



# 2019 ANNUAL NOTICE

FOR COUNTYCARE PROVIDERS

As part of the CountyCare Health Plan's commitment to the accreditation standards of the National Committee for Quality Assurance (NCQA) and to comply with state and federal government regulations and mandates, CountyCare would like to take this opportunity to communicate and reaffirm our longstanding policies regarding open communication and other important information about our Quality and Utilization Management Programs.



## Members' Rights and Responsibilities

The CountyCare Member Rights and Responsibilities policies clearly state:

1. Our commitment to treating members in a manner that respects their rights.
2. CountyCare's expectations of members' responsibilities.

CountyCare recognizes the specific needs of members and strives to maintain a mutually respectful relationship.

Members are notified of their Rights and Responsibilities in their CountyCare Member Handbook (provided in hard copy after enrollment) and in the Member Annual Notices, both available at <http://www.countycare.com/members/rights-and-policies> and in hard copy at any time by request. New and existing practitioners can find the CountyCare Member Rights and Responsibilities statements in the CountyCare Provider Manual. These are also available in hard copy by contacting CountyCare at 312-864-8200/855-444-1661 (toll free)/711 (TDD/TTY).

## Medical Management Communication Services and Decisions

It is the policy of CountyCare to provide access to staff for members and providers seeking information about the Utilization Management (UM) process and the authorization of care. CountyCare offers the following communication services for its members and practitioners:

- CountyCare employees are available at least 8 hours during normal working hours (excluding holidays) at 312-864-8200/855-444-1661 Fax: 866-209-3703.
- CountyCare employees can receive inbound communications regarding UM issues after normal business hours.
- CountyCare employees are identified by name, title, and organization name when initiating or returning calls regarding UM issues.

- TDD/TTY services for members who need them.
- Language assistance for members to discuss UM issues.

UM criteria and guidelines are used in conjunction with clinical judgment, and case specific consideration. The following are considered when making UM determinations, (1) member needs such as age, co-morbidities, complications, home environment, psychosocial/cultural issues, patient safety and community resources, and (2) the capabilities of the local delivery system. When applicable, UM criteria/guidelines are used to guide UM decision-making. Practitioners can request copies of the UM criteria and guidelines by calling 312-864-8200/855-444-1661 (toll free)/711 (TDD/TTY).

It is also the policy of CountyCare to monitor the impact of the Utilization Management Program to ensure appropriate utilization of services. The CountyCare Utilization Management Program does not provide financial incentives to employees, providers, or practitioners who make utilization management decisions that would create barriers to care and services.

1. Utilization Management decisions are based only on appropriateness of care, treatment and/or services, and the benefit provisions of the member's coverage.
2. CountyCare does not specifically reward practitioners, providers, or staff, including Medical Directors and Utilization Management staff, for issuing denials of requested care.
3. CountyCare does not offer financial incentives to encourage decisions that result in inappropriate utilization.
4. CountyCare informs those involved with Utilization Management decisions of the concerns and risks associated with under-utilization of medical care or services.
5. Members can also request a state fair hearing if he or she does not agree with a decision made by CountyCare.

## Pharmacy Benefit Management

CountyCare utilizes a preferred drug list (PDL) (lists of covered drugs) for members. The drugs represented have been reviewed by a National Pharmacy and Therapeutics (P&T) Committee and are approved for inclusion. The Health Plan Pharmacy Department annually and after updates, communicates changes to members, prescribing practitioners, and pharmacies. Updates include lists of pharmaceutical, restrictions and preferences, as well as explanations of limits and quotas. To access the most current versions of CountyCare's Formularies and regular updates, visit [www.countycare.com](http://www.countycare.com) and select For Providers, then Provider Resources and then Pharmacy Benefits.

## Access to Care Coordination

The Care Coordination Program helps CountyCare members with medical, behavioral health, and support services to improve their health care. Care Coordinators help members use their benefits to get needed services and find their way through the health care system. Practitioners who have identified CountyCare members who would benefit from these programs are encouraged to visit the Referral to Care Coordination section under the Provider Resources page at <http://www.countycare.com/resources> on instructions for making referrals.

## Continued Access to Care

CountyCare strives to ensure that all members receive the highest quality of care and utilizes systematic methods of detecting problems specific to continuity and coordination of care. Ongoing collaboration between Primary Care Physicians (PCPs) and specialists, and behavioral health providers, as well as between PCPs and other types of providers promotes a continuous plan of care that benefits the member. Other types of providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, and ambulatory surgical centers.

CountyCare's policy monitors and identifies potential problems with continuity and coordination of care for all of our members. The health plan also monitors continuity and coordination through transitions in care (changes in management of care between practitioners, changes in settings or other changes in which different practitioners become active or inactive in providing ongoing care for a patient).

If a practitioner or practice group leaves the provider network, except for cause, the member may have continued access to that practitioner under the following circumstances:

- Members undergoing active treatment for an acute medical condition have access to their discontinued practitioner through the current period of active treatment.
- Members undergoing active treatment for a chronic medical condition have access to their discontinued practitioner for a period of time, not to exceed 12 months from the date of the provider's termination.
- Members currently pregnant have access to their discontinued practitioner through the postpartum period.
- Members who are receiving care directly related to the treatment of a terminal illness have access to their discontinued practitioner for the remainder of their life.
- Members who had surgery or another procedure that is part of a course of treatment. Covered services must be recommended and scheduled for within 180 days from the date of the provider's termination.

If a PCP or practice group terminates with CountyCare, a notice is sent to the member at least 30 calendar days prior to the PCP termination with information to help the member select a new practitioner.