and documents.
16. The applicant will comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Subparts A and E, and Public Law 104-191. The applicant will also comply with all HIPAA regulations (45 CFR Parts 160, 162, and 164), as applicable, for electronic protected health information and transactions.
17. This Agreement shall be governed by the laws of the State of Illinois and applicable federal law.
18. The provisions of this Agreement are severable. If any provision is held or declared to be illegal, invalid or unenforceable, the remainder of the Agreement will continue in full force and effect as though the illegal, invalid or unenforceable provision had not been contained in this Agreement.
19. The applicant's failure or delay to exercise any right, power, privilege, or remedy in this Agreement will constitute a waiver. No provision of this Agreement may be waived by Illinois Medical Assistance, except in writing and signed by an authorized representative of Illinois Medical Assistance requesting the waiver.
20. The applicant will comply with the 89 Ill. Admin. Code §140.12(e), and all requirements of 42 USC §1396a (a) (68), when applicable. Applicant will upon demand present documentation of, education of employees, contractors and agents regarding the federal False Claims Act (31 USC 2729-3733) that complies with all requirements of 42 USC 1396a (a) (68). Providers subject to this requirement include a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, that receives or makes payments totaling at least \$5 million annually.
21. As a condition of enrollment, the applicant agrees and consents to be subject to enhanced oversight, screening, and review based on the risk of fraud, waste and abuse that is posed by the vendor. This includes, but is not limited to: criminal and financial background checks; fingerprinting; license, certification and

Terms & Conditions Final Page

Application ID: 20180829583337

Name: RHIIHtest1

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shall include, but is not limited to, significant injury, suicide attempt or death at the facility.

9. The provider shall ensure that all Program recipients have access to all medically necessary physical healthcare services required, consistent with the policies outlined in all Handbooks for Providers of Behavioral Health Residential Care.
10. The provider shall provide Illinois Medical Assistance with a minimum of 30 days written notice in the instance that the provider determined a Program recipient is no longer appropriate to be served at the provider's facility.
11. The provider shall make follow-up services available to Program recipients following discharge from the provider's facility, consistent with the policies outlined in the Handbook for Providers of Behavioral Health Residential Care.
12. Upon acceptance of these enrollment terms and conditions, the provider shall notify Illinois Medical Assistance in writing of any legal relationship that exists between the provider and a hospital. The provider shall include a description of the following: how the hospital functions are separate from the residential treatment functions of the provider, how the governance of the residential treatment facility is separate from the hospital, a distinct organization/management separation between the residential treatment and the hospital part of the provider's structure, and how a conflict of interest will not occur between the residential treatment and the hospital parts of the provider's organization. The provider shall notify Illinois Medical Assistance within 30 days of any changes in the provider's legal relationship with a hospital.
13. The provider acknowledges it is solely responsible for reporting per diem rate changes, as issued by the Illinois Purchased Care Review Board for residential treatment services to the Department consistent with 89 Ill. Admin 139.305.
14. The provider shall submit claims for authorized residential treatment services to the Department consistent with the established policies and procedures pertaining to the authorized service. The provider shall accept its per diem residential rate as payment in full for services rendered to Program recipients and shall not seek additional reimbursement from the Program recipient or the Program recipient's family.
15. The provider shall perform background checks on all staff, including, but not limited to a check of the following in the state in which the provider operates: the child abuse and neglect tracking system, the sex offender registry, and a fingerprint check by the State Police and the Federal Bureau of Investigation.
16. The provider acknowledges the immediate reporting requirements outlined in the Handbook for Providers of Behavioral Health Residential Care includes suspected child abuse or neglect consistent with the provider's responsibilities as a Mandated Reporter under the Abused and Neglected Child Reporting Act and suspected financial fraud and abuse in the Medical Assistance Program or Child Support Enforcement Program.
17. The provider shall attend all regional and other required meetings when notified more than 14 days in advance by Illinois Medical Assistance.
18. Behavioral Health Residential Care Providers who are enrolled with a Subspecialty of Sub-Acute Psychiatric or Sub-Acute Substance Use Disorder shall also comply with the following:
 - Compliance with 42 CFR 483. Submit a completed HFS Form 2734A to the Department, attesting to the facility's compliance with federal requirements regarding the use of restraint and seclusion in each of the following instances: 1) Upon initial enrollment with Illinois Medical Assistance as a provider; 2) Annually on July 1 of each state fiscal year to be received by the Department by July 15th; and 3) In the event of a change in the facility director;
 - Notify the Department and the State's designated Protection and Advocacy System of any significant injury, suicide attempt, or death that occurs at the facility, consistent with the requirements established by the Department;
 - Comply with 42 CFR 440.10 and 42 CFR 441 Subpart D as defined and interpreted by the Department in the administration of the Illinois Medicaid Program; and
 - Comply with all State Survey activities performed by the Illinois Department of Public Health, or its agent(s).
19. Behavioral Health Residential Care Providers who are enrolled with a Subspecialty of Sub-Acute Substance Use Disorder shall establish licensure and remain in good standing with the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (DHS-DASA) as a provider of residential substance use disorder services.

Billing Certification

For each paper or electronic claim or invoice I submit for payment, remittance advice and voucher issued, as a condition of my enrollment, I certify and acknowledge that I am familiar with pertinent Healthcare and Family Services policies and procedures as set forth in the Illinois Medical Assistance Program Handbooks, rules and statutes. With that knowledge, I certify that the billing information on claims, invoices, remittances and vouchers, and billing information attached to, or reference in, those documents is true, accurate and complete; I certify that the services as described on the claims, invoices, vouchers or remittance advice were provided; I certify that I will keep and make available such records as are necessary to disclose fully the nature and extent of the services provided; and I certify that I understand payment is made from State and federal funds and any falsification or concealment of the material fact may be cause for prosecution or other appropriate sanctions and legal action.

By checking this, I certify that I have read and that I agree and accept all the enrollment terms and conditions in herein that are applicable to me.

Additional Documentation for Enrollment

- IHH Provider Agreement
- Contracts/Cooperative agreements with required members of the Care Coordination Team
- Policies and procedures
- IHH Attestation of staffing ratios

IHH Agreement

- The IHH provider agreement and attachments describes the key responsibilities and standards that IHH providers are expected to meet

Agreement Attachments

- Attachment A
 - Key Responsibilities and Standards
- Attachment B
 - Care Coordination Activities
- Attachment C
 - Quality Measures
- Attachment D
 - Staffing Ratios

Contracts/Cooperative agreements with required Care Coordination Team

- IHH Providers must establish and provide copies of all contractual, cooperative and collaborative agreements with care coordination staff to meet the requirements of an IHH
- Care Coordination team must contain providers from these designated areas: physical, behavioral and social health

Care Coordination Staff Enrollment

- After HFS approval of IHH enrollment, all rendering care coordination staff will enroll and associate with IHH
- Care Coordination Staff will enroll as an individual provider with all required license

Care Coordination Team

- **Nurse Care Manager** – Must have at least one per practice who is a qualified RN. A practice may add additional nurse care managers who may be RN, RD, LPN or APN.
- **Clinical Care Coordinator** – Must possess a minimum of a bachelor's degree, previous case management experience and appropriate clinical license and/or professional certification, if applicable.
- **Physician** – Must have appropriate clinical licenses and/or professional certification and be able to refer to appropriate medical specialists.
- **Psychiatrist/Psychologist/Mental Health Specialist** – Must possess appropriate clinical license and/or professional certification (e.g., LPHA).
- **Substance Use Disorder (SUD) Specialist** – Must have one SUD Specialist with an appropriate clinical license, if applicable.
- **Social Worker/Social Service Specialist** – Must possess a minimum of a bachelor's degree in a relevant subject.

Policies and procedures

- IHH provider's must establish and maintain written policies and procedures to be used by all staff in the delivery of care coordination services
- These policies and procedures will need to be submitted to the department after application submittal

IHH Attestation of staffing ratios

- IHH providers must attest to meeting the staffing ratios identified by the department and maintain them ongoing
- IHH Providers must employ or maintain contractual, collaborative or cooperative agreements with specific personnel and maintain staffing ratios as part of the care coordination team

Question & Answers

Questions regarding IMPACT can be addressed to:

- Email: IMPACT.help@Illinois.gov
- Documentation Email:
HFS.IHHIMPACT@Illinois.gov
- Phone: 1-877-782-5565
 - Option 1 for English
 - Option 2 for Provider
 - Option 1 for IMPACT