CARE MANAGEMENT PROGRAM MANUAL

JANUARY 2026

This Program Manual provides CountyCare Health Plan's direction for its Care Management Program as administered by internal health plan and delegated Care Management Entities (CMEs). The content is updated as often as needed based on changes in requirements for CountyCare or changes for its CMEs. Expectations of Care Coordinators and CC/CM activities are detailed in this manual. This manual is equivalent to collection of CC/CM policies and procedures.

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Glossary

Authorized Representative or "responsible person "as identified in the "caregiver file" is an individual, case worker, group, entity, or other person(s) approved by DCFS Guardianship Administrator who is legally authorized to speak for or on behalf of the Enrollee and which has been communicated to the Contractor through DCFS.

Back-up-Plan means documented actions and/or interventions to take to ensure the member's health and safety in the event of an interruption to the critical service.

Buddy System is the cooperative arrangement whereby individuals are paired or teamed up and assume responsibility for the others instruction, productivity, welfare, and/or safety.

Care Coordinator is the general term used for all staff providing care coordination and care management services. CMEs may utilize various titles in their program but are required to adhere to any requirements for qualifications and training as specified in this manual and in the MCCN contract.

Care Coordination refers to a set of services in which assistance is provided any Enrollee including prevention and wellness messaging, condition specific education material, problem-solving interventions or any other support requested (MCCN KA 5 5.13.1.4)

Care Coordination and Support Organization (CCSO) is a community organization that serves as a centralized, accountable hub for a designated service area (DSA). Each CCSO has a trained team of professionals capable of responding urgently to mental health crises. Each CCSO has dedicated Care Coordinators with specialized training that work with families in Pathways to Success. CCSOs serve four key functions: (1) Provide Care Coordination and Support services to children enrolled in Pathways to Success, (2) Serve as the care coordination entity for children enrolled in the Family Support Program (FSP) and the Specialized Family Support Program (SFSP), (3) Operate as the fiscal agent for Individual Support Services (ISS) and Therapeutic Support Services (TSS), and (4) Serve as the designated Mobile Crisis Response provider for a DSA.

Care Management broadly means "services that assist Members in gaining access to needed services, including physical health, Behavioral Health, LTSS, social, educational, and other services, regardless of the funding source for the services (MCCN 1.1.27)." Within the CountyCare model, the factor that distinguishes the Care Management Program from Care Coordination services is the offer of Care Management, member acceptance of Care Management, and the enrollment into the Care Management Program via the establishment of an Individual Plan of Care. Certain categories of members are required by contract to be in Care Management. They are members in the HCBS waiver programs and members with a G-6 Obra Code (members served by DSCC). See "Care Management, offer of" for definition of members who must be offered Care Management. See "Care Coordinator" for definition of staff providing Care Management services.

Care Management Entity (CME) is an entity within the internal health plan or delegated by County Care to carry out the activities and services of care management and care coordination to its members.

Care Management, Offer Of. Means Informing a member enrollment in the care management program. Care management must be offered to members stratified to levels 2 and 3, pregnant members, Dual-Eligible adult

members, members residing in nursing facilities and members who receive Covered Services under an HCBS waiver. In addition, any member can request Care management. (MCCN KA 2, 5.12.1)

Care Management Program (otherwise known as complex case management, a NCQA term): Care Management applies systems, science, incentives, and evidence-based information to improve medical practice and encourage consumers to become engaged in a collaborative process designed to manage health conditions more effectively. Source: Center for Healthcare Strategies. (2007). Care Management Definition and Framework, http://www.chcs.org/media/Care_Management_Framework.pdf.

NCQA defines Complex Case Management a program of coordinated care and services for organization members who have experienced a critical event or diagnosis that requires extensive use of resources.

Care Management Risk Pool. This means members who have a predictive modeling risk score or condition indicative of high risk but have not been stratified to level 2 or 3, and members stratified to level 2 or 3 who are not enrolled in the Care Management Program. These members require care management outreach and follow up as appropriate. (MCCN 5.13.1,.1,.2,.3, MCCN, 5.13.3, MCCN KA-2, 5.13.1.4, MCCN KA-2, 5.16, 10/30/2018 MPR Instructions, P. 3., 1st paragraph, p. 5, 1st paragraph, p. 7, 1st paragraph.)

Child(ren) means any of the following: 1) an individual enrolled in one of the full-benefit Medical Assistance Programs administered by the Department, who is between the age of zero (0) and, up to but not including, the age of twenty-one (21); or 2) a Medicaid eligible individual that is admitted before the age of twenty-one (21) to an inpatient psychiatric institution qualifying as inpatient psychiatric services for individuals under age twenty-one (21) pursuant to Federal Medicaid regulations codified at 42 CFR 440.160, until the individual is either discharged from the institution or until the individual's twenty-second (22nd) birthday, whichever comes first (MCCN 1.1.32).

Also see: Special Needs Children

Child and Family Team (CFT)is a dedicated team of people working with each member of the Pathways to Success program. The CFT works together closely to create an Individualized Plan of Care for each member of the Pathways to Success program. The child and family pick the members of the CFT. The CFT may include formal supports, like service providers, and natural supports, such as family members, neighbors, friends, or other community members.

Chronically Homeless: Individual or family who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years and usually has a disabling condition.

Community Mental Health Center means an agency certified by DHS or DCFS and enrolled with HFS to provide Medicaid community mental health services.

Continuity of Care means the continued care of a member as the member transitions between different MCOs or between Managed Care and fee-for-service, whether due to eligibility changes or a change in MCO enrollment (MCCN 1.1.42).

Crisis Safety Plan means an individualized plan prepared for a Child at high risk of experiencing a Behavioral Health Crisis (MCCN 1.1.56).

Cultural Competence means to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. Developing cultural competence is also an evolving, dynamic process that takes time and occurs along a continuum (SAMHSA, 2016).

DCFS means the Illinois Department of Children and Family Services.

DCFS Caseworker means the representative of record who has primary responsibility for a DCFS Youth in Care's child welfare case management, working with the youth and the youth's family to identify services to address issues that brought the youth into the child welfare system and providing updates to and making court appearances in the youth's Juvenile Court case. The DCFS Caseworker may be employed by DCFS or by a contracted Purchase of Service (POS) agency and may also be referred to as a "permanency worker."

DCFS Service Plan means a written plan on a form prescribed by DCFS that guides all individuals in the plan of child welfare intervention toward the permanency goals for DCFS Youth in Care. The DCFS Service Plan is developed by the DCFS Casework and other members of the Child and Family Team in accordance with DCFS Procedure 302, and indicates all services required for the child including services that are ordered by the Juvenile Court.

DCFS Youth in Care means a youth who is under the legal custody or guardianship of DCFS.

DCFS Former Youth in Care means a youth under age 21 who was previously under the legal custody or guardianship of DCFS but was reunited with their biological family, was adopted, was placed in subsidized guardianship, or whose Juvenile Court case was closed and is no longer under the legal custody of DCFS.

DCFS Child of the Ward means child of the youth in custody.

Department refers to the Department of Healthcare and Family Services, with which CountyCare is contracted to provide managed care services.

Determination of Need (DON) is the tool used by the Department of Healthcare and Family Services to determine eligibility (level of care) for nursing facility services and HCBS Waivers for individuals with disabilities, HIV/AIDS, brain injury, supportive living, and the elderly. This assessment includes scoring for a mini–mental state examination, functional impairment levels, and unmet needs for care in 15 areas including ADL and IADL (MCCN 1.1.56).

Emergency Shelter: Low-demand, site-based, short-term housing designed to remove individuals and families from the imminent danger of being on the street.

Health, Safety, Welfare, Reporting and Follow-up of Incidents are any incidents that involve abuse, neglect, or financial exploitation of a member; is a reportable event for an HCBS waiver member; or is an incident that puts the member or a member's services at risk.

Health Services Advisory Group (HSAG) is contracted by HFS to do partial oversight of the MCCN Contract, including, but not limited to, reviews of staffing and caseloads, audits, readiness reviews, and administrative reviews.

High-Needs Child means any Child who has been stratified as Level 3 (high risk) (MCCN 1.1.96).

Home and Community-Based Services (HCBS) Waivers means waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed

to meet the unique needs of individuals with disabilities and the elderly who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities (MCCN 1.1.97).

Homeless: when an individual lacks a fixed, regular, and adequate place to sleep or who regularly spends the night in an emergency shelter, similar institution, or a place not meant for human habitation, or are sharing housing of other persons due to loss of housing or economic hardship (doubled-up housing).

Housing First Model "Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness, and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life." -National Alliance to End Homelessness.

Housing Instability: An umbrella term that encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care.

Housing Management Information System (HMIS): The data system used to identify people experiencing homelessness by capturing their encounters with emergency shelters, street outreach and including those who are now being supported in temporary or permanent housing.

Illinois Department of Healthcare and Family Services (HFS) is responsible for providing healthcare coverage for adults and children who qualify for Medicaid, and for providing Child Support Services to help ensure that Illinois children receive financial support from both parents. CountyCare is under contract with HFS to provide managed care services (HFS).

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS) mean the Illinois Medicaid version of a multi-purpose tool developed for services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Illinois Medicaid Crisis Assessment Tool (IM-CAT) is a screening tool used in the delivery of Mobile Crisis Response services. The IM-CAT is composed of a subset of items from the IM+CANS and is used as part of the crisis assessment to recommend whether an individual can be stabilized in the community, or a higher level of care may be needed.

Individualized Plan of Care (IPoC) means a written plan that identifies services and supports that a member requires. The IPoC is a member-centered, goal-oriented, and culturally relevant plan, which reflects the full range of a member's physical and behavioral health service needs and includes both Medicaid and non-Medicaid services, along with the informal supports necessary to address those needs (MCCN 1.1.106).

Individual Provider (IP) means an individual co-employed by DHS 1.1.107and the DHS-DRS Home Services Program Member who provides care to the Member as provided in the HCBS Waiver service plan. Such individuals include Personal Assistants, certified nursing assistants, licensed practical nurses, registered nurses, physical therapists, occupational therapists, and speech therapists (MCCN 1.1.107).

Integrated Health Home (IHH) means an integrated team of healthcare professionals who provide individualized care planning and Care Coordination resources, for physical health, Behavioral Health, and social care needs. IHH further supports Members with the highest needs through the facilitation of high-intensity Care Coordination and identification of enhanced support to help both Members and their families manage complex needs (MCCN 1.1.110).

Interdisciplinary Care Team (ICT) means a diverse group of medical professionals (e.g., care coordinator, physicians, social workers, psychologists, occupational therapists, physical therapists) and nonclinical staff whose skills and professional experience will complement and support each other in the oversight of and member needs (MCCN 1.1.111).

Literally Homeless: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

a) Has a primary night-time residence that is a public or private place not meant for human habitation.
b) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs), OR
c) It is exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Long-Term Care (LTC) Facility or Nursing Facility (NF) mean a facility that provides skilled nursing or intermediate LTC services, whether public or private and whether organized for profit or not for profit, that is subject to licensure by Department of Public Health under the Nursing Home Care Act (complete definition at MCCN 1.1.119).

Long-Term Services and Supports (LTSS) means Covered Services, provided in a Nursing Facility or under an HCBS Waiver, designed to help meet the daily needs of Members who are elderly or have disabilities and to improve their quality of life (MCCN 1.1.118).

Managed Care Community Network (MCCN) is an entity, other than a Health Maintenance Organization (HMO), that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department of Healthcare and Family Services (HFS) exclusively to persons participating in programs administered by the Department (HFS).

Medication Confirmation Post Hospital Discharge the process of identifying if member is taking medications prescribed during hospitalization. If member does not have all medications, assist with obtaining medications. Confirm member has post discharge appointment with provider to provide medication reconciliation.

Medication Reconciliation the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Memorandum of Understanding (MOU) is a documented agreement between the Care Coordinator, Member, and Provider (if applicable) indicating the member understands and agrees to adhere to the requirements of the HCBS program. The MOU may be utilized in instances of HCBS member "non-cooperation", program "interference" and/or instances in which the HCBS member/authorized representative or any family member/friend/acquaintance of the member/authorized representative demonstrates threatening and/or abusive behavior, as outlined in the administrative code.

MLTSS means dual eligible beneficiaries who receive institutional (except those receiving developmental disability institutional services) or community-based long-term services and supports (through five of the State's 1915(c) waiver programs). Beneficiaries receive the Medicaid institutional, and community based long-term services and supports (LTSS), transportation, and behavioral health services.

Mobile Crisis Response means urgent twenty-four (24) hour response Crisis intervention and stabilization services for Children Enrollees and their families who are experiencing a Crisis related to psychiatric or behavioral problems.

National Committee for Quality Assurance (NCQA) means a private 501(c) (3) not-for-profit organization that is dedicated to improving healthcare quality and that has a process for providing accreditation, certification, and recognition, such as Health Plan accreditation (MCCN 1.1.131).

N.B. Member refers to any Medicaid member receiving services as a result of the N.B. consent decree, requiring HFS to develop, through an Implementation Plan, a behavioral health delivery "Model" to provide Class Members with a continuum of Medicaid-authorized and required mental and behavioral health services, including home- and community-based services. All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders are eligible N.B. Members.

Negotiated Risk: Negotiated Risk means the process by which an Enrollee, or the Enrollee's representative, may negotiate and document with Providers what risks each is willing to assume in the provision of Medically Necessary Covered Services and in the Enrollee's living environment, and by which the Enrollee is informed of the risks of these decisions and of the potential consequences of assuming these risks (MCCN 1.1.135).

Pathways to Success is one part of the State's efforts to enhance the behavioral health service system for children and is designed to meet many of the State's commitments under the N.B. Consent Decree. It encompasses a program for children with complex behavioral health challenges and provides access to home and community-based services. It is built upon an intensive model of care coordination that addresses the broad range of child and family needs and is guided by System of Care principles that put children and families at the center of planning for services and supports**.**

Person-Centered Planning is a way to assist people needing HCBS services and support to construct and describe what they want and need to bring purpose and meaning to their life.

Person Experiencing Homelessness (PEH) is the descriptor used for members who are living in emergency shelters or on the street, capturing the current status of the member but not assigning homelessness as a personal attribute.

Predictive Modeling is a score based on demographics and member claims data to predict a member's future health risk. CountyCare utilizes CPDS-Rx to generate a PM score for each member, which is refreshed monthly based on new data.

Special Needs Children means children under the age of 21 who are eligible for services pursuant to Article III of the Illinois Public Aid Code (Aid to the Aged, Blind and Disabled) or are Medicaid-eligible and eligible to receive benefits pursuant to the Specialized Care for Children Act (via the Division of Specialized Care for Children (DSCC)) or to Title XVI of the Social Security Act (Supplemental Security Income for the Aged, Blind and Disabled). Children in receiving DSCC Medically Fragile Technology Dependent services or DSCC in-home shift nursing services are not included (MCCN 1.1.185).

Surveillance Data: This includes referrals, transition information, service authorizations, alerts, results of the Determination of Need (DON), or other assessment tools adopted by the state, and from families, caregivers, providers, community organizations and contractor personnel.

Systems Integrated Team (SIT): a SIT is a team of care coordinators, hospital staff, a project coordinator, street outreach workers, and housing case managers that meet as a team to streamline patient placement into appropriate housing, address issues that may impact housing stability and focus on patient health outcomes.

Transition of Care means the management and continuation of care as Member's transition between different Providers within the same Health Plan (MCCN 1.1.197).

Youth At Risk means a Child who is a part of DCFS's Intact Family Services, which is a relatively intense short-term, in-home, community-based intervention program (6-9 months) that works with families who have been identified by DCFS as at risk for foster care placement (MCCN 1.1.206).

Last revised: 5/29/20, 12/31/20, 9/7/2022, 3/8/2023, 8/30/2023

Assignment to the Care Management Entities (CMEs)

CountyCare Health Plan assigns each member to a Care Management Entity (**CME**), which is responsible for providing care coordination and care management services outlined in their respective contracts. Assignment to the Care Management Entities (CMEs) is managed by a detailed algorithm that considers two priorities: 1) empanelment to medical home organizations and 2) enrollment in specific programs such as Long-Term Services and Supports (MLTSS and LTSS), Pathways to Success or Youth In Care. Members enrolled in specific deprograms are assigned to CMEs contracted for and approved by CountyCare to provide care coordination for specific members. Each month the algorithm is applied to the entire CountyCare membership to ensure that all members' current circumstances are considered and drive assigned to a CME. As a result, member's CME may change from month to month. The current diagram describing the Care Management Assignment Algorithm is found in Appendix B.

If a Care Coordinator identifies a potential error in CME assignment, the Care Coordinator should report the concern to the Manager for review. CME Managers may report potential errors in CME assignment to countycarereferrals@cookcountyhhs.org. A representative of CountyCare will reply with an explanation or resolution to any error identified. Until a determination is made, Care Coordinators involved should continue current work to support the member with immediate needs. If a member needs care coordination and two CMEs are involved, or if no CME is currently involved, a representative of CountyCare will collaborate with the CME(s) involved to designate CME responsibilities.

Exceptions or Individual Overrides of the CME Assignment

CountyCare may approve an exception to the general rule for CME assignment through an override to the CME Assignment for specific members on a case-by-case basis.

CME requests to override the CountyCare CME assignment algorithm must come from a CME manager or director. Requests are also submitted by the Health Plan. Requests are sent to the CountyCare Manager of Care Management (**MCM**) who will review and approve requests on a case-by-case basis. Overrides will be approved when the MCM clearly determines that:

1. The needs of the member will be better served by the requested CME.
2. There will be no significant disadvantages to the overall individual plan of care.
3. No significant negative impact on CountyCare's agreements with its CMEs will result.

The MCM will take into consideration the member's history of engagement with care management, motivations for the request and any other factors about the member's health care or life circumstances that are relevant to the CME assignment.

Examples that may be approved include:

* A member who lives with another CountyCare member, but they are assigned to different CMEs, and both have significant needs for care management involving home visits
* A member whose current relationship with a Care Manager is a critical factor in their likelihood to adhere to treatment plans/service plans based on relevant history

In conjunction with the MCM, the Health Plan Director of Long-Term Services and Supports (LTSS) makes overrides to the CME Assignment algorithm is cases involving LTSS assignment.

Examples that may be approved include:

*Any member deemed in an interim waiver status by CountyCare clinical staff will require a CME override until the member has a waiver OBRA code come across on the state's enrollment file

*Any member who is newly waiver eligible or newly long-term care eligible or who moves between long term care facilities who require a CME override until the member has a waiver OBRA code or facility code come across on the state's enrollment file

MCM will not approve requests based solely on the current care manager; all care coordinators are expected to develop effective relationships to engage members through person-centered assessment, problem solving and care planning.

Once approved, the MCM notifies Evolent Client Analytics through a JIRA ticket containing the member RIN, the start date and if applicable, end date to assign the member by Recipient ID to the approved CME each month prior to applying the algorithm.

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Audits and File Reviews of Internal health plan and delegated CMEs

CountyCare Care Management Auditing Program

CountyCare Health Plan is responsible for oversight of the internal health plan and delegated partners and vendors. One method of oversight is auditing care management activities. CountyCare has an audit program that includes:

- Annual review
- Focused/topic or sub-population-based reviews.
- Case-based record reviews

CountyCare conducts annual audits of each CME utilizing the current NCQA methodology and Performance Measure Validation use by HFS. The Plan will audit CM files against NCQA standards 5% or 50 records. The member database is queried for members with a minimum of 60 days continuous enrollment in Care Management, excluding members who have opted out of Care Management. A randomization method is used to identify records, allowing for 10 alternate files if needed. A hybrid tool, including both MCCN contract requirements, NCQA standards, and CountyCare requirements, is used to measure care management activities' performance. CountyCare auditors review the appropriateness, completeness, and timeliness of activities and the quality and completeness of documentation. The results are analyzed, a written report is produced, and findings are shared and discussed with the CME in the monthly Joint Operating Meeting. Required remediation, if necessary, and other feedback is documented in the written report.

In addition to annual audits, CountyCare may audit at other times for focused/topic-based reviews, complex case reviews, sub-population reviews, mid-year performance assessments, to align with requests or priorities of HFS or HSAG, and at any time CME or health plan operations or systems significantly change. CountyCare will provide at least two weeks' notice with clear description of the audit's scope and instructions for preparation.

Specific case records may be requested and reviewed at CountyCare's discretion at any time.

External Audits and File Reviews

The Department, or any other entity connected with the Department, may audit care management records at any time. Health Services Advisory Group (HSAG) conducts quarterly on-site reviews of CountyCare' s waiver member records to provide analysis and feedback to HFS on health plan compliance with waiver care management program requirements. CountyCare and HFS utilize the findings from these reviews as part of the evaluation of CME compliance with CMS waiver performance measure requirements.

Additionally, CountyCare will audit CME waiver files for compliance with MCCN contract and CountyCare requirements related to the (M)LTSS HCBS programming.

CME Internal Audits

CMEs are expected to establish and implement a Quality Program that includes a structured program of audits of their own files for compliance with NCQA, MCCN, and CountyCare requirements. The CME will submit the results of these audits to CountyCare quarterly and results will be discussed in the Joint Operating Meeting.

Last revised: 11/02/2017, 2/19/2018, 04/16/2018, 10/04/2018, 1/16/2020, 8/30/2023, 7/31/2024; 12/12/25

Authorization of Services

CountyCare requires prior authorization for payment for certain services. The CPT Look-Up can be found under the Prior Auth Resources on the CountyCare website.

Roles and responsibilities for Utilization Management (**UM**) Staff and care coordinators are described for each category of service below:

Service Package	Prior Authorization Requirement	Roles and Responsibilities
Service Package 1 (SP1)	Services that require a determination of medical necessity to assure cost-effective and evidence-based use of health care services: • All inpatient services • Select outpatient services (e.g., invasive procedures, high-cost DME, extensive testing, etc.) • Specific formulary medications and all non-formulary medications. • Specific dental and vision benefits. Outpatient specialist consultation visits do not require prior authorization.	Only UM staff may approve or deny SP1 services that require prior authorization. UM accepts clinical information and input from providers and care coordinators to inform their determination of medical necessity. Pharmacy, dental, and vision benefit managers approve or deny medications or services that require prior authorization. Care Coordinators are responsible for understanding the prior authorization process and using resources to support members and providers to seek the services.
Service Package 2 (SP2)	All home and community-based services (**HCBS**) require prior authorization which requires alignment with a current assessment of needs and the integrated care/service plan Documentation: the Service Plan serves as the authorization of HCBS waiver services	Care management entities that serve (M)LTSS members are responsible for authorizing or denying HCBS services. Only care coordinators assigned to members in home and community-based waiver services may approve or deny HCBS SP2 services. These care coordinators and their managers must participate in the appeal process when a member disagrees with a decision and exercises his/her right to appeal.

Last revised: 06/19/2017, 2/19/2018, 04/16/2018, 10/04/2018, 5/31/2019, 11/26/2025

Behavioral Service Plan: Williams Consent Decree Members

CountyCare's Care Management Entities (CMEs) will implement, and Utilization Management (UM) department will authorize, any behavioral health service plan developed by Illinois Department of Human Services (**DHS**) Contractors for any member who is a class member under the Williams Consent Decree, unless the member and the member's Williams provider consents to a modification of such plan. The State, or its designee, will provide the CME and UM with a timely copy of any such plan.

Created: 10/31/2017. Last revised: 10/04/2018,

Care Gaps and Promoting Recommended Care

Care coordinators are central to helping members address gaps in care, especially preventive care screenings and services. These services include, but are not limited to, well-child visits, preventive exams, immunizations, women's health screenings, management of chronic health conditions, behavioral health follow up, and efforts to address any barrier to receiving needed health care. Members with care gaps are prioritized for outreach (see Outreach section).

Provider Link: Tool for the Identification of Members Experiencing Care Gaps

CountyCare offers direct access to a population health platform called Provider Link. Provider Link allows providers and care coordinators to review their overall HEDIS measure rates, measure compliant/non-compliant member-level data, and member-level claims history. The data in Provider Link is refreshed at least monthly and based off claims data including paid, denied, and adjudicated but not yet paid claims, in addition to supplemental data including lab results feeds, the Illinois immunization registry, and Electronic Medical Record data files from several provider groups. Data garnered from Provider Link allows the CMEs to target individual members to reduce gaps in care and improve quality performance.

In Provider Link, users can see the list of members eligible for a certain HEDIS measure. The list of members can be filtered and sorted by members who have met and members who have not met the HEDIS measures. Reports can be pulled with this member list and overall HEDIS measure rates. The member list includes the member's contact information and assigned PCP. From here, care coordinators and care managers are expected to conduct outreach to those members who have not met HEDIS measures, scheduling them for an appointment with their PCP, a preventive screening, or an immunization, and continuing to outreach and follow up with members throughout the year.

Care coordinators can receive training from CountyCare staff on HEDIS measures and how to access and effectively use Provider Link. Please contact the Department of CountyCare Population Health with any questions at countycarepophealth@cookcountyhhs.org.

Coordination of Care When an Enrollee Exhausts a Benefit

The Health Plan's goal is to support Enrollees with both covered and non-covered services to promote a comprehensive approach to health and quality of life.

Applicable NCQA Standards

QI 3 Element D. If covered benefits are exhausted while an Enrollee needs care, the health plan notifies the Enrollee about alternatives and resources for continuing care and how to obtain it, as appropriate. The health plan is not required to develop alternative resources.

Procedures for Department(s)/Business Unit(s)

In addition to complying with standard policies and procedures, each department or business unit utilizes specific procedures to support continuity of care.

Care Management Entities

- Upon identification of exhausted benefits, provide Enrollee with resources available and steps to obtain resources.
- Utilize referrals from other departments to initiate outreach to Enrollees to offer the service described above.
- Develop resource libraries and materials.

Utilization Management Department

- For requests exceeding benefit limitations, refer the request to a Medical Director for a determination that considers the Enrollee's individual needs.
- If the Medical Director denies the request, inform provider of potential alternative resources and refer Enrollee to CME
- Within UM data, identify when denials are due to exhaustion of benefits.

Member Services/Member Communication Materials

- Assist Enrollees with individual needs by providing further information, connecting to the appropriate resources, and/or referring to CME.
- Send and post to website commonly needed resources.

Created: 04/23/2018. Last revised: 10/04/2018, 1/16/2020, 12/31/20, 7/31/2024

Crisis, Help Lines, and Care Coordination Follow Up

Crisis and Aid Referral Entry Services (CARES) Line

The CARES line is a telephone response service that handles mental health crisis calls for children and adults in Illinois. CountyCare members can use the 24-hour CARES line at 1800-345-9049 (TTY: 1-773-523-4504) to talk to a behavioral health professional. Members can call if they or their child is a risk to themselves or others, is having a mental health crisis, or if members would like a referral to services. CARES line call logs are uploaded daily and shared with CMEs via a secure data file exchange and available in CMIS for CountyCare and Cook County Health Staff.

Help Line

24-hour Nurse Advice Line

The Carenet Health (aka Health Dialog) Nurse Line is a 24/7 Nurse at 312- 864-8200 / 855-444-1661 (toll-free) / 711 (TDD TTY) and Health Coaching Support phone line. CountyCare members have access to a live staffed registered nurse. The Nurse Line is secure access via phone and contains a library of health education materials. Members are informed about the 24-hour Nurse Line from the CountyCare member handbook. Carenet Health Nurse Line call logs are shared with CMEs via a secure daily data file exchange and available in CMIS for CountyCare and Cook County Health Staff.
Created: 5/31/2019, Revised: 3/2/2021, 9/7/2022, 3/8/2023; 4/30/25

Behavioral Health Crisis

Behavioral health crisis is any episode when a member utilizes telephonic crisis services (crisis lines or emergency medical services) or presents for crisis care at an emergency department or behavioral health provider agency. Behavioral health crisis is a trigger to care coordinators to engage members. The goal of engagement is to provide immediate treatment and support care to prevent further crisis. For members who are not already engaged in care coordination, care coordinators must perform outreach attempts until the member is reached or outreach is exhausted. Contact requirements include linking a member to crisis services if needed, supporting an existing crisis safety plan and if needed, collaborating with a PCP or behavioral health provider to establish a crisis safety plan. Following crisis care, the care coordinator is responsible for coordinating all necessary follow-up appointments and referrals for the member and ensuring that the member has accessed appropriate medication. Care coordinators are expected to complete a health risk screening, behavioral health risk assessment and, as indicated, comprehensive health assessment. All members experiencing behavioral health crisis should be offered enrollment in the care management program, and if enrolled, the care coordinator with work with the members to establish an Individualized Plan of Care (IPoC). Care coordinators identify barriers to receiving needed care and take action to decrease barriers and facilitate engagement in follow-up. Care coordinators document all activities in the CM system, include evidence of the health plan coordinating admission, including dates, time and provider information, pharmaceutical and discharge data, as necessary for follow-up services to promote continuity of care.

CountyCare ensures that CMEs are notified of behavioral health crisis through the following daily mechanisms:

- transmission of logs from the children's mental health crisis line (CARES).
- transmission of prior authorization data to each CME which is loaded into the CM system.

- Daily report of referrals from UM staff, CountyCare health plan staff or other referents who identify members with specific needs for care management.

- urgent referrals emailed to CME inboxes from UM staff, CountyCare health plan staff or other referents.

Behavioral health crisis is considered an urgent trigger for care management engagement and therefore the CME is expected to assign a care coordinator or notify the assigned care coordinator to begin engagement and schedule an appointment with a mental health provider after the crisis event. Care coordinators are expected to follow-up and engage CountyCare members who have called the crisis line.

The Care Coordinator is responsible for the following follow-up activities after a member calls the crisis line:

- Document follow-up with the member in their clinical documentation system.

- Create a crisis safety plan with the member and provide a copy to the member.

- Review and update the Care Plan (IPoC) and Health Risk Assessment with input from member.

- Schedule a follow-up BH appointment, within 7 days, max 30 days.
- Determine the outcome of a 7 and 30-day appointment and provide ongoing care management activities including rescheduling appointments and facilitating support to ensure appointments are attended by member as needed.

Children's Behavioral Health Crisis Follow-up

Care coordinators have additional, specific requirements for supporting children and adolescents experiencing and following behavioral health crisis.

CMEs must provide care coordination to all members under 21 who are utilizing behavioral health services. To the extent possible, family members and natural supports of children with behavioral health conditions should be included in all planning and treatment for the child. Services may also be provided to children's family members and other natural supports when those services are related to the behavioral health conditions of the children.

Each CME receives daily notification of assigned members who have utilized the children's mental health crisis line (CARES). The log contains data about the date and time of call, caller, concern, and the name of the Mobile Crisis Response (MCR), otherwise known as Screening, Assessment, and Support Services (SASS), agency contacted. The CME is expected to assign a care coordinator or notify the assigned care coordinator.

The Care Coordinator is responsible for the following:

- Coordinate with member/family, MCR provider, to deliver clinical and supportive services with other clinical providers (PCP, BH, hospital, etc.) to the member.
- arrange for the necessary transportation when an Enrollee requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting.

- Ensure a crisis safety plan is documented in the member record and obtain a copy of the crisis safety plan developed by the MCR provider.

- communicate to the member's PCP the psychiatric resource and medication efforts performed as part of Mobile Crisis Response service, consistent with all consents and releases.

- facilitate priority access to a psychiatric resource and ensure member has an appointment scheduled within one (1) business day after the crisis event to provide consultation and medication management services, as medically necessary, for a member for whom community-based services were put in place in lieu of psychiatric hospitalization, and within seven (7) days of discharge from inpatient hospitalization.

- convene an ICT meeting for the member within fourteen (14) days after the crisis event and within fourteen (14) days after discharge if the member is hospitalized. If the care coordinator receives notification that the member has been designated a Youth at Risk by DCFS, the CME will involve DCFS on the member's ICT.

For children who are hospitalized for behavioral health, care coordinators are responsible for the following activities related to discharge and transitional planning. The Care Coordinator:

- participates in planning that begins upon admission.

- participates in all inpatient staffing by phone, videoconference, or in person.

- notifies the member's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the member, and he or she shall make every effort to involve the member and the member's family and caregiver in decisions related to these processes.

- speaks directly with the member or member's family at least each week; if care coordinator is unable to speak with member or member's family, care coordinator should communicate with staff directly involved with member's care.

- in conjunction with provider, educate and train the member's family on how to use the Crisis Safety Plan while the member is receiving inpatient institutional treatment.

- participates in, and oversee admission, staffing, discharge, and transition processes as follows.

- coordinates communication of admission, pharmaceutical, and discharge data, consistent with the consents and releases secured, to the necessary primary care and other providers to promote continuity of care.

- coordinates all necessary follow-up appointments and referrals for the member upon transition back into the community; appointments should be established prior to discharge to ensure continuity across care providers.

- provides transitional services when being discharged from higher levels of care to lower levels or community-based services and work with the parties involved to facilitate appropriate follow-up services, including the scheduling of follow-up treatment appointments.

- retains accountability and responsibility for the member as the transition between levels of care occurs.

- encourages the member and the member's family to contact the Care Coordinator whenever a biological, psychological, or social intervention is required or requested.

- ensures that the entry and exit from any level of care is managed effectively, efficiently, and, when possible and appropriate, within the CountyCare network; when necessary, support members and member's family to access to non-Network Providers and to facilitate the timely provision of necessary and appropriate records to those non-Network Providers.

- ensures a link with institutional-based care Providers and initiate follow-up care within seven (7) days after discharge from higher levels of care (e.g., hospital, psychiatric residential treatment facility (PRTF), residential, and Crisis respite) and arrange for appropriate levels of services.

- complete a medication reconciliation (med rec) when members are discharged from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite).

- confirms that PCPs are made aware of any medications that have been prescribed for members during treatment at an institutional setting; and to confirm with the members that they can get prescribed medications.

- communicates directly with the member or member's family within forty-eight (48) hours after transition and sees the member in person in the member's home, or another location as mutually agreed by the member or the member's family within seven (7) days after the discharge from higher levels of care (e.g., hospital, PRTF, residential, and Crisis respite).

- assists the member with scheduling a follow-up appointment with a mental health provider within seven (7) days after discharge from the hospital and with attending all post-discharge appointments for follow-up care.

- provides appropriate care management based on concurrent assessment for an appropriate period following discharge, involving other parties (e.g., Mobile Crisis Response provider, DCFS caseworker) in the care management, as necessary.

- upon discharge, monitors and manages the member's care, as necessary.

Created: 11/3/2017. Revised: 12/11/2017, 04/16/2018, 4/22/2018, 5/31/2019, 8/21/2019, 3/2/2021, 3/8/2023, 8/16/2023

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM + CANS)

Beginning August 1, 2018, the Department of Healthcare and Family Services (HFS) introduced the service of Integrated Assessment and Treatment Planning (IATP) into the community behavioral health service array. HFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument.

- IM+CANs certification is required for BH providers administering the tool.

- Certification and training are free for Behavioral Health providers in Illinois, Stakeholders like MCO staff and Care Coordinators working with members who have BH conditions are strongly encouraged to complete the training.
    - Register for the training and download a copy of the IM+CANS document here: https://socialwork.illinois.edu/community-partnerships/agency-based-partnerships/provider-assistance-and-training-hub/
- The IM+CANS is updated every 180 days or a significant change by the provider administering the tool.
- The IM+CANS is required for Medicaid recipients to access community behavioral health services.

Care Coordinator Requirements:

- Utilize HRS/A, CARES crisis data, UM and claims data used to identify members who have BH conditions or needs.
- Provide education to members on how to access covered BH services.
- Provide education to members about available BH in-network providers.
- Document all efforts to connect members to behavioral healthcare services and providers, including communication with members about completing an IM+CANS with a community BH provider.

Created: 9/7/2022

Carenet Health - 24/7 Nurse Line Follow Up

CMEs will outreach CountyCare members on the daily Carenet (aka Health Dialog) referral list who require follow-up based on clinical evaluation.

i. **Care Coordinator Referral Required:**
    1. Members who need PCP or Specialist
    2. Help scheduling a medical appointment.
    3. Help with transportation.
    4. Referrals to community resources
    5. Members with BH needs.
    6. Pregnant members
    7. Access to medications
    8. **Based on clinical judgement**

ii. **Care Coordinator Referral not necessary:**
    1. Members who went to IP/ED - defer to individual CME TOC process.
    2. If Carenet Health Nurse resolved reason for call and no ongoing issues noted

The Care Coordinator is responsible for the following activities:

1. Outreach appropriate members within 48 hours of referral (excluding Saturday, Sunday, Holidays).
2. Address reason for Carenet Nurse line referral and member concerns.
3. Complete and review HRS/A and Care Plan with member as needed.
4. Document follow up with member in respective CME clinical documentation system.

Created: 11/3/2017. Revised: 12/11/2017, 04/16/2018, 4/22/2018, 5/31/2019, 8/21/2019, 3/2/2021, 3/8/2023; 4/30/25

Caseload Standards

CMEs are required to assign each member identified as requiring care management and any other member who requests services, to a care coordinator, unless the member actively opts out of care management. Care coordinators responsible for members with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. The maximum weighted caseload for a care coordinator is 600 with Level 1 (low risk) weighted as one (1), Level 2 (moderate risk) weighted as four (4), and Level 3 (high risk) weighted as eight (8). Care coordinators managing HIV and/or Brain Injury (BI) waiver cases are restricted to a maximum of unweighted caseload of 30 cases (of any kind).

Caseload standards are subject to change. The state may review existing caseloads at any time and require a change in methodology or a member's assignment to a caseload.

Maximum caseloads of care coordinators shall not exceed the following standards:

Risk Category	Caseload Maximum (Cases per Care Coordinator)
Level 1	600:1
Level 2	150:1
Level 3	75:1
Persons with Traumatic Brain Injury (TBI) Waiver or HIV/AIDS Waiver	30:1

Each quarter, and at other times as requested by HFS/HSAG, the CMEs are required to submit the HSAG Staffing Workbook. CountyCare monitors caseloads at the individual care management level by analyzing the Staffing Workbook quarterly and presenting the findings at the Joint Operating Meetings.

Last revised: 10/31/2017, 04/16/2018, 5/31/2019

Housing Programs, Collaboration- Care Coordinator Responsibilities

Care Coordinators serve a vital role in ensuring that CountyCare members who are experiencing homelessness or housing instability are getting their health needs met. Given the unique roles and direct patient contact, Care Coordinators can accomplish the following:

- Identify risks related to housing instability or homelessness.

- Assist members in coordinating care informed by member's unique circumstances in an individualized manner.
- Make referrals to resources.
- Gain permission from members to refer or release health information to housing and social service agencies not covered under HIPPA.

These responsibilities, among others, allow members experiencing homelessness or housing insecurity to navigate complicated health and housing systems with more ease, support, and confidence.

Philosophy

CountyCare aims to improve services to and health outcomes for a high need, high-cost population – members experiencing homelessness - by improving access to housing and to appropriate support services, with particular attention to reducing health disparity in this population.

Through partnership with the Advancing Health Equity, a national learning collaborative, sponsored by the Robert Wood Johnson Foundation, that assembles multi-agency stakeholders to devise and carry out a plan to reduce health disparities, CountyCare is committed to improving health equity and reducing healthcare disparities for CountyCare members experiencing homelessness by implementing and evaluating a payment innovation and other investments that integrate housing as a health care strategy and/or expand behavioral health system capacity.

CountyCare's commitment to health equity directly impacting people who are experiencing homelessness included an investment into the Flexible Housing Pool (FHP), targeting members whose health is threatened by homelessness augmented by mental illness and/or SUD or who have multi-person households including small children. These two populations experience disproportionate difficulties in accessing needed services. The program is a 'housing first' model, as providing housing appears to facilitate more effective provision of other services. The program is expected to improve health outcomes and demonstrate return on investment for cost and quality outcomes, by reducing member reliance on inpatient and ED services for needs that can be better met through community-based services.

Flexible Housing Pool (FHP) Overview

The FHP, a partnership of Cook County Health, the City of Chicago, and several community-based housing organizations, connects individuals who have been homeless and persistent users of crisis systems (e.g., emergency rooms, shelters, or jail) to supportive housing and necessary stabilization services. Each individual participant receives a three-year commitment to cover housing costs, tenancy supports, and other interventions to integrate housing services with health care and care coordination. The overall FHP Program is funded by a mix of public and private investors and is administered through a contract with the Center for Housing and Health and subcontractors. The FHP Program is also available to targeted investors, which may designate the recipients of services under their investment. Tenancy supports and housing services are provided through FHP partner agencies (listed below), and each agency has their own policies and procedures.

Flexible Housing Pool (FHP) Eligibility

The baseline criteria for FHP eligibility are established by the FHP's contracted evaluator and require all the following:

1. Literally homeless or unstably housed, AND

2. Persistent utilizer of homeless system (shelter, street outreach), AND
3. Persistent utilizer of Cook County Health System (Emergency Department/Cook County Jail Health Services)
4. Additional criteria and prioritization for eligible members is established by various funders/investors of the Flexible Housing Pool. Care Coordinators will be informed if a specific member is eligible or not for the Flexible Housing Pool.

FHP Program Acceptance

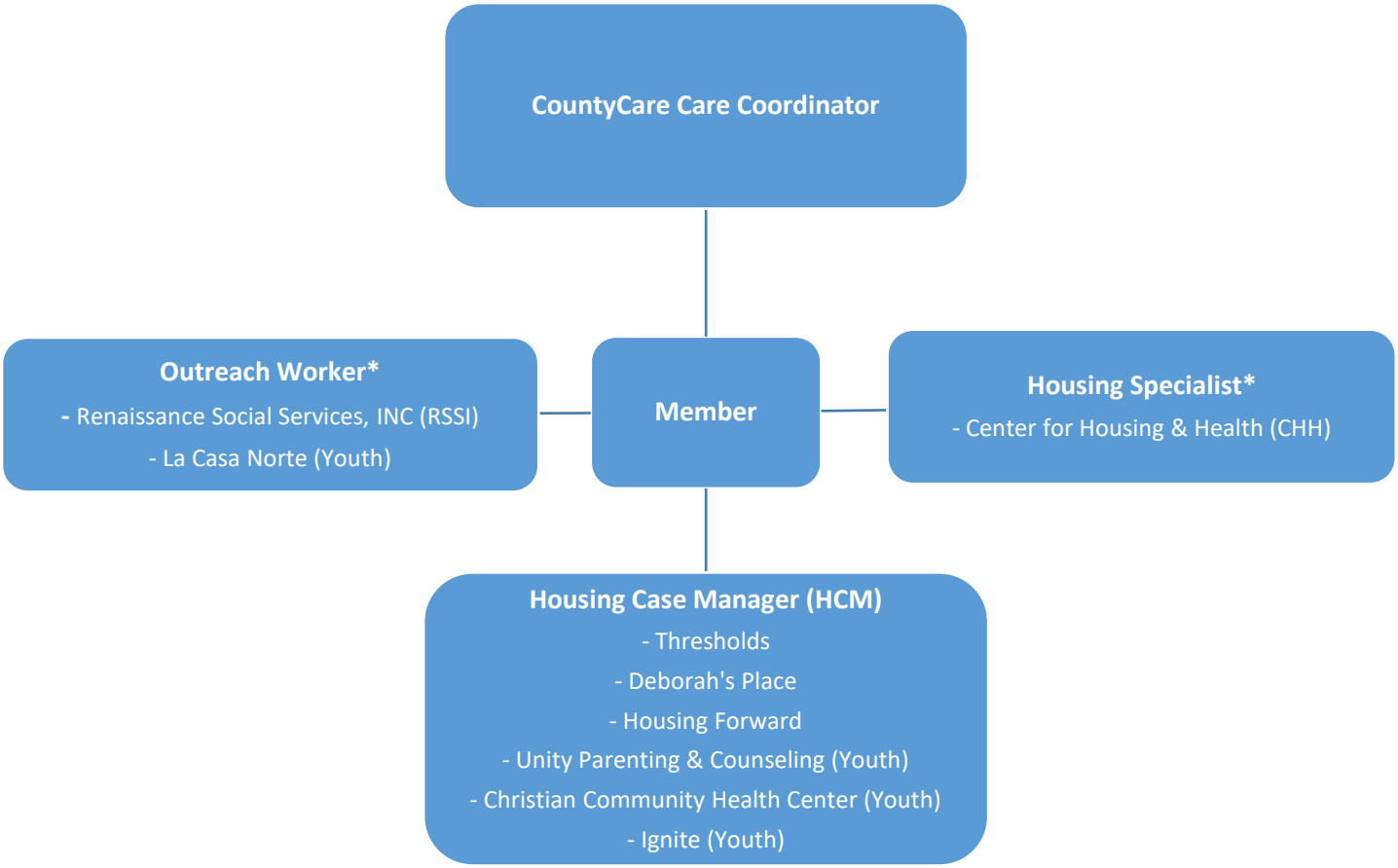
Members may accept or decline participation in FHP. If a member accepts, they will be required to complete an FHP intake packet that includes a Flexible Housing Pool flyer, Cook County Health Flexible Housing Pool Contact Form, and an authorization to disclose PHI from CCH to housing assistance agencies. If a member declines, they may accept later, assuming the FHP program still has capacity to provide the services. Members are not excluded from FHP for drug/alcohol use, relapses, criminal background, family size or composition, or medication adherence. If FHP participants are evicted from their unit, they will continue in the FHP program. Additionally, members are not required to participate in Care Management services to remain in the FHP.

FHP Housing Assistance

Rent is subsidized by the FHP program for three years, and if the member has income, the member is responsible for 30% of the rent. FHP Housing Specialists (HS) try to find units with utilities included to help reduce out-of-pocket costs. The FHP Program provides a "welcome home kit" that includes payment of security deposits, furniture, and moving costs. In addition to this, participants receive tenancy support services from Housing Case Managers (HCM). Services can vary depending on the needs of the individual. Tenancy support may include:

- Skill building in navigating housing systems
- Support to strengthen the landlord-tenant relationship.
- Support participant in improving skills necessary to be a tenant and meet obligations of a lease.
- Life skills, such as maintaining a budget.
- Connection to employment opportunities, interviewing skills, and resume building
- Assistance in accessing or maintaining benefits.

Members enrolled in the FHP are supported by multiple service providers, displayed in the below graphic.



*Outreach Workers and Housing Specialists have short-term involvement with members. Outreach workers support in locating members on-the-ground to aid in moving them through the FHP process. Housing Specialists help members identify, find, and secure a lease with permanent, supportive housing.

Flexible Housing Pool (FHP) Participants- Care Management Requirements

Regardless of risk level, any CountyCare enrollee identified as eligible for the FHP will be offered, and encouraged to participate in, Care Management services. However, Care Management is not a requirement for FHP participants.

Notification of Member Eligibility

Care Coordinators will be notified via email from the CountyCare Flexible Housing Pool Coordinator (FHPC) if a member assigned to their caseload is eligible for, or currently served by, the Flexible Housing Pool. FHPC will request confirmation of email from care coordinator. FHPC will provide the name, RIN, and DOB of members, and will copy relevant FHP program staff to alert emails to acquaint Care Coordination and FHP staff.

Flexible Housing Pool (FHP) Participants- Care Coordination Expectations

Persons experiencing homelessness (PEH) face innumerable barriers in addressing, and maintaining, health. Care Coordinators are expected to go above and beyond typical efforts to engage members to appropriately respond to their unique needs and circumstances. Care coordinators are required to ensure the proper release of information is obtained, which contains the members signature and permission to discuss member information with the FHP partner agency staff. Care Coordinators are expected to do the following activities to ensure FHP-involved members are receiving necessary care:

- Connect with member's assigned Housing Case Manager (HCM) to review member information and discuss updates and barriers as needed.
    - It is recommended that the HCM is added to the interdisciplinary Care Team (ICT), if member agrees
    - Maintain proactive and consistent communication with member's assigned Housing Case Manager, including relevant health updates such as hospitalizations, updates to IPoC, or change in providers.
    - NOTE: member must sign the authorization to disclose PHI from CCH to housing assistance agencies, as part of the FHP intake packet, prior to sharing information.
- When appropriate, join and contribute to Systems Integrated Team (SIT) meetings (definition in glossary) regarding the member, including providing updates and information that would support FHP staff in engaging the member.
    - Note: the SIT meetings are facilitated by the FHP Partners, and supplemental to ICT meetings. Care Coordinators will participate in SIT meetings as needed, and must update the ICT members, as appropriate, of matters discussed in SIT meetings.
- Convene ICT meeting as appropriate, to ensure that gaps in service and health needs are being met and communicate updates.
- Update or complete member HRS/A
- Update member IPoC.
- Assist with member PCP visits and encourage regular preventive health appointments.
    - Ensure member has a plan and the tools necessary to get to their appointments (i.e., securing First Transit)
- Provide education on redetermination and open enrollment, ensuring that member understands when their redetermination date is.
- Ensure that gaps in service acquisition are addressed, including:
    - Transportation
    - Regular reminders to members for upcoming, scheduled appointments
    - Access to a phone
    - Access to nutritious foods
    - Providing health education as necessary
- Care coordinators are expected to follow established processes to ensure behavioral health services are in place.
    - Provide member with Behavioral Health crisis resources (CARES, Avail)
    - Provide additional mental health education materials, as necessary.
    - Utilize motivational interviewing techniques to encourage member to follow through with behavioral health referrals.

- If member is hospitalized for a behavioral health crisis, please refer to the "Adult Behavioral Health Crisis Line Follow Up" section of the manual and follow established workflow as instructed.
    - Ensure that contact is made with the member while hospitalized and within 2 days of discharge.

Outreach and Engagement of Members Enrolled in FHP

Members targeted for outreach and enrollment in FHP may be extremely difficult to engage due to lack of consistent communication channels (i.e., phone, internet, consistent address). For members enrolled in FHP, Care Coordinators must follow the overall guidelines for outreach and engagement plus these additional requirements, which supersede the general standards:

- **Contact community providers involved in the member's care; including but not limited to the Flexible Housing Pool Outreach worker and/or member's assigned Housing Case Manager** to obtain up to date member contact information, locations where member may be found, and additional contextual information that help explain where member may be found or why they are difficult to reach now.
- **Participate in FHP SIT meetings** to discuss challenges and brainstorm possible solutions or next steps to better engage the member. Discuss ways to better connect member to a regular communication channel (i.e., obtaining a cell phone, identifying natural supports to contact who know about the members whereabouts and can relay a message to the member, completing three-way calls with FHP staff when the member is engaged and available, etc.).
- **Make a home or site visit** (i.e., shelters, hotels, warming centers, and public businesses)

Outreach to FHP participants will be considered exhausted when:

- All the steps outlined above have been completed and documented with no successful contact with the member after a minimum of 5 attempts to locate the member.
- Services are not currently in place.

CME Expectations

CMEs are expected to adapt standard workflows to individualize around the complexities of delivering the FHP program.

Risk Stratification

Members enrolled in the Flexible Housing Pool have been pre-identified as having higher needs. This is based off the following:

- Medical and pharmacy claims
- ED and inpatient hospital utilization
- History of housing instability
- Social determinates
- Behavioral health conditions

Outreach and case management services, should continue, minimally for the first year after program enrollment during a member's experience with the Flexible Housing Pool.

Members Who Are Ineligible for the FHP and Need Housing Support

For members who are experiencing literal homelessness that has not been identified as eligible for the FHP, there are several steps Care Coordinators can take to offer housing support.

Step 1: Update IPoC to include goals related to housing. If the member is experiencing housing instability or literal homelessness, create a housing crisis safety plan with the member that includes the following.

- Plan for safety and short-term housing (Shelter, with a friend, etc.)
- Provide the member with housing resources.
- Obtain the best contact information for the member and supportive persons who know how to get in contact with the member.

Note: A Housing Crisis Safety Plan template is available on the CountyCare, Care Coordination Resources webpage in the CountyCare Housing Resource Guide.

Step 2: For members who are sleeping in a shelter, outside, in a vehicle, or any place not meant for human habitation (literally homeless) Care Coordinators should call the Coordinated Entry Call Center at **312-361-1707** to complete a housing assessment. The call center is open Monday through Friday from 8:30am – 4:00pm. Please note, this may or may not lead to a housing option and does not solve immediate housing crisis needs. It is a prerequisite to accessing HUD-funded services and programs.

Step 3: Based on member needs and eligibility, identify availability of internal CCH programs, and follow referral processes described in the CountyCare Housing Resource Guide

Step 4: If CCH programs are not accepting referrals or do not meet the needs of the member, Care Coordinators are expected to investigate all other housing options as appropriate. If all options have been exhausted, contact CountyCare's Flexible Housing Pool Coordinator for support.

Step 5: As much as possible, support the member in preparing for housing, such as obtaining an ID, or creating a housing reference list.

Key Contact People and Escalation Resources Related to FHP

- Care Coordinators who have general questions about FHP should refer to their direct manager or supervisor.
- For assistance and/or questions about members who are enrolled in FHP, contact the Flexible Housing Pool Coordinator.
- CME Management may contact the Integrated Health Home Manager for assistance with unresolved issues and escalations for members enrolled in FHP.

Created: 2/24/21, 9/7/2022

Community Transitions Initiative (CTI)

General Overview

CountyCare, through the CTI, is responsible for the successful transition of members living in Nursing Facilities and Specialized Mental Health Rehabilitation Facilities (SMHRFs) into the community. CountyCare Care Management is required to work in collaboration with the University of Illinois at Chicago College of Nursing (UIC-CON, Maximus, and the Department of Human Services (DHS) Comprehensive Class Member Transition Program (DHS Comprehensive Program). CTI training and forms can be found on the UIC-CON website at: https://colbert-williams.nursing.uic.edu/communitytransitions-initiative/. CountyCare members that are part of this Initiative are considered either Colbert (Nursing Facility) or Williams (SMHRF) Class Members, which HFS has placed particular emphasis on for transitions.

Performance Targets

HFS will establish annual (calendar year) minimum Performance Targets for successful community transitions of CountyCare's (1) Colbert class members and (2) Williams class members.

Members Eligible for Participation

To be considered eligible for participation under the CTI, the member must meet the following criteria: Have continuously resided in a Nursing Facility or a SMHRF for a minimum of sixty (60) days;, and have a Transitional Assessment completed by the State or its representative(s)

Appropriate Housing for Transition

Appropriate housing must comply with the provisions of the Williams v. Pritzker and Colbert v. Pritzker consent decrees for community-based settings, which is generally defined as the most integrated community-based setting appropriate to promote a member's independence in daily living, economic self-sufficiency, and ability to interact with persons without disabilities to the fullest extent possible.

A community-based setting may include Permanent Supportive Housing (PSH), a Private Residence, a Supportive Living Program, or other appropriate supported or supervised residential settings that are specifically chosen by member. PSH means integrated permanent housing, with tenancy rights, linked with flexible community-based services that are available to members when they need them but are not mandated as a condition of tenancy. This includes scattered-site housing (section 811, subsidized units, etc.), apartments clustered in a single building, supported/supervised residential, supportive living settings. The consent decrees place additional requirements on, and may restrict, transitions to PSH if a building has more than 25 units known to be occupied by persons with mental illness or disabilities. While permanent supportive housing is the preferred setting for transition, other community, or independent living arrangements, such as residing with a family member, will be considered eligible transition settings under CTI.

Rental Assistance for Colbert and Williams Class Members

Class Members are prioritized for rental assistance through the Statewide Referral Network (SRN). Bridge subsidy vouchers may be accessed through the DHS Comprehensive Program for Class Members who have been on the SRN waitlist for 45 days or longer. Bridge subsidies may be utilized temporarily until a

permanent housing voucher becomes available. Policy, forms, and training for MCOs can be found at https://colbert-williams.nursing.uic.edu/community-transitions-initiative.

Transition Assistance Funds (TAF) for Colbert and Williams Class Members

Care Coordinators may access TAF through the Department to assist Colbert and Williams Class Members who are in the process of transitioning or have transitioned within the previous six (6) months from a Nursing Facility or SMHRF to a community-based setting. TAF may be used to assist Class Members with the supports and essentials required to establish and maintain community housing.

- Each Colbert Class Member has access to up to $4,000 in TAF. Each Williams Class Member has access to up to $2,800 in TAF.
- Housing must be identified by the Class Member before TAF can be utilized.
- The service planning process should include consideration of the Class Member's need for TAF to support community transition. If the Class Member's Transition Service Plan indicates a need for supports using TAF, details on the type and amount of supports within each of the allowable categories outlined below should be included and should be reasonable to meet the identified needs of the Class Member.

TAF can be used to purchase the following items:

- Apartment application fees.
- Security deposits or move-in fees.
- Utility connections or deposits, initial first month post-transition utilities assistance.
- Furniture.
- Air conditioner if housing arrangement does not include Linens and bedding.
- Dishes and other household essentials, initial set of clothing/personal items.
- Birth certificate, Social Security documents fees in order to submit housing applications or other needed transition applications.
- Medical and testing supplies not covered by the MCO.
- Medical equipment not covered by the MCO.
- Past unpaid utilities bills.
- Class Member's rent portions of housing option per Transition Service Plan.
- Food not to exceed $350 with focus on main food groups (meat, dairy, vegetables, fruits, and grains).
- Transportation expenses not covered by the MCO that are related to the securing or maintaining community-based housing, such as: exploring housing options, meeting the landlord, meeting with rental agency or landlord to sign forms, acquiring needed information (i.e. ID Card, birth certificate, Social Security documents) to complete housing applications. Bus passes not covered by other means are also permissible for transition planning, community access, and housing activities. Transportation includes regular vendors of transportation (cabs, ride-share, bus). Specialized transportation vendors should only be utilized for members with specialized transportation needs (e.g. wheelchairs, walkers).
- Trac phones and initial phone cards for purposes of safety, contact with the MCO, and service coordinator are permissible. TAF funds may not be used to supplant coverage of phone by publicly funded programs or provided under MCO policy. TAF are to be administered by the MCO. Under no

circumstances can MCOs give cash or cash-equivalent items (such as gift cards or money orders) to Class Members using TAF.

- Other items, that are within the TAF underlying philosophy of supporting the transition of Colbert and Williams Class Members to the community and are not included above can be submitted to HFS for review.

CTI Process for Outreach, Assessment, Transition Service Plan, Transitions

This section outlines the process Care Coordinators must follow in conducting outreach, assessment, transition service planning, and transitions for members under the CTI.

1. Maximus identifies members residing in Cook County State Nursing Facilities (SNFs) or statewide Specialized Mental Health Rehabilitation Facilities (SMHRFs) who may be interested in transitioning to the community. Once identified, Maximus conducts outreach and completes an assessment with the member. After the assessment is finalized, Maximus notifies the MCO through Assessment Pro to initiate next steps in the transition process. Care Coordinator conducts outreach to the member to determine interest in transitioning to the community. For Williams or Colbert Class Members: Care Coordinators must conduct outreach to Colbert and Williams Class Members within ten (10) calendar days of notification. Following the outreach, the care coordinator must review the Maximus Assessment of Findings and any additional documentation, then complete the 1.2 Member Outcome Form with the appropriate disposition. The completed form must be submitted to the UIC-CON within (2) business days of the outreach activity.
2. If the care coordinator determines they are unable to develop a CTI Transition Plan that adequately addresses the member's needs and preferences for community living and/or believes the member may not fully understand the potential risks of transitioning the care coordinator must request a clinical review with UIC-CON and HFS. This request should be documented on the 1.2 Member Outcome Form. In addition, the care coordinator must submit relevant clinical records to support the review.
3. Once all necessary documents are received the UIC-CON will complete an initial Clinical Review Form within ten (10) calendar days. As part of this process, UIC-CON will evaluate the clinical risks and rationale associated with the member's transition and prepare the initial form, which will be shared with the MCO prior to the scheduled clinical review call. The date for the clinical review call will be coordinated between the MCO, UIC-CON, and HFS. After the call is held, UIC-CON will finalize the Clinical Review Form and provide a clinical summary outlining any additional supports or community services the member may need to successfully transition. The finalized form will then be sent to the MCO.
4. Members recommended for transition with Pending Medical or Other Needs that require further stabilization and supports prior to proceeding with transition, the care coordinator must document reasons on the 1.2 Member Outcome Form and provide necessary clinical documentation to UIC-CON for review. Documentation must include a copy of the member's completed assessment, a list of medications and diagnoses, clinical documentation from the Cook County Skilled Nursing Facility or SMHRF and information on the pending medical or other needs and anticipated timeline for transition planning. For members that require skill development, MCOs should assess if these skills can be developed in the community and proceed with transition to community. It is critical that the member's transition to the community is timely and MCOs maintain, in coordination with UIC-CON, that the member is moving through the transition phases to transition.

5. MCOs must inform members and guardians in writing if it is determined that the MCO has determined the individual to be unable to transition to the community. The written determination must include all appeal rights and all appeal forms, as well as easy-to-understand instructions for filing an appeal with the MCO. Also, MCOs need to explain to the member and guardian that Maximus will provide continued follow up. Questions regarding the DHS Comprehensive Class Member Transition Program can be forwarded to ILOA@maximus.com.
6. MCOs must inform members and guardians and issue all Appeal Rights and applicable Appeal Forms for Not Recommended for Transition Assessments to members and guardians. MCOs must have an internal appeal review process and inform members and guardians of the State Fair Hearing process including presentation of the State Fair Hearing Letter.
7. If the member is recommended for transition, the Care Coordinator must promptly work with the member to develop a person-centered Transition Service Plan. The Transition Service Plan must be completed within ninety (90) calendar days of positive outreach as noted on the Maximus Transitional Assessment Summary of Findings. Form 3.1 Transition Service Plan must be submitted to UIC-CON within two (2) business days following completion. The Transition Service Plan must be forwarded to UIC-CON at least 10 calendar days prior to the transition proposed date to allow UIC-CON time to review and provide recommendations.

Transition Service Plan Requirements

Transition Service Plans must: 1) reflect the current status and service needs of the member; 2) reflect the member's housing plan; and 3) provide assurances that the housing plan is appropriate to the member's needs and is of quality standard and 4) identify the community services and supports including employment supports for the member's transition to the community. Updates must be made to the Transition Service Plan as the member's status or needs change.

- The transition of members shall occur as quickly as possible following approval of the Transition Service Plan by UIC-CON. If the member has not transitioned within thirty (30) calendar days after approval of the Transition Service Plan, the Care Coordinator must provide a written update via the 3.1a 30-Day Update form to UIC-CON outlining the reasons for the delay in transition and timeline for transition.

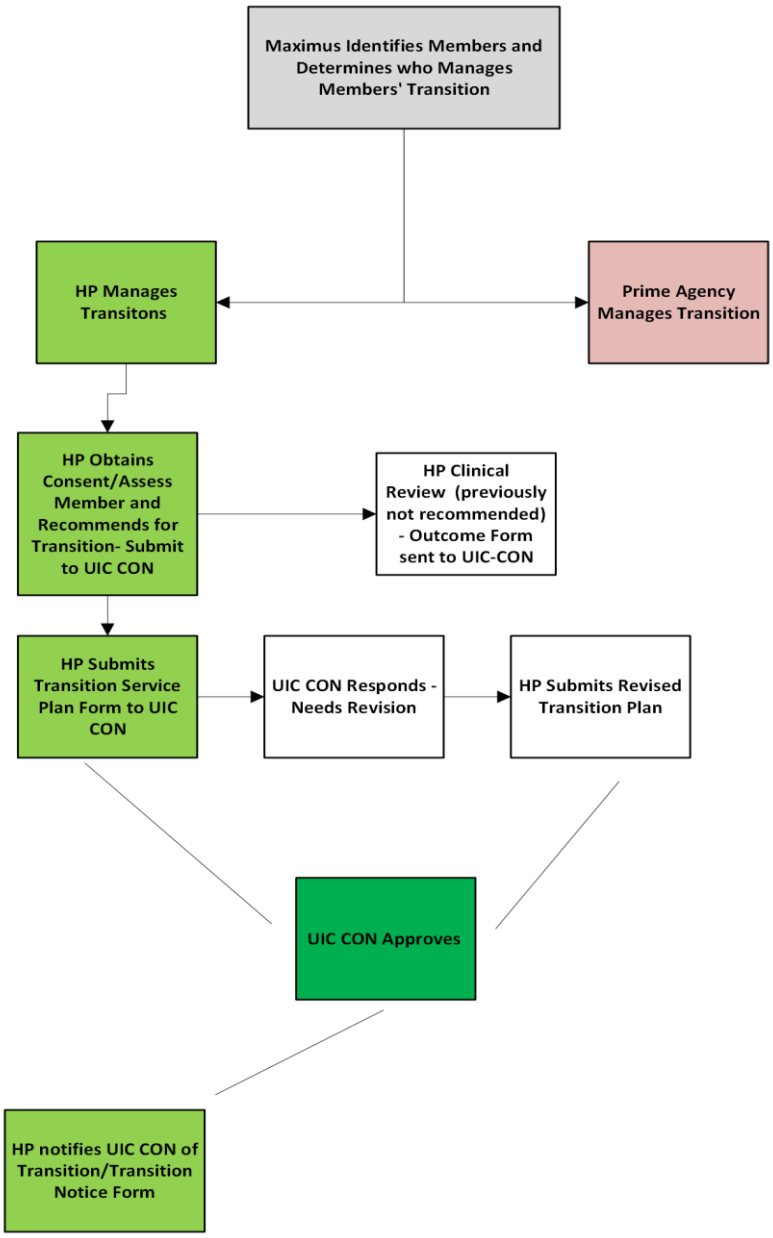
Once a member transitions to the community, the Care Coordinator must complete form 4.1 Transition Notice and submit to UIC-CON within two (2) business days after the member transitions.

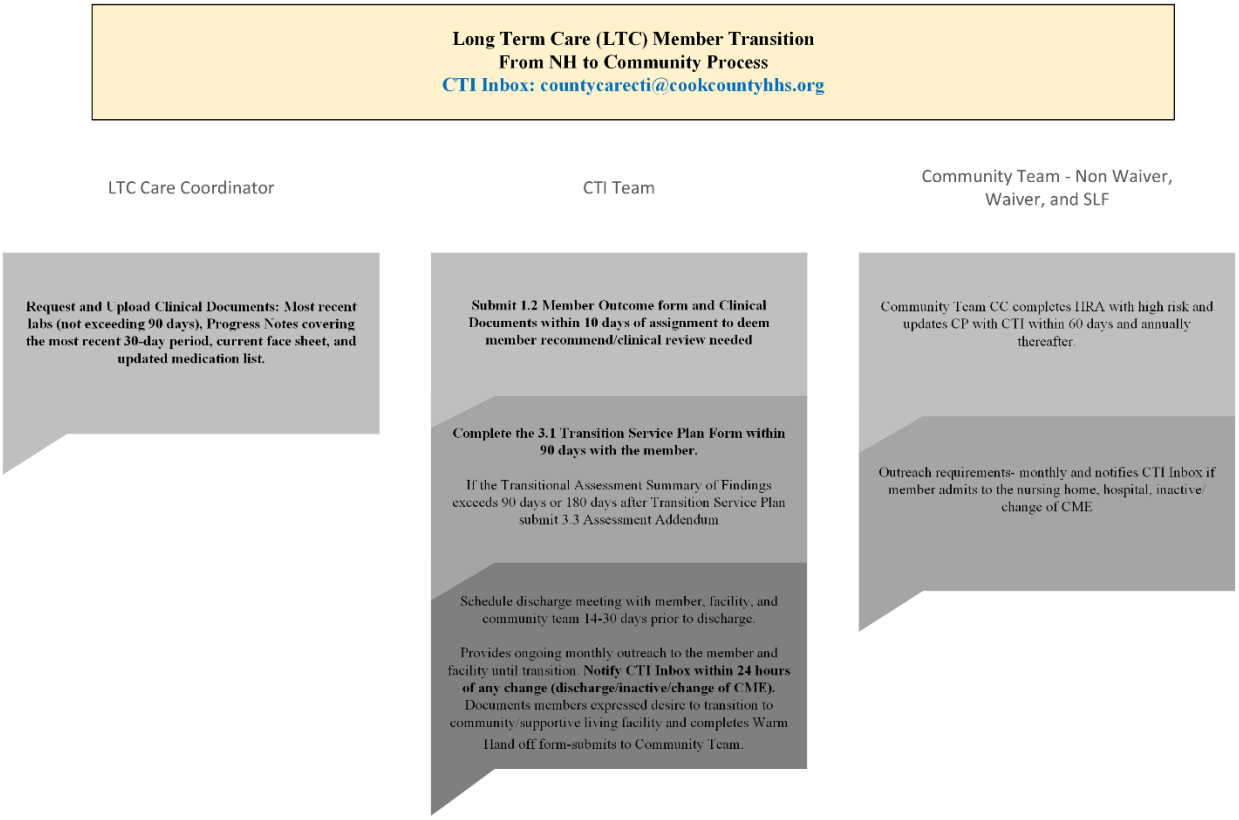
- For Williams and Colbert Class Members. Transition Service Plans must be updated every 180 calendar days if a member still has not transitioned or if there is a change in needs or preferences of the Class Member. If a member has not achieved the skills or the assessed needs necessary for transition at 180 days from the date of the 1.2 Member Outcome Form: **Member has made progress but needs more time**: complete a new 1.2 Member Outcome Form with the new date and Recommended 2 Category checked. A 3.3 Assessment Addendum will suffice in place of the Assessment. **Member have not made progress, and Clinical Review must be completed:** complete a 1.2 Member Outcome Form with a new date and request for clinical review**.** Form 3.1 Transition Service Plan must be completed and submitted to UIC-CON within two (2) business days following any update to a Class Member's Transition Service Plan.

8. Care Management shall comply with any requests for information or reporting from the UIC-CON on its activities related to CTI.

Care Coordinators involved with members participating in Community Transitions Initiative (CTI) follow a process defined HFS/UIC-CON and CountyCare, displayed in the below graphics.

Revised: 7/31/2024, 9/17/25





Successful Community Transition

For a transition to be deemed successful, the member must have successfully transitioned to the community following a Transition Service Plan approved by UIC-CON.

- Enrollee must continuously reside in the community setting for a minimum of six (6) months after the date of transition.
- Transitioned to permanent supportive housing or other appropriate housing arrangement.
- Maintained uninterrupted community tenure. Uninterrupted Community Tenure is defined as follows:
    - The member must not have been admitted to an inpatient or institutional setting for a stay of greater than 30 days per admission.
    - The member must not have spent more than 60 days (across all stays) in an inpatient setting within a six-month timeframe.
- If the member is away from their community placement on the six-month anniversary of transition, then they will not be eligible until they return to community, and then only if both items I and ii were met.

Maintained enrollment with the same MCO.

Created: 5/26/22, *Revised: 9/17/25*

Justice Involve (I) Overview and Transition Plan:

Population Background: Justice Involved (JI) persons are those who have been impacted by the legal system. Arrests and incarceration often destabilize an individual's life, including their health care, housing, employment, and social connectedness; even brief incarceration leads to adverse consequences, including poorer health and behavioral health, loss of employment including future employment opportunities and loss of housing.

The JI members who are coming from and going back to DIA (Disproportionately Impacted Areas) zip codes that face multiple SDOH Social determinants of health challenges may benefit from care management. SDOH are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

CountyCare's Justice Involved (JI) Population are individuals that have completed their Medicaid application at Cook County jail while detained and auto assigned to CountyCare Health Plan following release and reentry into the community as well as those who are new to Medicaid (or have had Medicaid and benefits interrupted once admitted into Cook county jail and completed a new application prior to release). The Justice Involved population face unique challenges to accessing essential services like healthcare. County Care Health recognizes these challenges and is working to provide returning residents the support they deserve to successfully restart their lives.

Pre-Release Engagement:
County Care collaborates with Cermak Health within Cook County Jail to ensure that those being discharged have completed an application for Medicaid. CountyCare completes prospective member engagement to initiate care management prior to release from Cook County Jail; including transition planning and timely and appropriate connections to services.

JI Program Services:
The Justice Involved program offers services to Cook County Jail detainees as they reintegrate back into their communities. County Care looks to identify health care and other basic needs for successful transition to the community. Information collected is used to develop a transition plan that connects the prospective member and members to needed services including mental health, substance use, workforce development, and health care services to assist in improved health outcomes, reduction in emergency department utilization and recidivism.

Timely and appropriate connections to services are critical. With a CountyCare transition of care social worker within Cermak Health the following services are implemented prior to release with the overall goal of connecting members to needed services.

- Identification of prospective member and/or member release date.
- Medicaid application completed.
- CountyCare Health Plan and care management education given prior to release.
- Completion of an individualized transition plan and community referrals

JI Transition Plan:
The goal of the transition plan is to develop a holistic approach that addresses the needs of the population. Its' goal is to reduce the likelihood of re-offending by providing necessary support and resources to facilitate successful reintegration into society. JI transition plan aims to address various aspects of the person's life, including healthcare, housing, employment, education, and social supports. It is a structured and individualized strategy designed to support an individual's reintegration into society. The transition plan includes but not limited to:

- Connect Member to PCP
    - Annual Check-up
    - Healthcare Education
    - Address Health needs.
    - Pharmacy and access to prescription needs

- Address Social Determinant of Health Needs/ Increase access to
    - Housing (Emergency /Transitional/PSH)
    - Transportation to safe location
    - Food
    - Clothing
    - Legal assistance
    - Employment
    - Public entitlements, SSI, etc.
    - Other Community resources

- Connect Members with BH Conditions:
    - Connection to BH Provider (Mental Health and/or Substance Use)
    - Crisis safety plan
    - Pharmacy and access to prescription needs

Care Management Entity Requirements:

CMEs receive a monthly list of JI members via share point and are expected to complete the following activities:

- Contact members and offer care coordination services.
- Complete the *CME JI Monthly Tracker*
- Monitor, assess, and evaluate care management engagement.
- Assess and adjust members risk level as needed.
- Provide community referrals for resources.
    - Educational opportunities, Housing stability, Social Support, Behavioral Health support, Employment Assistance, Legal support, etc.

Management of warm transfers for JI members:

The Social Work Transitional Care Coordinator (SWTCC) will continue engagement and providing services to the JI members for two weeks post release assisting with all Medical, Behavioral Health (BH) and Social Determinants of Health (SDOH) needs. A referral will be made to the assigned CME. The referral will include initiating a warm handoff for moderate and high-risk members to the assigned CME. The SWTCC will document care coordination activities provided to the member in CMIS and provide a copy of the Transition Plan and any additional relevant documents to the assigned CME.

Created: 12/28/2023

Care Management System Requirements

Case Management Systems provide the means for documenting care management activity. CME Case Management Systems are required to meet minimum standards to comply with NCQA requirements and to demonstrate documentation of required care management activity. CME Case Management System minimum requirements:

- Automatic recording of staff identification and the date and time of the action on the case or when interaction with the member occurred.
- Automated prompts for follow-up, as required by the care management plan.
- Determination of member's care management status.
- Documentation of ICT members
- Documentation of IPoC shared with:
    - Member
    - Provider
    - Other members of ICT
- Provider function
- Documentation of Provider notification when HRS/A is not completed within 60 days of enrollment function.
- CMEs are required to provide to members of CountyCare Health Plan's clinical and vendor oversight staff, at minimum, read-only access to the CM System.

Contact Standards and Documentation

Contact Standards for Non-(M)LTSS Members

Care coordinators providing services to non-(M)LTSS members are required to maintain contact with members as follows unless they explicitly opt-out of Care Management or care coordination services or are determined to meet the standard for "unable to reach." The contact standards listed below are described as minimum frequencies of contact. CountyCare expects that in general, it is necessary to maintain more frequent contact with members enrolled in the CM Program to help members achieve their goals and decrease risk. In addition, more frequent contact is needed during episodes of intense engagement with health care providers, such as a new diagnosis or hospitalization, or episodes of high need for members such as eviction or family crisis. Regardless of CM Program enrollment, the Department expects Care Coordinators to maintain contact standards as outlined below.

Level 2* and 3 members each have contact cadence requirements, Level 3 every 30 days; and Level 2 every 90 days resulting in a successful call contact. A successful call contact requires actually speaking with member or their legal health care representative reflecting that within the narrative of the note. This is based on the acuity status, not enrollment in Care Management, only exception is if member has explicitly opted out.

High risk members are required to receive a face-to-face contact every six months (180 days) with their care coordinator or a member of their ICT; preferably their assigned care manager.

Documentation of member contact, assessment, care planning event will be documented in the applicable case management application within 24- 48 hours of event. This is hours, not days, no exclusion for weekends or holidays. If there are extraordinary circumstances preventing meeting this standard, please note

specifically reason in professional manner, cause of this occurrence. Examples could be unexpected system down time, clinic business, etc.

Timing of documentation, please include date and time of actual interaction, intervention or contact if it differs from the electronic time stamp on file. This always applies to creating a notation at the 24 to 48 hours span.

Transition to a home and community- based service, or custodial in a nursing home.

Benefits that align with home and community services, such as application for waiver, Aging, Disability, Brain Injury, HIV or Supportive Living Facility, require involvement by an external State entity's assessment to deem member eligible for program. This eligibility is determined by State Entity, then communicated formally to the respective Manage Care Organization. During this determination and notification period the member remains active with the current CME team. Once the formal notification if provided to County Care Health Plan, the member will transition care management teams to our internal HP team. This can be a lengthy process, from days to months during which the CME assignment remains in place until formal notification is provided via State's determination entity.

Standards for (M)LTSS HCBS Waiver or LTC Members

Care coordinators providing services to (M)LTSS HCBS waiver members or LTC members are required to maintain contact with members as follows:

- Persons who are Elderly Waiver: a face-to-face contact with the member at least once every 90 days
- Persons with Brain Injury Waiver: contact with the member at least once per month and a face-to-face contact at least once every 2 months
- Persons with HIV/AIDS Waiver: contact the member at least once per month and a face-to-face contact at least once every 2 months.
- Persons with Disabilities Waiver: a face-to-face contact with the member at least every 90 days in the member's home
- Persons in a Supportive Living Facility (SLF) Waiver: face to face contact with the member at least once every 6 months
- Members in LTC: Care Management contact every 90 days for high-risk members (telephonic or face-to-face). Annual face-to-face contact for all members. If the member is stratified as high risk, face-to-face contact is required at least once every 6 months.

CountyCare has set certain face-to-face and contact requirements listed above the minimum requirement in the MCCN contract to better ensure the health, safety, and welfare of (M)LTSS members.

Last revised: 10/30/2017, 2/23/2018, 6/29/2018, 8/22/2018, 4/21/2019, 5/31/2019, 7/11/2019, 1/16/2020, 5/22/2020, 1/24/2022, 8/30/2023, 9/17/25, 02/17/2026

Contact with Waiver (HCBS) Providers – (M)LTSS

Notification to Begin Services

Following development of the service plan and member's selection of the provider(s) to deliver the services, the CME will notify the provider that the member has selected them, confirm their capacity to accept the case and notify them of the date they can begin delivering services. The CME sends the individualized plan of

care and service plan to the provider. The provider notification date must be documented in the member record.

Confirm Start Date

Within 10 days of notifying the provider(s) to begin services, the CME must follow-up with the HCBS provider(s) and confirm the date each provider started delivering services to the member. The start date(s) must be documented in the member record.

Sending Care Plan (IPoC)/Service Plan Reassessments and Updates

At each required reassessment – every 6 months for BI and HIV; every twelve (12) months for PWD, Elderly, and SLF – the CME will send the reassessed care plan (IPoC)/service plan to the provider(s). As reassessments are completed due to a significant change in the member's condition or at the member's request or any other reason, the CME will send the updated care plan (IPoC)/service plan to the individuals and provider(s) responsible for its implementation.

Service Validation

Prior to a scheduled contact with a HCBS waiver member, the care coordinator is expected to review the claims submitted by the waiver provider and/or the IP/PA vouchers and compare to the service plan to ensure consistency. In the absence or delay of provider claims, contact with the provider to establish the monthly units/hours provided to the member since the last visit/validation, is required. A review of the HCBS Member Communication Forms exchanged since the last member contact, should also occur. Any discrepancies in the service type, the HCBS provider indicated on the service plan, or the hours/units being provided to the member above or below the approved hours (equivalent to 10% of the monthly service plan hours), requires follow-up and should be addressed with the providers involved. A documented explanation for gaps in service (going under what was approved) or hours/units that exceed what was approved, equivalent to 10% of the monthly service plan hours, and not already accounted for via an HCBS Communication Form, is required. The service validation conducted with the provider should be documented in the member record.

Individual Provider/Personal Assistant Voucher Calculation

Add the total amount paid to the IP/PA each month, typically 2 payments. Divide the total amount by the hourly rate. For overtime payments, divide by 1.5 times the hourly rate. Add together to get the number of hours paid. Compare the number of hours paid to the service plan hours as described above.

Provider Agency Claims Calculation

Add the units submitted by the provider each month to get the total monthly units. Compare the monthly units submitted by the provider to the monthly units authorized on the service plan as described above. Every service type noted on the service plan must be validated, not just homemaker and PA.

(Homemaker service: 1 hour=4 units; EHRS: 1 unit=1mo of service; HDM: 1 unit=1meal; ADS: 1hr=4units).

Provider Communication

Notification and documented communication are required to take place with waiver providers in the following situations:

- When a member's contact information changes, such as their address or phone number.

- When a member elects to switch providers, the former provider must receive documented notification of their end date. In the case of an individual provider (IP), the service plan for that IP must be zeroed out.
- When a particular service is being ended/removed from the service plan the provider must receive documented notification of the end date. In the case of an IP, the service plan for that IP must be zeroed out.
- When a member's services need to be placed on hold for any reason, including member being out of the home/community for a period or waiver is pending closure.
- When the member returns to home/community and services should be resumed
- When a member disenrolls from the Health Plan, switching plans or returning to fee-for-service.

Last revised: 2/25/2018, 10/04/2018

Health, Safety, Welfare, Reporting and Follow-up of Incidents – Care Management Responsibilities

A critical incident is defined as any incident that: involves abuse, neglect, or exploitation of a member, or is an incident that puts the member or a member's services at risk including those that do not rise to the level of abuse, neglect or exploitation; this includes events that may cause substantial or serious harm to the physical or mental health of a member or the safety of a member's services. Additionally, events that are required to be reported for members in home and community-based waiver services in compliance with the Elder Abuse and Neglect Act (320 ILCS20/1 et seq.) and incidents required to be reported for residents of supported living facilities, nursing homes and group homes are incidents (see the Health, Safety, Welfare, Reporting and Follow-up of Incidents Reporting form). Critical Incident training is a requirement upon hire and annually. Record of participants will be recorded and maintained on file.

Beyond reporting, care coordinators and supervisors have specific responsibilities as part of identifying and resolving incidents.

- The care coordinator implements immediate interventions to ensure member safety.
- The care coordinator notifies and collaborates with a manager from their CME upon becoming aware of a critical incident.
- The care coordinator reports suspected abuse, neglect, and exploitation to the appropriate state agency and/or investigating authority immediately upon becoming aware of the incident. (See CountyCare Critical Incident Reporting form for a list of state agencies that receive reports.)
- The CountyCare Critical Incident Reporting Form must be completed and submitted to CountyCare the same day; the report must include complete and clear information about the incident and the actions taken to comply with mandating reporting and ensuring the safety of the member.
- CountyCare will send a Health, Safety, Welfare, Reporting and Follow-up of Incidents Required Follow-up Action form to a designated manager within the CME(s). The care coordinator and/or manager is required to complete the CountyCare Health, Safety, Welfare, Reporting and Follow-up of Incidents Required Follow-up Action form within five (5) business days, or earlier as noted. Actions taken should include all those recommended by CountyCare and may include any other actions that support the member toward health, safety, and welfare. All actions should be documented with dates and times in the Follow-up Action Form as well as the Care Management record.

- The care coordinator establishes direct contact with an investigator or other representative of any state agency/investigative authority to which the incident was reported and comply with directions provided by or decisions made by investigating authority within the timeframe given. The care coordinator must make at least two attempts to establish direct contact with the state agency/investigative authority.
- The care coordinator conducts a face-to-face visit with the member because of the incident and to implement incident follow-up.
- The care coordinator educates the member on abuse, neglect, and exploitation (and other education as applicable to the incident) and documents this education in the Follow-up Action Form as well as the Care Management record.
- The care coordinator updates the health risk assessment, the IPoC and the waiver service plan (if applicable) to address the change in condition and measures to ensure the member's safety and prevention of future incidents. For members not already enrolled in care management, the care coordinator initiates CM enrollment by completing a health risk assessment, IPoC and waiver service plan (if applicable).
- If the member cannot be reached after completing member contact attempts as specified in the Outreach and Engagement section of this manual, the CME leader must notify the CountyCare Population Health and Performance Improvement Department to determine if further action is required.
- The care coordinator takes actions to assure ongoing health, welfare, and safety of the member after an incident and documents those actions. Contact with the member should occur every two weeks until the incident has a resolution. Actions may include, but are not limited to community resource referrals, behavioral health consultation or services, crisis, or safety planning, medication reconciliation, police reporting, communication with provider, establishing guardianship or power of attorney, and others.
- Care coordinators or supervisors are expected to continue direct communication about the incident and its follow-up with designated State agencies. In addition, Care Coordinators or leaders are expected to update the membership of the Interdisciplinary Care Team (ICT) and communicate with and coordinate the ICT and other entities involved, including but not limited to hospitals and community agencies.
- Following the closure of an incident, care coordinators are expected to maintain appropriate contact with members and engage the member in care management to maintain the member's health, safety, and welfare. At minimum, the care coordinator contacts the member and updates the member's IPoC monthly for three (3) months to identify needs and, as appropriate, take action to support the member to prevent future incidents.
- If member transitions from one CME to another while an incident is open or three (3) months after its closure, the original CMEs are required to transfer all relevant information and documents related to the incident to the new CME. A warm handoff will ensure timely follow through of the incident process (see *Transitions across Care Management Entities* section for more information).
- All care coordination staff are required to undergo Health, Safety, Welfare, Reporting and Follow-up of Incidents training on an annual basis. This training may be provided by CountyCare staff or the CME.

Revised: 8/28/25

Health, Safety Welfare, Reporting and Follow-up of Incidents and Coordination with Adult Protective Services (APS)

For incidents involving reporting to Adult Protective Services the following applies:

A. Substantiated Cases **WITH CONSENT for APS Casework Services**

1. **Within 20 calendar days of receiving the ROS**, the Care Coordinator will outreach the APS Caseworker to ensure the Care Plan meets the needs of the member. Information that should be shared during this consultation are:
    a. The Plan of Care Notification
    b. The Determination of Need assessment

2. The Care Coordinator is recommended to review all claims, prior authorization requests, and pharmacy activity to ascertain if there have been services or products that have been denied, delayed, in process, or provided to the **member.** In this review, if there are any claims, requests, or pharmacy activities that would aid the APS Case Plan.

3. If the member is a DHS/DRS client, the Care Coordinator will review WebCM to review communication between DHS/DRS and the members to ascertain if there has been any gap in services or care, or if there have been any issues/concerns that have been documented.

4. **Within 20 calendar days**, the Care Coordinator outreaches member to follow up on the APS report. During this follow-up outreach, the Care Coordinator will review the current Care Plan and, if applicable, the Waiver Service Plan to assess if there are any changes that need to be added or modified. Questions could include:
    a. Is the member a current waiver recipient? If not, could they benefit from Waiver services?
    b. Has there been a referral for waiver services previously submitted?
    c. Does the member need additional community resources such as food pantry information or money management?
    d. Does the member need any medical follow-up or assistance in making appointments?

5. The Care Coordinator documents the services put in place (could be done through the Plan of Care) to remediate and/or mitigate the root cause(s) of the APS report.
6. If there is an open APS case, the Care Coordinator will share the updated Care Plan with the APSCW **within 5 business days of it being updated.**

7. With consented APS Casework Services, CountyCare will consider placing these members at a Moderate or High-Risk Level (depending on current Risk Level) and f**ollow-up for a period of at least 90 days.**

    a. Following member for 90 days demonstrates that CountyCare has done due diligence in assuring that the member does not need additional service(s) or assistance.

    b. If member is **unable to be contacted**, the Care Coordinator **will make 3 outreach attempts at 3 different times on 3 different days within a 1-month period for each of month through the 3 months at minimum.**

    c. **After 90 days, if the member continues to be unable to contact**, the Care Coordinator shall reach out to the APSCW to inform APS the member has not been contacted, document accordingly care coordination system and follow the HCBS waiver policy if the waiver is active. If the waiver is not active, CountyCare will follow required procedures for closing out of a case.

B. Substantiated Cases **WITHOUT CONSENT for APS Casework Services**

1. **Within 5 calendar days of receiving the ROS**, the Care Coordinator will reach out to the APS Caseworker to ensure the Care Plan meets needs of the member.

2. **Within 5 calendar days**, the Care Coordinator will outreach to the member. During this follow-up outreach, the Care Coordinator will review the current Care Plan and, if applicable, the Waiver Service Plan to assess if there are any changes that need to be added or modified. Questions could include:
    a. Is member a current waiver recipient? If not, could they benefit from Waiver services?
    b. Does this member have waiver services?
    c. Has there been a referral for waiver services already submitted?
    d. Does the member need additional community resources such as food pantry information or money management?
    e. Does the member need any medical follow-up or assistance in making appointments?

3. The Care Coordinator is recommended to review all claims, prior authorization requests, and pharmacy activity to ascertain if there have been services or products that have been denied, delayed, in process, or provided to the **member.**
    a. If the member is a DHS/DRS client, the Care Coordinator shall also review WebCM to review communication between DHS/DRS and the **member** to ascertain if there has been any gap in services or care, or if there have been any issues/concerns that have been documented.

    b. The Care Coordinator will document the services put in place (could be done through the Plan of Care) to remediate and/or mitigate the root cause(s) of the APS report.

    c. As the member has not consented to APS Casework services, if member is currently classified as a Low-Risk, Care Coordinator will assess for member to be moved to at least a Moderate-Risk Level. If the member is currently a Moderate-Risk Level, Care Coordinator will assess for member to be moved to a High-Risk Level. If member is currently a High-Risk Level, Care Coordinator will assess for member to be moved to an Imminent-Risk Level. These level changes are assessed to occur for **period of at least 90 days.**

i. Following member for 90 days demonstrates that CountyCare has done due diligence in assuring that the member does not need additional service(s) or assistance.

ii. If a member is **unable to be contacted**, the Care Coordinator shall make **3 outreach attempts at 3 different times on 3 different days within a 1-month period for each of month through the 3 months at minimum.**

iii. **After 90 days**, if the **member continues to be unable to contact,** the Care Coordinator will document accordingly in care coordination system and follow the HCBS waiver policy if the waiver is active. If the waiver is not active, the Care Coordinator will follow the required procedures for closing out of a case.

D. Substantiated Cases **WITHOUT CONSENT for APS Investigation**

1. **Within 5 calendar days of receiving the ROS,** the Care Coordinator will reach out to the APS Caseworker for any insight to see if the Care Plan is adequate to meet the needs of the member.

2. **Within 5 calendar days of receiving the ROS**, the Care Coordinator will outreach to the member During this follow-up outreach, the Care Coordinator will review the current Plan of Care and, if applicable, the Waiver Service Plan to assess if there are any changes that need to be added or modified. Questions could include:

    a. Is the member a current waiver recipient? If not, could they benefit from Waiver services?

    b. Does this member have waiver services?

    c. Has there been a referral for waiver services already submitted?

    d. Does the member need additional community resources such as food pantry information or money management?

    e. Does the member need any medical follow-up or assistance in making appointments?

3. The Care Coordinator will review all claims, prior authorization requests, and pharmacy activity to ascertain if there have been services or products that have been denied, delayed, in process, or provided to the member.

4. If the member is a DHS/DRS client, the Care Coordinator will also review WebCM to review communication between DHS/DRS and the member to ascertain if there has been any gap in services or care, or if there have been any issues/concerns that have been documented.

5. The Care Coordinator will document the services put in place (could be done through the Plan of Care) to remediate and/or mitigate the root cause(s) of the APS report.

6. As the member has not consented to the APS Investigation, if the member is currently classified as a Low-Risk, Care Coordinator will assess for member to be moved to at least a Moderate-Risk Level. If

the member is currently a Moderate-Risk Level, Care Coordinator will assess for member to be moved to a High-Risk Level. If member is currently a High-Risk Level, Care Coordinator will assess for member to be moved to an Imminent-Risk Level. These level changes will be assessed for suggested to recurrence for **period of at least 90 days.**

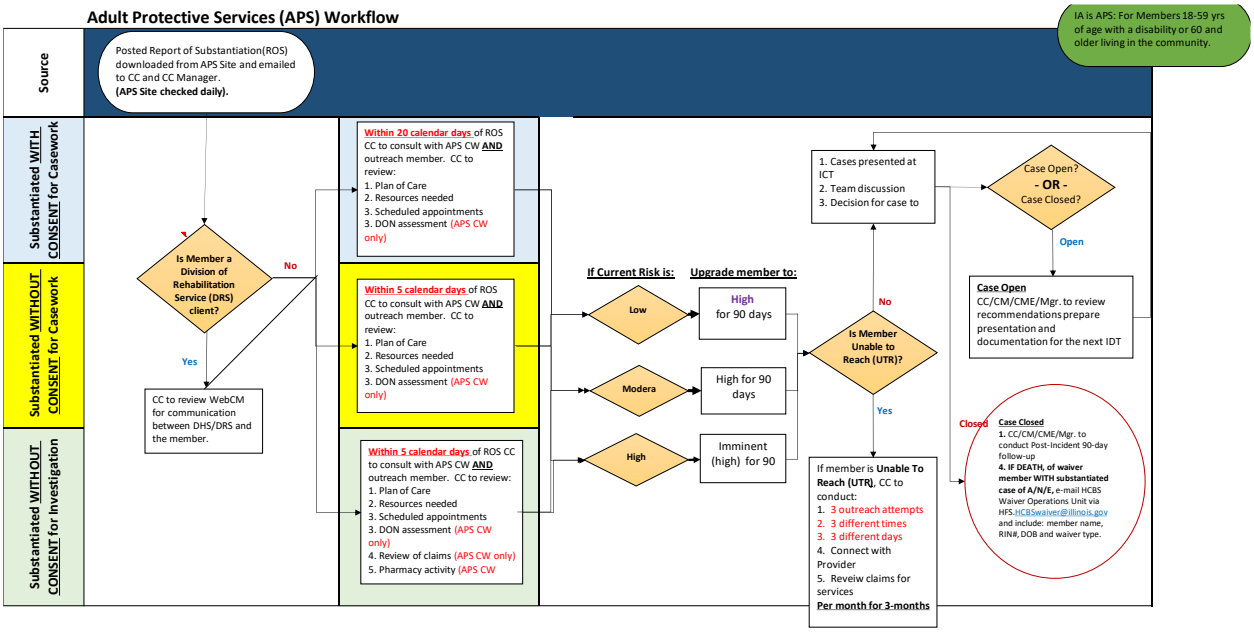
a. Following member for 90 days demonstrate due diligence in assuring that the **member** does not need additional service(s) or assistance.

b. If a member is **unable to be contacted,** the Care Coordinator shall make **3 outreach attempts at 3 different times on 3 different days within a 1-month period for each of month through the 3 months at minimum.**

c. **After 90 days, if member continues to be unable to contact**, the Care Coordinator will document accordingly in care coordination system and follow the HCBS waiver policy if the waiver is active. If the waiver is not active, the Care Coordinator will follow the required procedures for closing out of a case.

E. APS **Fatality Notification**

1. If Care Coordinator learns of a fatality involving an APS client, the Care Coordinator will notify the APSCW of the fatality **within 24 hours** of knowledge of the fatality.



Created: 04/13/2018, Last revised: 10/04/2018, 5/31/2019, 7/11/2019, 8/21/2019, 5/22/2020, 1/24/2022, 8/30/2023

Demographic Changes and Other Demographic Reporting

CountyCare members are required to report any demographic changes to the Illinois Department of Human Services (DHS).

- Members are required to report any new address if they intend to reside at the new address for 90 days or longer.

Care coordinators are expected to:

- Assist members with submitting any change of address or phone number to DHS:
    - Option 1: Submit the change electronically to the Application Assistance Call Center
        - Submit via email to: mailto:callcentermailroom@cookcountyhhs.org
    - Option 2: Report the demographic change online.
        - Assist member in creating an ABE "Manage My Case" account: https://abe.illinois.gov/abe/access/accessController?id=0.8049238354060066

If the care coordinator is aware of a demographic change and the member is unable or unwilling to report this information directly, the care coordinator should verify the demographic information with the member's listed contacts. Demographic changes cannot be reported to DHS until the member, or their listed contact has verbally confirmed that the information is valid.

Other Insurance

CountyCare members are required to report any additional medical insurance coverage to DHS.

Care coordinators are expected to:

- Assist member with submitting any additional insurance coverage member reports.
    - Option 1: Submit the change electronically to the Application Assistance Call Center
        - Submit via email to: callcentermailroom@cookcountyhhs.orgmailto:callcenterquestions@cookcountyhhs.org
    - Option 2: Report the insurance coverage online.
        - Assist member in creating an ABE "Manage My Case" account: https://abe.illinois.gov/abe/access/accessController?id=0.8049238354060066

Member Death

CountyCare is required to notify DHS of all member deaths.

Care coordinators are expected to notify CountyCare of the member's death:

When Care Coordinator/Care Manager is notified of the death of a member, the CC will complete online Death Notification form and upload acceptable documentation of member's death to SharePoint.

- Acceptable documentation of death notification includes:
    1. Death Certificate
    2. Obituary
    3. Notification directly from a Long-Term Care (**LTC**) or Supportive Living Facility Provider (**SLF**).
    4. Admission, Discharge, Transfer (**Point Click Care**) Report with member's name and date of death.
    5. Illinois Department of Aging (**IDOA**) Database.
    6. Illinois Department of Rehabilitation Services (**DORS**) Database.

Care Coordinators are to instruct family members to notify the Department of Human Services local office or caseworker to report the death of a Medicaid client. CME Management is expected to track deceased member cases until the Medicaid case is terminated.

See Death Notification Submission Workflow

Location: Care Coordination – CountyCare Health Plan

: .

Created: 10/04/2018. Revised: 5/31/2019, 1/24/2022, 3/8/2023, 1/31/25; 7/31/25; 12/15/25

Department of Children and Family Services (DCFS) – Coordinating with DCFS and Specific Care Management Requirements

Background and Overview

As of 9/1/2020, all Department of Children and Family Services (DCFS) Youth in Care (YIC), including Former Youth in Care (FYIC), Children of the Ward, and Youth at Risk, transitioned to the Youth in Care Program. The following sections highlight the roles and responsibilities Care Coordinators must follow when managing the care for DCFS-involved, or formerly involved, children and youth.

CME Assignment

Any CME may be assigned Former Youth in Care or Youth at Risk DCFS members. The remaining categories, Youth in Care and Children of the Ward, will be assigned to the Health Plan for Care Management services. If a Youth in Care or Child of the Ward is assigned to a CME other than the CountyCare Health Plan, this issue should be escalated immediately, following the escalation process described above. The DCFS Case Worker, identified in the Care Giver File, must be added to the communication. CountyCare has a standard escalation process. A contact tree is listed on the Care Coordinator Resources section of the CountyCare, Care Coordination webpage (http://www.countycare.com/carecoordination), on a document titled "Who to Contact at the CME."

Care Management Requirements for DCFS-Involved Children and Youth

Care Coordinators are required to collaborate with DCFS to support Youth at Risk, Former Youth in Care, or any child who is a part of DCFS's Intact Family Services, a relatively intense short-term, in-home, community-based intervention program [6–9 months] that works with families who have been identified by DCFS as at risk for foster care placement.

When the CME is notified that one of their assigned members has been identified as a Youth at Risk, Care Coordinators will incorporate this information into a re-assessment of the member's risk and need, involve DCFS case workers into the member's interdisciplinary care team (ICT), and act as a liaison between DCFS, the health providers, and CountyCare leadership and staff.

Caregiver Files for Former Youth in Care

CMEs need to provide Care Coordinators with information from the Caregiver file to verify the case or caregivers as authorized representatives, or responsible persons, for these members. FYIC are listed as the head of the case in the Illinois Eligibility System (IES). Therefore, CMEs will not see usual information about who is legally connected to or authorized to speak on behalf of the FYIC.

A majority of FYIC will have caregivers who want to speak and make decisions on their behalf. CMEs need to accept adoption or guardianship papers, or any legal documentation that shows their custody, to be submitted for the individual entitled to speak on the youth's behalf. Health plans, and their vendors, should make it as easy as possible for the Caregiver of a FYIC to submit documentation and make decisions on behalf of the youth.

Health Plan Care Management Requirements for Youth in Care and Children of the Ward

Caregiver Files for Youth in Care and Children of the Ward

HFS is currently sharing case/caregiver information via a daily Caregiver File with CountyCare. Each CME will be sent their portion of that Caregiver file daily if they have DCFS membership. Because each CME may manage Former Youth in Care or Youth at Risk DCFS members, it is essential that each CME receive and utilize the Caregiver File.

Youth in Care members have a Caregiver and therefore have a Caregiver File. Contact should *ONLY* be with the listed Caregiver. Caregivers can change frequently, so it is important to always check the Caregiver File prior to proceeding with all contact attempts. The file includes the following information:

- Youth/Member Information including ID number, first and last name, birthdate, sex, race, and ethnicity of the DCFS-involved youth receiving benefits.
- Current case information including open date and reason code.
- Current caregiver information including provider ID, if applicable, first, and last name, address, telephone number and location code if the caregiver is a facility instead of an individual caretaker.
- Case Manager information including first and last name, ID number, telephone number, and email address.
- Case Manager Supervisor information including first and last name, ID number, telephone number and email address.

The file is shared by HFS daily via a daily caregiver file. Details on the contents of this file are below:

- Includes Youth in Care, Former Youth in Care, and Children of the Ward
- Other pertinent fields include OBRA Type Code, OBRA Beginning and End Date, Language Code, Spanish Indicator, DCFS Living Arrangement Mailing Category Code, Home, or Facility Indicator

Psychotropic Medications for Youth in Care

All current YIC require a DCFS prior consent for all psychotropic medications. Without an approved consent, newly prescribed psychotropic medications for DCFS YIC will be rejected at the pharmacy. Prior consent forms are filled out by the YIC's doctor and sent to the University of Illinois at Chicago (UIC) Department of Clinical Services in Psychopharmacology by fax at 312-814-7015.

Significant Event Reporting for Youth in Care and Former Youth in Care

Per DCFS rule 331, specific events that occur for DCFS Youth in Care require specific reporting. This applies to YIC, and anyone aware of a Significant Event for these members should report immediately. The person making the report should determine the nature and type of Significant Event, contact the appropriate DCFS individuals based on the nature of the event, and complete a Health, Safety, Welfare, Reporting and Follow-up of Incidents Reporting form and forward to countycarequalityofcare@cookcountyhhs.org.

Significant events are serious, sometimes traumatic occurrences that affect children and youth served by DCFS, are subject to mandatory reporting requirements, and are described in additional detail in DCFS Procedure 331. Significant events can include abuse, neglect, or exploitation, or any incident that has the potential to place a CountyCare member, or the member's services at risk, but which does not rise to the level of abuse, neglect, or exploitation. Abuse can include physical, sexual, or emotional harm or injury to the member. Neglect is the failure to provide or willfully withhold the necessities of life from the member such as food, clothing, shelter, or medical care. Exploitation is the use of the member's financial resources without consent or the

withholding of such resources to the profit or advantage of the other individual. Events that do not rise to the level of abuse, neglect, or exploitation could include, but is not limited to, suicide attempts, serious transportation events, or assault by member of a caregiver/provider.

The only time that a significant event needs to be reported for FYIC is if the child/youth for whom DCFS was legally responsible dies ***within 1-year*** of discharge from guardianship or custody of DCFS. In this case, the event must be reported immediately. The Case Worker is the primary contact. If the Case Worker is unavailable the Case Worker's supervisor should be contacted. If the Case Worker's supervisor is unavailable, leave a message with another staff person ***AND*** contact the DCFS Advocacy Office at 1-800-232-3798. Finally, complete the Health, Safety, Welfare, Reporting and Follow-up of Incidents Reporting form and forward to countycarequalityofcare@cookcountyhhs.org.

Children's Behavioral Health Requirements for Youth in Care

Care Coordinators are expected to follow the same behavioral health requirements for Youth in Care and Children of the Ward as children who are not DCFS-involved, with the addition that the DCFS Case Worker must be included in all communications to the member, including in Integrated Care Teams, for all YIC members stratified as level 3 (high-risk) and level 2 (moderate-risk).

Additional Care Management Responsibilities for members who are identified as a DCFS Youth in Care:

- In the event that DCFS notifies the Health Plan that DCFS is not in agreement with the risk level determination made by Contractor for a DCFS Youth in Care Enrollee, Care Coordinators are responsible for notifying their manager. The Health Plan will work collaboratively with the Department and DCFS to resolve the disagreement and ensure that the best interest and needs of the DCFS Youth in Care Enrollee are met. Care Coordinators should complete the following steps:
    - Care Coordinator completes HRS/HRA, and risk stratifies the member.
    - Care Coordinator convenes an ICT meeting with ICT members, including DCFS Case Worker, to discuss member's assigned risk level and plan of care.
    - Care Coordinator updates the care plan and risk level as needed.

- Care Coordinators are responsible for supporting an ICT for all DCFS Youth in Care members stratified as Level 3 (high-risk) and Level 2 (moderate risk). Additional Care Coordination responsibilities for supporting an ICT for DCFS Youth in Cares Members include:
    - Collaborate with the DCFS Caseworker to ensure that the ICT is coordinated with all DCFS team-based decision-making processes, such as Child and Family Team meetings.
    - Participate, as needed, in the DCFS team-based decision-making process.
    - Update IPoC as necessary with information or decisions made during a DCFS team-based decision-making process.

- Care Coordinators are responsible for developing an IPoC for all DCFS Youth in Care Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate risk). Care Coordinators are responsible for including information from DCFS as available. The IPoC shall be coordinated and consistent with the DCFS Service Plan as follows, given that DCFS provides this information to Contractor:
    - The IPOC shall include all goals and services that are necessary to support the Permanency Goal established in the DCFS Service Plan, given that DCFS provides this information to the care coordinator.

- Information from the DCFS Service Plan will be incorporated into the IPoC as available.
- Care Coordinators shall notify the DCFS Caseworker within two (2) Business Days when the IPoC is updated. Care Coordinators are expected to send DCFS Caseworker updated IPoC, even though IPoCs are available through the Enrollee portal.
- Care Coordinators shall verify information is made only with Authorized Representatives and that consents, and releases are in the member record as needed.

- Care Coordinators assigned to DCFS Youth in Care Enrollees shall be familiar with DCFS-required assessments for DCFS Youth in Care and the DCFS team-based decision-making process. It is the responsibility of the CME to ensure that Care Coordinators assigned to YIC have, or receive, the proper trainings outlined in the "Training and Qualification Requirements for Care Coordinators Working with DCFS Youth in Care" section of the manual.

Created: 04/19/2018, Revised 4/7/2020, 5/22/2020, 12/2/2020, 3/2/2021

Eligibility for Care Management)

Eligibility for the Care Management Program (is primarily driven by the member risk level that is determined during a health risk screen, a health risk assessment, or by predictive modeling score.

The following populations must be offered care management:

- Level 2 and Level 3 (high risk) FHP/ACA/ICP members
- Dual-eligible adult members enrolled in the managed long-term services and supports (MLTSS) program.
- Members who are pregnant
- Members in a nursing facility for any length of time including members in long-term care (LTC)
- Members receiving home and community-based services (HCBS)*
- YIC
- Members who have been referred for or have received a transplant.
- Children and adolescents who have been hospitalized for behavioral health.
- Super utilizers of health care (see High Utilizer section)

The philosophy driving eligibility for the CM Program is that the program provides a structured set of services provided by health professionals aimed at helping members achieve their goals and decrease health risk. Regardless of risk level or special category, Care Coordinators should identify members who have diagnosis or health status that would be improved by participation in the CM Program. In addition, any member who request Care Management may be enrolled. CountyCare may designate additional criteria for eligibility for care management.

*Participation in the Care Management Program is required for members receiving HCBS. Members who do not participate will be disenrolled from HCBS.

Created: 09/28/2017; Revised 2/19/2018; Revised 1/16/2020: Revised 5/29/20, 8/30/2023

Enrollment and Disenrollment in Care Management

Enrollment and Disenrollment

The CM Program requires substantial resources and is designed for a subset of high risk or high need members willing to participate in the structure program. The CM Program is designed to be a finite program with a distinct start and end date. The duration of the program should be individualized to support the needs and goals of the members, but in most cases should have a target end date or goal for when the program will end, and the member will disenroll. This promotes active work toward achieving goals and supporting members toward self-management. Because of the substantial resources required, the CM Program at any given time may have a maximum capacity and resources should be prioritized for those with highest need; therefore, Care Coordinator must evaluate target end dates for enrollees regularly to open access to the program for new potential enrollees whose needs change and would also benefit from the program. CMEs must document enrollment status in the care management program. Members' eligibility in the Care Management Program begins after completion of the comprehensive health risk assessment and upon initiating an IPoC. Care coordinators must document the enrollment date and ensure that members sign the IPoC. Members enrolled in the Care Management Program must display as having the "active" enrollment status in their care management system with an enrollment date. CMEs are required to submit this member level data monthly in the State Reports file layout.

Members may "opt-out" from care management voluntarily. The action of opting out must be clearly documented in the care management system.

Members may disenroll or be discharged from the CM Program when their condition and circumstances improve such that a structured program is no longer warranted. The reason for disenrollment or discharge must be clearly documented in the care management system. The Care Coordinator must document that the member has disenrolled from the Care Management Program (either by unchecking "enrolled" or switching status to "disenrolled" with the reason that supports the status change).

Care Management Program Participation for HCBS Members – (M)LTSS

Members enrolled in home and community-based services (HCBS) must participate in care management. Failure to participate in home visits and/or provide written consent or acknowledgement will imply non-participation in care management. HCBS Members must also adhere to the program rules around cooperation: being present in the home to receive the services, notifying the provider in advance of any absences, allowing the provider to come into the home to provide the services, must not interfere with the delivery of services, and must not threaten or act abusively. A memorandum of understanding (MOU) (sometimes called a Care Management Agreement) may be established between the Care Coordinator and the member, stating the instances of "non-cooperation" that have occurred, outlining the care coordinator's attempts and provider's attempts to deliver waiver services. The MOU should indicate that the member understands, agrees, and will adhere to the requirements of the program. A timeline for the MOU should be established (typically 30-90 days) and is signed by member and care coordinator.

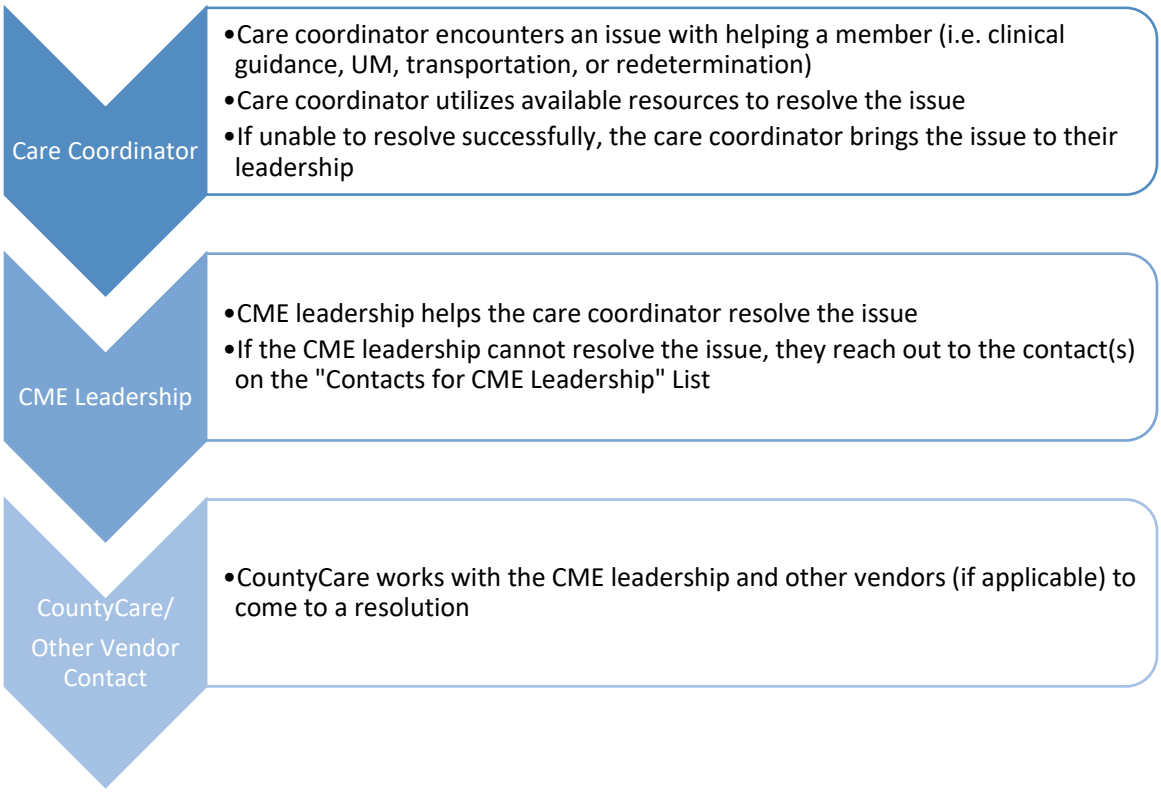
HCBS Members who do not permit home visits, refuse care coordination, or fail to abide by an established MOU will be referred to the respective state agency for review of waiver eligibility and initiation of case closure. The waiver contact requirements and care management for SP1 services will continue until the waiver is closed as evidenced in a state eligibility database. In addition, a letter must be sent to the member informing them when their waiver case has been closed, as well as notification to the provider(s) delivering covered services.

Last revised: 06/19/2017, 2/20/2018, 10/04/2018

Escalation for Problem Solving

Escalation from CME to CountyCare Health Plan

Care coordinators are expected to use a wide variety of resources to support members including all resources posted on the CountyCare website, general outreach, and research methods including contacting benefit management call centers and helplines, directories and reference documents for health, community and social service resources and consultation within the interdisciplinary care team. If an issue cannot be resolved by a care coordinator, it should be escalated for resolution within the CME leadership structure (supervisors, managers, and directors). If the CME leadership is not able to find a successful resolution, a member of the leadership team may reach out to the appropriate contact at CountyCare to help the member. These issues include (but are not limited to) prior authorizations, pharmacy, transportation, the provider network. CountyCare regularly updates a list of escalation contact persons at CountyCare or vendors, related to each topic area. This escalation list is posted on countycare.com/care coordination.



Escalation from CountyCare/Vendors to CME

CountyCare health plan staff or partners may identify a need for care coordination that requires escalation for resolution. An escalated referral to a CME should identify the problem or need, when possible, the recommended action and the date by which a resolution is needed. A designated member of the health plan will provide clarification as deemed necessary by the health plan. The CME is the lead in coordinating with the member and the ICT and when the member is not reachable or not able or willing to participate, the CME works with the ICT. The CME will identify the Manager who will assume responsibility for the problem resolution and liaise with the health plan and others. The CME takes the lead in pursuing

solutions. The CME identifies specific support needed from the health plan related to payment/contracting issues, facilitating work across CountyCare vendors or State agencies. The designated health plan staff member will follow-up via review of the CM documentation or direct communication with the CME Manager until a plan is in place to resolve the issue.

See CME Referral section of this manual for expectations of the CME to respond to urgent escalated referrals or requests for information/intervention with a member from the Health Plan.

Created: 04/19/2018 Updated 6/30/2019

Health Risk Screenings (HRS) and Assessments (HRA)

Health Risk Screenings (HRS)

The health risk screening (HRS) tool and scoring mechanism used by the internal health plan and delegated CMEs must be approved by CountyCare and is provided to the State. The HRS collects information about the member's physical, psychological, and social health. The primary purpose of the HRS is to identify members' needs so that the care coordinator can take action to address these needs for each member in an individualized way. Additional purposes are to:

- Engage the member actively in seeking assistance and creating and Individual Plan of Care (IPoC) and actions for the member and Interdisciplinary Care Team (ICT) to share.
- Trigger further assessments, including the comprehensive Health Risk Assessment (HRA), behavioral health assessments and the IM-CANS
- Determine a risk level to assign to the member.

CMEs are responsible for completing health risk screenings which include behavioral health risk with all new members within 60 days after enrollment in CountyCare by following the protocol for outreach and engagement. If attempts to complete an HRS are not successful within 60 days, the CME is responsible for continuing efforts and completing an HRS at the earliest opportunity. In addition, the CME shall notify the appropriate medical home or PCP of the enrollment of any new member who has not completed a health risk screening within 60 days, in order to facilitate contact. CMEs should work with medical homes to encourage PCPs to conduct outreach to their patients and make attempts to schedule visits.

If a member transitions to another CME within CountyCare, information from the HRS may be transferred to the CME or the new CME will be required to complete a new HRS. If a member disenrolls from CountyCare and later becomes eligible for CountyCare again and the member's eligibility was inactive for over 90 days, the CME must complete an HRS within 60 days of the new enrollment date.

A health risk assessment may be used in place of the health risk screening provided that it is administered within 60 days after enrollment.

Care coordinators are responsible for considering the HRS score in combination with data about recent claims and utilization and any other factors identified in the assessment process. Care coordinators exercise clinical judgment to stratify each member's risk level.

Last revised: 11/01/2017, 12/11/2017, 5/31/2019, 7/11/2019, 1/16/2020

Health Risk Assessments (HRA)

The health risk assessment (HRA) tool and scoring mechanism must be approved by CountyCare and is provided to the State.

All Members

For members enrolled in the Care Management Program, the Care Coordinator must begin the HRA within 30 calendar days of stratification to Level III or other conditions identifying the member eligible for the Care Management Program and complete the HRA within 60 calendar days of high-risk stratification.

High Risk members receive an HRA or have their HRA updated with current information at least every 12 months.

Non-(M)LTSS Members

Health Risk Screens are conducted, or predictive modeling is used to determine member risk level, need for a more thorough health risk assessment and enrollment in care management.

Care coordinators are required to complete a health risk assessment (HRA) for every member identified as Level 3 (high risk) or Level 2 (moderate risk) through the health risk screening (HRS) or predictive modeling analytics. HRAs may serve as an initial screen, instead of a HRS, as long as it is completed within 60 days of eligibility. The care coordinator completes the HRA either by telephone or in-person at a health care setting, home visit or other community location.

Last Revised: 10/31/24

(M)LTSS Members

Agencies contracted with the State complete a determination of need assessment to establish eligibility for Long Term Supports and Service (MLTSS and LTSS), which includes members in Long-Term Care (LTC) and Home and Community Based Services (HCBS). Individuals must meet criteria for being elderly, or a person with a disability.

For members who join CountyCare with (MLTSS and LTSS), (Legacy Members), the health risk screen or assessment must be completed within 60 days of enrollment. If only the health risk screen is completed within 60 days of enrollment, the health risk assessment is completed within 90 days of enrollment. The health risk assessment is completed in-person. For members deemed newly waiver eligible for HCBS waiver services at any point, the health risk assessment must be in-person and completed within 15 days after CountyCare is notified that the member is determined eligible for (M)LTSS HCBS waiver services.

For members in the Brain Injury (TBI) and HIV waiver program, the HRA will be completed in-person every six (6) months. All other (M)LTSS members receive a new in-person HRA at least every twelve (12) months or more frequently, when a member's circumstances or needs change significantly, or at the member's request.

For newly eligible members in the Supportive Living Program (SLP), the HRA is to be completed 15 days starting from the day the Health Plan receives the Resident Assessment Instrument (RAI) and Individualized Support Plan (ISP) information form from the Supportive Living Provider or from the date CountyCare is notified of the SLP admission. The Supportive Living Provider will pass the RAI and ISP to the health plan dedicated LTSS email address.

The completion of the initial HRA and subsequent HRA reassessments is monitored and reported monthly to the state and audited *quarterly.*

Last revised: 4/30/25

Contents of the Health Risk Assessment for (M)LTSS Members

The HRA will include the care manager's assessment of the members service needs, covering the following areas, and include a documented summary and conclusion for each area unless otherwise specified:

1. Assessment of members' health status, including condition-specific issues, self-reported health status, and medications with schedule/dosage (may be reported by the member or collected from another source).

2. Documentation of clinical history, including past hospitalization, surgery, significant past illness and treatment, and past medication. The information may be reported by the member or collected from another source (does not require a summary/conclusion) Assessment of activities of daily living, which aids in the assessment of the member's service needs
    a) Walking, sitting, rising from a chair, or standing
    b) Bathing
    c) Dressing and undressing
    d) Self-feeding
    e) Taking medication
    f) Toileting
    g) Grooming
    h) Other
3. Assessment of instrumental activities of daily living, which aids in the assessment of the member's service needs
    a. Doing Housework
    b. Preparing meals
    c. Shopping
    d. Managing money
    e. Driving or navigating public transportation
    f. Telephone use
4. Assessment of behavioral health status, including mental health and substance use disorders
5. Assessment of cognitive functioning, including ability to communicate and understand instructions, and ability to process information about an illness
6. Assessment of social needs, including housing instability, food insecurity, transportation access, childcare needs, employment
7. Assessment of social functioning, including engagement with family/friends and social isolation
8. Assessment of health beliefs and behaviors (e.g., optimism, nutrition habits and restrictions, and physical activity)
9. Assessment of cultural and linguistic needs, including preferred language, treatment/procedure restrictions for religious or spiritual reasons, family transitions related to decision making, illness, or end of life care
10. Assessment of member preferences, including preferred providers/LTSS providers, delivery of those services, preferred method of communication (phone, text, e-mail, in-person), and how case management is delivered
11. Assessment of visual, hearing, and speech needs, including need or use of aids or devices
12. Assessment of physical environment for risk, including observable safety hazards in the home environment
13. Assessment of paid/unpaid caregivers, including availability and adequacy of caregivers and caregiver support needs
14. Assessment of available benefits, including benefits member receives and adequacy to meet members needs
15. Assessment of community resources member may need, including initial eligibility determination
16. Assessment of life planning, including if member has received and reviewed life-planning information or education on advanced directives and if they have a written life plan and/or advanced directives
17. Assessing for any other identified needs and member's prioritized, person-centered goals.

Last revised: 4/30/25, 12/9/2025

Evidenced Based Assessment

CMEs utilize evidence-based assessment as a standard of practice. Evidence based assessment are developed based on research findings that confirm the validity of assessment items in predicting risks. Examples of evidenced based condition specific assessments include Patient Health Questionaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Drug Abuse Screening Test (DAST-10) and the Alcohol Use Disorders Identification Test (AUDIT)

Evidence from literature

- PHQ-9: https://pdfs.semanticscholar.org/de26/1882049731e262c7ba4a2e0a710cd0cc807c.pdf
- GAD-7: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326
- DAST-10: https://psycnet.apa.org/doiLanding?doi=10.1037%2F1040-3590.12.2.186
- Audit: https://www.ncbi.nlm.nih.gov/pubmed/8329970
-

Risk Stratification & Health Risk Reassessment

The risk level identified by the HRS, or predictive modeling may be used to stratify the member until which time a HRA is completed. The results of the HRA may change the risk stratification. The HRA will be repeated if member's condition changes significantly.

Contents of the Health Risk Assessment

Assessment and evaluation processes are developed, maintained, and followed by the internal health plan and delegated Care Management Entity (CME) including policies and procedures for why an assessment may not be appropriate and expectation for documenting in these circumstances. As part of comprehensive assessments, CME tools assess language and communication needs and capture care-relevant member preferences, including gender identity– and sexual orientation–related preferences, which are treated as sensitive and documented confidentially to support care planning. Care coordinators explain that the data requested is voluntary (do not have to answer), will be kept private, and will not affect the care and services received (not discriminatory purposes). Information shared is to assist in creating a welcoming and inclusive care environment. Gender identify is only requested for members >18 years old. C are Coordinators should refer to their mandatory training on LGBTQ+ and Demographic Collection Sensitivity Training for question and approach recommendations. CountyCare will utilize audits to ensure that CME tools contain all the following elements, and are utilized when appropriate:

1. Initial Assessment
   The initial HRA includes:
   - Screening for presence or absence of comorbidities and their current status
   - Member's self-reported health status
   - Information on the event or diagnosis that led to the member's eligibility for complex case management.
2. Documentation of Clinical History
3. The HRA must document clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages. Initial Assessment of Activities of Daily Living

The assessment must include functional status related to activities of daily living, such as eating, bathing and mobility.

4. Initial Assessment of Behavioral Health Status
   Assessment of behavioral health status must include:
   - Cognitive functions: 1) The member's ability to communicate and understand instructions and 2) the member's ability to process information about an illness.
   - Mental health conditions
   - Substance use disorders.
5. Initial Assessment of Social Determinants of Health
   Assessment of Social Determinants of Health should evaluate:
   - Housing and housing security
   - Access to local food markets
   - Exposure to crime, violence, and social disorder
   - Residential segregation and other forms of discrimination
   - Access to mass media and emerging technology
   - Social support, norms, and attitudes
   - Access, transportation, and financial barriers to obtaining treatment.
6. Initial Assessment of Life Planning Activities
   The HRA must assess life planning activities such as wills, living wills or advance directives, and health care powers of attorney for adult members over the age of 18. If a member does not have expressed life-planning instructions on record, the care coordinator determines if such a decision is appropriate, during the first contact. If a life planning activity is not appropriate, the care coordinator records the reason in the care management system. Life-planning information will be provided to all adult members over the age of 18 in care management, if not already available.
7. Evaluation of Cultural and Linguistic Needs
   HRA must include an assessment of culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. The process will include consideration of cultural health beliefs and practices, preferred languages, health literacy, preferred pronouns, and other communication needs.
8. Evaluation of Visual and Hearing Needs
   Each CME will specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.
9. Evaluation of Caregiver Resources
   The HRA must evaluate the adequacy of caregiver resources (e.g., family involvement in and decision making about the IPoC) during initial member evaluation.
10. Evaluation of Available Benefits
    The evaluation of available benefits will include a determination of whether the resources available to the member are adequate to fulfill the treatment plan.
        - Upon identification of exhausted benefits, provide Enrollee with resources available and steps to obtain resources.
        - Utilize referrals from other departments to initiate outreach to Enrollees to offer the service described above.
        - Develop resource libraries and materials.
11. Evaluation of Community Resources
    Care coordinators must assess eligibility for community resources that supplement care management activities, such as:
    - Community behavioral health
    - Disease management

- Wellness organizations
- Palliative care programs
- Other national or community resources, including Family Case Management and the Better Birth Outcomes program.

Last revised: 11/02/2017, 2/19/2018, 10/04/2018, 4/21/2019, 5/31/2019, 7/11/2019, 1/16/2020,4/14/2020, 5/22/2020, 1/24/2022, 7/31/2024; 12/12/25

HCBS (M)LTSS Member Education about Waiver Providers

CMEs providing care management to members in HCBS waivers must distribute provider packets to members and educate the member about their responsibility to ensure personal assistants and all other individual providers who provide covered services under the persons with disabilities HCBS waiver, persons with HIV/AIDS HCBS waiver, or persons with brain injury HCBS waiver receive the provider packets. CountyCare will ensure the CMEs receive the State-issued forms needed for creating the provider packets and any updates to the forms. The CMEs shall further educate members that such providers may not begin providing covered services until the fully and correctly completed packets have been returned to, and accepted by, the local DHS-DRS office.

Created: 12/11/2017; Last revised: 2/19/2018

High Utilization of Health Care

High utilization of health care can be caused by several factors, including but not limited to serious or complex health conditions and/or inappropriate use of health care. Lack of resources such as housing or food, lack of knowledge about appropriate health care, or lack of options for alternative treatments can exacerbate health conditions and increase the likelihood of high utilization. High utilization is a relative term and is defined for specific programs and interventions.

Members who use higher than average amount of health care are often referred to as high utilizers. Members who are in the highest tier of those utilizing a certain type of health care are referred to as super utilizers. These are succinct terms for program management, but whenever possible, person-centered language should be used instead because it acknowledges that high utilization of health care is a behavior, not a characteristic of the person. Person centered language also conveys that the behavior has the potential to be modified as factors about the member's health, knowledge and resources change. Care coordinators use screening, assessment and engagement and therefore should also describe the driving factors of high utilization of health care. Example: "the member is a high utilizer of the emergency department because she has pain that has not been effectively treated by outpatient providers."

Goals

Care Coordination and Care Management strategies are designed to encourage members to utilize preventative care universally, utilize outpatient care whenever it is available for a health condition, and utilize hospital or facility care when medically necessary.

Identifying High Utilization of Health Care

Care coordinators are expected to outreach to all members to perform health risk screening as well as ensure that any member they contact for other reasons has an updated health risk screening. Health risk screening identifies the member's recent health care utilization and if identified, the care coordinator completes a comprehensive assessment that provides complete information about health care utilization and factors that causes or contribute to it.

CMEs are expected to have systematic methods to identify members with high utilization by:

- data about utilization for individual members such as protocols for use of targeted screening tools and routine reviews of claims, authorizations and medication data loaded into the member's records.
- cohorts of members within the population who have patterns of high utilization, such as creating cohorts for targeted review and outreach; examples of cohorts are members with high-risk scores, high numbers of authorizations, real-time alerts of hospital care, high use of medication and high-cost care.

CMEs may set thresholds to identify member level high utilization such as a certain number of hospitalizations or emergency department visits in a set period.

In addition, CMEs are expected to have systematic methods to identify members at risk of high utilization either at the member level and/or through cohorts for outreach based of data such as predictive modeling scores, specific conditions or conditions that place a member at risk of high utilization.

Care Coordinator Actions for High Utilization of Health Care

Care coordinators are expected to perform a comprehensive health risk assessment for all members identified with high utilization of health care at least annually and upon significant changes in the member's health condition. The only exceptions are if the high utilization is resolved, or the member refuses the assessment. Care coordinators should offer to enroll the member in the care management program if the assessment identifies needs contributing to high utilization that can be met through care planning to either improve the member's quality of life, health care outcomes or decrease inappropriate utilization of health care. The Care Coordinator should prioritize IPoC goals and use of the Interdisciplinary Care Team to address high utilization and contributing factors.

Care Coordinator Actions for Super Utilization of Health Care

CountyCare creates and revises criteria for super utilization based on regular analysis of the membership and its health care utilization. Typically, a "super utilizer" is defined by being in the top tier of utilization for inpatient, emergency department or pharmaceutical services. CountyCare will post the current criteria for super utilization on the CountyCare website care coordination page and deliver lists to the CMEs that identify these members. CMEs are required to assign appropriately trained care coordinators to take the following actions with super utilizers.

i. comprehensive review of all information available about the member including medical records, authorizations, pharmaceuticals, claims, real-time alert history, previous care management records and recent updates from members of the interdisciplinary care team including utilization management staff
ii. perform outreach to member, family members and/or treating health care provider(s) within five (5) days of notification of super utilizer status or within 1 day of notification (by real-time alert, UM notification or member/provider notification), of emergency department or hospital admission, whichever comes first.
iii. after initial outreach, whenever possible same day outreach of notification emergency department or hospital admission

iv. contact with member or authorized representative with primary goal of engagement and establishing a trusting relationship.
v. if contact with member is not successful, contact with member of the treatment team or ICT.
vi. coordination of services with and providing support and resources to the member or treatment/ICT provider
vii. completion or update of standard care coordination and care management activities (health risk screen, comprehensive assessment and IPoC)
viii. convene care reviews/care conferences with ICT members.

If the member is not reached, refuses to participate in CM or has difficulty following an IPoC due to decisional capacity or bio-psychosocial barriers, the care coordinator will employ the following interventions as appropriate to the situation:

- Case conference with health plan leadership
- Referral to the Recipient Restriction program for pharmacies, prescribers, and/or outpatient providers
-
- Plans of care that organize interventions, even if the plan is developed with or signed by the member.

Created 5/31/2021

Last revised: 8/28/25

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rule allows covered entities, such as physicians, health plans and other health care providers, to use or share a member's Protected Health Information (PHI) without having to get patient authorization, in certain situations. For example, a doctor's office may share a patient's PHI with a health plan to support patient care coordination, care management, and quality of care efforts without obtaining the patient's authorization.

Care coordinators will educate members and providers that sharing information is permitted to coordinate care and that requiring members to sign consents to release information is not necessary. Care coordinators will also communicate with members when collecting individuals' race/ethnicity, language, gender identity and sexual orientation information the information is kept private and will only be shared with practitioners and providers in their care team. More information on Exchanging PHI under HIPAA and the use and protection of demographic data can be found on CountyCare's website and the Care Coordination webpage here). CountyCare health plan staff including the Compliance Officer are available to assist care coordinators in educating about HIPAA and when necessary, overcoming unnecessary burdens to care coordination related to misinformation about HIPAA.

Created: 04/05/2018, Last Revised: 12/12/25

HIV Data Exchange

CountyCare's CMO and designated staff uses the data received from the HIV/AIDS Registry, along with CountyCare's pharmacy, medical, and other claims data, to provide alerts to Care Coordinators to prompt them to ensure all best practices regarding the management and treatment of HIV are being followed with respect to members, including periodic viral load testing, drug regimen prescribing and adherence, and annual physician visits. These alerts are developed based on the data permitted to be shared under this Contract and may include viral suppression status ("suppressed" or "not suppressed"), the date of the last lab test, and name of the Provider that ordered the last lab test (if available).

Care Coordinator requirements:
Care management entities are expected to work with appropriate HIV consumer and legal advocacy groups for the target population to develop and implement best practices for outreach and engagement.

1. CMEs are required to designate a clinical lead as point person for management of HIV data.
2. Alert care coordinators for member outreach and engagement within 30 days of receipt of notification.
3. Follow HIPAA requirements and ensure HIV information is secure and shared as minimum needed.

Created 9/7/2022.

Individual Provider Compliance

Electronic Visit Verification (EVV)

All members and individual providers (IPs) are required to comply with the DRS program and paperwork requirements including use of the Electronic Visit Verification (EVV) timekeeping system, proper completion of the Home Services Program (HSP) Timesheet and management of the IP's hours within the members approved service plan.

It is the member's role to manage individual providers, including timekeeping, and therefore it is also their role to address non-compliance. The CME helps facilitate communication between the member and the IP around any changes related to timekeeping and EVV non-compliance.

DRS will notify CountyCare of an IP's failure to comply with EVV each time a non-compliance warning is given. The CME should provide education to the member upon each notification of EVV non-compliance. This education should be noted in both the CM software system and WebCM. IP's will receive three chances within a 6-month period to comply.

When a third notice of non-compliance is given, the CME is responsible for informing the member that the IP failed to comply with EVV and must be terminated and replaced with an agency provider. The information is given to the IP either directly from the member or in collaboration with the member and their care coordinator. In either case, it is the CME's responsibility to take action and terminate the IP. The notification to the member and action taken should be documented in WebCM.

The CME has 15 days to notify the member of the third strike and put a homemaker in place. The change in IP services must be communicated to DRS within that 15-day timeframe through the push file, reflecting zero IP hours.

Should CountyCare receive a member from another MCO or from fee-for-service in which an IP is in the midst of receiving EVV non-compliance warning(s), CountyCare must acknowledge those previous warnings. Non-compliance does not re-set because of a change in the member's health plan.

Over Hours

The member service plan, indicating services to be performed by an individual provider, outlines the specific tasks to be completed, on which days and for how many hours per week/month. IP's are to perform only those tasks outlined on the service plan and within the total hours approved. CountyCare and the CMEs are responsible for monitoring and identifying when a member is over his/her monthly authorized hours in excess of 5 hours each month. The care coordinator is responsible for contacting the member and determining the reason for the overage.

Acceptable reasons for overage include:

- Timesheet error which was corrected
- The member received prior approval from their care coordinator for the additional hours.
- An emergency or unexpected circumstance requiring additional assistance occurred at a time when the care coordinator could not be contacted (e.g., evening, night, or weekend)
- Court order

Unacceptable reasons for overage include:

- Failure to keep track of the approximate number of hours worked each period.
- Disagreements between the member and IP over the number of hours worked.
- Disagreement with the number of hours authorized on the service plan.

If the total number of hours for the month exceed the service cost maximum (SCM), the overage must be considered "unexcused," regardless of the reason, unless subject to a court order.

Upon the first unexcused overage of more than 5 hours within a 6-month period, the care coordinator will remind the member it is his/her responsibility to manage the IP's time so they don't exceed the number of hours on the service plan and that continued overages will result in the IP being replaced with an agency provider. If necessary, a review of the applicable rules and forms will be done with the member. Non-compliance and education provided to the member is documented in both the CM software system and WebCM. The overage is paid.

If the IP has a second unexcused overage of more than 5 hours within a 6-month period, the member will be informed verbally and in writing that if there is another unexcused overage in the 6-month period, the IP will be removed from their service plan and replaced with an agency provider. The non-compliance and education provided to the member is documented in both the CM software system and WebCM. The overage is paid.

If the IP has a third unexcused overage of more than 5 hours within a 6-month period, the care coordinator will amend the service plan to replace the IP with an agency provider of the member's choice. The IP will be terminated. The action taken is documented in both the CM software system and WebCM. The member will receive a copy of the amended service plan and a Notice of Action (NOA) that outlines the appeal process. If the member appeals, they will continue to use the IP until the appeal is heard, unless there are credible allegations of fraud, abuse, neglect, or exploitation.

This procedure is not applicable in situations in which the service hours are being actively challenged through either an administrative appeal or court filing. In these cases, there should be no action to warn the member nor should a request to modify/close the member's case occur.

Over Time

Per Admin Code 89 IAC 686.1520, Home Services Program (HSP) members, who utilize Individual Providers, must hire a sufficient number of providers to cover the weekly hours on their service plan and name a back-up caregiver for coverage when another Individual Provider is unable to provide services. A back-up caregiver may be a non-paid caregiver, an additional Individual Provider, or an agency.

The updated Individual Provider Overtime Policy is effective and strictly enforced beginning **November 1st, 2021** and can be found here - IDHS: HSP Overtime (state.il.us)

Key points of the HSP Individual Provider Overtime Policy:

1. Individual Providers (IP) who work more than forty (40) hours per work week shall be paid at time and one half the hourly rate up to a maximum of sixty (60) hours per work week.
    - **A work week is Sunday at 12:00am to Saturday 11:59pm.** Not to be confused with a pay period of the 1st-15th or 16th-End of Month.
2. IPs will not be allowed to work more than 60 hours per work week unless the Member has been approved for an Overtime Exception.
3. Unauthorized use of overtime will result in written notification to the Member and IP of an overtime occurrence. In a rolling 24-month period, every 4th occurrence may result in a 3-month suspension and twelve occurrences may result in an IP's permanent ineligibility for funding from HSP.
4. The Member must apply and be approved for an Overtime Exception to allow an IP to work over 60 hours in a work week.
5. Regardless of whether an overtime exception is granted, Members cannot exceed their monthly Service Plan hours and are not to authorize the Individual Provider to work more than the number of hours listed on the Service Plan.
6. Regardless of whether an overtime exception is granted, Individual Providers cannot work more than 16 hours in a 24-hour period.
7. Submitted travel time between Members will be counted toward the 60-hour cap.

Overtime Exceptions To avoid an overtime occurrence, possible providers suspensions, and/or a change to an agency provider, the Member must apply and be approved for an Overtime Exception to allow their IP to work over 60 hours in a work week.

The categories for overtime exceptions are noted in the table below:

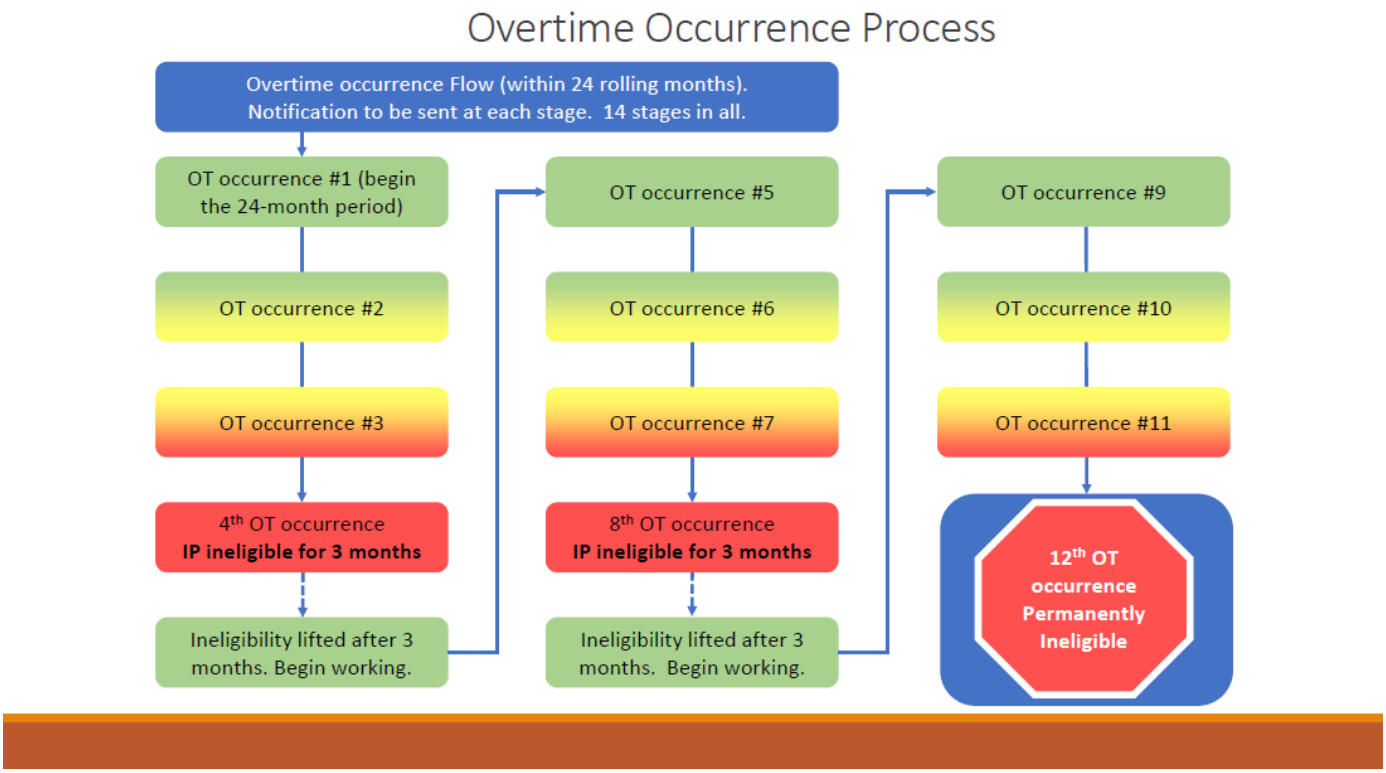
Exception Category	Description	Approval Period	Timing of Approval

Provider Capacity	One or more of the IP's can no longer work, is unfunded, no longer meets qualifications/expired credentials and/or no provider within 45 miles is able to provide needed services. The local CIL must also verify that they were unable to find a provider for member.	Valid for 1 year from approval. Will auto-renew for successive 1-year periods unless and until HSP denies the exception.	Pre-approval required. Must be applied for in advance or within 2 weeks of need.
Unique/Complex Needs	The member's health and safety would be at risk by adding additional IPs to the service plan. Medical documentation is required.	Valid for 1 year from approval. Will auto-renew for successive 1-year periods unless and until HSP denies the exception.	Pre-approval required. Must be applied for in advance.
Out-of-Town Situations	A member requires care to ensure their health and safety while out-of-town, and it is not feasible to bring additional IPs.	Can be used for up to 14 days per calendar year, limited to Personal Care only.	Pre-approval required. Must be applied for in advance.
Emergency Need	An urgent need for care arises and IP had to work over 60 hours in a work week to avoid risking the member's health and safety. An example would include an unexpected illness of an IP.	Can be used up to 4 times per calendar year for up to 10 hours per pay periods.	Post approval required. Must be applied for within 2 weeks of need and must provide pay period dates.

How the Member can apply for an exception:

1. Member will download and print the Request for Overtime Exception Form (IL488-2272), or the Care Coordinator can mail it to them. www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL488-2272.pdf
2. Submit the completed Request for Overtime Exception form and all necessary supporting documentation to:
    - Email: DHS.HSPOvertime@Illinois.gov
    - Fax: 217-557-0142
    - Mail: Home Services Program
Policy Unit
100 S Grand Ave E, 1st FL, Springfield, IL 62762
3. HSP Central Office Policy Unit will process the Member's exception and review the supporting information and/or medical documentation, HSP Policy Unit may reach out to the Care Coordinator for assistance in processing the exception.
4. The Request for Overtime Exception approval or denial will be mailed to the Member's address on file at the local DRS office.
5. If the Member's request is denied, they will receive appeal information and a request for appeal form with the denial letter.

Non-Compliance



Last revised 2/22/2015, 04/17/2018, 5/31/2019, 8/21/2019, 5/26/2022

Individualized Plan of Care (IPoC)

The comprehensive, person-centered member individualized plan of care (IPoC) must be developed by the Care Coordinator, the member, and the interdisciplinary care team (ICT) within 90 days after enrollment for members stratified as Level 3 (high risk) or Level 2 (moderate risk), Enrollees residing in Nursing Facilities, and members in a (M)LTSS HCBS waiver program. CountyCare requires the IPoC to follow the principles of Person-Centered care planning, in which care coordinators engage the member in the development of the IPoC as much as possible.

Elements of the Individualized Plan of Care

The IPoC:

1. Is inclusive of the HCBS service plan which encompasses all services provided to the member based on their assessed needs
2. Incorporates a member's medical, behavioral health, (M)LTSS, social, and functional needs (including those functional needs identified on the DON or other assessment tool that is adopted by the State for HCBS waiver members), as well as self-management and wellness goals.
3. Includes short term and long-term treatment and specific, prioritized, measurable goals to address the member's needs and preferences and to facilitate monitoring of the member's progress and evolving service needs, coordinate and provide referrals to ensure that a member's care plan is holistic and person-centered. Each goal must have a specific target completion date.

4. Includes, in the development, implementation, and ongoing assessment of the IPoC, an opportunity for member participation and an opportunity for input from the primary care providers, other providers, and a legal or personal representative and the family or caregiver if appropriate.
5. Identifies and evaluates risks associated with the member's care. Factors considered include, but are not limited to, the potential for deterioration of the member's health status; the member's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the member; and behavioral or other compliance risks.
6. Includes, the development of an individualized case management plan which includes services needed members' preferences and prioritized, person-centered goals.
    - Prioritized, person-centered goals that consider member's needs and preferences.
    - Services needed.
    - Resources
    - Level of family participation
7. Identifies barriers to meeting members' goals and preferences or implementing the plan.
    - Language or literacy level.
    - Access to reliable transportation.
    - Understanding of a condition.
    - Motivation.
    - Insurance issues (e.g., eligibility disputes, reduction of benefits, denial of services or appeals).
    - Cultural or spiritual beliefs.
    - Visual or hearing impairment.
    - Psychological impairment.
8. Includes a schedule for follow-up and communication with members.
    - Counseling
    - Member education.
    - Planned frequency of face to face and phone contacts
    - Self-management support
    - Determining when follow-up is appropriate
9. Includes a plan for follow-up and communication with LTSS providers.
    - When a member's contact information changes, such as address or phone number.
    - When a member elects to switch providers, the former provider must receive documented notification of their end date.
    - When a particular service is being ended/removed from the service plan, the provider must receive documented notification of the end date.
    - When a member's services need to be placed on hold.
    - When the member returns to home/community and services should be resumed.
    - When a member disenrolls from the Health Plan, switching plans or returning to fee for service.
10. Includes an emergency back-up plan customized to the member.
    - Emergency plan for short-term or long-term needs (e.g., natural disaster, power outage, equipment failure, other).
    - Emergency contacts and phone numbers.
11. Includes the development of a self-management plan.
    - Member's role in managing the effects of physical consequences, social consequences, and lifestyle changes inherent in living with a chronic condition or functional limitation.
    - Perform ADLs or IADLs
    - Ability to monitor their condition

- Reporting an exacerbation of a condition or change in caregiver availability that requires a change in services.
- Money management.
- Paperwork (e.g., annual assessments, financial redetermination, utility assistance, food benefits, transportation).
- Engaging with community resources.

12. Identifies referrals to resources
    - Facilitation of referrals to resources
    - Follow-up process to determine whether members acted on referrals.
13. Includes receipt of services
    - Timely follow-up with member and LTSS provider.
    - Document/confirm start of services.
14. Includes an assessment of members' progress against case management plans
    - Progress toward overcoming barriers to care
    - Meeting treatment goals
    - Adjusting the care plan and its goals at least every 12 months

Last revised 4/30/25; 12/9/25

Care Coordinators should incorporate the results of the health risk assessment into the IPoC. Include, as appropriate, the following elements:

1. The member's personal or cultural preferences, such as types or amounts of services.
2. The member's preference of providers and any preferred characteristics, such as gender or language
3. The member's living arrangements
4. Covered services and non-covered Services to address each identified need, provided that Contractor shall not be required to pay for non-covered Services.
5. Actions and interventions necessary to achieve the member's objectives.
6. Follow-up and evaluation
7. Collaborative approaches to be used.
8. Desired outcome and goals, both clinical and non-clinical
9. Barriers or obstacles
10. Responsible parties
11. Standing Referrals
12. Community resources
13. Informal supports
14. Timeframes for completing actions.
15. Status of the member's goals
16. Home visits as necessary and appropriate for members who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or cognitive disabilities, or who may be at increased risk for abuse, neglect, or exploitation.
17. Back-up plan arrangements for critical services
18. Crisis plans for a member with behavioral health conditions.
19. Wellness program plan

IPoC Requirements

The IPoC is not finalized until a signature from the member or authorized representative has been obtained. The member or member's authorized representative must review and sign the IPoC and all subsequent

revisions. Acceptable forms of signature include electronic forms such as e-signatures and voice recordings. For an Enrollee receiving HCBS Waiver services, a written signature is required for the IPoC, in accordance with 42 CFR 441.301(c)(2)(ix).

When a voice recording is used as the form of signature, the case documentation should state a voice recorded signature was obtained and identify the stored location of the voice recording. For an Enrollee receiving HCBS Waiver services, a written signature is required for the IPoC, in accordance with 42 CFR 441.301(c)(2)(ix).

The recording must include verification of the member's identity by the member stating his/her full name, date of birth or RIN number, and date of the recording. In the event the member has an authorized representative, the recording must include the stated name and relationship to the member, the member's full name, date of birth or RIN number, and date of the recording. Validation of care/service plan signatures is included in the on-site record reviews and voice recordings must be made available upon request.

In the event the member refuses to sign the IPoC, the care coordinator should:

- Document in detail the specific reason why the member refuses to sign the IPoC.
- Document actions taken by the care coordinator to address member's concerns.

The IPoC is considered a member-owned document. Members must be provided with a copy of the IPoC upon completion and may request a copy at any time In addition, CountyCare provides a fully operational portal through which members have access to relevant information the care management system, including access to the IPoC. CMEs must also provide updated IPoCs to providers that are involved in providing covered services to the member within 10 business days. Effective 11/1/18, providers can access IPoC's through the CountyCare Provider Portal. In addition, Care Coordinators can transmit IPoC's to providers via any other secure method. If the care management system does not have the capacity to print IPOC in member's preferred language, use an interpreter to share care plan with member and document in member's record.

Last Revised:12/28/2023, 10/31/24; 1/31/25

Enrollee Engagement Standards for Members with Care Plans (IPoC)

- Level 3 (High Risk) Member Requirements for Members Enrolled in Care Management:
    - Care Coordinator completes an IPoC within 90 days of enrollment if member is stratified as level 3 upon enrollment or completes IPoC within 90 days of risk stratification update to level 3.
    - Care Coordinator performs review of IPoC every 30 days.
    - Care Coordinator completes health risk assessment every 12 months for members with care plans.

- Level 2 (Moderate Risk) Member Requirements for Members Enrolled in Care Management:
    - Care Coordinator completes an IPoC within 90 days of enrollment if stratified to level 2 upon enrollment or within 90 days of level 2 risk stratification update.
    - Care Coordinator performs review of IPoC every 90 days.
    - Care Coordinator completes health risk assessment every 12 months for members with care plans.

Individualized Back-Up Plan: Aging Waiver Members

Each Aging waiver member will have an Individualized Back-Up Plan (Plan) to assist with minimizing any potential risk factors as part of the person-centered planning process (effective 7/1/2021). The Plan assists

the member, family members/authorized representatives, the care coordinator, and the aging waiver providers(s) identify key contacts in case of an emergency or an urgent need of service for the member.

The Plan will be completed in collaboration with the member at the initial assessment, the reassessment and/or whenever updates are needed. The Plan should be completed in its entirety with "N/A" being entered into any field which does not apply to the member. A copy of the Plan and the Back-Up Plan Cover Letter will be sent to the member and their authorized aging waiver provider(s) and will be uploaded to the member's care management file. If changes to the Plan are needed between re-assessments, the required adjustments will be made, and the revised Plan sent to the member and their authorized aging waiver provider(s) within 5 calendar days.

The care coordinator will share the importance of the Plan with the member at the initial assessment and annual re-assessments and provide detailed instruction on posting the Plan in a common area of the home. Alternative placement options should be discussed if the member does not want to post the Plan in a common area of their home. Should they refuse to post the plan altogether, the care coordinator must document the refusal to post the Plan, inform the aging waiver provider(s), and maintain a copy in the members care management record.

Last revised: 11/01/2017, 11/22/2017, 2/19/2018, 04/17/2018, 10/04/2018, 7/11/2019, 1/16/2020, 12/31/2020, 1/24/2022, 8/30/2023, 12/28/2023

Interdisciplinary Care Team: Roles and Responsibilities

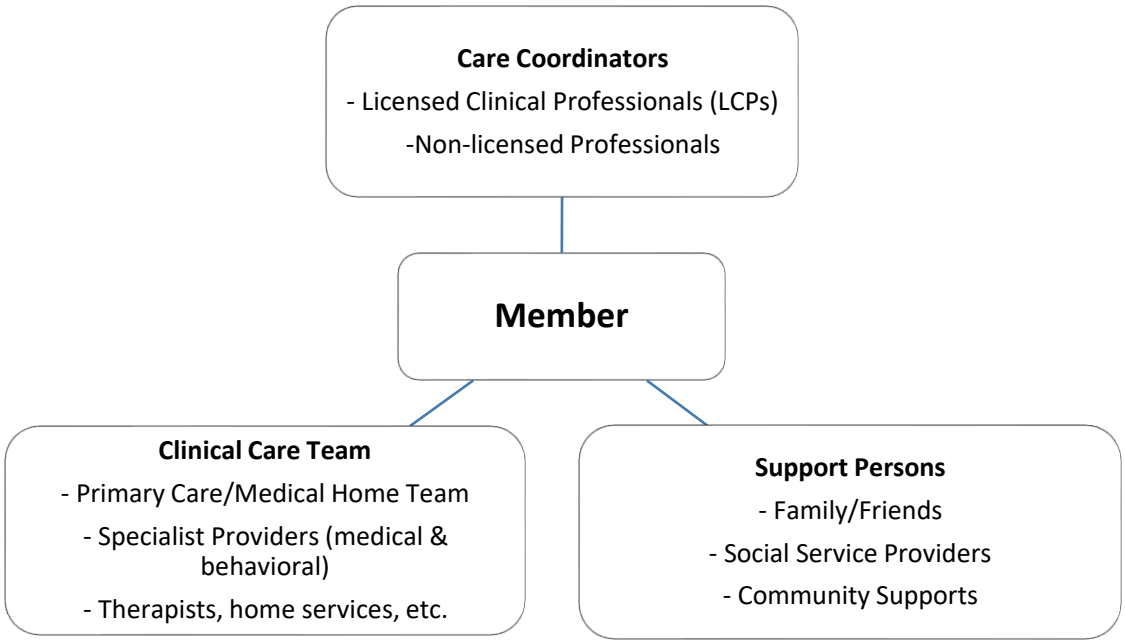
An Interdisciplinary Care Team (ICT) is a team of medical professionals (e.g., care coordinator physicians, social workers, psychologists, occupational therapists, physical therapists) and non-clinical staff whose skills and professional experience will complement and support each other in the oversight of addressing member needs. ICTs can also include family, friends, or other individuals or organizations that act as important supports in the overall health and wellbeing of the member and are included in the ICT at the member's request. An ICT provides person-centered, member-driven, integrated, and interdisciplinary care to all members enrolled in Care Management including all non-LTSS members stratified as high-risk (Level 3), and all (M)LTSS members. The ICT, which is a team of people, will ensure the integration of the member's services to meet the member's medical, behavioral health, social and, if appropriate, Service Package II care needs.

An ICT is a **team** of individuals, chosen by the member, who work together. Members of the ICT should be clearly identified in a member's care management record and IPoC. One of the main responsibilities of the ICT is to hold ICT meetings, with the overarching goal of ensuring that the member is getting necessary care and care coordination in a way that makes sense for the member and is timely. Being a member of an ICT and ensuring that ICT meetings are hosted, when necessary, requires a high degree of collaboration and communication.

ICT **meetings** are when the interdisciplinary care team meet, and this meeting should include the member when possible. ICT meetings should be person-centered, or in other words, driven and requested by the member and coordinated by the Care Coordinator. However, more often, the Care Coordinator will request an ICT meeting on behalf of the member and will document ICT activities in the members' chart. The Care Coordinator works closely with the member to identify members of the interdisciplinary care team, develop a plan of care, monitor, and add to the plan of care and address barriers.

Members of the ICT

Each ICT, which is a team of people, shall consist of clinical and non-clinical staff whose skills and professional experience complement and support one another in the oversight of each member's needs. The ICT is person-centered, meaning that it is built on each member's specific preferences and needs, and delivers services (interventions, activities, and team meetings) with transparency, individualization, respect, linguistic and cultural humility, and dignity. Care Coordinators are responsible for working with the member to create and name members of the interdisciplinary care team, incorporating family members and other informal supports as needed. For example, a member may identify a friend, neighbor, or other community support to participate in their ICT. The member and Care Coordinator create, name, and work with that member's unique team.



ICT Best Practices

The interdisciplinary care team's interactions are focused on the member's needs. There are best practices that support and enhance a member's participation in their care, indicated below:

- Assigning a Care Coordinator who has the experience most appropriate to support the member.
- Applying a high degree of collaboration and communication, with bi-weekly or monthly touchpoints, depending on needs of the member at that time
- Exercising motivational interviewing techniques in every interaction
- Utilizing SMART goals in the design of the care plan
    - **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely (for an example on how to write SMART goals, click here)
- Exploring alternative care options that are attentive to member needs, and allowing the member to make a choice, encouraging autonomy.
- Including (M)LTSS HCBS service plans, when applicable.

Care Coordinator Specific Responsibilities

In addition to the best practices listed above, the Care Coordinator's overarching responsibilities as part of an interdisciplinary care team are to do the following:

1. **Identify the team members and record this in the respective care management system.**
    a. Works with the member to create and name members of the ICT.
        i. Incorporating family members and other informal supports as needed.

2. **Collaborate with the member and other members of the ICT.**

a. Maintains regular communication with the members of the ICT.
b. Assists member in the development of an IPoC.
    i. Includes (M)LTSS HCBS service plans, when applicable
    ii. Supports member in meeting goals identified on the IPoC. The ICT supports the member and works through barriers collaboratively.
c. Clearly document in care management system that an IPoC is shared with a PCP and/or other members of the ICT.
d. Monitors and updates change or additions to the IPoC.
e. Communicates any updates or changes in the IPoC to the ICT
f. Maintains frequent contact with the member through various methods such as,
    i. Face to face visits, e-mail, and/or telephone, as appropriate to the member's needs and risk level or upon request
g. Assures integration of services and coordination of care across the healthcare system.

3. Schedule ICT meetings

a. The ICT is expected to convene a meeting:
    i. At the request of a member
    ii. Within 14 days after a child is discharged from the hospital or community stabilized following a mental health crisis
    iii. When a member is identified as a super utilizer
    iv. When a member is transitioning from nursing facilities into the community
    v. When a member is identified as eligible for or engaged in services with the Flexible Housing Pool program.
    vi. When an IPoC is updated
    vii. When a member is diagnosed with a BH and medical diagnosis
    viii. When a member readmits to an IP facility within 30 days
    ix. If member is stratified as high-risk, is a dual-eligible adult enrollee, or receives services under a HCBS Waiver
b. Schedule a time for the ICT to meet.
    i. If a member does not request a meeting with the ICT, but is willing to participate, the Care Coordinator can still schedule a meeting with the ICT. If the member does not participate in a meeting with the ICT, then the Care Coordinator still completes ICT activities (e.g., communicates with members of ICT, updates care plans, etc.).

Documentation of ICT Meetings and Other Team Activities

Members of the interdisciplinary care team must be clearly documented in the IPoC, and it must explicitly say that the member chose the interdisciplinary care team members. The interdisciplinary care team's activities are monitored by the Care Coordinator. Every occurrence of monitoring activity should include documentation that the activity was done in conjunction with the member and was based on the member's needs and preferences. Each member of the ICT will have their own activities and interventions necessary to accomplish the goals of the member's care plan. These activities and interventions are added to the member's chart by the Care Coordinator. Care Coordinators monitor the progress of each goal and update the care plan accordingly. If there is no progress, the Care Coordinator can discuss with the member the possibility of adjusting the goals on the IPoC. All ICT members are expected to share updates related to the member with one another and regularly come together and plan next steps based on the member's needs and preferences.

Please refer to Appendix A for a table that provides examples of the various activities that can occur as part of the ICT's responsibilities and how to document these activities.

ICT Responsibilities for Children's Behavioral Health

In cases where there has been a children's behavioral health crisis or activity, Care Coordinators are expected to do the following:

- Convene an ICT meeting for the member.
    - within fourteen (14) days after the event if the member is **community stabilized**
    - within fourteen (14) days after discharge if the member was admitted to the **hospital**.

Created: 11/01/2017, 10/4/2019, Revised: 12/31/2020(M)LTSS Appeals Process

The Care Management Entity is responsible for mailing a Notice of Action (NOA) letter to the member/guardian (must be certified for Aging waiver members) whenever a requested waiver service is being:

- Denied
- Reduced
- Suspended
- Terminated

The Notice of Action (NOA) clearly states the specific reason for the denial and cites the policy on which the decision is based. The notification process explains the denial in terms that relate directly to the member's condition or request. Each decision is supported by an assessment and a review of the members' care plan and service plan needs. The NOA should be signed off by supervisory level staff at the CME and uploaded into the care management software. The care coordinator also emails the signed NOA to the CountyCare centralized waiver inbox countycarewaivers@cookcounyhhs.org and the Evolent G&A inbox at CCAG@evolent.com

The member may appeal the action by contacting CountyCare Member Services via mail, telephone, facsimile, or electronic mail. An oral appeal must be followed by a written and signed appeal; however, the oral request counts as the initial receipt date of the appeal. Member must appeal within 60 calendar days of the NOA. If the member files a request for an appeal within 10 calendar days from the date of the NOA, services will continue at the same level until a final appeal decision is reached.

CountyCare Grievances and Appeals Department intakes the appeal and mails the member an Appeal Acknowledgement Letter within 3 business days of receipt of the member's appeal. A copy of that letter is also sent to the CME that issued the NOA.

The CME must submit an Appeal Packet to CountyCare at countycarewaivers@cookcountyhhs.org within 3 business days of the Appeal Acknowledgement Letter. The Packet should include all documentation and supporting documents, including the care plan and service plan, needed to clearly demonstrate the rationale and justification for the appealed action taken.

CountyCare (M)LTSS Appeals Committee will convene and review the Appeal Packet. The Care Manager and Supervisor are expected to participate in the committee meeting and present the materials to justify the

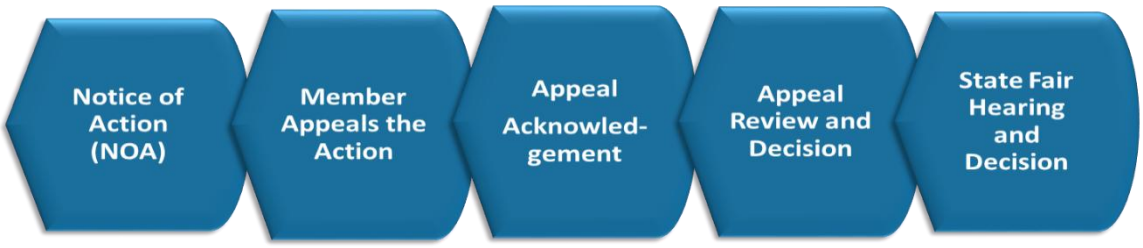
action taken. The committee makes a decision on the appeal and the member is notified via an Appeal Decision Notice within 15 business days from CountyCare's receipt of the appeal.

The Appeals Committee may request additional information from either the member or the Care Coordinator as part of their review and/or additional time (up to 14 calendar days) to process the appeal at the request of the Member or the Health Plan. The Health Plan extension request must meet the satisfaction of the appropriate State agency's hearing office.

If the adverse decision is upheld, the Decision Notice will include specific reasons for the appeal determination decision in easily understood language. It will reference the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based. And will detail member's right to request a State Fair Hearing.

The member may request a state fair hearing if the appeal decision is not wholly in favor of the member. If the member requests a state fair hearing, the hearing request must be made within 120 calendar days of the Appeal Decision Notice. If the hearing is requested within 10 calendar days of the notice, the services must remain at the same level until a final appeal decision is reached.

The care coordinator and their supervisor are expected to participate in the State Fair Hearing.



Sample Notice of Action (NOA) Letter Template

<<Date letter is going in the mail >>

<Member Name>
<Member Address>
<City, State, Zip>

For help to translate or understand this, please call 312-864-8200, 855-444-1661 toll free, or TDD/TTY hearing impaired 711.

Re: Member Name:
Member ID No.:
Reference Number: <Authorization # under which denial was issued>

Dear <Member Name>:

CountyCare looked at services requested for **<<MEMBER NAME>>.** The request received on **<<RECEIVED DATE>>** for coverage of **<<SERVICE>>** was [Denied, Suspended, Reduced, Terminated-pick one delete others]

<<RATIONALE>> <<NAME OF THE CRITERIA USED TO SUPPORT THE DECISION>>

This decision will take effect on: <<DATE = 15 calendar days from date of the letter>>

You, or someone you name to help you, can request a copy of criteria used in this decision. Your doctor knows about this decision. He/she can call to talk to us about this decision.

If you do not agree with this decision, you can file an "Appeal". This is how you ask us to change our decision. If you want your doctor or someone else to act for you in the appeal, you must tell us this in writing.

Appeals
You, your doctor, or someone that you name to act for you, can ask us to change our decision. This is called an appeal. You can ask for an appeal in writing or by calling us. If you appeal by phone, you must also send in a written, signed appeal request. If you want your doctor or someone else to act for you in the appeal, you must tell us this in writing. To appoint someone to make an appeal for you, you need to fill out the Authorized Representative Designation form attached to this letter. Call member services at 312-864-8200, 855-444-1661 toll free, TTY 711.

If you want to appeal, you must tell us within sixty (60) calendar days of the date of this letter. You can file an Appeal by phone, fax, or writing to us at:

CountyCare
Appeals Coordinator
PO Box 803758
Chicago, IL 60680
Phone: 312-864-8200, 855-444-1661 toll free, TTY 711
Fax: 312-548-8200

We will let you know what information we need to work on the appeal. We will give you an answer within fifteen (15) business days from the date we received your appeal request. Up to fourteen (14) more calendar days may be taken to make a decision on your case if we need to get more information before we make a decision. We will notify you and your doctor in orally and in writing of our decision.

The written appeal should include the following information:

- Your name
- Your member number
- A phone number where we can reach you
- Why you think we should change the decision
- Medical information to support the request

If you or your doctor believe that waiting the standard time to decide your appeal could seriously risk your life or health, including being able to reach, keep, or get back to your maximum function, you or your doctor should tell us this when asking for an appeal. If we agree, we will make a decision sooner (within 24 hours of receiving all required information) on your appeal. This is called an "expedited appeal". You do not have to request an "expedited appeal" in writing. We will notify you and your doctor of our decision orally and in writing.

If we are going to reduce, or stop a service we had approved you to receive in the past, you have the right to request to keep getting the service until we make our decision on your appeal.

To keep getting the service, you must ask to continue the service and file an appeal on or before 10 days of the date of this notice. If you appeal the action and keep getting service you may have to pay for the service if the appeal decision is not in your favor.

If you have questions, you can call us at 312-864-8200, 855-444-1661 toll free, TTY 711.

Sincerely,

[SIGNATURE BLOCK].
Cc: **<<facility_name>> <<pcp_full_name>>**

Enclosure – CountyCare Authorized Representative Designation Form

Created: 04/25/2018 Revised: 7/11/2019, 4/30/2025, 11/19/2025

Member Rights and Responsibilities

All members, including (M)LTSS and non-(M)LTSS member Rights and Responsibilities are provided as listed below. Member rights and responsibilities are made available to all other CountyCare members through the Member Handbook, CountyCare Website, or from the Care Coordinator.

CountyCare members have the right to:

1. Have information about CountyCare programs. Have information about CountyCare, our staff, and their qualifications.
2. Choose not to participate in CountyCare programs or services.
3. Know the staff members responsible for your case management services. Know how to change your care manager.
4. Have CountyCare support when making health care decisions.
5. Know all the case management services that are available. Discuss these services with your provider.
6. Have your medical information kept safe. Know who has access to your information. Know how CountyCare keeps your information safe.
7. Be treated with respect and dignity by CountyCare's staff at all times.
8. Communicate a complaint to CountyCare. Know how to file a complaint. Know how long it takes to get an answer to your complaint.
9. Have information in a language or method you can understand.
10. Be understood. This includes if you have limited English, have a different culture, or a disability.
11. Receive a copy of your care plan (Individualized Plan of Care/IPoC).

You are able to use your rights without any action taken against you.

Member Responsibilities

CountyCare members have the responsibility to:

1. Follow the instructions and care plan (Individualized Plan of Care/IPoC) agreed upon by you and your provider.
2. Treat your care manager and your care coordination support team with courtesy and respect at all times.
3. Give CountyCare the right information so we can give the services you need.
4. Let CountyCare and your treating provider know if you leave the CountyCare Care Coordination program.

Disenrollment

A member may disenroll or "opt-out" from care management voluntarily and/or when their condition and circumstances improve. The member notifies the care coordinator or may notify another individual who must notify the care coordinator. The care coordinator records the date and any information about the decision to opt-out and indicates this change in program status within the care management record to ensure appropriate reporting. Care management or care coordination services may be discontinued for members who do not fulfill their responsibilities listed above. Refer to the Outreach and Engagement section "Addressing Challenging Behavior" for further description of this process.

A (M)LTSS HCBS member's consent must be documented, as well as their written acknowledgement of understanding their rights and responsibilities, which include:

- Education on their member rights at the time-of-service initiation, at the time of change in service and annually
- Being given the opportunity to participate in choosing the types of services being delivered and providers
- Right of members to have input and agreement on the care plan (Individualized Plan of Care/IPoC)
- Right of the member to refuse treatment or services and the implications of such refusal relating to benefits eligibility and/or health outcomes
- Education on how and to whom to report abuse, neglect, and exploitation at the time of the assessment and reassessment.
- Use of end of life and advance care directives
- Right to receive notification and rationale when CC/CM services are changed or terminated.
- Alternative approaches when the member and/or family are unable to fully participate in the assessment phase.

For all other members, participation by telephone, in-person or other two-way communication implies consent and no separate consent process is required.

Created: 09/28/2017; Last revised: 2/20/2018, 7/11/2019

Outreach and Engagement – All Members

CMEs are required to engage and enroll all members in the populations outlined in the Eligibility for Care Management (Complex Case Management) section of this Manual, and additional priority populations, unless and until they actively opt-out.

Prioritizing Outreach

CMEs will utilize phone calls, standard mail, and face-to-face visits, as well as a variety of additional outreach strategies to locate and engage members with preventive services and care coordination. The following should be prioritized for outreach. Members who:

- have been stratified to high or moderate risk.
- have high predictive modeling risk scores.
- have a substance use disorder.
- have recently been hospitalized, especially for mental illness or intensive care.
- frequently utilize the emergency room or inpatient care.
- are pregnant, new parents, or newborns.
- have been stratified to moderate risk; are due or past due for preventive or chronic disease management services including visits to the medical home within the past year.
- have conditions identified by the health plan as quality focus areas or special populations.

Methods of Outreach

The following are required outreach activities. Simultaneous outreach attempts should be made to any locations the member may be located including home, alternate addresses, shelters, hospitals or other health and community service facilities.

- Make a contact attempt to each number on record (at least 5 attempts, using morning and evening and different days of the week across at least a 2-week period but also within a 60-day period
- Look in data systems to find additional phone/contact information:
    - Government websites
    - CountyCare Portal
    - CME Software Systems
    - PointClickCare
    - Electronic Health Records
    - UM System (Identifi)
    - Housing system (HMIS)
    - Criminal Justice system (Cook County Jail, Illinois Department of Corrections)
    - Pharmacy system
    - ICARE
- Contact providers and organizations who may have information about the member's last known location and/or where member has history of utilization.
    - Hospitals and nursing facilities
    - Providers who service the member at home: HCBS providers, home-delivered meal providers, home health agencies, DME companies
    - Pharmacies where members get prescriptions.

    - Community agencies commonly used by members such as churches, food pantries, currency exchanges, Family Case Management, and the Better Birth Outcomes program.
- Send at least one letter via regular mail to all addresses on file following unsuccessful phone attempts.
- Make a home visit.
- Make a hospital visit when member is hospitalized.
- Contact the Provider/Specialist/Medical Home for collaboration and establish the ICT:
    - Request the provider notify/instruct member to call the care coordinator.
    - Notify the care coordinator of upcoming appointments so that they can meet member at provider's office.
- If at any point, the reason for outreach is determined to be urgent to the member's health, safety and/or welfare, multiple outreach strategies may be performed including accessing City of Chicago Services through 311, joint home visit with a Chicago Police Department Community Assistance Program (CAP) officer or request the police department of the local jurisdiction to perform a health and wellbeing check.
- Send certified letters as indicated to members who may experience specific negative consequences from lack of contact with Care Coordination Services

The outreach activities listed above shall be completed within 60 days.

Outreach will be considered "successful" if care coordinator makes contact with a member. Once the member is located, and at every contact with the member, the care coordinator will confirm contact information – primary and alternate phone number/s, address of residence, e-mail address and preferred method of contact – and update the contact information in the CM system.

Successful outreach may result in a member opting out of the Care Management Program. Care Coordinators are expected to use engagement techniques to prevent opt out and keep lines of communication with the member open. This may include negotiating preferred time and methods for communication, limiting contact to specific topics, or offering another member of Care Management team if preferred. If the member explicitly states that they do not want to be contacted by Care Coordinators, they may be categorized as opt Out for Care Coordination Services.

The opt out date is the date the member stated that they do not want to be contacted; the Opt Out date will be documented in the care management software, and the member will be flagged for future outreach in 6 months. While a member has opted out of the Care Management Program, unless specifically directed by the member, the Care Coordinator is still expected to coordinate services among care providers, benefit managers and health plan staff. A change in the member's health status prompts a reassessment and subsequent new risk level that may trigger the CME team to again offer the care management program sooner than 6 months following opt-out.

An outreach is considered "unsuccessful" if the care coordinator does not speak with the member or their legal representative. Members who have been unable to reach in adherence to the formal outreach process described above may be designated as Unable to Reach (UTR). The member will be flagged for future outreach in 6 months. While a member is UTR, the Care Coordinator is still expected to coordinate services among care providers, benefit managers and health plan staff. A change in the member's health status prompts a new outreach to the member, reassessment and subsequent new risk level that may trigger the CME team to again offer the care management program sooner than 6 months following UTR.

All outreach attempts, successful and unsuccessful, must be documented in the CME's care management software. Last Revised: 1/31/2025

Engagement

Care Coordinators are expected to utilize a wide variety of person-centered engagement techniques, including motivational interviewing, and styles of communication that are practical, relevant, and culturally competent for each member.

Engagement of members with high needs

Care Coordinators are expected to proactively identify members who have high or rising risks or needs. Care coordinators should use all information available to them, including health risk screens and assessments, review of medical records, interactions with members and support persons, reports from providers or other health/community service staff, daily notifications of hospitalization and emergency department visits, refreshed data including claims, predictive modeling scores, flagged conditions or statuses, etc. Routine and early engagement of members with high or rising risks and needs is expected, to prevent further health problems. Members who demonstrate a high level of hospital utilization should be prioritized for additional outreach and engagement. Members with high utilization often experience a significant lack of resources and barriers to care, alienation from social relationships, and may also have behavioral health conditions. In order to establish individualized plans of care for these members, extra effort is required to engage the member and his/her healthcare network.

Addressing Challenging Behavior

Engagement with members may require repeated and varied attempts by the care manager to engage the member. If the member refuses to engage with the care coordinator, they should attempt to identify a partner within the CountyCare network who may be able to engage with the member as part of the Interdisciplinary Care Team. Alternatives to care coordinators include community health workers, behavioral health consortium staff, Assisted Outpatient Treatment staff, medical home staff, or other professionals. If the member is unwilling to engage any member of the ICT, care coordinators are expected to engage with the Health Plan, providers, and facilities regarding member care.

Care coordinators may set appropriate limits with members who are disrespectful, threatening, or inappropriate. Care Coordinators are expected to involve supervisors when members do not behave within appropriate limits, or there is a perceived risk to the safety of care coordinators or other health care staff. With supervisor involvement, care coordinators may establish specific expectations for productive communication with members, clearly identifying the limit and the consequence of discontinuing communication within specific timeframes with members if such expectations are not met. CMEs may terminate the care coordination relationship. Care coordinators must document behavior, expectations, and corresponding actions in the care management record. If a member is enrolled in HCBS, the care coordinator must follow additional procedures to terminate the care coordination relationship.

Care Management Agreement (Memorandum of Understanding)

As part of the Integrated Plan of Care (IPoC), care coordinators may also need to establish a written plan with members who behave in a manner that is out of compliance with the administrative rules that govern the HCBS waiver program, or if a member in the HCBS waiver program chooses a living arrangement that poses risk to their health safety or welfare.

A care management agreement is a written plan for members whose behavior is not compliant with the terms of participation for the Division of Rehabilitation Home Services Program or the Department on Aging Community Care Program. A care management agreement outlines member behavior that is out of compliance with the rules of the HCBS waiver program and the minimum behavior required for the member to participate in the program. The consequences of continued non-compliance and a time period for reevaluating the member's behaviors are included as well.

Care Coordinator Safety

Safety and respect are top priorities for Care Coordination. Applicable areas are community based activities associated with individual residences, clinics, facilities, and all localities were care coordinators complete work activities.

CountyCare Health Plan establishes a standard of practice for completing face-to-face visits with members in a safe and effective manner that includes. Assessment, effective observation, and application of judgment of the immediate physical environment to ensure safety, while developing capacity to fulfill the health plans commitment to meet people where they are.

Practical Safety Practices include the following:

- Complete home visits in neighborhoods staff are unfamiliar with, go first thing in the morning and do not schedule appointments later in the afternoon.
- Do not park in dead end streets or cul-de-sacs.
- If immediate help is needed, check for open and highly trafficked businesses or public buildings in the area (retail store, restaurant, laundromat, library, police, or fire station)
- Call immediately before approaching the member's location. Ascertain any changes or things you may have forgotten to ask about (allergens, visitors, suspect activities, doorbells, elevators, or other access equipment in disrepair, etc.).
- If the member claims they are home alone and you hear lots of background noise, ask again.
- Ultimately, if it does not feel right, don't go.

Personal Safety Practices include the following:

- Complete a safety assessment and drive through to check out new neighborhoods and addresses.
- Utilize the Buddy System for known risks and speak with your direct manager.
- Utilize Personal safety devices such as whistles, loud siren with keys, etc.
- Have your keys ready before getting into your vehicle.
- Check inside of your vehicle before entering and lock doors immediately upon entering your vehicle.
- Download a locator application on your work cell phone so you can be located in emergent situations.

Mitigating Risks: When scheduling home visits ask the member about parking and any areas of concern. In an unfamiliar neighborhood, assess parking or other necessary details to maintain a safe visit. Do not

sit in a parked car outside of the member's home to chart or do work, do so in an alternative safe location.

Community Infection Control Safety:
Personal measures are expected for all CMEs and care management staff completing home visits. Masking, handwashing, use of sanitizer, and gloves are good measures to take against disease control. Have the discussion with your members prior to the visit to ascertain their level of comfort. Masking requirements for CountyCare staff: CCH COVID Staff Alert 5.3.2023.pdf (cchhs.local).

Last revised: 11/01/2017, 11/22/2017, 2/19/2018, 04/17/2018, 10/04/2018, 4/22/2019, 5/31/2019, 8/21/2019, 1/16/2020, 11/22/20, 5/26/2022, 8/30/2023; 8/28/25

Brighter Beginnings - Care Coordination Program for Pregnant Women, Infants, and Families

Brighter Beginnings is a program to help expectant families and babies stay healthy during pregnancy and after the baby is born. Through care coordination, the program guides members through prenatal appointments, and assists with adding the newborn to the family's Medicaid coverage. Care Coordinators assess all pregnant members for high-risk pregnancy, and all pregnant members are offered Care Management. As part of Brighter Beginnings, CountyCare coordinates services with Better Birth Outcomes and Family Case Management.

Care Coordinator Expectations:

- Contact all pregnant members, screen for high-risk pregnancy, and offer Care Management
- Connect pregnant members to pregnancy-related resources including person-centered health education.
- Reinforce the CountyCare Rewards program.
- Complete care plan that incorporates pregnancy-centric goal
- Assist member with specialty care referrals and appointments as needed.
- Ensure initiation and continuation of prenatal care.
- Ensure postpartum appointments are scheduled, including one between 21-56 days after birth, including timely family planning services.
- After the baby is born, ensure newborn appointments are scheduled and assist with referrals for any needed ongoing care.
  Assist pregnant women and new mothers, or legal guardians, to add the newborn to the family's Medicaid coverage.
  Last revised: 08/21/2019

NICU CARE MANAGEMENT PROGRAM DESCRIPTION

The NICU Care Management program provides care coordination for newborns and their families from admission to a Neonatal Intensive Care Unit through discharge and post-discharge.

Program Goals:

- Care Management supports families with a newborn with quiring Neonatal Intensive Care at birth.

Care Management Activities:

- Identification of neonatal population, including care management needs through screening of mother and baby, development of family focused care plan, education of family members, and coordination of available resources to facilitate discharge.

Objectives:

- Early Identification of the NICU population, including name, RIN, CME Assignment
- Screening, assessment, care plan and PCP/medical home identification for baby as indicated.
- Coordination of supportive services during hospitalization and in preparation for discharge.
    - Hospital Grade Breast Pump,
    - Car Seat
    - Safe Sleep Kit
    - Transportation assistance for mothers to visit babies during long NICU stays.
        - 7-day bus passes
- Identification of barriers to discharge, such as DCFS involvement, inadequate family housing, etc.
- Weekly ICT rounds with NICU team for the facilitation of readiness for discharge and support of family during NICU hospitalization.
    - Weekly NICU Census by CME provided weekly.
- Collaboration with Maternal Care Management teams, with a focus on moms with behavioral health needs, including SUD, bereavement, etc.
- Collaboration with hospital NICU Discharge planners, Care Management teams.
- Post-discharge support, if indicated.

CARE MANAGEMENT EXPECTATIONS

Resources:

- DME, such as Oxygen, feeding pumps, suction, pulse oximetry, etc.
- Identification of community resources, including bereavement support
- Early Intervention Services
- WIC services
- Facilitating necessary resources (Housing, specialized equipment/services, specialty of care) if indicated.

INCLUSION CRITERIA

INFANT INCLUSION FACTORS

- Prematurity ≤ 35 weeks of gestation
- Low Birth Weight

- Respiratory Failure requiring Mechanical Ventilation and/or Oxygen.
- Congenital Anomalies, including congenital heart disease.
- Surgical Conditions, such as Diaphragmatic Hernia, TE Fistula, Cleft Palate, etc.
- Multiple Births (Twins, Triplets, Quads)
- Feeding Disorders

- Neonatal Abstinence Syndrome
- Neonatal Death for any reason
- Congenital Syphilis

MATERNAL INCLUSION FACTORS – for all babies regardless of NICU criteria

- Maternal Medical conditions, such as Diabetes, SLE, Congestive Heart Failure, Cystic Fibrosis, etc.
- Maternal Death
- Behavioral Health determinants
    - Inpatient Psych
    - Developmental Delay
- Social Determinants
    - Unhoused
    - Teen Mom
    - Violence (MVA, DV, Assault, GSW)
- Substance Use Disorder during current pregnancy.
- DCFS Involvement in current case

INCLUSION FACTORS REQUIRING CLINICAL JUDGEMENT

- Late Preterm infants (36 – 39 weeks' gestation) with no complications or clinical indications
- Chorioamnionitis
- Rule Out Sepsis

EXCLUSION CRITERIA

- Full term infant or infant ≥ 36 weeks' gestation with no complications
- Full term infant or infant ≥ 36 weeks with minor conditions of the newborn, such as hyperbilirubinemia requiring only phototherapy.
- Full term infant or infant ≥ 36 weeks with transitory adjustment following birth (resolving within 24 – 48 hours), baby discharged with mom with no special follow up needs or appointments.
    - TTN (Transient Tachypnea of the Newborn)
    - Brief respiratory support at birth (PPV or Oxygen)
    - Recovery from maternal Magnesium infusion for pre-eclampsia

  Created: 7/31/2024

Outreach & Engagement – (M)LTSS HCBS Waiver Members

For members enrolled in HCBS, Care Coordinators must follow the overall guidelines for outreach and engagement plus these additional requirements, which supersede the general standards.

- **Newly Waiver Eligible Members:** all outreach activities, engagement efforts, and attempts to complete the initial assessment, must be completed within 15 calendar days of the Notification Date
- **Legacy Waiver Members:** all outreach activities, engagement efforts, and attempts to complete the initial assessment, must be completed within 90 calendar days of the Health Plan Enrollment Date

Methods of Outreach

1. The following are additional required outreach activities for waiver care management:

- **Contact the Assessing or Referring Agency** to obtain member contact information:
  - CCU/Agency that completed the DON, particularly for 2 day and 15-day members.
  - Previous MCO waiver team/CCU/provider providing waiver care coordination – 90-day members.
- **Contact the Waiver Provider** to obtain member contact information or schedule a joint visit:
  - 90-day Members are established waiver members who likely have services in place that can be leveraged to connect with the member
- **Letter #1 –** send regular mail to all addresses on file following unsuccessful phone attempt.
- **Make a Home Visit**
  - Interim Members – within 2 days of referral or hospital discharge
  - 15-day Members – if otherwise unable to reach member and prior to the 10th day
  - 90-day Members – if otherwise unable to reach member and prior to the 60th day
- **Letter #2 –** send letter indicating the contact requirements of the program and consequences including and up to termination from the waiver program.

If a care coordinator is unable to contact a member in a HCBS waiver within 90 days after enrollment, they must, after documenting all forms of no fewer than 5 attempts to contact the member, contact the appropriate operating agency, provide documentation of the various attempts to contact the member and request that they no longer be in an HCBS waiver.

Successful/Valid Outreach Contact

Successful or valid outreach contact is defined as documentation of discussion between the care coordinator and the member that ensures the member's health, safety and welfare are being maintained, potential gaps in service delivery are discussed, and that services are being provided in accordance with the member's IPoC and service plan.

Valid justification *is defined as:* clear documentation of a minimum of three efforts/attempts to outreach the member occurring at different times of the day, different days of the week, and in advance of the required contact period. The use of community resources (e.g., outreach to paid providers, agencies, pharmacies, physicians) to engage the member is to be documented in the member's record.

Valid justification *would also* include when a delay in, or missed, contact was due to member refusal or request to change contact appointment.

Valid justification *would not* include: if the only contact attempt included outreach attempts that occurred on the same day that the contact was due.

Exhausting Outreach

Outreach to an HCBS waiver member will be considered exhausted when:

- All of the steps outlined above have been completed and documented with no successful contact with the member after a minimum of 5 attempts to locate the member.
- Services are not currently in place.
- There have been no paid claims or individual provider payments for the member in the last 60 days.

Initiating Waiver Closure

After all possible resources to locate the member have been exhausted and documented and there is no evidence of a waiver provider serving this member (via claims/vouchers), the waiver care coordination lead or designee will notify the waiver oversight agency – Department of Rehabilitation Services (BI, HIV, PD), Illinois Department on Aging (Elderly) or Bureau of Long-Term Care (SLF) and initiate waiver case closure.

The Operations team must complete the following task:

- Notification to BEAM (IDoA), Local DRS Office, or HFS
- Certified mail to members informing them that case closure has been initiated.
- Notification to the most current provider(s) of the closure request (as applicable) (Identify what services are ending and document who will provide the services)
- End authorization (as applicable)
- Monthly follow-up with the Waiver Oversight Agency until the closure is complete.

The care coordinator must continue to document contact attempts, resources, and additional case closure actions until such closure is made, including:

- Zero out the service plan (as applicable)
- Must document the date the member declined waiver services.
- Must document how members' needs will be met without waiver services in place.
- Request a Notice of Action (NOA) Letter to be mailed out by Operations team.

After 10 days of the NOA letter mailing and have been verified, then Care Coordinator can proceed with the Waiver Closure process.

Waiver Oversight Agency Contact Information for Waiver Closure Requests

- IDoA/Beam Unit - Aging.Advisor@illinois.gov
  - Submit the MCO Participant Transfer Form to Care Coordination Unit
- DRS– Notice is sent to DRS Managed Care email box of: DHS.HSPManagedCare@Illinois.gov
  - Reason for the waiver closure request
  - Info and details that support the request.
- HFS/SLF - HFS.SLF@Illinois.gov

Service Satisfaction

Each member of contact should include an assessment and documentation of the member's satisfaction with their waiver services and quality of life. A Personal Assistant (PA) Evaluation is completed with any DRS member that has a Personal Assistant providing services in the home. The PA Evaluation must be completed for every PA providing services to the member and each time there is a change in the PA to assess the member's satisfaction level. The Evaluation is completed annually for members in the Disability (PWD) Waiver and bi-annually for members in the HIV/AIDS or TBI Waiver. The care coordinator is expected to document, follow-up, and address issues noted by the member.

For members in the Elderly Waiver, a Participant Outcomes and Status Measures Quality of Life Survey (POSM) is completed at the Initial Assessment and then annually The POSM survey helps indicate the Elderly Waiver Member's satisfaction and assessment of their quality of life. The care coordinator is expected to follow up and address issues noted by the member and document in the member record.

Last revised: 09/28/2017, 11/22/2017, 12/11/2017, 2/20/2018, 04/17/2018, 6/27/2018, 10/04/2018, *5/31/2019, 12/31/2020, 8/30/2023*

Pathways to Success / N.B. Consent Decree

Background: On January 16, 2018, United States District Judge Jorge L. Alonso approved the terms of the N.B. Consent Decree, which was agreed to by the state of Illinois and the Plaintiffs. The purpose of the Consent Decree is to design and implement a systemic approach through which all Medicaid-eligible children under the age of 21 in the State of Illinois, with reasonable promptness, will be provided the Medicaid-authorized, medically necessary intensive home and community-based services, including residential services, that are needed to correct or ameliorate their mental health or behavior disorders.

Program Description: Pathways to Success is one part of the State's efforts to enhance the behavioral health service system for children and is designed to address many of the State's commitments under the N.B. Consent Decree. The program is designed for children with complex behavioral health challenges and provides access to home and community-based services. It is built upon an intensive model of care coordination that addresses the broad range of each child and family's needs and is guided by systems of Care principles that put children and families at the center of planning for services and support.

Eligibility: Members may be eligible for Pathways if they meet the below criteria.

a. Has Medicaid
b. Is under the age of 21.
c. Has a Mental Health Diagnosis
d. Has complex, intensive needs identified on their IM+CANS that are significantly affecting them at home, at school, or in their community.

HFS will make a final determination of Pathways eligibility based on review of the IM+CANS. If eligible, HFS will then assign the member to a program tier (Tier 1 or Tier 2), determined by HFS for decision support criteria based off risk factors and domains from the IM+CANS. Tier 1 (High Fidelity Wraparound) has more intensive program requirements than Tier 2 (Intensive Care Coordination).

Timeline: Pathways to Success is live as of January 1, 2023.

Member Identification: Pathways members may be identified through the NB or NM OBRA code, or the CCC-HP-Pathways CME tag.

Member Risk Level: All Pathways members must be stratified at high risk (Level 3) during their time in the program and for 90 days after disenrollment from Pathways.

Care Coordination and Support Organization (CCSO) Assignment and Responsibilities: All Pathways members will be assigned to a CCSO based on their geographic location. CCSOs are responsible for providing Care Coordination and Support Services to Pathways members. All children enrolled in Pathways will be assigned as a care coordinator from their CCSO. The CCSO care coordinator is required to complete key activities in specific timeframes (contacts, IM+CANS review, CFT Meetings, etc.) and to operate consistent with the values and principles of Systems of Care, Wraparound, and Family-Driven Care.

Care Management Requirements: All members enrolled in the Pathways program will be assigned to the Health Plan for care management and will be assigned as a Health Plan Care Manager. See below for Care Manager program requirements.

Warm Handoffs: Upon assignment of a Pathways member, Care Managers will review all available member information. If the member was previously assigned to a different Care Manager and/or CME, the newly assigned Care Manager must outreach the previously assigned Care Manager and complete a warm handoff. Likewise, when a member disenrolls from Pathways, the Care Manager must complete a warm handoff back to the previous Care Manager/CME.

Collaboration with CCSO: CountyCare Care Managers for Pathways members are expected to closely collaborate with the member's CCSO Care Manager. Upon assignment of a Pathways member, CountyCare Care Managers are expected to outreach the CCSO and connect with the member's CCSO Care Manager. Care Managers should exchange contact information, as well as key member documents (IM+CANS, Safety Plan, etc.). Any documents received by the CCSO must be uploaded to CMIS. All contacts with the CCSO must be documented in CMIS.

Participation in Child and Family Teams (CFTs): The CCSO will work with the child and family to form a CFT in the first 30 days of a child's enrollment in Pathways. The CFT will work directly with the family to develop, review, and update the IM+CANS, particularly the Individualized Plan of Care. The MCO Care Manager is expected to participate in the CFT meetings. CFT meetings take place every 30 days for Tier 1 members and every 60 days for Tier 2 members. The MCO Care Manager should collaborate with the CCSO Care Manager to ensure inclusion in these meetings.

Documentation: Care Managers should document all activities for Pathways members in CMIS. This includes, but is not limited to, (1) contacts with the CCSO, (2) contacts with the member, (3) CFT meetings and minutes, (4) and any documents received by the CCSO (IM+CANS, safety plan, crisis plan, CFT documents, etc.).

HealthChoice IL Care Management Requirements: The MCO Care Manager is responsible for completing all HealthChoice IL care management requirements for high-risk members. This includes HRSs, HRAs, Care Plans, contacts, care plan reviews, and reassessments.

LTSS Members: Some Pathways members may also receive LTSS services. These members will have a primary LTSS Care Manager who is expected to complete all LTSS program requirements for the member, in addition to coordination of their Pathways program requirements.

Created: 3/8/2023

Beacon Portal Youth

Background

The Beacon Portal is a component of the Illinois Children's Behavioral Health Transformation Initiative (CBHTI) that aims to address gaps in care for youth requiring mental health needs. This initiative brings together a variety of organizations to collaborate and improve access to behavioral health services. The Beacon Portal was established to connect families to programs, services and people within one place. This portal is a shared platform for all agencies to work collaboratively together.

Care Coordination Services and CME Assignment

Youth are entered into the portal by parents/guardians, state agency staff, hospitals, or other agencies that recognize the high-risk needs of the youth. Youth who are recognized as Portal Youth will be managed by the Pathways to Success Care Coordination team. In the instance that a youth is assigned to another CME, a CME change request will be processed by the HealthPlan. A warm handoff should occur with the previously assigned CME and the Pathways to Success Care Coordinator. Once the process is completed, the youth and family will receive care coordination services to address their at-risk behavioral health needs.

Created: 1/31/2025

Phones: Assisting Members with Obtaining a Government Funded Phone

Care Coordinators are responsible for assisting members with obtaining government-funded phones. Members are responsible for providing proof of Medicaid eligibility. SafeLink and Assurance are two resources for assisting members to obtain a phone. SafeLink and Assurance phones can be requested by online application or by phone.

https://www.safelinkwireless.com/Enrollment/Safelink/en/Web/www/default/index.html#!/newHome

https://shop.assurancewireless.com/phones.html

Last Revised:5/22/2020

Predictive Modeling Scores and Risk Stratification

CountyCare systematically assigns an initial risk level within the first fifteen (15) days after enrollment. CountyCare utilizes CDPS+Rx as its predictive modeling (PM) tool, to create a numeric score that is intended to predict all members' risk of future health care utilization. CDPS+Rx incorporates demographic data and claims for medical care, behavioral health, and pharmaceuticals to generate a score. CountyCare provides member level PM scores through a data feed into each CME's care management system as well as access to Vision, an online population health tool. CMEs are expected to train staff on the use and meaning of the score and display scores in each member's profile so that care coordinators will utilize the PM score, in combination with any other data they gather about the member, to stratify members into three risk levels, proactively identify high risk members, and monitor gaps in care. Care management entities should use the CDPS-Rx for risk stratification after 90 days of CountyCare eligibility in the absence of risk stratification by health risk screen or assessment.

1. CMEs are expected to use population and individual-based tools and real-time data to identify a member's risk level and any special conditions. These tools and data include but are not limited to:

    a. **Health risk screens and assessments:** CMEs are required to make their best efforts to administer the health risk screening and, if needed, a behavioral health risk assessment to all new members within 60 days after enrollment, to collect information about the member's physical, psychological, and social health
    b. **Predictive Modeling:** Based on demographics and member claims data, CountyCare utilizes CPDS-Rx to generate a PM score for each member, which is refreshed monthly based on new data.
    c. **Surveillance Data:** This includes referrals, transition information, service authorizations, alerts, results of the Determination of Need (DON), or other assessment tools adopted by the state, and from families, caregivers, providers, community organizations and contractor personnel.

2. Based upon an analysis of the information gathered through the tools and data described above, CMEs are expected to stratify all members into three levels to determine the appropriate level of intervention by its care management program:
    a. Level 1 (low risk) - includes low or no-risk members who will be provided, at a minimum, prevention and wellness of messaging and condition-specific education materials.
    b. Level 2 (moderate risk) - includes moderate-risk members who will be provided with problem-solving interventions.
    c. Level 3 (high risk) – includes members who will be provided with Care Management (Complex Case Management) for reasons such as addressing acute and chronic health needs, behavioral health needs or addressing lack of social support.

Minimum percentages of members		
Population	**Level 2 and 3 (combined moderate- and high-risk)**	**Level 3 (high-risk)**
Families and Children Population	N/A	2%
ACA Adult population	N/A	2%
DSCC	N/A	100%
Special-Needs Children	40%	20%
Seniors or Persons with Disabilities	20%	5%
Dual-Eligible Adults	90%	20%

3. PM scores are available in CME care management systems and CountyCare's Vision software.

4. Each month, CMEs are expected to identify PM scores for the following priority groups of members:
    a. Members eligible for ≥ 90 days who have an unassigned risk level by health risk screen.
    b. All members with high PM scores
5. For all members who have been in CountyCare ≥ 90 days who have an unassigned risk level, CMEs will review risk scores and prioritize outreach to those with high-risk scores because they are likely to have risk factors and need care management support.
6. For all members with high PM scores, analyze PM scores in combination with other screening, assessment, and surveillance data, and make risk level changes if appropriate.
7. CountyCare will periodically generate reports and review complete records for a sample of members at each risk level to assess if the CME is using all available data to assign appropriate risk levels.

Last revised: 10/31/2017, 04/17/2018, 5/31/2019, 7/11/2019,4/22/2020, 5/22/2020, 10/7/24

Reassessment and Ongoing Care Planning

Care coordinators and CME teams are expected to analyze predictive modeling scores and other surveillance data of all members monthly to identify risk level changes. As conditions and risk levels change, care coordinators must complete reassessments as necessary, as well as update IPoC's and make modifications in interventions for the member. Care coordinators are required to review member IPoC's and intervention of high-risk members at least every thirty 30 days, and members at moderate risk at least every 90 days, and conduct reassessments as necessary based upon such reviews. At a minimum, care coordinators will conduct a reassessment every 12 months for each member who has an IPoC. In addition, for (M)LTSS members receiving HCBS waiver services or reside in a nursing facility, a face-to-face reassessment will be completed each time there is a significant change in the member's condition or at the member's request. For members in the HIV or BI waiver program, their reassessment will occur at a minimum, every 6 months.

Within ten (10) business days of creation and updates, the care coordinator will provide an updated IPoC to the PCP and any other providers that are involved in providing covered services to the member.

Last revised: 10/30/2017, 04/17/2018, 10/10/2019, 1/16/2020, 12.28.2023, 10/31/24

Recipient Restriction Program

Program Purpose

The purpose of the Recipient Restriction Program (RRP), also known as the Member Lock-In Program, is to identify, detect and prevent abuse of the pharmacy benefit, as defined by specific criteria outlined in federal and state laws and regulations and contained in the CountyCare Contract with the Illinois Department of Healthcare and Family Services (HFS), and ensure more effective utilization of health care services by health plan members. The program can also be used as a tool to promote care coordination, support IPoC goals and protect member safety.

Health Plan to CME Notification

Each month, HFS notifies CountyCare of members who have been enrolled in the RRP. It is CountyCare's responsibility to maintain the RRP for at least 12 months or until CountyCare's Medical Director approves termination. CountyCare will provide a monthly report to the CME. The first component of this report will detail the active members who have been added to the Recipient Restriction Program. The second component of this report will detail members who have been removed from the Restrictions Program. The report will indicate the risk factor prompting the RRP and if the member is restricted to a prescriber, a pharmacy or both.

Throughout the month, if CountyCare's Medical Director approves additional members to be added to or terminated from the RRP, the CME will be notified through the daily referral log.

CME Expectations

The CME notifies the member's assigned care coordinator of the members who are new and terminated from the program. The CME ensures that enrollment in the RRP program is documented or updated in the Care Management system, ideally using a flag or field. The Care Coordinator will work with the member to ensure that the member is aware of the Restriction Program. The care coordinator will work with providers as needed to assist with coordination of care for the member and, when appropriate, further educate the member and provider about the program and appeal rights. The CME will also notify the Health Plan if they have reason to suspect that a member is continuing to obtain excessive and/or inappropriate prescriptions.

Care Coordinators have additional responsibilities while supporting members who are experiencing issues related to abuse of the pharmacy benefit. In addition, the Care Coordinator is responsible for assessing and monitoring member changes related to the pharmacy benefit. Care Coordinators are encouraged to use direct and indirect reports from providers involved in the members of care related to determining if the member should be referred to the Recipient Restriction Program.

Once a member is identified as a candidate or referred for the Recipient Restriction Program (RRP), the Care Coordinator is responsible for the following:

- Engage in the member in Care Coordination
- Schedule and participate in an ICT meeting (with member) within one week of the member's identification or referral. (Via phone, in writing, in person meetings, etc.)
    1. The ICT will recommend if the member should be 'Locked in' or not.
    2. The ICT will recommend the role of the prescriber (s)
- Submit the Recipient Restriction (Lock-In) Program Referral form (If one has not been submitted by another person involved in the member's care)
- Update the members' risk level as needed.

- Update the members of the IPOC.
- Obtain appropriate consents for sharing member information.
- Communicate with ICT about ongoing and changing needs of the member.
- Outreach members in Recipient Restriction Program based off of enrollment in care coordination and attempt more frequent contacts as needed.

Referrals to the Recipient Restriction Program

Members may be referred to the Recipient Restriction Program by care coordinators, providers or by members themselves. Referral is made by completing the Recipient Restriction Program Referral Form. The form can be found on the CountyCare website and includes instructions on how to submit required information. If the member would like to make a self-referral, s/he may request assistance from a care coordinator or may call member services and make a request verbally. The CountyCare clinical team will review the request, gather additional research, and submit a recommendation to the Medical Director who must approve all requests. If the member is approved for RRP, notification will occur as stated above.

Last Revised: 7/11/2019

Redeterminations

Uninterrupted Medicaid eligibility is integral to continuity of care and members' ability to access health benefits.

Redetermination (**rede**) is the review by the State of Illinois to confirm an individual's eligibility for Medicaid, All Kids, SNAP, or cash assistance benefits. If the individual or family still meets the eligibility criteria, their coverage will continue. Medicaid recipients, with a medical case only, are re-determined annually, and Medicaid recipients, with a medical/SNAP combined case, are re-determined every six (6) months.

Re-determination Timeline:

The Department of Human Services mails rede packets 60 days prior to the benefit period end date.

If forms submitted by the due date:

- When the member is determined to be eligible, their case remains open with no break in coverage.
- After DHS review, members' cases are cancelled at the end of the month if they are found no longer eligible.

If forms are submitted after the due date:

- The member's case is canceled and remains canceled until DHS reviews.
- When the member is later determined to be eligible, their case is reinstated and backdated to cancelation date.
    - Members reinstated within 60 days of cancelation:
        - HFS attempts to re-enroll members in health plans with no break in eligibility or MCO coverage.
- Forms submitted 90 days after cancellation are not honored, and members must reapply.

Care Management Expectations

On a monthly basis, CMEs receive a list of members that need to complete Medicaid redetermination to maintain Medicaid eligibility. This list includes all members assigned to the CME. While redetermination is managed by the State in compliance with Federal regulations, care coordinators to actively work to ensure that assigned members complete their redetermination requirements.

CMEs are expected to:

- Prioritize outreach to support members in active episodes of care for which, if Medicaid eligibility is interrupted, may result in a poor outcome for the member's health, safety, and welfare.
- Do targeted outreaches for all members that stratify Level 3 (high risk), (M)LTSS members in nursing facilities, or those receiving home and community-based services.
- Assist members due for rede within the next 30-60 days with completion and submission of redetermination paperwork when requested by the member or by CountyCare staff. This
    - Assisting the member to create a "Manage My Case" account on the Application for Benefits Eligibility (abe.illinois.gov) to access and submit their redetermination forms
    - Coordinating with CountyCare's redetermination resources to request new forms, ask questions about completing the forms, and verify reasons for cancellation.

    - Submitting completed redetermination forms on behalf of members to the DHS Central Processing Unit via fax. Copies of the completed forms and fax confirmation will be forwarded to the CountyCare Call Center at callcenterquestions@cookcountyhhs.org.

- Provide members with the phone numbers to call for assistance and/or assisting members in making three-way calls.
- Help members to update their addresses and phone numbers with the state so that they receive timely notification.
- Integrate redetermination dates into their care management software at the individual member level to improve care coordinator visibility and ability to assist member.
- Educate all members about redetermination and remind members of their redetermination date during all contacts with the member, including during their initial health risk screen, assessment, and any subsequent contacts via phone, email, or face-to-face.

Redetermination Key Contact Phone Numbers and Resources

Helpful links:

- ABE Manage My Case (online redetermination, change of information, and add programs)
- Application for Benefits Eligibility (for new medical, SNAP, or cash assistance applications)
- Webinar Slides on ABE Manage my Case (step-by-step instructions for setting up a Manage My Case account

Redetermination Submission:

- Fax redetermination forms to HFS at: 844-736-3563
- Additionally, email forms to CountyCare Call Center at callcenterquestions@cookcountyhhs.org

General Questions about Redetermination

- **CountyCare Call Center:**
    - Phone: 312-864-8200, Option 1 or 312-864-REDE (7333)
    - Hours: Mon-Fri 8:00 AM – 7:00 PM or Sat 9:00 AM – 5:00 PM
    - Additional services: request copies of redetermination forms, confirm their redetermination date, verify reasons for cancellation or suspension, verify if forms have been processed, report a change of address.
- **Department of Healthcare and Family Services**
    - Phone: 800-843-6154 and TTY 866-324-5553
    - Fax: 844-736-3563
    - Hours: Mon-Fri 8:00 AM to 5:00 PM
    - Address: PO Box 19138 Springfield, IL 62763
- **Illinois Department of Human Services (DHS) Help Line**
    - Phone: 800-843-6154 and TTY: 800-447-6404
    - Hours: Mon–Fri 8:00 AM to 5:00 PM

Created: 04/17/2018

Referrals to Care Management

CME General Delivery Email Inbox

CMEs are required to maintain a general delivery email inbox to facilitate communication with the Health Plan, Health Plan partners and providers. A designated staff member in the CME with requisite experience and authority to direct referrals and responses will check their general delivery inbox throughout the day and minimally at the start of the day, midday, and before close of business. CMEs are required to take action on email inbox communication within one business day and communicate with referring entity to acknowledge receipt of referrals. If a referral need is urgent or time-sensitive, or generated by an escalation resource, the CME must respond within an appropriate time to address the urgent need.

Providers, members, or caregivers may refer or self-refer for care management or care coordination. There are multiple avenues for referral.

Assistance from Member Services

Providers can send a secure message to Member Services through the Provider Portal or call Member Services at 312-684-8200 to find out who the member is assigned to for care coordination. Members can use the Member Portal or contact the same Member's Services number. Member services, in turn, will contact the CME's intake number and provide information about the referral.

Care Coordination Referrals

Providers, Discharge Planners, FHP Housing Managers, members, or caregivers can fill out and submit the Care Coordination Referral Form. For general referrals, the Care Coordination Referral forms are sent to the email address countycarereferrals@cookcountyhhs.org or fax 312-466-2997 and sent to the appropriate CME through the Identifi daily referral report. The referred member must be contacted by the care coordinator within five (5) business days of the referral date or sooner if indicated in the referral communication. Once the member has been assigned to a care coordinator and contacted, CMEs must provide confirmation to the referral source that the member was contacted. The Health Plan tracks referral follow up activity through the CME's clinical documentation system. Care Coordinators are expected to:

- Contact the member and address the identified issues from the referral.
- Assist the member with additional presenting concerns.
- Document the interaction and intervention in the CME documentation system.

General referrals can also be of any topic/type, including members requesting to be outreached by their assigned care manager to address their needs. Urgent referrals are sent directly to the CME via secure email, and a response to the health plan is required within two business days, or sooner if specified. Examples of urgent referrals to care management include Grievances, HFS Escalations, and UM to CM Referrals.

Direct Referrals to Care Coordination

Providers, members, or caregivers who are familiar with the CME and care coordination resources are encouraged to directly contact the CME or care coordinator directly with any request for support.

Referrals from (M)LTSS care management to Non-(M)LTSS care management

Members who lose eligibility for (M)LTSS services who remain with CountyCare and are referred to the appropriate CME as part of closing the (M)LTSS service, so that the member has ongoing care management support following formal closure from the (M)LTSS service.

Referrals for (M)LTSS HCBS Waiver Services

Referrals for Division of Rehabilitation Waiver Services (Persons with Disabilities, Brain Injury and HIV waivers) are made online at: https://wr.dhs.illinois.gov/wrpublic/wr/dynamic/referral.jsf

Assistance with Referrals to Department on Aging Waiver Services (Elderly waiver) can be found at: https://www.illinois.gov/aging/Resources/Pages/helpline-main.aspx.

Referrals from Member Services and the Grievance and Appeals Team

When a member calls Member Services and has an immediate care need, they will make a warm transfer to the assigned CME or send the Care Coordination Referral Form. When a member is calling with an urgent need, a shorter timeframe for follow up may be indicated If a member files a grievance through the Grievance & Appeals Team, and the G & A Team requires outreach from the care coordinator to resolve the grievance, a referral to Care Management will be sent to the CME for follow up. Grievances require a response within 5 days and resolution within 45 days.

Referrals from Utilization Management to Care Management

Specific circumstances trigger referrals from CountyCare Utilization Management to CMEs for further assessment of care coordination and care management needs. These conditions include:

1) Members with unmanaged chronic diseases as evidenced by frequent utilization.
2) Members who are utilizing non-par providers
3) Members with a newly diagnosed catastrophic (terminal or otherwise) illness.
4) Physician referral (UM Medical Director)
5) Barriers to transitions of care

UM staff review authorizations and refer to the respective CME with the following information.

Member Name	**UM RN name**
RIN	**phone**
DOB	**e-mail**

Urgency of Referral: Check box on left

Needs call < 24hrs

Needs call < 2 business days

Currently Hospitalized: Check box on left

Yes Hospital: Contact:

No

Referral Reason: Check box on left to those that apply; complete right column with key details.

New terminal/catastrophic diagnosis	Dx:
Poorly managed chronic disease	Dx:
Repeated use of OON provider	INN provider type/specialty needed:
UM Medical Director request	Reason:
Barriers to transitions of care	Reason:

Additional Information: Free text to expand on above from clinical documentation.

CMEs will review requests, prioritize, and take action according to their clinical judgement. The CME will provide feedback on the referral when possible. UM will document any feedback from CME in a member note in the UM system, Identifi, and refer to these notes when making future CM referrals on the member. If the CME has successfully engaged the member (accepts or declines CM), UM should wait for 6 months to make the next referral when triggered, however UM may re-refer sooner if there is new information that may impact care management. If the CME replies that they were unable to reach the member, UM continues to make referrals as triggered. If the CME does not reply, UM will continue to make referrals as they are triggered.

Referrals from Behavioral Health Access Line (BHAL) to Care Management

The Behavioral Health Access Line (BHAL) is staffed by licensed clinical staff and receives behavioral health referrals from a variety of sources including, members, parents and guardians, providers, and care coordinators.

The BHAL access line responds to referrals by arranging provider appointments as requested. Additionally, a referral is sent to the assigned CME for care coordination follow up or for care coordinator information.

All documentation regarding Care Management Referrals, Grievances, HFS Escalations should be entered into the designated CM system within the timeframe requested from the referral source.

Created: 07/05/2017, Revised: 2/20/2018, 04/17/2018, 10/04/2018, 1/16/2020, 2/3/2020, 5/22/2020, 1/24/2022, 9/7/2022, 3/8/2023, 1/31/2025; 1/31/26

Revisions to the CM Manual

This CM Manual provides CountyCare Health Plan's direction for its Care Management Program as administered by the internal health plan and delegated care management entities (CMEs). The content is updated as often as needed based on changes in requirements for CountyCare or changes for its CMEs. Expectations of care coordinators and CC/CM activities are detailed in this Manual, and it is equivalent to a collection of
CC/CM policies and procedures.

The CM Manual is reviewed and updated as regularly as needed. The updated version is posted on the CountyCare web site for care coordinators at http://www.countycare.com/carecoordination. The date of most recent revision is included in the document footer and at the bottom of each Manual section. CountyCare will provide notification in writing of new additions to the CM Manual and changes will be reviewed during Joint Operating Meetings or All CME Meetings. The expectations outlined in the CM will be implemented by the internal health plan and delegated CMEs within 30 days of notification or an alternate timeline as approved by the Care Management Oversight Team.

Created: 03/18/2018

Rewards Program (CountyCare Rewards)

Through the CountyCare Rewards Program, members qualify for a variety of rewards for participating in care coordination activities and other preventive health services.

Care Management Entities are expected to:

- Help members understand that they can receive rewards by completing the health risk screen and individualized plan of care.
- Provide education on the other rewards that they may qualify for to improve member retention and encourage healthy behaviors and health care utilization.
- Connect members to CountyCare Member Services (312-864-8200) when experiencing an issue with them over the counter (OTC) card, or if they have questions on the rewards or value-added benefits that cannot be answered by the care coordinator.

CountyCare Rewards and Value-Added Benefits Resources

- General information on the Rewards Program is found at: http://www.countycare.com/rewardsprogram

Created: 04/19/2018; 1/31/2025

Self-Management Education and Tools

CountyCare supports members in managing their health and health care in a variety of ways.

1. Access to information and resources about health on CountyCare's website, including interactive health education tools.
2. Direct access to resources that members can utilize without meeting specific criteria or going through an intermediary. These include:
    a. Primary Care, community behavioral health care and outpatient specialty care
    b. Care coordination services.
    c. Programs such as Weight Watchers
    d. Events such as "Redetermination Events" where staff help members renew their Medicaid.
3. CountyCare Rewards. This program gives members monetary rewards for completing preventive health services.
4. Self-management programs for populations of members with specific health needs. An example of a self-management program is the Canary Telehealth Self-Management Program for adults with diabetes, asthma, hypertension, and obesity, which involves text-message coaching services to utilize self-monitoring devices and communicate with health care providers about results.

Member services, Care Management Entities, providers, and other partner organizations perform outreach to members by phone, mail, and text about opportunities to engage in these services, program, and events. Care coordinators educate members about the self-management process and the benefits of self-management and steps members can take to manage their health and health care. Care Coordinators take steps to facilitate participation in self-management activities by collaborating with members to identify and overcome barriers to participation such as practical challenges or incomplete information about the opportunity or relevance to the member. Care coordinators reinforce this education by:

- utilizing techniques that reinforce self-management such as motivational interviewing in communication.
- supporting members to understand their health and identify their needs and goals.

For members enrolled in care management, Care Coordinators ensure self-determination and management through person-centered and individualized care planning and by ensuring approval of the mutually developed plan of care through voice-recording or written signature.

CountyCare reviews and updates self-management resources and tools at least every three years and more often as needed. Care Coordinators encourage members to update their information with any program or service they utilize to ensure that the tools are as relevant as possible.

Created 11/7/19.

Service Plans for Home and Community Based Services (HCBS)

Timeframes for Service Planning

The CME should develop person-centered service plans as follows:

- **Newly Waiver Eligible Members (15-day members - CountyCare members new to a waiver):** For a member who is not receiving (M)LTSS HCBS waiver services on the date that such services become covered services, the CME shall ensure that the person-centered planning process is initiated, and the service plan is developed within 15 days after they are notified that the member is determined eligible for (M)LTSS HCBS Waiver services. The CME is responsible for HCBS waiver service planning, including the development, implementation, monitoring of the service plan, and updating the service plan when a member's needs change. The planning process shall be led, when possible, by the member and include individuals chosen by the member. A member's HCBS Provider(s), or those who have an interest in or are employed by the HCBS Provider(s), shall not participate in the planning process unless the provision of 42 CFR 441.301(c)(1)(vi) is met. The CME is responsible for procedures to assist members in the planning process, including how to resolve conflicts and disagreements that include conflict-of-interest guidelines. The care coordinator will assist the member in leading the (M)LTSS HCBS waiver person-centered service planning and will coordinate with the ICT.

Determining Hours and Types of Services for Newly Waiver Eligible Members (15-Day Members)

1. Determination of Need (DON)
    - A case management representative or counselor from the Illinois Department on Aging (IDoA) or the Division of Rehabilitative Services (DRS) determines an individual's Home and Community-Based Services (HCBS) Determination of Need (DON) score.
    - This DON assessment tool evaluates the person's care needs and available resources to determine a person's eligibility for programs that provide HCBS and long-term support services
    - The resulting DON score is then sent to the relevant CME (Care Management Entity) to confirm eligibility for services

2. Notification of Eligibility
    - The CME (Care Management Entity) receives notification that a CountyCare member is determined eligible for (M)LTSS HCBS Waiver services along with DON score
        a) Via email at countycarewaivers@cookcountyhhs.org for Aging and SLP waivers
        b) Via Pull File within CountyCare Care Management Information System (CMIS) for PWD, TBI and HIV/AIDS waivers

3. Initiate Person-Centered Planning
    - Within 15 calendar days of receiving the eligibility notification and DON score, a care coordinator will meet with the member face to face:
        - Complete a comprehensive needs assessment Health Risk Assessment (HRA)

a) Evaluate members' ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

- Person centered care plan
  a) The plan must reflect the members' goals, preferences, and needs
  b) Include individuals chosen by the members (family, friends, advocates)
  c) Care plan is shared with provider(s)
- Develop the HCBS service plan
  a) Service hours are determined based on the member's individual needs, DON score, and the Care Coordinator's clinical assessment, as documented in the person-centered care plan
  b) Serves as official authorization of services
  c) Service plan is shared with provider(s)

- **Legacy Members (90-day members - waiver members new to CountyCare):** For any member who is receiving (M)LTSS HCBS waiver services on the date that such services become covered services, the internal health plan will implement the member's existing service plan. That service plan will remain in effect for at least a 90-day transition period unless changed with the input and consent of the member and only after completion of a face-to-face comprehensive needs assessment. The internal health plan will ensure receipt of the existing service plan for these members. The planning process shall be led, when possible, by the member and include individuals chosen by the member. A member's HCBS Provider(s), or those who have an interest in or are employed by the HCBS Provider(s), shall not participate in the planning process, unless the provision at 42 CFR 441.301(c)(1)(vi) is met. The CME is responsible for procedures to assist members in the planning process, including how to resolve conflicts and disagreements that include conflict-of-interest guidelines. The care coordinator will assist the member in leading the process for changing or updating the (M)LTSS HCBS waiver service planning, as appropriate, through coordination with the ICT.

Determining Hours and Types of Services for Legacy Members (90-Day Transition)

1. Notification of Eligibility
    - The CME (Care Management Entity) receives notification of CountyCare legacy members
        a) Via a monthly 834 file sent by Illinois Department of Healthcare and Family Services (HFS)
    - Confirm the member is receiving (M)LTSS HCBS waiver services on the date those services become covered under CountyCare

2. Obtain and Implement Existing Service Plan
    - The internal health plan must ensure receipt of the member's current service plan
    - Continue the current service plan for at least 90 days as a transition period.
        - Complete a comprehensive needs assessment Health Risk Assessment (HRA) within 90 days of the notification date
            a) Evaluate members' ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
        - Person centered care plan
            a) The plan must reflect the members' goals, preferences, and needs
            b) Include individuals chosen by the members (family, friends, advocates)
            c) Care plan is shared with provider(s)
        - Develop the HCBS service plan
            a) Service hours are determined based on the member's individual needs, DON score and the Care Coordinator's clinical assessment, as documented in the person-centered care plan
            b) Serves as official authorization of services
            c) Service plan is shared with provider(s)

Reassessments are conducted at minimum every 6 months for HIV and BI members and at least every twelve (12) months for all other waiver members. Additionally, a face-to-face reassessment will be completed each time there is a significant change in the member's condition or at the member's request. Additional service requests, including a change in the number of hours, would be determined at a reassessment with the member.

Federal CMS determined there were two active service plans for SLP members—one developed by the SLP provider RN, and another created by the care coordinator. CMS has clarified there can only be one service plan for waiver participants. The care coordinators are responsible for service planning for SLP members. Current SLP members will have their ISP in place until their annual plan is due, at which time the Plan's care coordinator will develop a service plan, with input from the SLP RN. The care coordinator will send a copy of the service plan to the SLP provider and update, as necessary. SLP members will continue to be included in the development of their service plan. The SLP RN will no longer be completing an ISP for residents enrolled in managed care after July 1, 2020. For newly eligible SLF members, the notification date and 15-day clock for the service plan will start the day the health plan receives the Resident Assessment Instrument (RAI) and Individualized Support Plan (ISP) information form from the Supportive Living Provider or from notification made to the health plan of the new SLP waiver status. *Revised 4/30/25, 11/26/2025*

Service Plan Content

Each person-centered service plan must be written in a manner that is understandable to the member and include: (1) documentation that the setting in which the member resides is chosen by the member, is integrated into and supports access to the community, and meets, when applicable, the HCBS Settings rule requirements at 42 CFR 441.301(c)(4)-(5); (2) the member's strengths and preferences; (3) the clinical and support needs identified through the Determination of Need; (4) person-centered goals and desired outcomes; (5) paid and unpaid services and supports that will assist the member to achieve identified goals, the Providers of those services and supports, including those self-directed by the member; (6) identified risk factors and strategies, including back-up plans, to minimize potential undesirable outcomes associated with those risks; and (7) the individual or entity responsible for monitoring the service plan.

The CME shall ensure that the final person-centered service plan is finalized with the informed written consent of the member and is signed by and distributed to individuals and Providers responsible for the service plan's implementation, as applicable.

CME shall ensure the person-centered service plan is reviewed and revised upon reassessment of functional need at least every twelve (12) months, when a member's circumstances or needs change significantly, or at the member's request.

For a member who is receiving HCBS Waiver services and who ceases to be eligible for services, the CME shall notify the member's existing HCBS Waiver Provider(s) in writing of service authorization termination date no later than seven (7) days from such date.

For SLP members, the person-centered service plan must address areas or service needs that are identified by the SLP provider staff and care coordinator during the assessment process. The plan is driven by what is important to the SLP member and includes adequate information that will enable the SLP staff to provide services needed and preferred by the member.

Increasing or Decreasing HCBS Hours

1. Identified Need for Modification of Waiver Service Hours

- A member may request an increase or decrease in service hours
- The Care Coordinator's assessment will determine whether HCBS hours should be adjusted, either increased or decreased, based on the members' individual needs

2. Care Coordinator will Conduct a Face-to-Face Reassessment
   - Changes to the plan during this period require:
     - Complete a comprehensive needs assessment Health Risk Assessment (HRA)
       c) Evaluate change in members' ability to perform ADLs and IADLs
       c) Review the member's condition and circumstances
       c) Document the specific reason for the change (e.g., health or safety concerns for increases, improvement in conditions for reductions)

- Person centered care plan
    c) The plan must reflect the members' goals, preferences, and needs
    c) Include individuals chosen by the members (family, friends, advocates)
    c) Care Plan is shared with provider(s)
- Develop the HCBS service plan
    c) Changes in service hours are determined based on the members' individual needs and the Care Coordinator's clinical assessment, as documented in the person-centered care plan
    c) Serves as official authorization of services
    c) Service plan is shared with provider(s)

3. Care Coordinator will Document Justification of HCBS Hours
    - For increases:
        - Identify and record the specific, individualized need
        - Explain how the change addresses health or safety concerns
    - For reductions:
        - Provide evidence of improvement or reduced need
4. Care Coordinator will Monitor Effectiveness
    - Conduct ongoing care coordination through face-to-face visits
    - Track whether the modification meets the members' needs
5. Care Coordinator will Schedule Periodic Review
    - Regularly review the service plan and care plan to confirm continued necessity
    - Adjust care plan and service plan as needed based on updated assessments

Waiver Service (HCBS) Validation

Within 10 days of notifying the HCBS provider(s) to begin services, follow-up with the member must occur to confirm services are in place.

Prior to each scheduled contact with an (M)LTSS HCBS waiver member, the care coordinator is expected to review the claims submitted by the HCBS provider and/or the Individual Provider/Personal Assistant (PA) vouchers and compare to the service plan to ensure consistency. In the absence or delay of provider claims, contact with the provider to establish the monthly units/hours provided to the member since the last visit/validation, is required.

The care coordinator should also perform a review of the HCBS Member Communication Forms exchanged since the last member contact. Any discrepancies in the service type, the HCBS provider indicated on the service plan, or the hours/units being provided to the member above or below the approved hours (equivalent to 10% of the monthly service plan hours), requires follow-up and should be addressed and clarified with the member during the contact. A documented explanation for gaps in service (going under what was approved) or hours/units that exceed what was approved, equivalent to 10% of the monthly service plan hours of service and not already accounted for via an HCBS Communication Form, is required. The type and number of services should be re-assessed and updated via the service plan, as necessary. The service validation with the member should be documented in the member record.

Informed Client Choice

The CME's person-centered planning process shall provide sufficient information and guidance to ensure the member is enabled to make informed choices regarding services, supports and Providers. The planning process must reflect cultural considerations of the member and is conducted using accessible information presented in readily understood language. Alternative home and community-based settings considered during the planning process must be documented in the service plan.

Arranging for Covered Services

In arranging for covered services for members in the elderly (M)LTSS HCBS waiver and (as required by CountyCare) for all other waivers, when members do not express a choice of provider, the internal health plan is required to fairly distribute the members requiring services, taking into account all relevant factors among providers in the network who meet applicable quality standards.

Environmental Accessibility Adaptations for the Home (Home Modifications)

CMEs that provide care coordination to members in (M)LTSS HCBS waivers provided through the Division of Rehabilitation Services must ensure that the work required to meet the need for home modifications is satisfactorily completed by a qualified provider within 90 days after the CME becomes aware of the need.

Personal Assistants

CMEs should refer members to the Centers for Independent Living or other available resources for assistance in locating potential personal assistants.

Transition of Service Plan

For a member who is receiving HCBS waiver services through the CountyCare internal health plan and ceases to be eligible for CountyCare but continues to be eligible for (M)LTSS HCBS waiver or equivalent home care services, the internal health plan must transmit the member's existing service plan to the applicable state agency or new health plan within 15 days after new coverage information is reflected in MEDI.

Last revised: 10/31/2017, 11/14/2017, 12/11/2017, 7/11/2019, 12/17/2019, 1/16/2020, 12/31/2020, 11/26/2025

Training and Qualification Requirements for HCBS Care Coordinators

Care coordinator qualifications for members in the Home and Community Based Service (M)LTSS HCBS waiver programs are determined by contract with the Department of Healthcare and Family Services (HFS). The following are the qualification requirements of HCBS care coordinators:

Persons with Elderly Waiver

Care coordinators must meet 1 of the 4 following requirements:

1. RN licensed in Illinois.
2. Bachelor's degree in nursing, social sciences, social work, or related field
3. LPN with 1-year experience in conducting comprehensive assessments and provision of formal service for the elderly.
4. One year of satisfactory program experience may replace one year of college education, at least 4 years of experience replacing baccalaureate degree.

Persons with Disabilities Waiver

Care coordinators must meet 1 of the 9 following requirements:

1. Registered Nurse (RN)
2. Licensed Clinical Social Worker (LCSW)
3. Licensed Marriage and Family Therapist (LMFT)
4. Licensed Clinical Professional Counselor (LCPC)
5. Licensed Professional Counselor (LPC)
6. PhD
7. Doctorate in Psychology (PsyD)
8. Bachelor's or master's degree prepared in human services related field
9. Licensed Practical Nurse (LPN)

Persons with Brain Injury Waiver

Care coordinators must meet 1 of the 7 following requirements:

1. Registered Nurse (RN) licensed in Illinois.
2. Certified or licensed social worker
3. Unlicensed social worker: minimum of bachelor's degree in social work, social sciences, or counseling
4. Vocational specialist: certified rehabilitation counselor or at least 3 years' experience working with people with disabilities.
5. Licensed Clinical Professional Counselor (LCPC)
6. Licensed Professional Counselor (LPC)
7. Certified Case Manager (CCM)

Persons with HIV/AIDS Waiver

Care coordinators must meet 1 of the 3 following requirements:

1. A Registered Nurse (RN) licensed in Illinois and a bachelor's degree in nursing, social work, social sciences or counseling or 4 years of case management experience.

2. A social worker with a bachelor's degree in either social work, social sciences, or counseling (a Bachelor of Social Work or a Master of Social Work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred).
3. Individual with a bachelor's degree in a human services field with a minimum of 5 years of case management experience.

In addition, it is mandatory that the care coordinator for members within the Persons with HIV/AIDS Waiver have experience working with:

1. Addictive and dysfunctional family systems
2. Racial and ethnic minorities
3. Homosexuals and bisexuals
4. Persons with HIV/AIDS
5. Substance abusers

Additional Training Requirements for (M)LTSS HCBS Care Coordinators

HCBS care coordinators must receive additional training. Required topics are determined by contract with HFS and include the HCBS waiver specific processes, the Determination of Need (DON) document, completing the comprehensive assessment, developing, and implementing a person-centered service plan, implementing services identified in the service plan consistent with the participant's input and approval and appropriate follow-up monitoring. A minimum of 20 hours of continuing education concerning HCBS waiver services must be provided initially and annually to (M)LTSS HCBS care coordinators. For partial years of employment, training will be prorated to equal 1.5 hours for each full month of employment. Training topics and number of hours completed by each care coordinator must be maintained by each CME. Care coordinators must be trained on topics specific to the type of HCBS waiver member they are serving as outlined below:

HCBS Waiver Program	Emphasis
Elderly Persons	• Techniques specific to partnering with elderly. • Aging related subjects
Persons with Brain Injury	• Provision of services to persons with brain injury
Persons with Physical Disability	• Techniques specific to partnering with persons with disabilities. • Disability sensitivity training
Persons with HIV/AIDS	• Infection's disease control procedures • Sensitivity training • Updates on treatment procedures
Supportive Living Facilities (SLF)	• Resident rights • Prevention and notification of abuse, neglect, and exploitation • Behavioral interventions • Techniques for working with the elderly and persons with disabilities. • Disability sensitivity training

Last revised: 10/30/2017, 2/20/2018, 7/11/2019, 1/24/2022

Training and Qualification Requirements for Care Coordinators Working with High Needs Children

High needs children are defined as any child under 18 that stratifies as Level 3 (high risk).

Care coordinators that work with children with special health needs (high needs children) must meet the following requirements:

- Bachelor's degree in nursing, social sciences, social work, or related field
- One year of supervised clinical experience in a human services field

Care coordinator supervisors must meet the following requirements:

- Master's degree in nursing, social sciences, social work, or related field
- No fewer than 3 years of supervised experience in the human services field

Created: 11/2/2017, Revised: 04/17/2018, 5/31/2019, 1/16/2020, 9/7/2022

Training and Qualification Requirements for Care Coordinators Working with DCFS Youth in Care

- Care Coordinators assigned to DCFS Youth in Care Enrollees shall be familiar with DCFS-required assessments for DCFS Youth in Care and the DCFS team-based decision- making process. CMEs are responsible for ensuring Care Coordinators assigned to DCFS Youth in Care Enrollees are trained in various aspects of the Illinois child welfare system to include trauma informed care, the psychotropic consent process, Illinois Medicaid Child and Adolescent Needs and Strengths (IM-CANS), motivational interviewing, and other relevant information that receives the Health Plan Prior Approval.

  The Health Plan is responsible for obtaining the Departments prior approval for CME care coordinator DCFS specific training. The health plan shall have no less than two (2) Care Coordinators who have attended the Department-sponsored DCFS managed care and child welfare training.

Created: 11/5/2020

Transitions across Care Management Entities (CMEs)

CountyCare's CME assignment is primarily driven by medical home empanelment. Special program enrollment and care needs (such as MLTSS, LTSS, and children with special health needs) will supersede the traditional assignment algorithm. Changes in empanelment, identification of special conditions and changes in member conditions or circumstances may warrant a transition of care coordination responsibilities across CMEs.

CMEs receive a weekly report listing all members who have changed CMEs and primary care providers (PCPs). CMEs use this list to activate transition activities for members who leave their CME.

Reassignment of Special Cohorts

CountyCare may identify and select a cohort of high needs children and adolescents for reassignment when one CME may be better suited to serve the population or cohort.

Reassignment Due to a Change of Primary Care Physician

The Health Plan notifies CME on a weekly basis of changes in member empanelment by way of the member change report.

The Health Plan reviews the member change report to identify members who have an open incident or an active prescriber or pharmacy restriction through the Recipient Restriction Program.

CME are required to submit an inclusive summary of all members who have transition out of their CME and the list of documents listed below (Transmission of Relevant Documents) to the Health Plan by the 10th of each month for all member who transferred the previous month.

The Health Plan reviews the list of all members who transferred the previous month for completeness and accuracy and forwards the member lists and documents to the resp

Transmission of Relevant Documents

For all members being transferred, the original CME must transfer critical information for care coordination. This includes and is not limited to:

1) Initial health risk screen (closest to date of enrollment)
2) Most recent comprehensive assessments (HRA/CR
3) Current individualized plans of care (IPoCs)
4) Current service plan
5) Relevant notes for care coordination (primary care (medical/behavioral), specialists, hospitalizations, home care, durable medical equipment (DME) support services, etc.
6) Current contact information for member
7) Point person and contact information for primary care team.
8) Health, Safety, Welfare, Reporting and Follow-up of Incidents Reporting transfer form for members with an open Health Safety and Welfare incident.
9) A summary of member pharmacy and prescriber restrictions for members with recipient restrictions

Process to Inform Members

The process for notifying the CountyCare member of pending care coordination transition includes:

1) If engaged with current CME, the care coordinator should make an initial attempt to inform member of:
    a. Pending transition (effective date)

b. Endorsement by a primary care provider, if applicable
c. Reason for transition
d. Provide contact information of new care coordinator.

2) If no documentation of engagement with current CME team, the new care coordinator may reach out to member and inform member of:
a. Pending transition (effective date)
b. Endorsement by a primary care provider, if applicable
c. Reason for transition
d. Provide care coordinator's contact information

Mechanism to Share Current Episode(s) of Care

Information of active episodes of care should be conveyed with new care coordinator. Episodes of care may include care provided in specialized settings, support services and/or specialized treatment.

1) Specialized settings
a. Hospital
b. Step-down care
c. Skilled nursing

2) Support services
a. DME providers
b. Waiver applications
c. Special programs
d. Community-based services, including Family Case Management and Better Birth Outcomes

3) Specialized treatment
a. Chemotherapy
b. Radiation
c. Wound care
d. Therapy (i.e., physical, occupational, speech)

Joint Care Conference (optional)

CMEs are encouraged to develop a case review for members with complex needs.

Warm Hand of for High Risk and Complex Members

A warm hand off is defined as a time sensitive, member specific transferring between two CME's. The intent is to ensure each CME meeting the needs of the member during the transitioning process and after. Also, to guarantee seamless care management functions and service continuity without any gaps. It is a collective effort of both receiving and transferring entity.

The warm hand off should occur after the member changes the CME and the CME tag has been updated. CME's can track member changes using the CME/PCP change report that is delivered weekly to CMEs. The current CME will be responsible for the members needs until the new CME tag has been updated and the member has officially switched CMEs. There are some exceptions to this when the member gains a waiver.

A warm hand off for high risk and complex members occurs when a member switches from one CME to another or for any of the following reasons below:

- CME change
- PCP change

- Members obtaining new waiver.
- New pathways member
- Cohorts of high needs children and adolescent identified by CountyCare for reassignment when one CME may be better suited to serve the population or cohort.

A warm hand off may be imitated and appropriate for members with low and moderate risk levels but, it is especially important this process is followed for high-risk members and complex members (NICU, high utilizers, etc.). There are some exceptions of this process when a member gains a waiver or is a former youth in care member.

To ensure a smooth transition the member must be notified of the change and the original care coordinator must provide the new care coordinators with the following documents when available:

- Initial HRA/HRS completion forms
- IPOC
- Medication list (If applicable/available)
- Standard warm-hand off form (can be found on the CountyCare website here)
- Any other relevant notes the care coordinator deems necessary.

Last revised: 07/05/2017, 04/17/2018, 09/01/2018, 11/23/2020, 12/28/2023

Transition of Care (TOC)

CMEs are expected to manage transition in care and continuity of care for all new members and any members moving from an institutional setting to a community setting. CountyCare requires each CME to have an interdisciplinary transition of care team to implement transitions of care within its organization as well as supporting each member through individual transitions. The complete Transition of IPoC can be found as appendix to the Care Management Program Description.

Critical Transitions of Care (Eligibility and Coverage)

A critical transition of care occurs when a member is experiencing both a transition and a critical episode of care. Critical transitions occur for prospective members prior to eligibility with the health plan, new members within the first 90 days of eligibility, current members while eligible and former members within 90 days of eligibility termination.

CountyCare internal health plan and delegated care management entities will collaborate to prevent disruptions in care due to changes in eligibility. See Transitions of Care section for member transitions across care settings.

Prospective members

Prospective members who contact CountyCare are assisted with finding a PCP or WHCP or to continue a course of treatment before the health plans' coverage becomes effective. When a prospective member contacts the health plan seeking support with continuity of a treatment plan, member services will assist the member and for needs requiring care coordination, will refer the member to a CME to assign a care coordinator who must contact the member within two (2) business days.

New members

CMEs will prioritize new members for outreach and health risk screening. In addition, CMEs will have processes in place to identify new members who require transition of care services by using a variety of sources:

- Prior claim history, which is reflected in the predictive modeling risk score provided to CMEs.
- IPoC's and prior authorizations (which will be honored by CountyCare) as provided by the prior managed care organization, delivered to CMEs at the beginning of each month for each new member.
- Results of health risk screenings
- Communication with providers requesting information and service authorizations for members.
- Communication from members
- Communication with existing agencies or service providers that are supporting members at the time of transitions.

CMEs are expected to assist and manage care needs when a member is undergoing a transition in health care coverage and is in a current episode of care of treatment that requires continuity to protect the member's health and safety. If a member is experiencing both a transition and a critical episode of care, the transition is considered a critical transition. CountyCare supports the continuation of existing treatment plans during critical transitions provided that the member's treatment plan is current, a

covered service, and medically necessary. This applies to all new members experiencing a current episode of care that require continuity including, but not limited to:

1. Pregnant women in their third trimester of pregnancy or within the first six weeks postpartum
2. Members who are hospitalized at the time of the transition
3. Other members for whom the discontinuation or abrupt change in treatment plan or provider(s) could compromise the member's health or safety.

The care coordinator utilizes an interdisciplinary transition of care team ICT for TOC will also evaluate the appropriateness of care management and education for each member identified with a pre-existing condition.

Care Coordinator Actions for Critical Transitions

The care manager is required, no later than two (2) business days of the referral, to initiate the following:

1) Outreach to the Members to assess:
    a. the Members' service needs for covered benefits.
    b. the Members' current providers, including whether the providers participate in the CountyCare network.
    c. alternatives and resources for continuing care and how to obtain it; and/or
    d. potential or actual barriers or gaps in continuity of care.
2) Coordinate the provision of medically necessary covered services through communication with entities involved in the transition, stabilization, and provision of uninterrupted access to covered service, assessment of members ongoing care needs, monitoring of continuity and quality of care and services provided.
3) In the case of former members, ensure that coordination of care is handed off to the receiving MCO or fee for service Medicaid.

Last revised: 06/19/2017, 04/16/2018, 5/31/2019
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Transitions for new members

CMEs will have processes for facilitating continuity of care for new members including:

- Identification of members deemed critical for continuity of care.
- Communication with entities involved in members' transitions.
- Stabilization and provision of uninterrupted access to covered services
- Assessment of members' ongoing care needs
- Monitoring of continuity and quality of care and services provided.
- Medication reconciliation
- Ensuring that appropriate follow-up care is utilized.

Transition from Hospital to Post-Acute Care

TOC Resources within the CME

CMEs are required to have a phone number designated for TOC referrals and the ability to respond to a TOC request from a hospital or any other individual expressing an urgent need within two hours. CMEs also have policies and procedures designating staff responsible for TOC activities which include, at minimum, those requested below. CMEs are encouraged to develop additional TOC resources and protocols.

Notification

CMEs are expected to utilize all methods of notification that members are hospitalized. CMEs are notified of inpatient hospitalizations by the following means.

- **PointClickCare or the State Designated ADT Vendor.** Admission Discharge and Transfer (ADT) data is shared with CMEs via a secure daily data file exchange and available in CMIS for CountyCare and Cook County Health Staff. PointClickCare is updated in real time 24 hours per day, seven days per week throughout the year including all holidays. PointClickCare also reports discharges from the ED or hospital. If a member is admitted to an inpatient setting from the ED, at the time of inpatient admission, the alert appears as an inpatient alert and is removed from the ED alerts.
- **Authorization data file**. CountyCare's utilization management department generates a daily file of all authorizations for inpatient and outpatient services and sends it to each CME each weekday. The data is provided in format that CMEs are required to load in their care management system software so that the information is available at the level of each member's record and as a set of data to use for daily TOC workflows.
- **Referrals from UM/health plan (Identifi log).** CountyCare's utilization management staff and health plan staff utilize a member level referral protocol to send detailed notifications for specific members. UM staff enter the referral information into the UM system. Each business day in the morning, all notifications from the previous 24 hours are sent to the designated recipient at the CME.
- **Requests for immediate TOC support.** CountyCare's utilization management staff, health plan staff, member services supervisors and hospitals may contact the CME or send individual expedited notifications to the designated CME escalation contact.

Notifications of hospitalization typically do not include services specifically for substance abuse treatment services by substance use disorder providers unless the member has consented.

Review of Hospitalized Members

A staff member within the CME is designated to review all members who are hospitalized within one business day or sooner if appropriate. The designated staff member will review available information about the hospitalization, eligibility history, health and health care history including prior authorizations and claims for recent utilization of medical, behavioral and pharmacy services, care management records including HRS, HRA, IPoC and recent activity related to the member (e.g., case notes, correspondence, referrals, etc.). The staff member is expected to use this information to determine the need for and level of contact required to engage members during and after hospitalization and to build the immediate care management interventions appropriately based on information available.

TOC Contact during Hospitalization for Priority Members

A care coordinator is designated to contact members, providers, and/or family members at the earliest possible point in the hospitalization for priority members. Priority members include members for whom the member, a hospital or health plan staff member requests specific TOC support as well as any members who are:

- designated by the health plan as super-utilizers.
- admitted for behavioral health inpatient care.
- stratified as high risk.
- identified as a special need child.
- hospitalized within the past 30 days.
- enrolled in (M)LTSS (long-term care or HCBS)
- exhibiting a significant change in health status.

The goals of contact during hospitalization are to engage in the care coordination program, complete required care management activities and participate actively in discharge planning to support effective engagement after discharge and completion of follow-up care.

For those listed above and any additional members at the CME's discretion, care coordinators may use a variety of means to contact members, providers and support persons during the hospitalization including electronic, telephonic, and in-person contact. The care coordinator is expected to use methods that are effective in achieving the goals of contact and change methods quickly if needed to achieve these goals prior to discharge. At minimum, the care coordinator is responsible for the following:

- contact with member or member's team while inpatient.
- ensuring the HRS/A is complete and updated.
- scheduling a post-hospital practitioner appointment or confirming appointment is scheduled.
- resolving barriers to obtaining needed medications upon discharge and performing medication reconciliation before or after discharge
- identifying members of the ICT
- obtaining a discharge plan or other information about the hospitalization and needed follow-up care.
- maintaining bi-directional communication with UM whenever necessary to ensuring each team has complete information about the case and coordinates effectively.

CMEs are encouraged to use in-person contact whenever possible because it enhances assessment and engagement with members, their support persons, and the hospital care team. CMEs are also encouraged to participate in-person in case conferences or hospital rounds discussing the member's care.

Specific standards for Children's behavioral Health TOC are specified in the "Children's Behavioral Health" section of this manual and require additional activities. If a member refuses to engage in care coordination contact, the care coordinator is still required to work with providers to coordinate care and complete as many of the above activities as possible. The only exception to this expectation is if the member explicitly directs the care coordinator otherwise.

If a hospital does not respond or expresses resistance to care coordinator's request to communicate about hospitalized members, the care coordinator will escalate to supervisors or leaders within the CME who utilize management techniques to resolve the situation. If management techniques are not effective, CME management will escalate to the health plan resources listed on the escalation list.

TOC Contact after Hospitalization

All members, including priority members, require outreach establish member contact within 48 hours of discharge. Care coordinators may use a variety of means to contact members after hospitalization including electronic, telephonic, and in-person outreach. Care coordinators will use contact information available

through all sources by utilizing all contacts in the CM system, PointClickCare data, contacting providers including post-acute providers (home health, DME, nursing facilities), primary care, specialty and HCBS providers.

The goals of contact after hospitalization for all members are to ensure the member has scheduled necessary follow-up care and obtained medications required post-discharge to increase the likelihood of recovery and decrease the likelihood of hospital readmission. At minimum, the care coordinator is responsible for the following:

- ensuring a post-hospital practitioner appointment is scheduled to occur within seven days of discharge if possible and no later than 30 days post-discharge.
- barriers to obtaining needed medications upon discharge are resolved.
- other post-acute services ordered by the hospital are in place.
- a HRS is completed and follow-up on risk factors identified including enrollment in care management when applicable.

Care coordinators can perform these responsibilities indirectly by partnering with hospital staff or members of the ICT who may have a more direct role in working with the member during the transition. Care coordinators will follow the outreach protocols described in the outreach section.

TOC Contact after Hospitalization for Priority Members

In general, priority members have higher needs for TOC support are at higher risk of not receiving needed services and being readmitted to the hospital. Therefore, for priority members, in addition to the responsibilities listed above, there are additional expectations for care coordination contacts after discharge:

- performing medication reconciliation if not completed during the hospitalization, as well as providing additional support with medication adherence once discharged.
- providing support to the member to start ordered services/attend appointments.
- linking/arranging appropriate support services for the member e.g., housing services, food access, AA, support groups, training programs, etc.
- determining the outcome of the follow-up appointments and continue rescheduling and facilitating support to attend appointments as needed.
- reviewing the case weekly, at minimum, through 30 days post-discharge and initiating weekly contacts with the member, support persons and ICT members as appropriate
- maintaining active communication with the ICT.

Transitions through Levels of Care

In addition to hospital to post-acute care, the following are situations that require coordination between Care Management, Utilization Management, and providers for effective transitions of care:

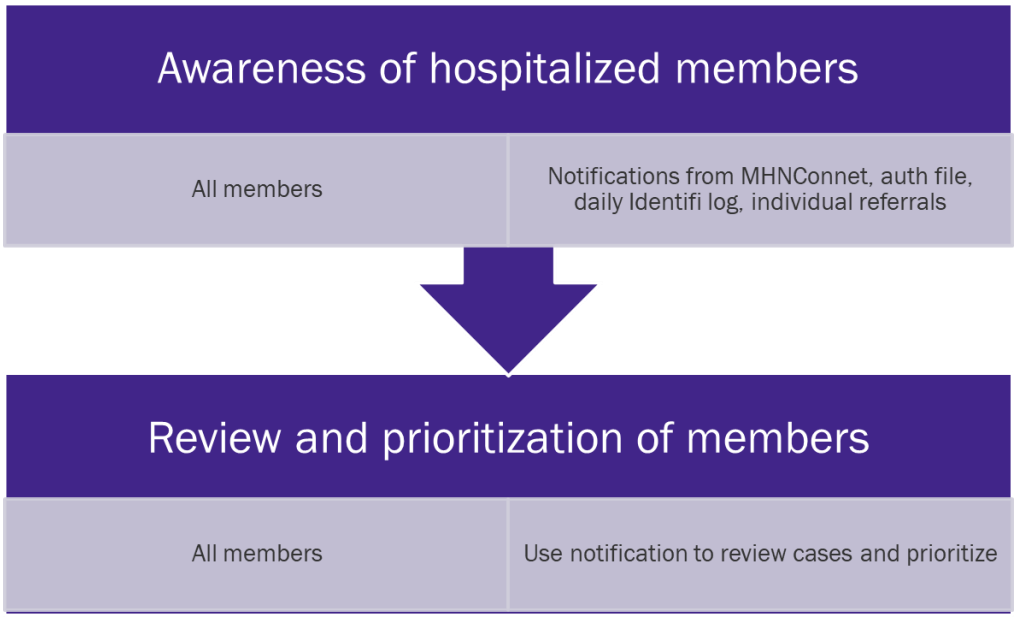
- Transition from long-term care to community (including MFP/Consent Decree members)
- Transition from hospital to post-acute facility or home
- Crisis care (ED, crisis unit, mobile crisis response)
- Outpatient care to more intensive services
- New members to CountyCare
- Leaving CountyCare to another HealthChoice MCO
- Leaving CountyCare to FFS Medicaid or other insurance
- Leaving CountyCare due to loss of Medicaid coverage (uninsured)

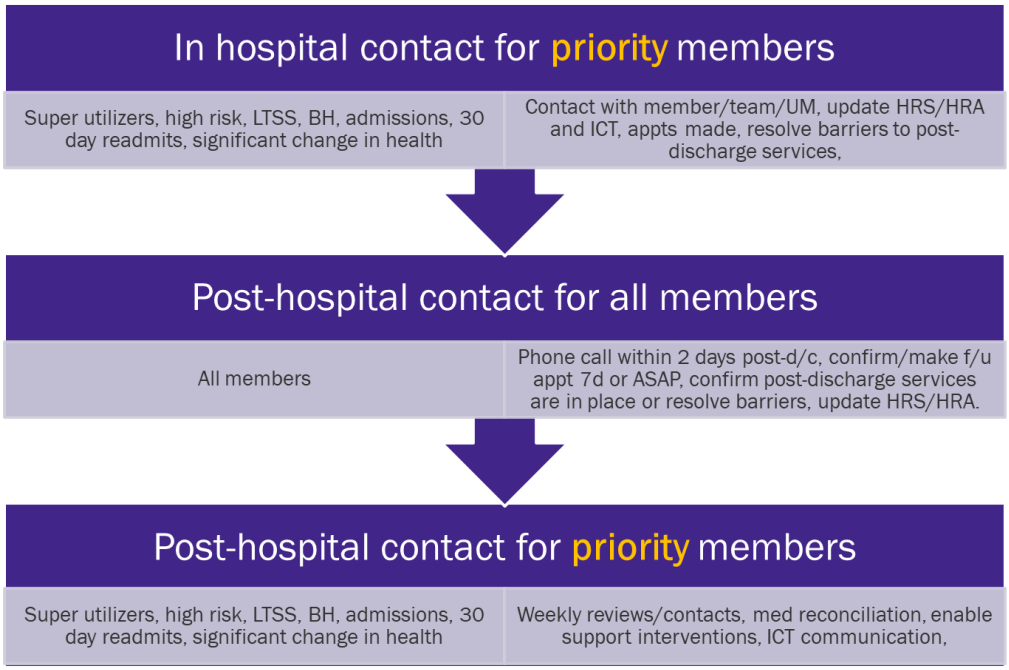
CMEs are required to collaborate with existing community agencies that provide MFP/Consent Decree transition coordination services (and assume the lead role upon termination of the MFP Program) in supporting individuals transitioning from institutional settings to the community. CMEs are expected to meet face-to-face with members to explore their desire/interest in transitioning; review their current health status, the members LTC chart, speak to nursing and social service staff, learn more about the member's strengths, resources, familial/social supports, housing needs and other challenges that must be met in order to determine the possibility of a safe transition to the community.

CMEs are required to support members who become uninsured to establish a transition to providers and resources that meet their ongoing needs. CountyCare's partner, the Complex Care Coordination (CCC) unit Cook County Health may offer additional care coordination resources and all CMEs may collaborate with CCC for members whom they were assigned while covered by Medicaid and/or CountyCare.

CME staff primarily communicate with members and their providers. UM staff primary communicate with providers. CMEs and UM are expected to communicate with each other and establish consistent messages to share with their respective contacts to maximize the efficiency and clarity of communication and minimize confusion. While specific roles provide leadership on different responsibilities, clear communication channels are in place between teams because responsibilities rely on contributions from multiple teams. Communication channels are:

- CM to ICT (providers, member, supports) to develop and implement plan of care.
- CM to UM for questions/concerns about benefits and authorizations
- UM to CM to refer when it is identified that care needs can be better met.
- UM to providers to notify of authorization and request additional information when needed to process requests.





Created: 12/11/2017, Revised: 04/23/2018, 5/31/2019, 8/21/2019, 3/8/2023

Transitions for Members Receiving Care Out of Network

Out of Network providers may be needed in cases of continuity of care and when a medically necessary service is not available from an in-network provider. Out-of-Network care requires authorization from Utilization Management.

- **Continuity of care.** CountyCare will authorize medically necessary covered benefits for out-of-network providers for up to 90 calendar days (180 days for Special Needs Children moving from fee-for-service Medicaid to CountyCare) in these situations:
    - New Enrollees who are in a current episode or treatment from an out-of-network provider when they join CountyCare.
    - Other members who received emergency treatment from an out-of-network provider and it is determined to be medically necessary to continue care from that provider.
- **Services not available from an in-network provider.** The Care Coordinator first research options within CountyCare's network by utilizing all resources available such as the provider directory and contacting member/provider service representatives. Care Coordinators consult individuals within the member's Interdisciplinary Care Team (ICT) and may need to directly contact potential providers who may be able to serve the member. Care Coordinators may escalate to a CME Manager to contact CountyCare Utilization Management to further research options.

Out-of-network providers submit a request for authorization. Provider must provide clinical information and as needed, information about continuity of care. Care Coordinators support the member and provider in this process by providing information about the process and taking actions to coordinate among the parties involved. When a Care Coordinator is aware that a request for out-of-network care was submitted, the best

practice is to have a CME Manager contact the Utilization Management (UM) escalation contact to share information about the situation to ensure a thorough review of the prior authorization request. UM reviews the prior authorization request for clinical appropriateness and continuity of care and may collaborate directly with the Care Coordinator.

Single Case Agreements

If out of network provider requests a single case agreement, the request is submitted through the CountyCare website. Contracts and Letter of Agreement Requests – CountyCare Health Plan

1) Providers must have a UM authorization to request a single case agreement.
2) UM/CM Liaisons will guide provider on how to complete the SCA and required paperwork via county care website:

Process for members admitted to out of network hospitals or receiving care outside of Cook County

CountyCare recognizes unforeseen circumstances may cause a member to receive care at out-of-network hospitals or outside of Cook County. When UM is notified that a member is seeking coverage of health services outside of Cook County and/or contracted CountyCare providers, UM will ask the out of area provider to solicit information about member's current address and intentions for returning to the service area. UM will also notify CountyCare's Enrollment and Retention Manager and make a referral to the CME to contact the member, his/her authorized representatives, and providers. The Care Coordinator will perform outreach to gather information about whether the member has moved outside of Cook County, if the member intends to return within 90 days and any other needs or circumstances affecting the member's current care. The Care Coordinator incorporates information about the member's current needs and goals into person-centered problem-solving, providing resources and care planning. UM will lead the communication about the case and make determinations about service authorization. The Enrollment and Retention Manager will lead actions related to ongoing CountyCare eligibility. The Care Coordinator is the primary support for the member in receiving needed services. UM, CM and the Enrollment and Retention Manager will share the results of their research and coordinate to assist the member either transition to out of area care or return to Cook County and receive need follow-up care in-network.

UM leads the process of coordinating any needed transfers between out-of-network and in-network hospitals. Care coordinators actively help the timely transfer process by providing information to the member, support persons and providers and coordinating with UM to ensure communication among the parties involved. Care Coordinators will support the individualized plan until the member's care and follow-up is complete, or until the member declines further care coordination. If the member becomes no longer eligible for CountyCare, Care Coordinators will support the member as necessary and appropriate to support the member before and during the immediate aftermath of the transition.

Created 5/20/2019; Revised: 11/7/2019, 1/16/2020, 10/31/24

Transitions of Care from Adolescent to Adult Healthcare

Optimal health is advanced through the delivery of medically and developmentally appropriate care. CountyCare supports a planned health care transition, whenever possible, to maximize appropriate health care, lifelong functioning, and well-being for all individuals. CountyCare supports its members and providers in making health care services available in an uninterrupted manner as the member moves from adolescence to adulthood. CountyCare achieves this by periodically assessing membership to identify enrollees reaching adulthood and guide them in selecting an adult primary care practitioner as well as widely distributing information about how members can get help choosing an adult primary care practitioner.

Health Plan Role:

- Assess its membership identify members between 17 and 18 years of age and mails notification letters to each of these members and their parents/guardians to inform them of the need to select an adult primary care practitioner and/or women's health care practitioner.

- Provides a list of eligible members between 17 and 18 to each respective care management entity (CME) to support medical home outreach efforts regarding the transition process. High Needs children or Special Needs Children may remain with their current providers through age 21.

- Communicates via its member newsletter, information about how adolescents reaching adulthood can get help choosing an adult primary care provider.

- In situations when a young adult member has special health care needs and the member, family or staff are unable to easily identify an appropriate provider, the health plan staff, including member services, provider relations and care coordination staff will work together on an individualized plan. Health plan support activities include performing additional research and if necessary, assigning a specialist as a primary care provider or contracting with additional providers to meet the needs of the enrollee.

- Communication is with parent/caregiver unless they provide consent to speak with the youth (17 or younger) or if the member identifies that they are seeking to access care for which they do not need parental consent.

Care Coordinator Role:

- Care Coordinators communicate about transition from pediatric to adult health care via phone, mail, or secure email to assist them in selecting an adult primary health provider if they have not already done so, and link members to the redetermination application process as applicable.

- Care Coordinators identify high needs adolescents and young adults or those designated Special Needs Children enrolled in the care management program between the ages of 20 and 21 by using the list provided by the health plan and other care management system tools. Care Coordinators will actively outreach to these families to assist with the transition from pediatric to adult health care. For this population, care coordinators will ensure that care plans are transferred to the adult practitioner and any new members of the interdisciplinary care team.

- Care Coordinators will link members to adult community resources and supports, with a special emphasis on supporting those with chronic conditions.

Created 10/4/2019. Last revised: 1/16/2020

Transition of Individualized Plan of Care (IPoC)

When members transition between MCOs or between CMEs, their IPoC's should transition with them to prevent: 1) interruptions in progress towards the member's health goals and 2) a halt in care management activities for members that require complex case management or long-term services and supports (MLTSS and LTSS).

For members transferring MCOs for whom an IPoC has been developed, the CME will use the member's existing IPoC, and that will remain in effect for at least a 90-day transition period unless changed with the input and consent of the member and only after completion of a face-to-face comprehensive needs assessment and transition IPoC is in place (to be updated and agreed to with the new provider, as necessary).

For new members transferring from another MCO, the CME will be notified of the previous MCO, and the CME will request the member's IPoC from that MCO. For past members who have left CountyCare, CMEs will provide a member's IPoC to the new plan within 10 business days after receiving a request for it from the MCO in which the individual is enrolled.

IPoC Transfers between CMEs

- CME utilize the weekly "Member Change Report" to identify members leaving and joining the CME. The Member change report includes information about the member's status that includes source of change, risk level, Waiver status, LTC status, Care management activity, PCP, and eligibility status.
- Care Coordinators are responsible for following identifying transferring members and completing the transfer of IPoC and other member information as outlined in the "Transitions across Care Management Entities (CMEs) section of this manual.
- Care Coordinators are responsible for identifying members joining the CME on the "Member Change Report" and ensuring that member IPoC are received.
- Care Coordinators are responsible for ensuring that IPoC's and other required transfer documents are provided to the receiving CME via email as listed in the "General Referrals column of the "Who to Contact at the CME" list with 15 days of member transfer.

IPoC Transitions for Non-Waiver Members

For non-waiver members, IPoC's transferred from the former MCO, or CME can be used up to 90 days or until the current CME conducts a new health risk screening and/or health risk assessment and creates a self-directed IPoC with the member. The CME must update the transferred IPoC within 90 days. For members with IPoCs, it is required that the CME honor the risk level determined by the former MCO or CME until a new assessment has been completed.

IPoC Transitions for Waiver Members

As for non-waiver members, any IPoC and service plan will remain in effect for the transition period of up to 90 days for members who are receiving HCBS waiver services as of their effective enrollment date. The CME is required to issue the provider a 90-day Continuity of Care service plan authorization indicating the services/hours in place and a start date as of their effective enrollment date. When members are deemed newly eligible for HCBS waiver services, the member IPoC and service plan must be developed within 15 days

after the CME is notified that the member is determined eligible for HCBS waiver services, even if they are concurrently transitioning between health plans.

Adult Day Service & Integrated Plan of Care Policy – Aging Waiver (effective date 5/1/19)
In response to a federal HHS OIG audit, IDoA implemented a policy change to the IPOC process for ADS providers serving aging waiver members. A standard, uniform IPOC and process is in place across all the ADS providers, which is integrated, incorporates information from the CCU/MCO and includes member involvement. The CME responsibility in this process:

1. CME sends the ADS provider the following documentation via secure email or fax within **15** calendar days of the ADS service plan authorization date:
    a. Needs Assessment (HRA)
    b. Client Demographics
    c. Physical Health History
    d. Behavioral Health (MMSE)
    e. Current Medications
    f. Plan of Care
    g. Signed Participant Agreement
2. With this information, the ADS provider completes the Person-Centered ADS Plan of Care Addendum and obtains signatures by the member/participant, ADS Program Nurse and Program Coordinator/Director. The IPOC addendum is submitted to CountyCare/CME within 2 business days of development/signatures via secure email or fax from the ADS Provider.
3. The CME acknowledges receipt of the Person-Centered ADS Plan of Care Addendum with a signature on the designated area located on the bottom of the form and returns within 2 business days via secure email or fax.
4. The CME ensures the POCNF, and the Person-Centered ADS Plan of Care Addendum are uploaded into the member record.

IPoC Transitions for Members in Nursing Facilities

When a resident in a nursing facility first transition to CountyCare from the fee-for-service system or from another plan, the CME will honor the existing IPoC and any necessary changes to that IPoC until it has completed a comprehensive assessment and new IPoC, to the extent such services are covered benefits, which shall be consistent with the requirements of the Resident Assessment Instrument (RAI) Manual.

When a member is moving from a community setting to a NF, and the CME is properly notified of the proposed admission by a network NF, and the CME fails to participate in developing an IPoC within the time frames required by NF regulations and contractually, the CME must honor an IPoC developed by the NF until the CME has completed a comprehensive assessment and a new IPoC to the extent such services are covered benefits, consistent with the requirements of the RAI Manual.

Transition of ETI Forms

Enrollment Transition Information (ETI) forms are required for HCBS waiver members that are transitioning between health plans (with any active HCBS waiver) or transitioning to DRS due to disenrollment from managed care. The form is completed **every time** the member disenrolls from the health plan. The ETI form should be completed by the CME and sent to the member's new health plan (MCO email addresses are listed on the form) or to DRS at DHS.HSPManagedCare@illinois.gov, within fifteen (7) days of CountyCare disenrollment. For SLF members, the ETI form is only needed when switching health plans. (This form is not used to request termination of waiver services from DRS.)

The ETI form must be completed in its entirety and must include all current provider(s), listing service hours authorized as well as home modifications within the last 5 years, including any mods done by the previous MCO. **Care Coordinators must always list the waiver services in place**, even if the member has only been in the plan for 30 days or if the Care Coordinator has not met with the member yet. In this case, Care Coordinators indicate the services established by the previous MCO/DRS. DRS needs this information to ensure prompt payment to providers currently authorized. It should be a very rare occurrence that a waiver member disenrolls without waiver services in place. This should be validated prior to indicating a waiver member is leaving the plan without waiver services in place and an explanation must be provided. The provider(s) must be notified in writing that the member has left CountyCare and transitioned to a new payor (MCO/DRS) within seven (7) days of disenrollment from the health plan. There must be documented evidence of your notification to the provider(s).

Required Attachments and Other Transitioning Information (to include with the ETI):

- CM Summary
- Advanced Directive Paperwork
- Guardian/Conservatorship Paperwork
- Last Contingency Plan – if receiving in-home caregiver services

MCO Participant Transfer Forms

MCO Participant Transfer forms are used when an active elderly waiver member disenrolls from the Health Plan and Managed Care and is transitioning to the Community Care Program (CCP) through the CCU/IDoA. The Form is completed **every time** an elderly waiver member disenrolls from the health plan and returns to CCP. MCO Participant Transfer forms should be complete and include all the necessary information including any current service providers as well as the hours of service authorized. The MCO Participant Transfer Form should be completed for active elderly waiver members within 10 days of CountyCare disenrollment to the assigned Care Coordination Unit. This form is also utilized to report a member's change of address to IDoA or to request the termination/closure of Elderly waiver services for an active CountyCare waiver member.

- **Top of the Form:** The top portion of the form must be filled out on every submitted form. You must also accurately select the intent and purpose of the form – Disenrollment, Change of Address, or Termination.
- **MCO Disenrollment Date:** This should be completed only if the member has disenrolled from CountyCare. The disenrollment date is always the last day of the month. This should be left blank if the member will remain with CountyCare, but no longer requires waiver services.
- **Services Currently Authorized:** When a member disenrolls from CountyCare the CME must list all current provider(s) and services hours authorized in the "Services Currently Authorized" section of the MCO Participant Transfer form (Section C). **Care Coordinators must always list the waiver services in place,** even if the member has only been in the plan for 30 days or if the Care Coordinator has not met with the member yet. In this case, you would indicate the services established by the previous MCO/Aging. IDoA needs this information to ensure prompt payment to providers currently authorized. It should be a very rare occurrence that a waiver member disenrolls without waiver services in place. This should be validated prior to indicating a waiver member is leaving the plan without waiver services in place and an explanation must be provided. The provider(s) must be notified in writing within seven (7) days of member leaving CountyCare and transitioning to a new payor (IDoA). There is to be documented evidence of your notification to the provider(s).
- **Termination of Services**

You will complete this section for members who remain with CountyCare, but you are requesting the termination/closure of their waiver eligibility. You must check off the reason for requesting waiver termination and provide the affiliated date. The waiver will be termed based on the date you provide. You must also complete the section on Services Currently Authorized indicating the providers that were in place and the date you notified each provider to terminate services. There must be documented evidence of your notification to each provider.

- **Memorandum of Understanding (MOU):** You will check the box for MOU under Disenrollment's or Terminations if you have **ever** established a Memorandum of Understanding with the member. You must attach the MOU, and any pertinent documentation related to the MOU. This ensures the member will still be held to the agreement they signed once they transition back to CCP.
- **Signature and Date: Please** ensure sign-off and a date on all forms.

CMEs receive two reports that assist them in identifying members who have left the health plan. On a weekly basis, each CME receives a CME/PCP Change Report, which identifies the members who have been added to the CME and members who have left the CME. The report covering the last week of the month will include members who have left the CME due to disenrollment from the Health Plan, activating the disenrollment process and activities to be completed (written notification to Providers by the 7th of the month and disenrollment forms to the new payor by the 10th). On a monthly basis, each CME receives a monthly Disenrollment Report from CountyCare which also identifies the waiver members who have disenrolled from CountyCare the previous month. This report can be used to cross check and confirm that all waiver members who left the plan have had their disenrollment activities completed.

Last revised: 11/01/2017, 8/10/2018, 10/04/2018, 7/11/2019, 8/21/2019, 10/4/2019, 1/16/2020, 12/31/2021

Written Member Communication

At minimum, all written member communications must:

1. Use template/standard language at or below 6.9 on the Flesch-Kincaid grade level (Microsoft Word readability statistics under Review in "Spelling & Grammar")
2. Develop template/standard language that is also available in Spanish and Polish, where translation has been certified in writing and is on file for that document.

Written communication from CMEs falls under two categories of approval:

1. **Documents that can be produced and approved by the CME**. The communications must:
    a. Contain the required elements discussed above.
    b. Be translated into another language at the member's request.
    c. Be sent in the member's preferred language (if indicated)

CMEs must provide all administrative issue templates utilized for care coordination communications to CountyCare's CME Oversight team annually. Although these templates do not require formal CountyCare approval, these templates will be reviewed, stored for reference and CountyCare may recommend changes. A record of the Flesch-Kincaid score should be kept on file. Documents that fall in this category include but are not limited to the following:

Types of Communication
1. Appointment reminders
2. Outreach attempts
3. Intro to Care Coordination
4. Cover letters for: • IPoCs • Resource lists • Disease specific pamphlets

2. **Documents that require CountyCare approval** (Care Management Oversight and Compliance). These include written education, outreach, or marketing materials that:
    a. Contain language about the member's health plan benefits.
    b. Contain language that promotes CountyCare as a health plan (marketing)
    c. Are sent on behalf of ("from") CountyCare Health Plan vs. the care management entity.
    d. Are sent to all the CME assigned members.

These types of written materials are likely to require Department of Healthcare and Family Services (HFS) approval. CountyCare will manage the process of attaining HFS approval. Please note that HFS can take up to 30 calendar days to approve or deny documents. Documents that fall in this category may include but are not limited to the following:

Types of Communication
1. Education materials on CountyCare benefits
2. Marketing and promoting CountyCare
3. Materials sent on behalf of CountyCare
4. Outreach materials to recruit new members

1. All written education, outreach or marketing member communications for care coordination purposes must contain the following statement, "*Illinois Client Enrollment Services will send you information about your health plan choices when it is time for you to make a health plan choice and during your Open Enrollment period*."

2. Significant Publications and Communications.
    a. All significant publications and communications must include the CountyCare nondiscrimination notice and appropriate taglines indicating the availability of language assistance services, free of charge, in at least the top fifteen languages spoken by individuals with limited English proficiency in Illinois.

    b. For small sized significant publications and communications, the CountyCare notice may be shortened, and the taglines are required to be printed in only the top two languages in Illinois spoken by individuals with limited English proficiency.

    c. Definition of Significant Publications and Communications.
        i. A publication and/or communication will be considered "significant" if it is targeted to health plan members, health plan applicants, or members of the public and it:
            1. Pertains to the rights of the health plan member (e.g., Notice of Privacy Practices).
            2. Pertains to the benefits of the health plan member (e.g., Summary of Benefits and Coverage).
            3. Requires a response from the member; or
            4. Is a member consent, complaint form, written notice of eligibility criteria, rights, denial, loss, or decrease in benefits or services?
    d. The following materials have been determined by OCR to not be "significant":
        i. Radio or television ads.
        ii. Identification cards (used to access benefits or services).
        iii. Appointment cards.
        iv. Business cards.
        v. Banner and banner-like ads.
        vi. Envelopes; and
        vii. Outdoor advertising, such as billboard ads.

3. CountyCare Compliance will utilize its Material Review Tool to review communications and publications to determine whether the materials require 1557 notice and tagline content, as well as whether HFS approval of the materials is required, at request.

Workflow for documents that require CountyCare and/or HFS approval.

4. CME sends communication to Manager of Care Management, indicating the following points:
    a. The purpose of the written member communication
    b. Intended population.
    c. Target timeline to start using the document.
    d. Flesch-Kincaid grade level (include evidence of score)
5. CountyCare CME Oversight Team reviews and approves document content.
6. CME Oversight Team forwards document and supporting materials to CountyCare Compliance

7. Compliance reviews and approves document (with revisions as necessary)
8. Compliance works closely with CountyCare's communication point person to obtain HFS/State approval if necessary.
9. CountyCare notifies CME Oversight team of final determination.
10. CME Oversight Team informs CME upon final approval and:
    a. Sends CME final approved version.
    b. Request's translation of document into Spanish and Polish
    c. Saves final approved document and notification from Compliance to DPM
11. Translated document and Certificate of Translation should be sent back to the CME Oversight Team

Last Revised: 06/09/2017, 04/18/2018, 5/31/2019

Appendix A

Examples of ICT activities and how to document.

Activity	Description of Activity	Documentation Must Include	Example
Creation of ICT	Formal creation of an ICT, a group of individuals who participate in the care of, and support for the member. **The member must be involved in creation of the ICT.**	• Names of each member • Relationship of each ICT member to CountyCare member • Roles of each member • Contact information and preferred mode of contact. • Additional contextual information (this could include reasons why ICT was convened, how long member has known each ICT member, etc.)	Name: Jane Doe, LCSW Relationship: Clinical mental health service provider Roles: - Provides clinical mental health services. - Before each ICT, discusses goal setting with member. Contact information Email: jdoe@email.org Work cell: 888-888-8888. • Prefers email. Additional information: Jane Doe has been member's LCSW for 8 years now and they have strong rapport established. The ICT was created in conjunction with the member and is based on the member's needs and preferences.
ICT Meeting	Member requests or wants to participate in a meeting with all members of their ICT. Care Coordinator responsible for scheduling the meeting with all members of the ICT, including the member.	• Date of meeting • List members of ICT who attended meeting. • List progress that has been made toward individualized goals. • List any barriers that were identified. • List action steps, who is responsible for the action step, and the due date for that action step.	Care note title: **"ICT Meeting 1/20/2020."** ICT meeting took place 1/20/2020 via Zoom. Care Coordinator, PCP, SW, Member, and Member's cousin were present. Care Coordinator called the meeting to discuss transition of care plan after a BH hospital admission. Progress made since admission: - Member reports feeling better, happier. - Member noted that they liked the psychiatrist at the BH hospital more than their regular psychiatrist and would like to switch providers.

			- Member desires to add new goal of weight loss to IPoC but prefers to take virtual classes at home. Barriers identified: - Member's cousin is member's main transportation support, and he just got a new job and will not be able to take member to appts anymore. Action steps: 1. Care Coordinator to connect member to transportation services- due by 1/23/20. 2. SW to identify free or low-cost virtual fitness programs and send to member- due by 1/30/20. 3. Care Coordinator to support switching psychiatrists – due by 2/1/20.
ICT ongoing monitoring/changes	Members of the ICT may change. Either members will be added or removed based on member's needs and preferences.	• Date • Name of the member being removed/added. • Role of the member being removed/added. • Relationship of new member to CountyCare member • Contact information and preferred mode of contact for new member. • Reason member is being removed or added to the team. • Additional contextual information, if necessary	Care note: ICT ongoing monitoring/changes. • 6/7/2021 • Jane Doe, LCSW is no longer on the ICT. She moved out of state and the member has a new therapist. • June Doe, LCSW is member's new therapist and is being added to the ICT. • Her contact info is J.Doe@agency.com and her phone number is 888-888-8888. She prefers to be contacted via email. • This change to the ICT was made in conjunction with the member and is based on the member's needs and preferences.
Collaborative Activities	Coordination of care on behalf of the member, which can include any	• Date of activity • Description of activity that took place.	• Date: 1/20/20 Activity Description: Care Coordinator reached out to Jane Doe, LCSW to assist in

	activity that supports and/or improves member's access to necessary care or services.	• List ICT members, or non-ICT members, who were involved in activities. • Result or outcome of activity	discharge planning. Discharge plan is outlined below: • Date: 1/21/20 Activity description: Care Coordinator outreached to Deborah's Place to ask about waitlist for housing. Deborah's Place Coordinator indicated that the wait list is 6 months. • Date: 1/21/20 Activity description: Care Coordinator called PCP office to obtain better phone number for member. Care Coordinator received 888-888-8888 as alternative number.
Outreach to Member	Any communication to member	• Date of outreach • Reason for outreach • Outcome or result of outreach	• Date: 1/20/20 Reason for outreach: Outreach attempt #2. Care Coordinator attempted to call member within 48-hours post-discharge. Phone number no longer in service. Care Coordinator will call pharmacy and PCP to try to find different number(s). • Date: 1/20/20 Reason for outreach: Care Coordinator called member to give update on Deborah's Place waitlist. Member indicated they would like to be placed on waitlist. • Date: 2/2/20

			Reason for outreach: Care Coordinator called to schedule ICT meeting with member, SW, PCP, and cousin to follow up on IPoC progress. ICT meeting scheduled for 2/15/20 via WebEx.

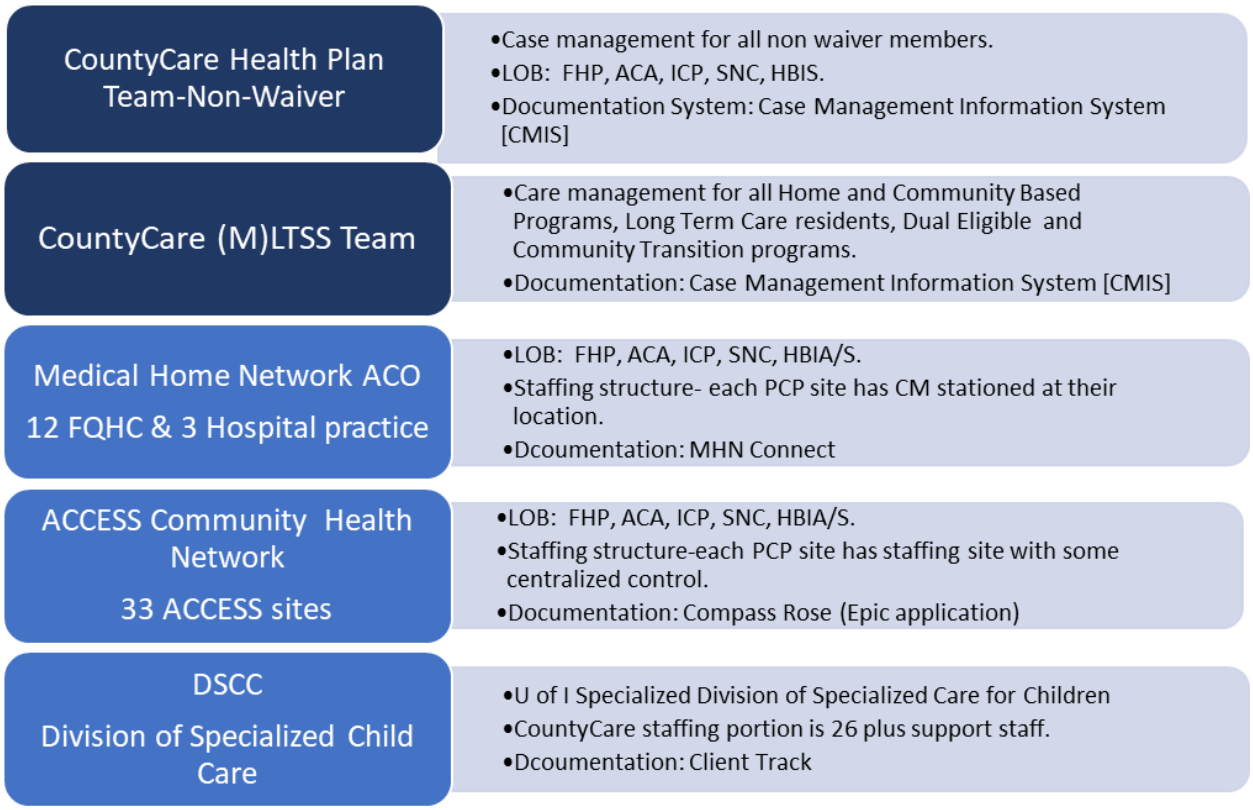
Sharing of, or updates to, an IPoC	It is critical that sharing of an IPoC is clearly documented in CM systems. This includes documentation of any edits to the member's IPoC, such as updates, revisions, details of goals met or barriers to achieving goals.	• Date
		• Indicate whether it is:
		  ○ Being shared for the first time
		  ○ in addition to the care plan
		  ○ a revision of the care plan- this can include adjustments of a goal based on new needs or barriers.
		  ○ a closed goal for goals that have been achieved.
		• Include who the IPoC is being shared with
		• Additional contextual notes, if applicable/relevant
			• On 10/7/20, IPoC was created and led by the member. IPoC was subsequently shared with member's PCP via secure messaging. PCP confirmed receipt of IPoC and will review next week.
			• On 1/1/2021, GOAL MET. ICT met with member. Member indicated that they met their goal of losing fifteen pounds. Member credited support of their cousin and a free fitness program that their LCSW identified in their success.
			• 4/5/2021, REVISION to IPoC. Care Coordinator spoke with member over the phone who indicated that they like their new therapist and would like to schedule sessions once a week instead of twice a week. They stated that they do not feel like they need two meetings a week anymore. Care Coordinator to follow up with therapist to coordinate.
			• 7/8/2021, ADDITION to IPoC. PCP communicated to ICT that member expressed interest in smoking cessation program. LSCW to share resources with Care Coordinator, and Care Coordinator to follow up with member to coordinate.

Resources Provided to Member	Any time members of the	• Date that resource was provided.	• On 4/5/2021, member met with dietitian who

	ICT shares resources, such as educational materials, websites, financial literacy, health literacy, or other materials that support the member in achieving optimal health.	• Who provided the resource(s)? • Description or copy of resource, if possible	counseled member on heart healthy diets and meal prepping. Dietitian sent member home with a monthly meal plan and shared with Care Coordinator to send to ICT. See attached meal plan. • On 6/2/2021, member experienced a BH crisis on 6/1/2021 and were stabilized in the community by the C4 SASS provider. Care Coordinator outreached SASS provider (6/2/21) for copy of crisis plan, and SASS provider also shared that they left the member's mother with a brochure for local support groups for them and their child. See attached copies of resources.

Appendix B

CME Algorithm



Revised: 3/8/2023

Version Control

CM Program Manual Version	Date	Change
Version 2	April 2018	Added CME Algorithm; Edits/Additions to align with 2018 Health Choice Illinois Contract with the Department of Healthcare and Family Services.
Version 3	October 2018	Edit: Critical Incidents, Added: High Needs Member Engagement, Edit: Outreach-HCBS Waiver Members, Edit: Contact Standards – Waiver Service Validation, Edit: Contact with Waiver (HCBS) Providers, Edit: Transitions of IPOC Waiver Member Disenrollment, Added: CME General Delivery Email Box, Added: Version Control
Version 4	May 2019	Edits: Authorizations of services Behavioral Health Crisis Children's Behavioral Health Waiver Service Validation Critical Incidents Critical Transitions of Care Contact Standards Demographic Changes Health Risk Assessment Health Risk Screen Outreach & Engagement Care Coordination referral Member Outreach Predictive Modeling Score and Stratification Additions: Recipient Restriction Transitions of Care High Utilization of Health Care
Version 5	June 30, 2019	Edits: Contact Standards Critical Incidents Escalation from CME to CountyCare Health Risk Assessment Health Risk Screen Individualized Plan of Care (M)LTSS Appeals Recipient Restriction Member Rights and Responsibilities Health Risk Assessment
Version 6	August 21, 2019	Edits: Brighter Beginnings Children's Behavioral Health Critical Incidents Individual Provider Compliance Outreach and Engagement- All Members

		Transition of Cares- TOC Transition of Individualized Plan of Care
Version 7	November 8, 2019	Edits: Care Management Assignment Children's Behavioral Health Critical Transitions of Care (Eligibility and Coverage) *moved to Transitions of Care section.* Individual Care Team: Roles and Responsibilities IPOC Transitions for Waiver Members Overtime Policy Transition ETI Forms Transitions of Individualized Plans of Care Additions: Adult Day Service & Integrated Plan of Care Policy – Aging Waiver Individual Overrides of the CME Assignment Self-Management Education and Tools Transition from Adolescent to Adult HealthCare Transitions for Members Receiving Care Out of Network
Version 8	January 16 2020	Edits: Glossary Assignment to Care Management Entities Audits and File Reviews of Internal health plan and delegated CMEs Care Gaps and Promoting Recommended Care Behavioral Health Crisis Contact Standards Contact with Waiver (HCBS) Providers Eligibility for Care Management (Complex Case Management) Health Risk Assessment (HRA) Health Risk Screening (HRS) Individualized Plan of Care (IPoC) Outreach and Engagement – All Members Reassessment and Ongoing Care Planning Referrals to Care Management Service Plans for Home and Community Based Services (HCBS) Transition of Care (TOC) Transition of ETI Forms and MCO Participant Transfer Forms Training and Qualification Requirements for Care Coordinators working with High Needs Children
Version 9	May 22, 2020	Additions: Phones: Assisting members with obtaining government funded phone Evidence-Based Assessment Glossary Edits:

		Contents of Health Risk Assessment Contact Standards and Documentation Critical Incidents DCFS Youth in Care Eligibility for Care Management Risk Stratification levels Referrals to Care Management
Version 10	March 5, 2021	Additions: Negotiated Risks Reassignment due to PCP change DCFS Youth in Care Flexible Housing Pool Edits: Glossary: Care Coordination Waiver Service (HCBS) Validation Service Satisfaction Modifications and Enhancements to ICT section Crisis Lines
Version 11	January 24, 2022	Additions: Glossary: Health, Safety and Welfare Definitions: Medication Reconciliation, Medication Confirmation Post Hospital Discharge Individualized Back-Up Plan: Aging Waiver Members Edits: Health, Safety and Welfare Demographic Changes and Other Demographic Reporting Referrals to Care Management Advance Directives Contact Standards and Documentation
Version 12	May 26, 2022	Additions: Community Transitions Initiative Edits: Outreach and Engagement- All Members Individual Provider Compliance - Overtime
Version 13	September 7, 2022	Additions: HIV Data Exchange Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM + CANS) Edits: Training and Qualification Requirements for Care Coordinators Working with High Needs Children Flexible Housing Pool Crisis, Help Lines and Care Coordination Follow Up

Version 14	March 8, 2023	Additions: Pathways to Success/N. B Consent Decree Edits: Glossary Health Dialog Transition from Hospital to Post-Acute Care Crisis, Help Lines, and Care Coordination Follow Up Appendix B Demographic Changes and Other Demographic Reporting
Version 15	August 30, 2023	Additions: Definitions: Care Coordinator Safety Edits: Glossary Audits and File Reviews of Internal health plan and delegated CMEs Children's Behavioral Health Contact Standards and Documentation Care Coordinator Safety Health Safety and Welfare (HSW Diagram) Initiating Waiver Closure IPOC Requirements Outreach & Engagement – (M)LTSS HCBS Waiver Members
Version 16	December 28, 2023	Additions: Justice Involved (JI) Edits: IPoC Requirements Reassessment and Ongoing Care Planning Transitions across Care management Entities (CMEs)
Version 17	July 31, 2024	Additions: NICU Care Management Program Description Exhausted Benefits Edits: Audit and File Review of Internal health plan and delegated CME's Children's Behavioral Health Follow Up Community Transitions Initiative (TAF and Care Coordination)
Version 18	October 31, 2024	Additions: N/A Edits: Health Risk Screenings (HRS) and Assessments (HRA) Individualized Plan of Care (IPoC) Predictive Modeling Scores and Risk Stratification Transitions for Members Receiving Care Out of Network

Version 19	January 31, 2025	Additions: Beacon Portal Youth Edits: Member Death IPOC Requirements Method of Outreach Referrals to Care Management Rewards Program (County Care Rewards)
Version 20	April 30, 2025	Additions: Contents of Health Risk Assessment for M(LTSS) Edits: Table of Contents: Carenet Health 24/7 Nurse Line Table of Contents: Carenet Health 24/7 Nurse Line Follow up Crisis, Help Lines, and Care Coordination Follow Up Children's Behavioral Health Crisis Follow-up Elements of individualized Plan of Care MLTSS Appeals Process Timeframes for Service Planning
Version 21	July 31, 2025	Edits Member Death Negotiated Risk Agreement (Ad Hoc Revision)
Version 22	December 15, 2025 October, 31, 2025 Release postponed: December 2025	Additions: Determining Hours and Types of Services for Newly Waiver Eligible Members (15-day members). Determining Hours and Types of Services for Legacy Members (90-day Transition). Increasing or Decreasing HCBS Hours Edits Assignment to the Care Management Entities (CMEs) Audits and File reviews of Internal health plan and delegated CMEs Authorization of Services Community Transitions Initiative (CTI) Contact Standards and Documentation Member Death Contents of the HRA for (M)LTSS Members Contents of the Health Risk Assessment HIPAA Individualized Plan of Care (M)LTSS Appeals Process Service Plans for Home and Community Based Services (HCBS)

Version 23	February 20, 2026	Additions Care Coordination Referrals Edits: Standards for (M)LTSS HCBS Waiver or LTC Members