CountyCare
A MEDICAID HEALTH PLAN

Provider Manual

PROVIDER RELATIONS

312-864-8200, 711 (TTY/TDD)

JANUARY 01, 2023

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Welcome to CountyCare

A MEDICAID HEALTH PLAN

Thank you for joining our network of physicians, hospitals, clinics, laboratories and other health care professionals. Our mission is to improve the health of our members. Our number one goal is the promotion of health through preventive health care and member engagement in self-care.

CountyCare Health Plan (CountyCare) works to accomplish this goal by partnering with providers like you to oversee and deliver health care services to our members.

ABOUT US

Operated by Cook County Health, CountyCare is a Managed Care Community Network (MCCN), a non-profit health plan formed for the specific purpose of prioritizing those most in need. We have Health Plan accreditation from the National Committee on Quality Assurance (NCQA) and are contracted with the Illinois Department of Healthcare and Family Services (HFS) to offer HealthChoice Illinois Medicaid services to the following populations:

- Families and children population (Family Health Program (FHP))
- Affordable Care Act (ACA) adults
- Seniors and persons with disabilities (SPD) eligible for Medicaid, but not eligible for Medicare (ICP)
- Department of Child and Family Services (DCFS) Youth in Care
- Special needs children
- Individuals eligible for home and community-based services (HCBS) waiver services or long-term care (Managed Long-term Services and Supports (MLTSS)/Long-term Services and Supports (LTSS))

We partner with our providers to focus on successful outcomes and member/provider satisfaction in a coordinated care environment. Our goals are to:

- Ensure access to primary and preventive care services
- Deliver care in the best setting to achieve an optimal outcome
- Ensure and improve access to all medically necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

We believe that you and those in our provider network are the key to achieving these goals, and our role at CountyCare is to support you. We look forward to partnering with you.

ABOUT THIS PROVIDER MANUAL

CountyCare is committed to our providers and strives to create a positive working experience. This Provider Manual is your comprehensive source of information for our product, offerings, member benefits, care coordination, quality of care, operations and related policies and procedures. The Provider Manual is updated periodically and designed to be a resource for you.

Changes to CountyCare policies, procedures, and practices will be included in the latest version of the Provider Manual posted online. Provider Relations will notify providers through a provider notice at least thirty (30) days, if possible, before implementation and upon posting revisions to the manual. Provider Relations will provide training to network providers and staff regarding updates and policies when applicable.

Providers can obtain the most recent downloadable and printable version of the Provider Manual on our website.

Please contact our Provider Relations Department at 312-864-8200 if you have any questions about the Provider Manual or need additional assistance.

CONTACT INFORMATION AND QUICK REFERENCE GUIDE

For a downloadable version of the Provider Quick Reference Guide click here. Below provides contact information by functional area for your convenience.

	Notes	Contact Information
CountyCare Website	Visit for documents, forms, important health plan information, and provider and member resources.	https://countycare.com
Provider Portal	Provides access to member eligibility, essential documents, forms, authorization submissions, status, claim status, claim review requests, and panel rosters. Also contains the current care plan for members enrolled in the Complex Care Management Program.	https://countycare.valence.care/
HFS MEDI System	Utilize the system to verify Medicaid eligibility.	https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx
Universal Provider Roster	Submit any provider additions, changes, or terminations monthly and send a complete IAMHP universal roster quarterly.	CountyCareProviderRosterSubmission@cookcountyhhs.org
Member Services and Provider Relations	Monday – Friday 8:00 a.m. – 6:00 p.m. CT Saturday 9:00 a.m. – 1:00 p.m. CT	P: 312-864-8200, 711 (TTY/TDD)
Transportation Scheduling	Contact First Transit to request a ride three (3) business days before member need.	P: 630-403-3210 F: 630-873-1440

	Notes	Contact Information
Fraud & Abuse Hotline	Use our anonymous and confidential hotline to report concerns.	P: 844-509-4669
Provider Disputes	Submit disputes within sixty (60) calendar days from Explanation of Payment (EOP).	http://countycareproviderdispute.jira.evolenthealth.com/
Health, Safety, Welfare (HSW) (including Critical Incidents) -Reporting and Follow-up of Incidents	Complete a Health, Safety, Welfare, Reporting, and Follow-up Form: https://countycare.com/wp-content/uploads/CCR_CriticalIncidentReportingForm_English_092120.pdf	countycarequalityofcare@cookcountyhhs.org P: 312-864-8200, 711 (TTY/TDD) F: 312-637-8312

Claims (Medical And Behavioral Health)

	Notes	Contact Information
Clearinghouse Vendor	Change Healthcare	http://countycareproviderdispute.jira.evolenthealth.com/
Paper Claims Mailing Address		CountyCare Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Payer ID	06541	
Claims Timely Filing Requirement	Submit claims one hundred eighty (180) calendar days from date of service or discharge date.	
Claim Review Process	Complete a claim review form within sixty (60) days of EOP receipt: https://countycare.com/wp-content/uploads/CCR_Claim-and-Medical-Necessity-Review-Form_Dec2020.pdf	https://countycare.valence.care/ P: 312-864-8200, 711 (TTY/TDD)

Medical Management

	Notes	Contact Information
Inpatient Admissions	Contact Provider Services within twenty-four (24) hours of patient admission.	P: 312-864-8200, 711 (TTY/TDD) F: 866-209-3703
Prior Authorization CPT Look up	Use the CPT look-up to determine if authorization is required.	https://countycare.com/providers/prior-authorizations/
Prior Authorization Requests Medical and Behavioral Health	Complete the authorization request form: https://countycare.com/wp-content/uploads/CCHInpatientPriorAuthorizationFormEnglish_092618.pdf https://countycare.com/wp-content/uploads/CCH_OutpatientPriorAuthorizationForm_English_092618.pdf	https://countycare.valence.care/
Communicating with Care Management about Members in HCBS Waivers	Report key member updates, needs, changes and/or issues via the HCBS Member Communication Form: https://countycare.com/wp-content/uploads/CCR_HCBSMemberCommsForm_English_050818.pdf	P: 312-864-0200, 711 (TTY/TDD) countycarewaivers@cookcountyhhs.org
Other Referrals to Care Coordination	Complete the care coordination referral form: https://countycare.com/wp-content/uploads/CCRCareCoordinatioReferralForm_English_050319.pdf	

Medical Management (continued)

	Notes	Contact Information
Dental Preauthorization	Request at the Avesis.com Provider Portal.	https://www.avesis.com/commercial3/providers/index.aspx P: 855-337-1594
Vision Preauthorization	Request at the Avesis.com Provider Portal.	https://www.avesis.com/commercial3/providers/index.aspx P: 855-337-1594
Pharmacy Preauthorization (including Specialty)	Submit the MedImpact medication request form: https://countycare.com/wp-content/uploads/MedImpact-Prior-Auth-Medication-Request-Form.pdf	F: 858-790-7100 P: 800-788-2949
Medical Necessity Appeals	Report key member updates, needs, changes and/or issues via the HCBS Member Communication Form: https://countycare.com/wp-content/uploads/CCR_HCBSMemberCommsForm_English_050818.pdf	P: 312-864-0200, 711 (TTY/TDD) countycarewaivers@cookcountyhhs.org
Other Referrals to Care Coordination	Submit appeals within thirty (30) days of an authorization denial. https://countycare.com/wp-content/uploads/CCR_NoticeCorrectedClaims_English.pdf	http://countycare.valence.care/ CountyCare Health Plan P.O. Box 21153 Eagan, MN 55121-0153

COMMUNICATING WITH COUNTYCARE

Provider Relations

The Provider Relations department's goal is to make the provider's experience positive, by being your advocate within the plan. Provider Relations is responsible for the following for our network providers:

- Physician, provider, and office-staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates including Provider Notices, and training
- Researching claims inquiries
- Updating provider rosters and contact information
- Maintenance of the CountyCare Provider Manual
- Liaising with contracting team on contract issues and alternative reimbursement strategies

The Provider Relations team will ensure you and your staff have the tools, resources, and information to enable you to provide the highest quality of care and services to CountyCare members.

Website

www.CountyCare.com

Visiting the "For Providers" link on https://countycare.com/providers/ can significantly reduce the number of telephone calls you need to make to the health plan. The comprehensive website creates efficiencies for you and your team. The website has easy to follow menus and a power "Search" box at the top; we encourage you to search by key words to access information directly. The website is continuously updated with the latest news and information. Save www.countycare.com to your Internet "Favorites" list and check the site often.

The following information can be found on the CountyCare website:

- Billing resources and guidelines
- Clinical guidelines
- Health, Safety, and Welfare Incidents including Critical Incident reporting guidelines
- Fraud, Waste and Abuse reporting guidelines
- Prior authorization lookup by CPT code
- Provider complaints, member grievances, and appeals training
- Provider Directory
- Provider manual and forms
- Provider newsletters and notices
- Provider training modules

- Member benefits
- Member communications
- Preferred Drug List (PDL or formulary)
- Population Health and Care Management Program Information
- Wellness information

Secure Provider Portal

https://countycare.valence.care/

CountyCare's web portal service allows providers to access many tools and resources, which makes giving care to CountyCare members more manageable and more efficient. Contracted providers and their office staff can register for the secure provider portal. On the home page, select the Log On link, and follow the instructions.

Once you are registered, the secure portal will allow you to do the following:

- View your panel list (for PCPs)
- Request and track authorizations
- View claims payment history
- Verify member eligibility
- Contact us securely and confidentially
- Access the provider directory
- Submit a claim

Please contact Provider Relations at ProviderServices@countycare.com, or by phone at 312-864-8200 for a secure site tutorial or click here to access the Provider Portal User Guide.

Get The Assistance You Need

Where	Provider Portal	Provider Relations	Your Provider Representative
When	Twenty-four (24) hours a day, seven (7) days a week	Monday – Friday: 8:00 a.m. – 6:00 p.m. CT Saturday: 9:00 a.m. – 1:00 p.m. CT	Monday – Friday 8:30 a.m. – 5:00 p.m. CT
How	https://countycare.valence.care	P: 312-864-8200 ProviderServices@countycare.com	Via phone and email
For What?	Self Service • Submit authorizations • Check authorization status • View member eligibility • Check claims status • View EOPs • View panel rosters • Access important documents and forms • Submit a claim review	Live Representative Service • Verify member eligibility • Understand member benefits • Check claims status • Request authorizations • Check provider status • Report Health, Safety and Welfare Incident(s) including Critical Incidents • File appeals or grievances	• Discuss escalated issues, concerns, or questions • Request training (products offered, portal processes, claims, etc.) • Schedule meetings to partner with CountyCare on optimizing programs and processes

VERIFYING ELIGIBILITY

Members should always present their ID card at the time of service, but an ID card is not required for services nor a guarantee of eligibility. Providers must verify a member's identity and eligibility on every service and record such documentation.

Information such as member ID number, effective date, and 24-hour health plan phone number is included on the card.

Please ask to see photo identification. If you suspect fraud, please contact our CountyCare Fraud Hotline at 844-509-4669 immediately.

Verify a member's eligibility by using any of the following resources:

Provider Portal	Contracted providers can log onto the secure provider portal at https://countycare.valence.care/. Search by date of service, plus any one of the following: • Member's name and date of birth • CountyCare ID number • Medicaid ID number Within the provider portal you can look up multiple members in a single request.
Provider Panel Lists	CountyCare's secure provider portal also allows Primary Care Providers (PCPs) the ability to access their panel lists, which provide details on CountyCare members who have selected a PCP or have been assigned to a PCP. The list is a snapshot, posted on the first day of every month.
MEDI System	Medicaid providers can also utilize the state's MEDI system, which can be found at https://www.illinois.gov/hfs/medicalproviders/EDI/medi/pages/default.aspx.
Interactive Voice Response (IVR) Phone System	Call 312-864-8299 and choose the menu option to reach our automated eligibility-verification system. You will be asked to enter the following information: • CountyCare Member ID number • Member date of birth • Month of service If you cannot confirm a member's eligibility using the secure provider portal or IVR phone system, call CountyCare at 312-864-8200 between 8:30 a.m. and 5:00 p.m., Monday-Friday, and follow the menu prompts to speak to a Provider Relations Representative before rendering services.

PRIMARY CARE PROVIDERS (PCPS) AND MEDICAL HOME

The PCP is the cornerstone of CountyCare's service delivery model. The PCP's practice serves as the "medical home" for the member. The Patient-Centered Medical Home (PCMH) concept helps to establish a member-provider relationship, support continuity of care, eliminate redundant services and ultimately improve outcomes in a cost-effective manner. Federally Qualified Health Centers (FQHCs), multi-specialty health practice groups, Community Mental Health Centers (CMHCs) and physician offices can all be effective PCMH settings. The PCP serves as the lead of the member's Interdisciplinary Care Team (ICT). The ICT integrates all aspects of each member's care, including behavioral health and waiver services.

PCP Specialties And Provider Types

CountyCare offers a robust network of PCPs and Women's Health Care Providers (WHCPs) to ensure every member has access to a provider within reasonable travel distance standards. Providers who may serve as PCPs or WHCPs include physicians, advanced practice nurses and physician assistants specializing in:

- Family Medicine/General Practice
- Internal Medicine
- General Practice Geriatrics
- Pediatrics
- Women's Health including Obstetrics and Gynecology

PCP Assignment

Members must choose a PCP from the CountyCare network of providers. Members are permitted to change PCPs once per month. PCP assignments and reassignments take effect the first day of the month following the member's selection. For members who do not select a PCP by their enrollment date through the Illinois Client Enrollment Broker, CountyCare will use an auto-assignment algorithm to assign an initial PCP. CountyCare takes the following criteria into consideration in the PCP auto-assignment algorithm:

1. Member history with a PCP
2. Family history with a PCP
3. PCP type (e.g., age and gender)
4. Geographic proximity of a PCP to the member residence

Medical Records

Network providers are required to maintain a permanent medical record for each assigned member. The medical record shall be released only to authorized persons, including the Plan or HFS, upon request, and following regulatory standards. It must be available to other providers involved in the member's care. If a member transfers to a new PCP, a copy of the medical record shall be sent to the new provider.

Medical records shall be released only following federal or state law, including court orders, subpoenas, or a valid records-release form executed by the member. The medical record shall contain relevant historical and updated information about the following:

- Member identification
- Provider identification
- Dated, legible, accurate, complete information
- Personal health, social history, and family history
- Health risk assessment(s)
- Obstetrical history and profile
- Hospital admissions and discharges
- History of current illness or injury and physical findings
- Diagnostic and therapeutic orders
- Clinical observations, including results of treatment
- Reports of procedures, tests, and results diagnostics
- Patient disposition and pertinent instructions for follow-up care
- Immunization record allergy history
- Exam record
- Weight and height information and, as appropriate, growth charts
- Referral information
- Health education and anticipatory guidance provided
- Family planning and counseling
- Documented efforts to obtain the member's consent when required by law

CountyCare does not reimburse for medical records requested in connection with an audit or investigation.

Specialist As PCP

CountyCare members have freedom of choice to select a PCP. A PCP may be a Women's Health Care Practitioner (WHCP) when appropriate. If a member is pregnant or has a chronic health condition, a disability, or special health care need, they may request to designate a specialist as a PCP. Members can request this accommodation themselves, or a provider or care coordinator may submit it. Requests for a specialist as a PCP are made using the form posted on the CountyCare website.

Requests must contain sufficient information about the need for a specialist as a PCP. The requested specialist must be willing to fulfill the role of a PCP, including all PCP responsibilities. The Chief Medical Officer, Medical Director, or designee will approve or deny a specialist as a PCP based on criteria and individual factors.

PCP For Homebound Members

If a member is determined to be homebound by the PCP or care coordinator, he/she may be assigned, either temporarily or permanently, to a PCP who will see the member in his/her home. CountyCare contracts with PCPs and other providers who visit patients' homes, these providers are not listed in the general directory and may be requested through a care coordinator. A provider or care coordinator must submit a PCP change request form with sufficient information certifying that the member is homebound. The Chief Medical Officer, Medical Director, or designee will approve or deny assignment to a PCP contracted to provide PCP services in the home based on criteria and individual factors.

Specialty Care Providers

The PCP is responsible for providing and/or coordinating all their assigned members' health care services. The PCP will initiate referrals to specialists and other providers when care is needed beyond the scope of their practice. The specialty physician may order diagnostic tests without PCP involvement by following the CountyCare authorization guidelines, which are listed in this provider manual.

PROVIDER RESPONSIBILITIES

- Be enrolled as a qualified provider in the HFS Medical Program's IMPACT system and not be an Excluded Person and not be a person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement.
- Have admitting (and delivery, where applicable) privileges at a participating hospital or other inpatient facility or a written referral agreement with a provider who has inpatient privileges and provides for transfer of medical records and coordination of care between providers.
- Submit a complete Illinois Association of Medicaid Health Plans (IAMHP) roster quarterly. Any provider additions, changes in name, address, office hours, spoken languages, patient age ranges, accessibility status, tax ID, taxonomy, education, hospital affiliation or admission status, licensure or board certification, or terminations must be sent every month to: CountyCareProviderRosterSubmission@cookcountyhhs.org.
- Confirm members' eligibility before providing services.
- Obtain authorizations for selected inpatient and outpatient services as listed on the current Prior Authorization List: https://countycare.com/providers/prior-authorizations/.
- Work in partnership with the member's plan-assigned care coordinator/care manager.
- Participate on the member's Integrated Care Team (ICT) as needed.
- Educate members on how best to comply with medical advice when they are sick and what plan resources are available to help them direct their own care and/or develop an Individual Plan of Care.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Partner with CountyCare to coordinate specialized services (e.g., interpreters and accommodations for members with cognitive limitations).
- Communicate all appropriate treatment options to CountyCare members, regardless of cost or benefit coverage for such opportunities.
- Practice according to generally accepted minimum standards of care and nationally recognized clinical practice guidelines as documented on CountyCare's website.
- Adhere to the CountyCare Cultural Competence Plan, which can be found at https://www.countycare.com/providers/provider-training.
- Adhere to Access and Availability requirements, including linguistic and physical accessibility standards, appointment availability and after-hours coverage.
- Communicate in a manner that accommodates the member's individual needs.

- Assist CountyCare in its efforts to maintain updated member contact information by providing it upon request.
- Maintain confidentiality per HIPAA and state law standards and federal regulations.
- Comply with CountyCare's credentialing and re-credentialing requirements.
- Cooperate with CountyCare's quality improvement activities and participate in the CountyCare Quality Improvement (QI) Program. Cooperation with the QI Program includes, but is not limited to:
    - » Cooperate with the CountyCare data-collection process by reviewing medical and administrative records for identified members and submitting requested documentation to CountyCare;
    - » Assist and accommodate CountyCare staff in scheduling onsite visits;
    - » Facilitate access to members' medical records including electronic medical records, for Quality Assessment Performance Improvement (QAPI) program reporting and other CountyCare quality improvement initiatives and activities related to the appropriateness of service and quality of care;
    - » Respond in a timely manner to quality-of-care complaints and concerns;
    - » Participate in Medical Home surveys;
    - » Facilitate access to member and other records or submit to audit or investigation by HFS or other agency staff when requested. HFS requires that network providers afford HFS the same access to records as afforded to CountyCare;
    - » Providers may not charge CountyCare for copy fees related to requests for medical records;
    - » Permit CountyCare to publish results related to Provider/Practitioner clinical performance;
    - » Provide screening, well care, and referral information to community health departments or other agencies following HFS provider requirements and public health initiatives;
    - » Refer to your CountyCare Provider Agreement for complete information regarding provider legal obligations and reimbursement;
    - » Refrain from any activity or communication that might be considered marketing a health plan to a member or prospective member;
    - » Never bill the member for covered services.
- Respect and support member freedom of choice and access to all willing and qualified providers.
- Recognize potential concerns related to Abuse, Neglect, and exploitation, and report suspected or alleged Abuse, Neglect, or exploitation to investigating authorities in accordance with state and federal mandated reporting laws as well as to CountyCare as Health, Safety and Welfare incidents.
- Obtain member consent, as required by federal and state law, for the release of specially protected information to CountyCare for payment and health care operations purposes (i.e., care coordination/ management, quality metrics, etc.).
- Comply with CountyCare's Fraud, Waste and Abuse policy and procedures, as articulated in this manual; report any instances of alleged fraud, abuse, neglect or exploitation within required reporting parameters, as delineated in this manual.
- Comply with required CountyCare training.

HCBS Waiver Provider Responsibilities

HCBS Waiver Provider responsibilities include those listed under the "Provider Responsibilities" section plus the following:

- Work collaboratively with CountyCare's care coordination team to support the member's goals.
- Provide only the services as outlined in the service plan. If a provider believes a change is necessary for the member's well-being, they should contact CountyCare's care-coordination team to discuss and request approval of the change.
- Notify the care coordinator of any significant changes to the member's health, living conditions or circumstances (i.e., hospitalizations, extended time out of the home, change of address, etc.).
- Notify CountyCare if you are or become a provider that administers the DON or Pre-Admission Screening (PAS) required under the HCBS waiver programs. CountyCare must notify HFS of any contracted provider that administers these tools.
- Important note related to HCBS Providers Stopping Services for HCBS Members:
    - » Providers are expected to notify CountyCare Health Plan prior to stopping services with the reason and effective date. It is not acceptable, at any time, for a provider to stop services due to an issue with claims payment without prior notification to CountyCare and arrangements made for members to continue receiving service without interruption.

Supportive Living Program and Long-term Care Facility Responsibilities

Supportive Living Program and Long-Term Care Facility responsibilities include those listed under the "Provider Responsibilities" section plus the following:

- Work in partnership with the member's health plan-assigned care coordinator/care manager.
- Notify Care Coordination and Utilization Management (UM) in advance of elective hospital admissions.
- Notify UM of emergency hospital admissions within twenty-four (24) hours of the admission.
- Be available to communicate with the Care Coordinator and PCP.
- Coordinate the member's care with the Care Coordinator and PCP.
- Provide the Care Coordinator and PCP with reports and other appropriate records within five (5) business days.

Outpatient Laboratory Responsibilities

Outpatient Laboratory responsibilities include those listed under the "Provider Responsibilities" section plus the following:

- Maintain current Clinical Laboratory Improvement Amendments (CLIA) certification for all draw sites and comply with all CLIA regulations.
- Submit values to the plan at least monthly and in a mutually agreeable electronic format used for state reporting and calculation of Healthcare Effectiveness Data Information Set (HEDIS) Performance Measures.

Hospital Responsibilities

Hospital responsibilities include those listed under the "Provider Responsibilities" section plus the following:

- Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list.
- Notify UM of emergency hospital admissions, elective hospital admissions and newborn deliveries within twenty-four (24) hours of admission.
- Notify UM of member emergency room visits for the previous business day via fax or electronic file. The notification should include the member's name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number.
- Notify the PCP within twenty-four (24) hours after the member's visit to the emergency department or emergency admission.
- Notify UM of members who may benefit from care coordination services, such as members who may have frequent visits to the emergency room.
- Providers shall ensure members hospitalized for mental illness have an outpatient follow-up visit with a qualified mental health provider within fourteen (14) calendar days from discharge.

Inpatient Psychiatric Network Provider Responsibilities

On Admission

- Administer a physical examination to the member within twenty-four (24) hours after admission.
- Begin discharge planning upon admission and allow and encourage Community-based Providers responsible for providing service upon the member's discharge to participate in inpatient care conferences by phone, videoconference, or in person.

Discharge Planning and Transitional Services

Providers should encourage the member and their family to contact the member's care coordinator whenever a health care or social service intervention is required or requested. Providers shall ensure that referrals are made to other service providers effectively, efficiently, and, when possible and appropriate, within CountyCare's network.

Crisis Safety Plan

Providers are responsible for establishing an individualized crisis safety plan for members experiencing a behavioral health crisis that includes concrete interventions that will assist in ameliorating the circumstances leading to the crisis for each member.

The crisis safety plan should be developed in collaboration with the member and the member's family. Providers should educate and orient the member on the components of the crisis safety plan and provide physical copies of the crisis safety plan to the member and the member's family.

Providers shall collaborate with CountyCare Care Coordinators staffing and assist with member communication for members who are being treated by an inpatient hospital provider following a crisis event. This includes allowing care coordinators access to members by phone, in person during visitation hours, and ICT participation. Providers are responsible for sharing the crisis safety plan with all necessary medical professionals, including care coordinators, consistent with authorization established by consent of release.

Medication Management Review

Providers shall cooperate with care coordinators to ensure that a medication management review has been completed prior to discharge from higher levels of care (e.g., hospital, Psychiatric Residential Treatment Facility (PRTF), residential, and crisis); to confirm that PCPs are made aware of any medications that have been prescribed for members during treatment in an institutional setting; and to confirm with members that they have the ability to get prescribed medications.

Discharge Plan

- Providers shall review the discharge plan with the member prior to discharge including all scheduled follow-up appointments.
- Providers shall ensure the member has an outpatient follow-up visit with a qualified mental health provider within fourteen (14) calendar days after discharge.
- Providers shall facilitate members attending all post-discharge appointments for follow-up care.
- Providers shall collaborate with care coordinators in their efforts to provide appropriate care management based on concurrent assessment.
- Providers shall educate members who may be eligible for the State-funded Family Support Program pursuant to 89 Ill. Adm. Code 139 about Family Support Program to help these members access community-based services.

Notification of Discharge

Hospitals and other facilities must notify CountyCare or the Mobile Crisis Response Team, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays.

Mobile Crisis Response Provider Responsibilities

- Deliver MCR services consistent with all service requirements established by the Department including, but not limited to, those outlined in the Department's Handbook for Providers of Community-Based Behavioral Services.
- Provide immediate and sufficient Crisis and Stabilization services to stabilize an Enrollee in the community when at all possible and appropriate for the Enrollee.
- Ensure that Mobile Crisis Response services are available every day of the year, twenty-four (24) hours per day.
- Provide the member's family with contact information that may be used at any time, twenty-four (24) hours a day in moments of crisis, to contact the Provider in moments of crisis.
- Educate members who may be eligible for the State-funded Family Support Program pursuant to 89 Ill. Adm. Code 139 about Family Support Program to help these members access community-based services.
- Escalate access to care issues to CountyCare when:
    - » A member requiring psychiatric inpatient hospitalization remains in an Emergency Department for a period of twenty-four (24) hours or greater due to the inability to locate a hospital willing or able to admit the member; and
    - » A member receiving psychiatric inpatient services is identified as at significant risk of remaining at the inpatient facility after the member has been medically cleared for discharge.

Screening

- Provide a face-to-face crisis screening within ninety (90) minutes of notification to all members experiencing a Behavioral Health Crisis.
- Provide a face-to-face in-person crisis screening within twenty-four (24) hours for a non-emergency referral when the member is not at immediate risk of harm but still requires an MCR screening (i.e., court-ordered screening, Enrollees admitted to a psychiatric hospital prior to an MCR screening).
- Utilize the Illinois Medicaid Crisis Assessment Tool (IM-CAT) as the standardized MCR screening tool for all face-to-face mobile crisis screenings. 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.
- Complete an IM+CANS on all members who require mental health services within thirty (30) days of initiation of services. The IM+CANS is a comprehensive, multi-purpose tool that provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois.
- Facilitate the member's admission to an appropriate inpatient institutional treatment setting when the member in crisis cannot be stabilized in the community.

Crisis Safety Plan

- For all enrollees that present in Behavioral Health crisis, create, or review and update, an individualized Crisis Safety Plan in collaboration with the member and the member's family prior to the completion of the Crisis intervention for any member stabilized in the community or prior to the member's discharge from an inpatient psychiatric hospital setting.
- Provide members and families of members with physical copies of the Crisis Safety Plans. Educate the member's family to the components of the Crisis Safety Plan, review the plan with the family regularly, and explain to the member and their family how the plan is updated as necessary.
- Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators from the MCO and CCSO as applicable, consistent with the authorizations established by consent or release.

Follow-Up

- Share the psychiatric resources and medications provided as part of Mobile Crisis Response Service, consistent with all consents and releases, with CountyCare and all necessary medical professionals, including the member's PCP
- Participate in emergency Interdisciplinary Care Teams (ICTs) convened by the member's Care Coordinator. The ICT meeting must take place within fourteen (14) days after a Crisis event for members who were community stabilized or within fourteen (14) days after discharge if the member was hospitalized.
- Communicate to the Enrollee's PCP the pharmacological services performed as part of MCR service, consistent with all consents and releases.

Member Appointments

- Refer and immediately link members who have been community stabilized following a Crisis event with an urgent appointment with a mental health provider within one (1) Business Day after the Crisis event, if deemed medically necessary.

- Cooperate with care coordinators to ensure members receive priority access to a psychiatric resource for consultation and medication management within the following time frames:
    - » Within three (3) calendar days after the date of the Crisis event for a member for whom community-based services were put in place in lieu of psychiatric hospitalization, or
    - » Within fourteen (14) calendar days after a member's discharge from an inpatient psychiatric hospital admission.

Inpatient Institutional Treatment

- Facilitate the member's admission to an appropriate inpatient institutional treatment setting only when the member in crisis cannot be stabilized in the community.
- Inform the member and their parents, guardian, caregivers, or residential staff about all the available inpatient Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.
- Convene an emergency ICT for any Enrollee identified that minimally includes the MCR Provider, the Enrollee's guardian, if appropriate, any community providers offering community-based services to the Enrollee, and representatives from any State Agencies offering services to the Enrollee within forty-eight (48) hours of notification of the Enrollee's status.
- Begin discharge and transition planning upon admission by:
    - » Participating in and taking lead in coordinating staffing, discharge, and transition processes with assistance from the member's Care Coordinator, including coordinating all necessary follow-up appointments and referrals for the member upon transition back into the community. Appointments shall be established prior to discharge to ensure continuity across care providers;
    - » Notifying the member's family and caregiver of key dates and events related to the admission, staffing, discharge, and transition of the member, and making every effort to involve the member and the member's family and caregiver in decisions related to these processes; and,
    - » Speaking directly with the member at least once each week while the member is receiving inpatient services.

Community Mental Health Center (CMHC) and Community Behavioral Health Organization (CBO) Provider Responsibilities

- Educate and train the member's family on how to use the Crisis Safety Plan while the member is receiving inpatient institutional treatment.
- Participate in all inpatient care conferences while member is hospitalized.
- Provide consultation and medication management services within fourteen (14) days of inpatient psychiatric discharge or within three (3) days of crisis stabilization in the community.
- Communicate to the PCP the psychiatric resources that were provided to the member.

Advance Directives

CountyCare provides to members information about Advance Directives in the CountyCare Member Handbook. PCPs and other providers delivering care to CountyCare members provide counseling for advanced directives (living will and healthcare power of attorney), collect those documents, if available, and store them in the medical record.

Terminating Care of A Member

Any provider type may request to terminate the care of a member if the member:

- Repeatedly fails to keep scheduled appointments.
- Fails to comply with the treatment plan.
- Is abusive to the provider or staff (physically or through words).
- Impedes operations of the practice through disruptive behavior unrelated to their medical condition.

The provider may discontinue seeing the member after the following steps have been taken:

1. Incidents have been appropriately documented in the member's medical record.
2. A certified letter has been sent to the member, with a copy to CountyCare Provider Relations, documenting the reason for the termination, indicating the date for the termination, informing the member that the provider will be available for urgent care for thirty (30) days from the date of the letter, and instructing the member to call Member Services or their care coordinator for assistance in selecting a new provider.
3. A copy of the letter and certification information is entered into the member's medical record.

The member is responsible for contacting Member Services to select a new provider. The provider or member services may refer the member to a care coordinator to assist the member in finding a different provider. If the provider terminating a member's care is the member's PCP, and the member does not select a new PCP, CountyCare will auto-assign the member to a PCP.

Suspending, Stopping, or Terminating HCBS Waiver Services

An HCBS provider may request suspension of services by notifying the member's care coordinator. Services may not be suspended until the care coordinator is notified and confirms that a plan and/or appropriate alternative services are in place.

Suspension of services may be appropriate under the following circumstances:

- The member or authorized representative is uncooperative.
- The member or authorized representative causes interference with the delivery of service.
- The member or authorized representative displays threatening behavior.
- There are other unsafe conditions in the home.

The care coordinator will work directly with the provider to resolve any potential issues, and if necessary, suspend services. HCBS Providers are expected to notify CountyCare before stopping services with the reason and effective date.

It is not acceptable, at any time, for a Provider to stop services due to an issue with claims payment without prior notification to CountyCare and arrangements made for members to continue receiving service without interruption.

Leaving The Network and Continuity of Care Requirements

Providers must give CountyCare notice of termination following the terms of their participation agreement with our health plan. For a termination to be valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. Also, providers must supply copies of medical records to any member's new provider upon request and facilitate the members' transfer of care at no charge to CountyCare or the member.

Providers must continue to render covered services to members as follows:

- Continuation of care at the time of termination for up to sixty (60) calendar days or until such time as CountyCare can arrange for appropriate health care for the member with a participating provider, whichever comes first.
- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.
- Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.

CountyCare will continue to reimburse providers for medically necessary covered services in these circumstances and will notify affected members in writing of a provider's network termination. If the terminating provider is a PCP, CountyCare will request that the member select a new PCP. If a member does not select a PCP before the provider's termination date, CountyCare will automatically assign one to the member.

PROVIDER ACCESSIBILITY

Appointment Access Standards and Annual Audit

CountyCare follows the accessibility requirements set forth by regulatory and accrediting agencies. Appointment accessibility standards are shown in the table below by provider type. Providers will be randomly selected to participate in at least an annual telephone survey to monitor compliance with these standards.

24-Hour Access for Members

CountyCare primary care and specialty providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week. After-hours coverage must be accessible using the medical office's published daytime telephone number. Voicemail alone after hours is not acceptable. After-hours calls must be documented in a written format and transferred to the member's medical record. The selected method of 24- hour coverage must connect the caller to someone who can provide clinical advice to the member or reach the practitioner or covering medical professional. The practitioner or covering medical professional must return the call within thirty (30) minutes of the initial contact.

Provider	Category	Standard
PCP	Regular, Routine Care (preventive >6 months old) Routine Care (infant <6 months old) Non-Urgent Problem or Complaint Urgent Care	Within five (5) weeks Within two (2) weeks Within three (3) weeks Within twenty-four (24) hours
Prenatal Care	Prenatal – 1st Trimester Prenatal – 2nd Trimester Prenatal – 3rd Trimester	Within two (2) weeks Within one (1) week Within three (3) days
Behavioral Health	Care for non-life-threatening emergency Urgent Care Initial Visit for Routine Care Follow-up Routine Care	Within six (6) hours (or directed to ER or BH crisis unit) Within forty-eight (48) hours Within ten (10) business days Within twenty (20) business days
Specialty Care	Initial Visit for Routine Care Follow-up Routine Care	Within four (4) weeks Within four (4) weeks
All Provider Types	Average Office Wait Time All Appointment Types	Less than one (1) hour No more than six (6) scheduled per hour
Primary, Behavioral Health, and Specialty Care	After-hours care	24/7 coverage (voicemail only not accepted)

Covering Providers

PCPs and specialty practitioners must arrange for coverage with another CountyCare network provider during scheduled or unscheduled time off. Covering providers are compensated following the terms of their contractual agreements.

PCP Member Panel

Panel sizes are limited as follows:

- FHP/ACA members: 1,800 per physician, and 900 per advanced practicing nurse (APN), physician assistant (PA), or resident physician full-time equivalent (FTE).
- ICP members: 600 per physician, and 300 per APN, PA, or resident physician FTE.

CountyCare does NOT guarantee that any single provider will receive a certain number of members. A PCP who has not reached the maximum panel size may close their panel to new members by notifying Provider Relations in writing at least forty-five (45) calendar days in advance. Any established patient within a PCP practice who becomes a CountyCare member will not be considered a new patient.

Accommodations for Members with Disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability but are regarded as having a disability.

It is unlawful to discriminate against persons with disabilities or to discriminate against a person based on that person's association with a person with a disability.

Provider locations where CountyCare members receive covered services must comply with the ADA standards. Accommodations for people with disabilities include:

- Physical accessibility
- Effective communication
- Policy modification
- Accessible medical equipment

Providers should capture information about accommodations that may be required in the patient's medical record, and when making referrals to other providers, communicate with the receiving provider regarding any necessary accommodations that may be required (e.g., wheelchair, interpretive linguistic needs, non-compliant individuals, cognitive impairments, etc.).

CountyCare monitors provider compliance with the ADA by:

- Collecting ADA compliance attestations via the IAMHP roster, and;
- Reviewing member complaints for evidence of ADA non-compliance.

If a Provider fails to meet ADA requirements, a Provider Relations representative will contact the provider to resolve the deficiency.

CULTURAL COMPETENCE

Overview

CountyCare is committed to having all CountyCare network providers fully recognize and care for the culturally diverse needs of the members they serve. To accomplish this aim, CountyCare has established a Cultural Competency Training to help guide and monitor efforts to ensure cultural competency, building on CountyCare partner experience and established relationships in the communities served.

CountyCare's Cultural Competency Plan is based on adopting the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the US Department of Health and Human Services' Office of Minority Health in 2000 and NCQA Health Plan Standards and Guidelines.

Culturally and Linguistically Appropriate Services (CLAS) are health care services that are respectful of, and responsive to, the patient's cultural and linguistic needs. Care is designed to be effective, understandable, and respectful.

> **Effective Care** successfully restores the client to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions. For health services to be effective, the clinician must accurately diagnose the illness, discern the correct treatment for the individual, and negotiate the treatment plan successfully with the member.
>
> **Understandable Care** focuses on the need for patients to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff. To be understandable, the concepts must "make sense" in the cultural framework of the individual.
>
> **Respectful Care** includes considering the values, preferences, and expressed needs of the member and helping to create an environment whereby patients from diverse backgrounds feel comfortable discussing their individual needs with any staff member.

Training Goals and Requirements

CountyCare network providers, vendors, and their staff must deliver culturally competent health care and services by possessing attitudes, skills, and policies that enable effective work in cross-cultural settings. Training is available to support providers meet to goals that include but are not limited to:

- Being educated about the linguistic needs and cultural differences of members
- Understanding the populations we serve
- Being responsive and sensitive to the member's needs
- Having the ability to communicate effectively with members

Although CountyCare will provide Cultural Competency training, provider offices should also have their own specific cultural sensitivity and competency training.

COVERED SERVICES

CountyCare covers services offered under Illinois Medicaid, HealthChoice Illinois. CountyCare network providers deliver a variety of medical benefits and services. Questions related to covered services can be directed to Provider Relations at 312-864-8200 from 8:00 a.m. to 6:00 p.m., Monday through Friday and 9:00 a.m. to 1:00 p.m. on Saturdays (excluding holidays). Providers can also reference the CountyCare website.

Out-of-network services are not covered unless services are for emergency services, family planning, or when the health plan provides prior authorization.

Non-Covered Services

CountyCare's non-covered services include:

- Medical/surgical procedures solely for cosmetic purposes.
- Diagnostic or therapeutic procedures related to infertility/sterility.
- Services that are experimental or investigational.
- Intermediate Care Facility for Developmentally Disabled (ICF/DD Facility).
- Non-emergency services provided by an out-of-network provider and not prior authorized by CountyCare.

The chart below summarizes services covered by CountyCare for HealthChoice Illinois Medicaid. Some services require prior authorization. For current information on specific prior authorization requirements and benefit limits, refer to the CPT look-up tool on CountyCare's website or contact Provider Relations or UM.

Medicaid Covered Services

- Audiology Services
- Behavioral Health Services
- Chiropractic Services
- Community Support Services
- Dental Services
- Diagnostic Testing
- Dialysis
- Durable Medical Equipment
- Emergency Services
- Emergency Transportation
- Family Planning
- Gender Affirming Care
- Genetic Counseling, Testing
- Home Health Care
- Home Infusion
- Hospice Care
- Hospital Services
- Inpatient Admissions
- Interpretation Services
- Inpatient Hospital Stays – Medical, Mental/Behavioral, Substance Use Withdrawal Management
- Laboratory Services
- Medical Supplies
- Orthotics
- Out-of-network Physicians/ Facility/Service
- Outpatient Therapy (PT, OT, ST, cardiac, pulmonary)
- Pharmacy Services
- Podiatry
- Post-stabilization Services
- Practice visits for members with disabilities
- Primary Care Visits
- Prosthetics
- Radiology
- Services rendered in school-based health centers
- Specialist Outpatient Visits
- Specialist Physicians
- Sterilizations
- Surgery
- Telehealth/Telemedicine
- Transplants
- Transportation (Emergency and Non-Emergency)
- Vision Services

NOTE: Out-of-network services are not covered unless for emergency services, family planning, or when the health plan provides prior authorization.

Telehealth

Telehealth is the delivery of medically appropriate physical or behavioral health care services or consultations using a two-way audio-visual platform. Typically, physicians or other licensed health care professionals must be present with the patient at the originating service site. During the COVID-19 emergency, the health care professional is not required to be in the same room as the patient. The distant site provider must be practicing within their scope of services and be duly licensed. Medical data may be exchanged through a telecommunication system. When a visual and audio connection is not possible, then telephonic communication is accepted.

For more information, reference the telehealth guidance released by IAMHP in conjunction with HFS, including the IAMHP Billing Guide for all billing and coding details.

Rewards and Extra Benefits

CountyCare offers a variety of extra benefits to members. Below provides a summary of those benefits.

CountyCare Rewards Card Program

When members receive certain medical services, they will be sent a CountyCare OTC Rewards Card in the mail. The card will have cash credit on it and can be used as a debit card at participating retailers listed below. Visit the website for the most up-to-date information on the CountyCare OTC Rewards Card Program.

Participating Retailers

- CVS (not in Target stores)
- Dollar General
- Family Dollar
- Food4Less
- Jewel/Osco
- Mariano's
- Walmart
- Walgreens

Funds will be added to the card as members receive qualifying services. Members have six (6) months to use the funds from the date the reward is added to the card. Funds can be used to purchase a wide range of everyday items such as shampoo, diapers, antacids, and cleaning tools. Find more examples of what members can buy with their OTC Rewards Card at www.countycare.com/members/benefits-rewards/.

The following are services that qualify for a reward and the amount earned:

Eligible Services	Amounts Earned
Annual Health Risk Screen	**$50**
PCP (assigned) Annual Visit	**$50**
Prenatal Visit (up to 14)	**$10**
Postpartum Visit (within first 12 weeks)	**$25**
Well Child Visit (first month)	**$50**
Next 5 Well Child Visits	**$10**
First 10 immunizations for babies	**$10**
Annual Mammogram (45-74)	**$50**
Managing Diabetes - Annual Diabetic Screening (blood test and urine screening)	**$25**
RD/Inpatient Aftercare/Follow-up visits	**$20/$10**
Colorectal Cancer Screening (45-75)	**$50**
Cervical Cancer Screening (21-64)	**$50**
Annual Flu Shot (6 months and older from a PCP, Pediatrician, or an in-network pharmacy)	**$10**
Notification of Pregnancy (Members who are pregnant can earn a $50 reward when they complete the Notification of Pregnancy Form located on our "Member Resources" page of our website.)	**$50**

Additional CountyCare Extra Benefits
Free LASIK Eye Surgery for members who qualify
Free Monthly Diaper Coupon for kids up to 2 years old who are on schedule for their shots
Free Car Seat for Pregnant Members and Children up to 8 years old
Free Sleep Safe Kit for Pregnant Members who complete at least 4 prenatal visits
Free Annual Book Club for Kids ages 3-16
Free Pregnancy Test
Free Weight Watchers Meeting Vouchers for members 13 and older

For complete details about CountyCare Rewards and Extra Benefits, please visit the website or call Member Services at 312-814-8200, 711 (TDD/TTY).

Covered Services for Members Eligible for Home and Community Based Services (HCBS)

CountyCare network offers a variety of additional benefits and services for those who qualify for waiver services. Each waiver provides a different set of covered services. In collaboration with the member, the care coordinator determines which services meet the member's needs to help keep them safely at home. A service plan is developed, which delineates the service type(s), quantity, and duration of services the member receives.

Covered Services for Members Living In Long Term Care Facilities

For Long Term Care Facilities, CountyCare covers room and board for qualified members with a prior authorization or notification to the plan.

HCBS Covered Services

Services	Aging Waiver	Disability Waiver	HIV/AIDS Waiver	Brain Injury Waiver	Supportive Living Facility Waiver
Adult Day Service	✓	✓	✓	✓	
Adult Day Service Transportation	✓	✓	✓	✓	
Assisted Living					✓
Automated Medication Dispenser	✓				
Behavioral Services				✓	
Day Habilitation				✓	
Home Delivered Meals		✓	✓	✓	
Home Health Aide		✓	✓	✓	
Home Modification		✓	✓	✓	
Homemaker	✓	✓	✓	✓	
Nursing, Intermittent		✓	✓	✓	
Nursing, Skilled		✓	✓	✓	
Occupational Therapy		✓	✓	✓	
Personal Assistant		✓	✓	✓	
Personal Emergency Response System	✓	✓	✓	✓	
Physical Therapy		✓	✓	✓	
Prevocational Services				✓	
Respite		✓	✓	✓	
Speech Therapy		✓	✓	✓	
Specialized Medical Equipment and Supplies		✓	✓	✓	
Supported Employment				✓	

Covered Services For Members In The Supportive Living Program

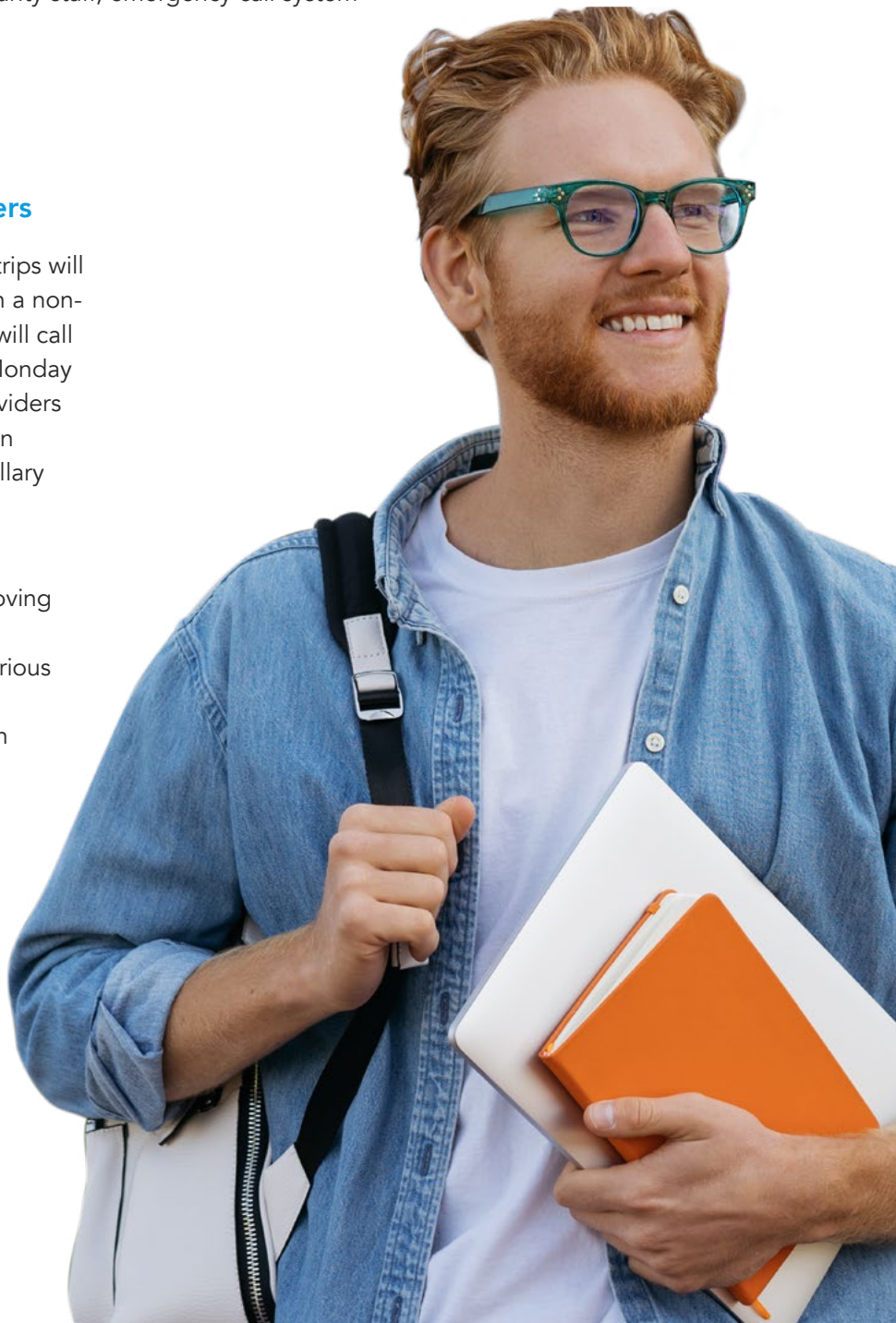
The following services are included in the global rate, and should be provided to CountyCare members:

- Nursing Services
- Personal Care
- Medication oversight and assistance with self-administration
- Laundry
- Housekeeping
- Maintenance
- Social and recreational programming
- Ancillary services
- Twenty-four (24)-hour response/security staff; emergency call system
- Health promotion and exercise
- Daily checks
- Management of resident funds

Transportation Services for Members

As of 1/1/22, all non-emergent ambulance trips will be carved out to HFS Fee-for-Service. When a non-emergent ambulance is needed, members will call First Transit FFS directly at 877-725-0569 (Monday through Friday, 8 a.m. to 5 p.m. CST.) If providers are having any fee-for-service issues, you can contact the Bureau of Professional and Ancillary Services at 877-782-5565.

Please note, only non-emergency ground ambulance transportation services will be moving from MCOs to First Transit FFS for handling. All other transportation requests for other various types of transport (Air Ambulance, Medicar, Service Car, Taxi and Private Auto) will remain the same.



UTILIZATION MANAGEMENT (UM)

The CountyCare UM Program is designed to ensure that members receive access to the right care in the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, extended-long-term care, and ancillary care services.

The UM program seeks to optimize a member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide medically necessary services, covered benefits appropriate to the patient's condition, rendered in the appropriate Setting, and meet professionally recognized standards of care.

Overview

CountyCare's UM department hours of operation are Monday through Friday from 8:30 a.m. to 8:00 p.m. (excluding holidays). Call 312-864-8200.

Referrals

PCPs refer a member to a specialist or other provider when care is needed that is beyond the scope of the PCP's training or practice parameters. CountyCare does not require a referral from the PCP for payment of an in-network specialist, however the PCP should always provide clinical information to the specialist. Specialists should communicate with the PCP if there is a recommendation for a referral to another specialist.

Certain services may require prior authorization from CountyCare. See information on Prior Authorization.

Medical Necessity

Medical necessity is defined for CountyCare members as health care services, supplies or equipment provided by a licensed health care professional who:

- Provides appropriate and consistent diagnosis or treatment of the patient's condition, illness, or injury.
- Follows the standards of good medical practice consistent with evidence-based care and CountyCare's clinical practice guidelines as found on our website at: https://countycare.com/providers/clinical-care-guidelines/#preventative-health-guidelines.
- Acts not primarily for the convenience of the member, family, or provider.
- Recommends the most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member.
- Works in a setting appropriate to the patient's medical need and condition.

CountyCare has adopted the medical necessity criteria of its Benefits Managers. These criteria are established and periodically evaluated and updated with appropriate involvement from appropriate clinicians, and providers may obtain the criteria at the time of request or notification to the requesting practitioner/facility of an adverse determination.

Prior Authorizations for Medical And Behavioral Health Services

Some services require prior authorization from CountyCare for reimbursement to be issued to the provider. Prior authorization (PA) requests must include all relevant clinical information needed to make a medical necessity decision. Inadequate clinical information may result in an adverse determination. CountyCare clinical staff will request clinical information that is minimally necessary for medical necessity decision making. Failure to obtain prior authorization for services that require plan approval may result in payment denials.

Use the CPT look up to determine if authorization is necessary. The CPT look-up tool has the most up-to-date requirements, however, below are general services that require authorizations:

- Any services related to any type of inpatient confinement.
- Any services rendered by a non-contracted (out-of-network) provider unless related to emergency services.
- All DME rentals (regardless of purchase price).
- All transplants.
- Some pharmaceuticals (see prior authorization in Pharmacy section).
- All elective cardiology or oncology service authorizations should be requested and performed by specialists within New Century Health scope. Call 888-999-7713 if more details are needed.

Covered Services: Prior Authorizations and Limitations

Service	Description	Prior Authorization Limitations, Notes
Audiology	Consults and testing>$500	If services total greater than $500 in a year, PA is required.
	Hearing aids	Once every three (3) years.
Behavioral health services	Psychological testing	Required.
	Intensive outpatient therapy Psychological testing, Electroconvulsive therapy (ECT)	Required.
	Inpatient services in a state-operated hospital	Except if member is admitted under civil status.
	IOP, PHP, ABA	Required.

Service	Description	Prior Authorization Limitations, Notes
Community support services	Psychological testing	After 200 units (fifty (50) hours) per member, per provider.
	Case management	
	Psychosocial rehabilitation services	After 800 units (two hundred (200) hours) per member, per provider.
Durable Medical Equipment (DME)	>$1,000	If available for rental, standard three-month initial; resubmit for continued rental or purchase.
Gender affirming care		Complete necessary form.
Genetic counseling, testing		Required.
Home health care	5 or more visits per diagnosis	Includes nursing services, outpatient therapies, wound care, diagnostics.
Home infusion		Required.
Hospice care in the home and facility		Required.
Inpatient admission from 23-hour observation		Required. When 48-hour observation is converted to inpatient, the observation is treated as the first inpatient day.
Inpatient hospital stays	Medical	Planned services pre-authorized; emergent services submitted within twenty-four (24) hours.
	Mental/behavioral	
	Substance use withdrawal management	

Service	Description	Prior Authorization Limitations, Notes
Medical supplies	>$500	Refer to CPT code look up (hand priced codes may require PA).
Orthotics		Refer to CPT code look up (hand priced codes may require PA).
Out-of-network physician/ facility/service		Required.
Outpatient therapy	PT, OT, ST, cardiac, pulmonary	Required after first six (6) visits. If joint replacement, PA is not required for 1-12 visits.
Podiatry		Required after three (3) visits.
Post-stabilization services		CountyCare must respond within one hour of request by any provider, regardless of contract network status, or service is considered authorized.
Prosthetics		Refer to CPT code look up (hand priced codes may require PA).
Radiology	High-tech	Includes CT, MRI/MRA, PET.
	Interventional	Includes radiation therapy, ultrasound-guided needle biopsy, nuclear cardio stress test.
	Non-high-tech imaging	Required after three (3) for OB US. Includes ultrasound, X-ray.
Specialist	Outpatient visits – plastic surgery, pain management	All services in an office setting. Services that are for cosmetic purposes only are not a covered benefit.

Service	Description	Prior Authorization Limitations, Notes
Surgery	Non-emergency	Varies – see online CPT code look up.
	Outpatient or ambulatory	
	Reconstructive	
Transplants		Required.

NOTE: Out-of-network services are not covered except for emergency services, family planning, or when the health plan provides prior authorization.

Inpatient Admissions

All inpatient hospital admissions require notification within twenty-four (24) hours of admission to CountyCare.

Emergency Services

Emergency services do not require authorization however, notification is necessary one (1) business day from admission.

How To Request A Prior Authorization

The preferred method for submitting authorization requests is via the Provider Portal (https://countycare.valence.care/). Requests will be processed faster and providers have direct access to details about the request and outcome.

If providers cannot submit via the portal, they must use the Prior Authorization forms on the CountyCare website.

a. Behavioral Health Authorization Request Form

b. Inpatient Medicaid Authorization Request Form

c. Outpatient Medicaid Authorization Request Form

If not using the Provider Portal, submit applicable forms to:

- Fax Behavioral Health Form to: 800-498-8217
- Fax Inpatient Medical Form to: 800-856-9434
- Fax Outpatient Medical Form to: 866-209-3703

Services performed without a prior authorization, when required, will not be eligible for reimbursement. To verify whether a prior authorization is necessary, use our CPT Checker on the website.

Authorization Timelines

Prior Authorization for any service, including behavioral health, should be requested before the requested service delivery date. CountyCare renders decisions on routine requests within four (4) calendar days of receiving the request. CountyCare renders decisions on urgent requests within forty-eight (48) hours of receipt of the request. Requests for expedited authorization should be indicated on the request to the UM Department.

Second Opinion

A member or a health care professional with the member's consent may request and receive a second opinion from a qualified professional within the CountyCare network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain a second opinion from an out-of-network provider at no cost to the member. Second opinions from out-of-network providers require prior authorization.

Clinical Decisions

CountyCare affirms that UM decision-making is based only on appropriateness of care and service, use of contracted providers whenever possible, and the existence of coverage. CountyCare does not specifically reward practitioners or other individuals for issuing denials of service or care. In conjunction with the member, the treating physician is responsible for making all clinical decisions regarding the care and treatment of the member.

All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CountyCare is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and health care operations.

Review Criteria for Medical And Behavioral Health Services

CountyCare has adopted InterQual, developed by Change HealthCare®, and the American Society of Addiction Medicine utilization review criteria to determine medical and behavioral healthcare services' medical necessity. InterQual medical necessity criteria are developed by specialists representing a national panel of community-based and academic practitioners. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. CountyCare may develop review criteria for specific services in the form of a stand-alone medical policy approved by CountyCare's UM Committee.

The Medical Director reviews all potential medical-necessity denials and makes decisions in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the medical necessity criteria on the CountyCare Provider Portal or by contacting Medical Management at:

312-864-8200

CountyCare Health Plan
PO Box 21153
Eagan, Minnesota 55121-0153

New Technology

CountyCare evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The UM team may identify relevant topics for review pertinent to the CountyCare population. CountyCare may develop policies with criteria for new technology to use for the determination of the medical necessity for relevant requests.

Please contact the UM department 312-864-8200 for a new-technology benefit determination or have an individual case reviewed.

Continuity Of Care (COC) Coordination

When members are newly enrolled and have been previously receiving health services, CountyCare will make best efforts to maximize the transition of members' care through providing for the transfer of pending prior authorization information and work with the provider to honor existing prior authorizations.

General COC Eligibility	# of Days Continued from Enrollment Date
Ongoing Course of Treatment	90
Special Needs Child (SNC) in active course of treatment	180
Entered 2nd or 3rd trimester pregnancy (at time of enrollment)	Through delivery and postpartum care.

Specific Course of treatment COC guidelines	# of Days Continued from Enrollment Date
Transplant cases	COC continues for members who are in the transplant evaluation phase or have completed the transplant evaluation, members that have been listed for transplant and post-transplant care up to one (1) year from date of transplant.
Surgeries/procedures and follow-up	COC applies for a scheduled procedure in which the provider has completed the pre-procedure consult and work-up within the past three (3) months. Post op care COC- Follow-up with a provider who performed the procedure within the past three (3) months.
Specific conditions	COC applies for treatment for newly diagnosed conditions or complications within the last three months. COC period is ninety (90) days, SNC COC is one hundred eighty (180) days. If a member has terminal illness and received care from provider within past three months. Same as above.

Specific Course of treatment COC guidelines	# of Days Continued from Enrollment Date
Most Specialists (except Oncology)	COC continues for members in active treatment for an acute condition, such as myocardial infarction (MI), cerebrovascular accident (CVA) or unstable chronic conditions; recent surgeries still in the follow up period (generally 6-8 weeks post op).
PCP	COC continues for members in active treatment for an acute condition, such as MI, CVA or unstable chronic conditions. COC period is ninety (90) days, SNC COC is one hundred eighty (180) days.
Oncology	COC continues up to after completion of the initial treatment plan.
Bariatric (Weight Loss)	COC established by member being seen and evaluated by bariatric surgeon prior to 3/2019.
Diagnostic	Honor existing auths x1st ninety (90) days (180 for SNC) for any service already scheduled.
DME	Honor existing auths x1st ninety (90) days (180 for SNC) for any service already scheduled.
BH outpatient services (counseling, psychiatry, PHP/IOP, community based, ABA)	COC continues for members that have received recent treatment (within previous ninety (90) days) and were established patients for an existing/active condition/diagnosis. Members have ninety (90) days to transition to an INN provider.
Other ancillary services including therapies (PT, OT, ST)	Honor existing auths x1st ninety (90) days (180 for SNC) for any service already scheduled.
INN Providers with members newly effective with CountyCare	Follow normal PA rules above.
Inpatient on effective date	*Previous payor is Medicaid:* Professional fees are paid by CountyCare, facility charges are paid by the previous payor, providers must notify UM for an authorization; if previous payor was *Commercial/No insurance:* CountyCare reviews for bed days and professional fees on the member's effective date; Providers must notify UM and submit clinical for a medical necessity review before the claim is submitted.
Hospice	Terminal illness life expectancy </=6 months COC will continue for that period.

Exclusions – What Does Not Qualify for COC:

- Routine exams, vaccinations, and health assessments
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension, and glaucoma
- Acute minor illnesses such as colds, sore throats, and ear infections

Discharge Planning

Hospitals have the primary responsibility for discharge planning and arranging post-discharge services to meet each member's specific needs. To ensure that members receive appropriate post-hospital discharge care, UM and Care Management staff assist with the discharge plan with the member and/or member's family or guardian when the hospital is unable to identify needed services within the CountyCare network or in order to coordinate with the members' Individualized Plan of Care, Service or unique Interdisciplinary Care Team.

Retrospective Review

Retrospective review is an initial review of services provided to a member for which authorization and/or timely notification to CountyCare was not obtained due to extenuating circumstances related to the member. Requests for retrospective review, for services that require authorization by CountyCare, must be submitted promptly upon identification but no later than sixty (60) days from the first date of service. Decisions are made within thirty (30) calendar days following receipt of all necessary information for any qualifying service case.

Appeals for Adverse Decisions

An adverse decision is when CountyCare or one of its benefit vendors denies a request for authorization or makes changes to an authorization such as a service reduction. They may also suspend or terminate authorization for services that have already been approved. In the event of an Adverse Benefit Determination, the CountyCare or its benefit vendor will send a notice that includes the reasons for the determination; right of Enrollee to request and be provided, free of cost, access to and copies of all relevant information; right of Enrollee to request an appeal and procedures to request an appeal, including an expedited appeal; and the Enrollee's right to request and have benefits continue during the appeal process.

If a requesting provider (participating or non-contracted) disagrees with a decision regarding an authorization, the provider may request a peer-to-peer review within two (2) days of the decision. The provider may make this request by contacting the UM Department via CountyCare's main number and asking to speak with a Medical Director. A UM staff member may also coordinate communication between the Medical Director and requesting provider.

A member or health care professional, with the member's consent, may request an appeal related to an adverse benefit determination. Please refer to the Appeals Section of this manual for further information.

PHARMACY

CountyCare is committed to providing appropriate, high-quality, cost-effective drug therapy to all members. CountyCare works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. The plan covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a CountyCare clinician. CountyCare collaborates with a Pharmacy Benefits Manager (PBM), MedImpact, to administer pharmacy benefits, including the prior authorization process.

Formulary/Preferred Drug List (PDL)

CountyCare adheres to the HealthChoice Illinois Medicaid Preferred Drug List (PDL). A link to the most up to date PDL can be found on the CountyCare website. The PDL describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of the physician/clinician or pharmacist.
- Relieve the physician/clinician or pharmacist of any obligation to the patient.

CountyCare's Pharmacy and Therapeutics (P&T) Committee has reviewed and approved, with input from its members and in consideration of scientific evidence and standards of practice, the list of drugs requiring UM. The Formulary aims to make available safe, appropriate, and cost-effective drug therapy to all CountyCare members.

The CountyCare PDL includes a wide variety of generic and brand name drugs. Clinicians are encouraged to prescribe from the CountyCare PDL for their patients who are members of CountyCare.

The pharmacy program does not cover all medications. Some drugs have a generic equivalent or a brand-name drug from a different manufacturer that is covered.

Some medications require prior authorization (PA) or have limitations on previous therapies, age, dose, and quantity. For more detailed information, please visit https://countycare.com/providers/preferred-drug-list/.

Covered OTC Medications

The CountyCare pharmacy program covers a variety of OTC medications, all of which appear on the Formulary. OTC medications are covered only with a valid prescription from a licensed provider.

Generic Substitution

CountyCare encourages generic substitution when a generic equivalent is available.

Specialty Medications

Specialty medications are considered high-cost drugs that include injectables, infusions, oral formulations, or inhaled formulations that often require specific storage and shipping requirements and patient education from a healthcare professional. Specialty medications can offer treatment for complex, chronic, life-threatening diseases.

Specialty medications may be covered under the Pharmacy or Medical benefits. Often, these medications require a Prior Authorization. A prior authorization request is initiated by completing the Medication Request Forms located on the CountyCare website.

Urgent or After-hours Request

For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the MedImpact Pharmacy Help Desk at 888-402-1982.

Maintenance Medications

CountyCare offers a 90-day supply of maintenance medications through Cook County Health's mail-order pharmacy or through any in-network retail pharmacy.

Pharmacy Prior Authorization (PA) Process

The Formulary includes a broad spectrum of generic and brand-named drugs. Some preferred drugs require PA and are marked with a "PA" notation throughout the PDL. Any drug not listed on the PDL requires a PA. Prescribers may initiate requests for prior authorization via electronic prior authorization (ePA), phone, or fax.

Prior authorization requests must include all relevant clinical information needed to make a medical necessity decision. Inadequate clinical information may result in an adverse determination. CountyCare renders decisions on requests within twenty-four (24) hours of the receipt of request. If a PA request is denied, information about the denial and appeal rights is provided to both the member and the provider. Failure to obtain prior authorization for services that require plan approval may result in payment denials.

Peer-to-Peer Services

Peer-to-Peer services provide prescribers an opportunity to engage in discussions with a peer physician related to Prior Authorization requests. The review allows for case specific discussions designed to address unique case details, denial rationale, and provide an opportunity for the prescriber to present additional rationale to support the request.

Electronic Prior Authorization (ePA)	Prescribers may submit requests for prior authorization on online via the MedImpact Portal. MedImpact Pharmacy Processing Information: RxBin = 017142 RxPCN = ASPROD1 RxGRP = CCX01
Phone	Prescribers can initiate a PA by calling 1-800-788-2949. When calling, please have your own NPI number, as well as the member ID number, complete diagnosis, medication history, and current medications readily available.
Fax	Prescriber may send the Medication Prior Authorization Request Form via fax to MedImpact at 858-790-7100. This form can be found on www.countycare.com.
Peer-to-Peer Services	Prescribers can initiate a Peer-to-Peer review by calling 1-866-397-0191. When calling, leave a message w/ needed info (as instructed by prompt): [i.e., member name/ID, PA #, provider contact info]. A return phone call to complete the review should be received within eight (8) business hours. Peer-to-Peer services hours of operation are Mon – Fri 9:00 am to 6:00 pm.

Quantity Limits

Quantity limitations apply to certain medications to ensure their safe and appropriate use. Quantity limitations are approved by the CountyCare P&T Committee and noted throughout the Formulary.

Step Therapy

Step Therapy is the practice of beginning drug therapy for a medical condition with drugs considered first line as determined by their safety and cost effectiveness. CountyCare requires evidence of Step Therapy for certain medications. The PBM claims system will automatically check the member profile for evidence of prior or current use of the required agent. If there is evidence of the required agent on the member's profile, the claim will process automatically. If not, the claims system will notify the pharmacist that a PA is required.

Age Limits

Some medications on the CountyCare PDL have age restrictions. These are set for certain drugs based on FDA-approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of medications.

Newly Approved Products

Newly approved drug products are reviewed for placement on the CountyCare PDL by the CountyCare P&T Committee following the first six (6) months of product availability on the market.

BEHAVIORAL HEALTH

CountyCare offers our members access to all covered and medically necessary behavioral health (BH) services to address their mental-health and substance-use disorder needs. The network of BH providers is comprehensive and comprised of inpatient and outpatient providers, allowing CountyCare to assist members throughout the continuum of their care and treatment. Working with our providers, we track and monitor members as they step down from intensive levels of care (inpatient, residential, partial hospitalization) to less intensive levels (intensive outpatient, routine outpatient), ensuring that they have access to the most appropriate and effective treatment. Care Coordination provides outreach to higher risk members who often have complex psychosocial needs, along with mental health and substance use disorders, impacting their discharge plan.

Coordination And Communication Between Behavioral Health Providers and PCPs

CountyCare encourages PCPs and behavioral health and substance use treatment practitioners to communicate and collaborate on members' care. Each provider may have extensive knowledge of the member's conditions, health and personal history, mental status, psychosocial functioning, and family or living situation. Providers should communicate when new issues are identified, when a treatment plan is developed or updated or when there is a challenge to engage the member in care, all of which that can affect the members' conditions and/or treatment being rendered by other providers. Communication of this information, with member consent when required, should occur at the point of referral and during the course of treatment.

All member's service providers should participate in coordination of care with a member's Interdisciplinary Care Team (ICT).

Examples of some of the information shared include:

- Prescription medication.
- Results of health risk screenings.
- Known abuse of over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
- Treatment for various diagnoses.
- Progress toward meeting the goals established in the treatment plan.
- Significant change in condition or level of functioning.

CountyCare requires that practitioners report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member when required, it is the behavioral health provider's responsibility to keep the member's PCP abreast of the treatment status and progress in a consistent and reliable manner.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment.
- Member's completion of treatment.
- Results of an initial psychiatric evaluation, initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order and results of functional assessments.
- Written notification of the member's noncompliance with treatment plan (if applicable).

Behavioral Health CARES Line

CountyCare utilizes the Crisis and Referral Entry Services (CARES) line for members, their family members, or other concerned parties seeking to refer members for Behavioral Health Crisis Services. The CARES line number 800-345-9049, TTY: 773-523-4504. The crisis line can also be reached by dialing CountyCare's Customer Service line 312-864-8200 and following the prompts connecting callers to the line or waiting for a Customer Service Representative to help you connect to the line.

The CARES line is answered by staff who are:

- Qualified for and capable of addressing a behavioral health crisis upon a direct answer.
- Knowledgeable and authorized to engage the plan's Mobile Crisis Response System.
- Knowledgeable about CountyCare's behavioral health services and resources, including for children. CARES line staff dispatch mobile crisis response providers based on the location of the individual in crisis.

Care Coordination and Support Organization (CCSO) Responsibilities

CCSO means a provider with responsibility for delivering Mobile Crisis Response and Care Coordination to eligible Enrollees ages 0 to 21 within a designated service area.

Pathways to Success means a program that provides an evidence-informed model of intensive Care Coordination and additional home and community-based services for Enrollees under the age of twenty-one (21) who meet eligibility criteria demonstrating complex Behavioral Health needs requiring intensive services.

Network CCSOs are responsible for:

- Delivering CCS services consistent with all service requirements established by the Department, including but not limited to those outlined in the applicable Department Handbook; and,
- Providing CountyCare with a minimum of ninety (90) days advance written notice in the event the Provider is no longer willing or capable of continuing to serve as a CCSO within parts or all the Provider's designated service area.
- Locating, engaging, and educating Enrollees identified as N.B. class members or as eligible for participation in Pathways using a multifaceted approach that may include, but is not limited to: direct Enrollee outreach; use of Enrollee claims and care management data; PCP engagement; CFT member engagement; and usage of Care Coordinators, Community Health Workers, Family Peer Support workers, or other community liaisons.
- The CCSO should be in regular contact with the MCO Care Coordinator, coordinating efforts and assigning tasks to CFT members as appropriate to ensure that all necessary activities for Pathways Enrollees are occurring.
- The CCSO must make the IM+CANS, established by the CCSO and the Enrollee's Child and Family Team (CFT), available to the MCO.

CountyCare facilitates priority access to a psychiatric resource to provide consultation and medication management within the following time frames:

1. Within fourteen (14) calendar days after a member's discharge from an inpatient psychiatric hospital admission, or
2. Within three (3) calendar days after the date of the Crisis event for a member for whom community-based services were put in place in lieu of psychiatric hospitalization.

Facilities must communicate with CountyCare and, if necessary, the member's PCP, the psychiatric resources and medications provided as part of Mobile Crisis Response Service, consistent with all consents and releases.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

EPSDT is Medicaid's comprehensive preventive child-health program for individuals under the age of 21, mandated by state and federal law. EPSDT services include periodic screening, vision, dental, and hearing services.

CountyCare provides coverage for the full range of EPSDT services as defined in, and in accordance with, HFS policies and procedures for EPSDT services. Such services include, without limitation, periodic health screenings and appropriate up-to-date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care.

The following minimum elements are included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development).
- Comprehensive unclothed physical examination.
- Immunizations appropriate to age and health history.
- Assessment of nutritional status.
- Laboratory tests (including finger stick hematocrit, and urinalysis (dipstick).
- Sickle cell screen, Tuberculosis (TB) skin testing and rapid plasma reagin (RPR) serology (if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual.
- Objective developmental screening including screening for Autism Spectrum Disorder (ASD).
- Vision screening and services, including at a minimum, diagnosis, and treatment for defects in vision, including eyeglasses.
- All dental screening and services, including at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health.
- Although an oral screening may be part of a physician examination, it does not substitute for examination through direct referral to a dentist.
- Hearing screening and services, including at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids.

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member. CountyCare requires that providers cooperate to the maximum extent possible with efforts to improve the health status of CountyCare members, and to actively participate in the increase of the percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules.

CountyCare will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations. Providers shall participate in the Illinois Department of Public Health (IDPH) Vaccine for Children Program (VFC), or in Chicago, the Chicago Department of Public Health Vaccine for Children Program. Vaccines from VFC should be billed with specific antigen codes for administrative reimbursement. No payment will be made on the administration codes alone.

CARE COORDINATION AND CARE MANAGEMENT

The goal of the Care Coordination program is to collaborate with the member, their PCP, and an ICT to support the member in achieving the highest possible levels of wellness and quality of life. The model is designed to help members obtain needed services and assist them in the coordination of their health care and other needs.

All members have Care Coordination services available to assist with accessing care, transitions in care, and self-management support. The Complex Care Management program is a structured partnership between the member and a Care Manager. Care Management is provided to all members who live in a nursing facility, receive Home and Community-Based Services or are DCFS Youth in Care. Care Management is offered to members who are pregnant or are assessed as high or moderate risk. Any member may request to participate in the Complex Care Management Program.

In developing a member's care plan, the Care Manager incorporates clinical assessments, determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities, and transportation needs. Both covered and non-covered services may be included in a member's care plan, as it is intended to provide a holistic approach to a member's needs. The Care Manager identifies the member's Interdisciplinary Care Team, including the PCP and invites team members to provide input for the care plan. The care plan is made in partnership with the member, who signs or otherwise provides confirmation that they are in agreement with the plan and is made available to both the member and their providers. For HCBS members, the Care Manager also develops a Service Plan outlining the covered waiver services authorized to be delivered by the HCBS provider. The Care Coordinator provides the care plan to the providers involved in the member's care.

Referrals To Care Coordination

Any network provider or staff member, including PCPs, specialists, HCBS providers, discharge planners, and UM professionals can refer a member to the Care Coordination program. Additionally, members or their caregivers may refer themselves.

Complete the care coordination referral form and submit it via secure email to countycarereferrals@cookcountyhhs.org or fax it to Care Coordination Referrals at 312-466-2997.

A care coordinator will respond to the referral within five (5) business days. If the need is more urgent, please call 312-864-8200.

Integrated Care Teams

Members receive services through Interdisciplinary Care Teams (ICTs), which address the physical, behavioral, and psychosocial aspects of a member's health. ICTs include licensed medical and behavioral health professionals, key personal support people, as well as care coordinators and social workers, and provide:

- Facilitated access to care across the continuum (e.g., in the community, acute-care settings, and with outpatient specialists).
- Comprehensive assessments (e.g., physical health, behavioral health, social determinants, etc.).
- Individualized and person-centered care planning, with SMART goals and ongoing monitoring.

- Support with self-management plans, including medication adherence and behavior change.
- Disease-management interventions for chronic conditions.
- Education on preventive health care, as well as on complex clinical conditions and treatments.
- Community-based referrals to wellness programs, food assistance, housing, and legal support.
- Frequent contact with members, their support networks and their health providers to support their wellness goals and treatment plans.

Transition Of Care

CountyCare has processes and procedures in place to ensure smooth transitions to and from CountyCare's care coordination to other plans/agencies such as another Managed Care Organization, the Department on Aging, the Department of Rehabilitative Services, and HFS. During transitions between entities, CountyCare assures ninety (90) days of continuity of services and will not adjust the member's Individualized Plan of Care without the member's consent during that timeframe. Additionally, CountyCare has processes and procedures in place to ensure smooth care transitions after a hospital stay and when member transition from a facility setting to a home and community-based setting.

CountyCare providers must communicate with the member and facilitate the transition to another PCP should they no longer serve them as their chosen PCP (for example, transition a pediatric patient when he or she reaches adulthood). Practices serving pediatrics should have a written policy for the transition of care of adolescents from pediatric to adult health care that addresses the needs of adolescents with and without chronic medical or behavioral health conditions and adolescents who become pregnant.

Health Risk Screening And Assessment

New members receive a health-risk screening (HRS) within sixty (60) days of health plan enrollment. The HRS is used to understand a member's risks, assign a risk level, and determine what services and resources a member may need.

The HRS tool assesses:

- Functional abilities
- Physical and behavioral-health conditions
- Social, environmental, and cultural issues
- Ability to live independently
- Access to medications
- Other needs

Members who are identified to have high or moderate risk level, either through the health risk screen or through other data, qualify for a comprehensive health risk assessment (HRA), which is the basis for developing the Individualized Plan of Care (IPoC) for members who enroll in the Care Management Program. Care Coordinators will notify the PCP if the member does not complete a HRS within sixty (60) days of enrollment and request collaboration from the PCP or medical home to assist by providing additional contact information, engaging the member and/or completing the HRS by the medical home.

BILLING AND CLAIMS SUBMISSION

CountyCare is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. CountyCare follows the Centers for Medicare and Medicaid Services (CMS) and Illinois HFS billing requirements. For questions regarding billing requirements, contact a CountyCare Provider Relations representative at 312-864-8200 or visit our Provider Billing Resources webpage at www.countycare.com/providers/provider-billing-resources.

General Billing Guidelines

Providers must submit claims using the most current version of ICD-10 CM, CPT4, and HCPCS Level II for the date of service was rendered, in accordance with federal and state guidelines. It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment.

- Submit professional claims with current and valid CPT4, HCPCS, or ASA codes and ICD-10 codes.
- Submit dental claims with current and valid American Dental Association (ADA) codes.
- Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-10 codes and DRG codes (when applicable).

Claims will be rejected or denied if billed with:

- Missing, invalid, or deleted codes.
- Codes inappropriate for the age or sex of the member.
- An ICD-10 CM code missing any 4th, 5th, and 6th character requirements and 7th character extension requirements.

Claim Requirements

The following information much be included on every claim:

- Name and appropriate TIN number of the health professional or facility that provided treatment or service, with a matching NPI number based on the billing guidance for the IMPACT provider type.
- Patient (RIN and/or MCO-specific Plan ID, address, and date of birth).
- Date (mm/dd/yyyy) and place of service.
- If necessary, include any applicable prior authorization number provided by the MCO.
- A valid Diagnosis, Procedure, Modifier, and Location Codes (Ensure all Diagnosis Codes are to their highest number of digits available - 4th, 5th, and 6th character requirements and 7th character extension requirements).

- Ensure all other insurance resources (e.g., Medicare or other third-party coverage) have been exhausted before submission. Include any coordination of benefit (COB) documentation (e.g., a copy of the primary insurance explanation of benefits (EOB) – including pages with run dates, coding explanations and messages) with the claim submission. Medicaid is always the payer of last resort.
- Be certified by the provider that the claim:
    - » Is true, accurate, prepared with knowledge and consent of the provider.
    - » Does not contain untrue, misleading, or deceptive information.
    - » Identifies each attending, referring, or prescribing physician, dentist, or another practitioner.

Timely Filing

Providers must submit clean claims to CountyCare within one hundred eighty (180) calendar days from the date of discharge for inpatient services or the date of service for all other services. The start date for determining the timely filing period is the "from" date reported on a CMS-1500 or 837-P for professional claims or the "through" date used on the UB-04 or 837-I for institutional claims.

When CountyCare is the secondary payer, claims must be received within one hundred eighty (180) calendar days of the final determination of the primary payer. All requests for a claim review, claim disputes, or appeals must be received within sixty (60) calendar days from the date of the Explanation of Payment.

The timeframe for submitting corrected/replacement claims is one hundred eighty (180) days from the date of service or date of discharge, whichever is later. A provider can resubmit a corrected claim/replacement claim as many times as necessary as long as it is within one hundred eighty (180) days.

The following items can be accepted as proof a "clean" claim was submitted timely:

- A clearinghouse electronic acknowledgment indicating claim was electronically accepted by CountyCare.
- Provider's electronic submission sheet that contains all the following identifiers:
    - » Patient name
    - » Provider name
    - » Date of service to match Explanation of Benefits (EOB)/claim(s) in question
    - » Prior submission bill dates
    - » CountyCare's product name or line of business

The following items are examples of what is not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) Rejection Letter.
- A copy of the provider's billing screen.

Clean Claims

A "clean claim" is a claim from a Provider for covered services that can be processed without obtaining additional information from the provider of the service or from a third party. Claims submitted by or on behalf of a Provider who is under investigation for Fraud, Waste and Abuse or claims that are under review for Medically Necessity are not considered "clean claims." A "clean claim" for a nursing home admission means that the admission is reflected on the patient credit file received from HFS or listed on the LTC Inquiry in the HFS Eligibility system.

Clean claim processing requirements are:

- 90% of clean claims will be processed within thirty (30) days of receipt.
- 99% of clean claims must be processed within ninety (90) days of receipt.

It is important to note that the requirements are for claims processing, also known as claims adjudication. Claims processing/adjudication does not indicate that payment is made. It does indicate that a determination has been made as to the outcome of the claim process. Those determinations can include pending the claim, denying the claim, or claims payment.

Claim Forms

Claims may be submitted either by paper or electronically. Claims must be filed on either:

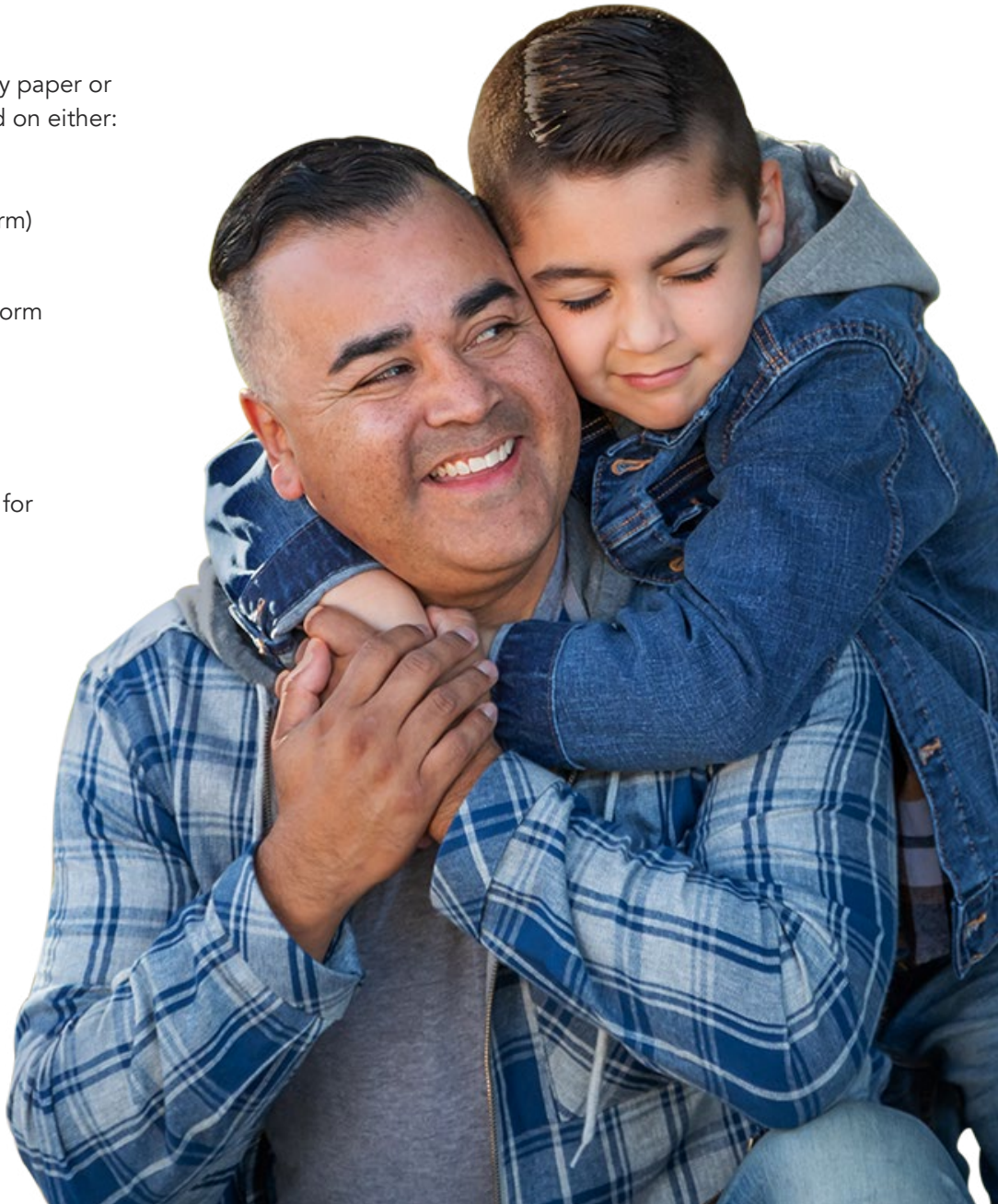
Paper Claim Forms:

- Original CMS1500 (red form)
- UB-04
- ADA Dental 2019 Claim Form

Electronic Claims:

- 837P or 837I
- 837D for dental claims
- NDCDP electronic format for pharmacy claims

Submit claims for professional services and durable medical equipment on a CMS 1500. Submit claims for hospital-based inpatient and outpatient services as well as swing bed services on a UB-04 form.



Claim Submission

Claim Type	Submission Information
Professional CMS 1500 and Institutional UB04 ***Electronic Claim Submission***	Clearinghouse: Change HealthCare Payor ID: 06541 For additional detail on claim submission, view our Provider Billing Resources on the CountyCare website.
Professional CMS 1500 and Institutional UB04 ***Paper Claim Submission***	Mail Paper Claim to: CountyCare Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Dental Claims	**Vendor:** Avēsis **Portal:** www.avesis.com/commercial3/providers/index.aspx **Electronic:** Payer Identification Number: 86098 **Paper:** Avēsis Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Vision Claims	**Vendor:** Avēsis **Portal:** www.avesis.com/commercial3/providers/index.aspx **Electronic:** Via Clearinghouse – Payer ID 86098 **Paper:** Avēsis Third Party Administrators, Inc. PO Box 38300 Phoenix, AZ 85069-8300
Transportation Claims ***Emergent Claims and Non-Emergent Ambulance Claims***	**Paper:** CountyCare Health Plan P.O. Box 211592 Eagan, MN 55121-2892 PAYOR ID 06541
Transportation Claims ***Non-Emergent Non-Ambulance Claims***	CountyCare c/o First Transit 799 Roosevelt Rd. Bldg. 4, Ste. 200 Glen Ellyn, IL 60137 Fax: 630-873-1450 Electronic claims can be submitted via the Kinetik provider portal.

Payment for services is contingent upon compliance with prior authorization procedures, medical policies, and outlined billing guidelines that include:

- The member is effective on the date of service.
- The service provided is a covered benefit on the date of service.
- Prior-authorization processes were followed.
- The plan does not require additional information to determine medical necessity.
- Claim conforms to billing guidelines as outlined in this manual.
- The provider is enrolled in HFS' IMPACT system.
- Billed services are not related to a Provider-preventable condition (as identified in the State Plan) caused by the billing provider.
- The provider is not under investigation for Fraud, Waste, or Abuse or excluded from the Medicaid program.

Coordination of Benefits

Third-party liability (TPL) refers to any other health insurance plan, carrier (e.g., individual, group, employer-related, self-insured, self-funded, commercial carrier, automobile insurance, or worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

CountyCare, like all Medicaid programs and plans, is always the payer of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services provided to CountyCare members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform CountyCare that efforts have been unsuccessful.

CountyCare will make every effort to work with the provider to determine liability coverage.

If TPL coverage is determined after services are rendered, CountyCare will coordinate with the provider to pay any claims that may have been denied for payment due to TPL.

Other Claim Type Instructions

MLTSS Billing Guidance

MLTSS members are considered dual-eligible; Medicare remains the primary payer for dual-eligible beneficiaries enrolled in HealthChoice Illinois MLTSS. Please use the following tips when submitting claims:

- Medicare-covered services must be billed to the patient's Medicare carrier.
- Non-Medicare covered long-term-care services, home and community-based waiver services, non-Medicare behavioral health services, and non- emergency transportation services must be billed to the Medicaid MLTSS MCO.
- All other non-Medicare covered services covered by Medicaid (e.g., non-Medicare Durable Medical Equipment, prescription drugs, inpatient hospital, dental services, vision services, Medicare rollover services, etc.) should be billed to Medicaid fee for service (FFS) unless they are covered as part of a long-term care facility per diem.

- Claims questions or appeals should be sent to the entity responsible for covering the service (Medicare, HealthChoice Illinois MLTSS MCO, or the Medicaid FFS).
- MLTSS coverage under CountyCare Health Plan is ONLY for the following benefits and services:
    - » HCBS Waiver Services
    - » Mental Health Services
    - » Nursing Facilities/Supportive Living Program
    - » Non-Emergency Transportation
    - » Care Coordination additional information

For additional billing guidance related to the MLTSS dual-eligible population, please reference the MLTSS Billing Guidelines found on the CountyCare Provider Billing Resources page under Billing Guidelines, Tips, Reference Guides. Visit the page by clicking on the link below:

www.countycare.com/providers/provider-billing-resources

Billing Guidelines for LTSS Providers

A variety of HCBS waiver providers contract with CountyCare. HCBS waiver providers are considered an 'Atypical' provider who delivers services to Medicaid recipients that are not considered health care services.

These providers are not required to obtain an NPI (National Provider Identifier). The Centers for Medicare and Medicaid Services defines Atypical Providers as providers that do not provide health care. Defined under HIPAA in Federal regulations at 45 CFR 160 .103. Taxi services, home, and vehicle modifications, and respite services are examples of Atypical Providers reimbursed by the Medicaid program. HCBS providers

include adult day services, automated medication dispenser service, home adaptation providers, home health agencies, day-habilitation providers, homemaker services, home-delivered meal services, personal emergency response systems, respite providers, specialized medical equipment and supplies vendors and Supportive Living Program facilities (SLPs).

It is important that providers ensure CountyCare has accurate billing information on file. Please confirm with Provider Relations that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend that providers notify CountyCare thirty (30) days in advance of changes pertaining to billing information. Please submit this information on a W-9 form to the Provider Contracting Department or your assigned Provider Relations Representative. Changes to a Provider's TIN and/or address when conveyed via a claim form are not acceptable and claims may be denied as out of network.

Claims for HCBS Waivers

HCBS providers, excluding supportive living program facilities, are required to submit claims on a CMS 1500 form. When billing HCBS services, Atypical providers should only use their HFS' Legacy Provider Number (Medicaid ID) and should NOT include an NPI on the claim. MCOs will require that the HFS' Legacy Provider Number (Medicaid ID) on the claim matches the IMPACT Legacy Provider Number (Medicaid ID). Billing guides and instructions are available on our website at www.countycare.com. CountyCare requests providers bill usual and customary rates versus billing the Medicaid allowed amount for all claims. This will ensure we are able to reprocess claims on file for retro rate increases without requiring providers needing to rebill a corrected claim at the higher rate. This is due to the standard "lessor of" language within the contract, which means that we will pay the HFS rate or billed charges, whichever is less.

Basic guidelines for completing the CMS-1500 Claim Form for HCBS:

- Use one claim form for each recipient.
- Enter one procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider, and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month.

Claims for Long Term Care Facilities

Supportive Living, Nursing, and Specialized Mental Health Rehabilitation, Long-term care (LTC) facilities are required to bill on a UB-04 claim form. Short-term acute stays and custodial care are covered benefits.

When submitting claims for short-term subacute stays, facilities must ensure they are utilizing the appropriate revenue codes. CountyCare requests providers bill usual and customary rates versus billing the Medicaid allowed amount for all claims. This will ensure we are able to reprocess claims on file for retro rate increases without requiring providers needing to rebill a corrected claim at the higher rate. This is due to the standard "lessor of" language within the contract, which means that we will pay the HFS rate or billed charges, whichever is less.

Patient Credit File

For LTC facility claims to be processed, the member must be on the HFS Patient Credit File (PCF) for the billing LTC facility. The HFS PCF is provided monthly to the plans. The file shows the amount the member needs to pay for residing in the facility as a patient liability. There may be a delay in the member being added to the Patient Credit File. As a result, some LTC facility claims may be denied for payment.

CountyCare has a process to ease the administrative burden on LTC facilities in these instances. Each quarter when we receive the Patient Credit File, CountyCare will check each member listed on the file against any previously denied claims. If there are claims that have been denied as a result of the member not appearing on the Patient Credit File, and all other necessary information is included on the claim, the previously denied claim will be reprocessed and paid. It is important to note that LTC providers must still submit claims within 180-day timely filing time frame.

Corrected Claims

A Corrected Claim is when a claim is originally denied for missing or incorrect information.

Corrected/replacement claims may be submitted up to one hundred eighty (180) days from DOS or sixty (60) days from EOP, whichever is later. A provider can resubmit a corrected claim/replacement claim as many times as necessary as long if it is within one hundred eighty (180) days.

Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) could result in a claim denying as a duplicate, a delay in processing, or denied for exceeding the timely filing limit.

Corrected/replacement claims can be submitted via:

1. EDI - see process/guidelines noted below
2. Paper submission – Submit to:

CountyCare Health Plan
P.O. Box 211592
Eagan, Minnesota 55121-2892

Electronic Funds Transfer and Electronic Remittance Advice

Network providers are encouraged to participate in CountyCare's electronic claims/encounter filing program. CountyCare can receive ANSI X12N 837, or the most current version, professional, institution, or encounter transactions. In addition, CountyCare can generate an ANSI X12N 835, or the most current version electronic remittance advice known as an Explanation of Payment (EOP). CountyCare provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) electronic remittance advice known as an Explanation of Payment (EOP) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access to remittance information, and straightforward reconciliation of payments.

Providers that bill electronically have the same timely filing requirements as providers filing paper claims. In addition, providers that bill electronically must monitor their error reports and explanation of payments (EOPs) to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Recoupment of Overpayments to Providers

When claims have been mistakenly paid due to retroactive member termination or other issues, CountyCare will request a refund from the provider.

The provider has sixty (60) days to issue the refund to the plan or respond in writing. If the refund is not issued, the response becomes a claim dispute and is handled per the policy and timelines in this manual. CountyCare reserves the right to process refunds by deducting incorrectly paid amounts from future payments.

Providers must send refunds of processed claims to the following address:

CountyCare Health Plan
P.O. Box 211592
Eagan, Minnesota 55121-2892

Claim Reviews and Provider Disputes

Providers have the right to request a review or dispute of any decision made by CountyCare. Please reference the chart below for more information on the options available.

Review Type	Description	Process
Claim Review	A Claim Review is an initial attempt at reconsideration of an adjudication. Examples include the claim denied for contract rate/ payment, duplicate claim, no authorization, or other. Claim Reviews may be submitted within sixty (60) days of EOP.	• Contracted providers can submit online through the Provider Portal at www.countycare.com/providers/portal • Request a Claims Review by calling Provider Relations at 312-864-8200 • Outreach to a Provider Representative at : ProviderServices@CountyCare.com or call 312-864-8200, Option 6 • Mail a Claim and Medical Necessity Review Form to: CountyCare Health Plan P.O. Box 211592 Eagan, MN 51121-2892
Provider Dispute	A Provider Dispute is a formal dispute related to claims, payment, contracting, eligibility, prior authorization, enrollment or system errors. Submit a Provider Dispute within sixty (60) days of the EOP, where applicable.	The CountyCare Provider Dispute System link can be accessed in the "Provider Dispute User Guide" on the CountyCare website at https://countycare.com/providers/provider-resources/ under Training Materials. Fill out all fields in the dispute form and attach all applicable documentation before submitting. Failure to include all necessary documentation may result in dispute closure.

BILLING THE MEMBER

Providers are prohibited from billing members for any covered services provided (also called "balance bill"), even if the provider's usual and customary charge for the covered services is greater than what is allocated in the CountyCare fee schedule. Payments made to providers by CountyCare for Medicaid covered services for CountyCare members are considered payment in full.

Under Section 1128B(d) of the Social Security Act, balance billing Medicaid patients for covered services is a felony punishable by up to five years imprisonment and fines up to $25,000. Providers cannot charge CountyCare members for copayments, participation fees, deductibles, coinsurance, or any other form of patient cost sharing related to CountyCare covered services.

A provider cannot bill, demand, or otherwise seek reimbursement from the member, or from a financially responsible relative or representative of the member, for any service for which CountyCare reimbursement would have been available. A reduction in payment because of claims policies or processing procedures is not an indication that the service provided is a non-covered service. Providers also cannot ask the member to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees. Providers may not make arrangements to provide more costly services or items than those covered by CountyCare on the condition the member supplement payments are made by CountyCare.

NETWORK PARTICIPATION

Credentialing and Provider Rosters

The state requires all providers and practitioners to enroll through the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system prior to participation. Provider enrollment in the IMPACT system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing. Once credentialed through the IMPACT system, CountyCare will require additional provider enrollment documents including the Disclosure of Ownership and Control Interest Statement, W-9 Form, and the Universal IAMHP Roster.

CountyCare conducts monthly exclusion and sanction screening of network providers and monitors for complaints and quality-of-care events. To the extent deficiencies or areas for improvement are identified, CountyCare reserves the right to initiate actions as specified in the provider agreement, up to and including termination of the contract or participation status. The right of appeal is available to providers whose participation in our network has been limited or terminated for quality reasons.

Submit updated provider data at least every thirty (30) days via the IAMHP Roster Template. Changes to a provider's Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form; this information should be submitted on a W-9 form with an updated Universal IAMHP Roster. Submit completed rosters via email to CountyCareProviderRosterSubmission@cookcountyhhs.org and copy your Provider Relations Representative. Please remember to submit your full Universal IAMHP roster quarterly and any additions, changes, or terminations on a monthly basis. The Universal IAMHP Roster Template is located on the CountyCare website within 'Provider Resources' https://countycare.com/wp-content/uploads/CCR_UniversalProviderRosterTemplate_English_062118.xlsx.

QUALITY IMPROVEMENT

CountyCare's model, systems, and processes are structured around our mission to improve the health of all enrolled members and our commitment to quality as NCQA Accredited Health Plan. The Quality Assessment and Performance Improvement Program (QAPI Program) utilizes a systematic approach to quality by using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs.

Our program provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and the designation of adequate resources to support the interventions.

CountyCare recognizes our excellent opportunity to positively influence population health as well as our legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings.

Program Structure

Cook County Heath's Board of Directors, (BOD), has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI program and has established various standing and ad-hoc committees to monitor and support it.

The Quality Improvement Committee (QIC) is a senior management committee with network provider representation, which ultimately reports up to the BOD. The purpose of the QIC is to promote a system-wide approach to Quality Assurance, provide oversight and direction in assessing the appropriateness of care and services delivered, encourage provider participation, and continuously enhance and improve the quality of care and services provided to members. In addition, the QIC has the responsibility for developing and implementing the QAPI program. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of the member, providers, and staff regarding the QAPI and UM programs.

- Pharmacy and Therapeutics Committee
- Utilization Management Committee
- Performance Improvement Workgroups
- Grievance and Appeal Committee
- Peer Review Committee (Ad Hoc Committee)
- Family Leadership Council
- Enrollee Advisory and Community Stakeholder Committee
- Provider Quality Review Committee
- Customer Quality Management Committee

Practitioner Involvement

CountyCare, recognizing the integral role practitioner involvement plays in the success of its QAPI program, requires provider representation at various levels of the process. The QIC consists of a cross representation of providers, including PCPs, specialists, dentists and LTSS representatives from the network and across the service area. CountyCare encourages PCP, behavioral health, and women's health care representation on key quality committees such as, but not limited to, the QIC, Pharmacy and Therapeutics Committee, UM Committee and select ad-hoc committees.

Quality Assessment and Performance Improvement Program (QAPI) Scope and Goals

CountyCare's QAPI Program addresses the quality of both clinical care and services provided to members and providers for all demographic groups, benefits, and care settings. It also addresses all health care services, including medical and behavioral, preventive, emergency, primary, and specialty care, as well as acute care, short-term care, long-term care, home care, pharmacy, and ancillary services. Areas subject to quality oversight include:

- Acute and chronic care management and disease management.
- Adoption and compliance with preventive health and clinical practice guidelines.
- Behavioral health care management and coordination with medical practitioners.
- Continuity and coordination of care and network provider profiling and performance measurements.
- Employee and provider cultural competency, including monitoring to ensure member linguistic and physical accessibility.
- Health disparities.
- Member grievance and appeals.
- Member satisfaction.
- Health education and promotion.
- Network accessibility and appointment availability, including specialty practitioners.
- Patient safety, including appropriateness and quality of health care services.
- Provider satisfaction.
- Selection and retention of skilled, quality-oriented practitioners and facilities.
- UM, including analysis of under- and over- utilization.

Performance Improvement Process

The QIC reviews and adopts an annual QAPI program and QAPI work plan, based on Medicaid managed-care-appropriate industry standards. The QAPI utilizes quality/risk/UM approaches to problem identification with the objective of identifying improvement opportunities. Overarching goals are updated annually to align with the strategic plans of HFS, Cook County Health and CountyCare Health Plan. Initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service.

Performance improvement projects, focused studies, and other quality-improvement initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each initiative is also designed to allow monitoring of improvement over time.

The QAPI work plan serves as a continuous working guide for quality-improvement efforts. It integrates quality-improvement activities, reporting, studies from all areas of the organization (clinical and service) and dictates timelines for completion and internal reporting, as well as requirements for external reporting. Studies and other performance-measurement activities and issues to be tracked over time are scheduled in the QAPI work plan.

CountyCare communicates activities and outcomes of its quality-improvement program to both members and providers through avenues such as the member newsletter, provider newsletter and the CountyCare web portal. At any time, providers may request additional information on programs including a description of the QAPI program and a report on plan progress in meeting the QAPI program goals by contacting the Population Health and Performance Improvement department at countycarepophealth@cookcountyhhs.org.

Health Effectiveness Data Information Set (HEDIS)

HEDIS is a group of standardized performance measures developed by the NCQA, which allows comparison across health plans, based on comparative quality.

HEDIS reporting is a required part of NCQA Health Plan Accreditation, as well as CountyCare's contract with HFS to provide coordinated care services to the *HealthChoice* Illinois population. Consumer and purchasers of health care use the aggregated HEDIS rates to evaluate a health insurer's ability to demonstrate improvement in preventive health and outreach to its members. CountyCare uses HEDIS data as one way of evaluating the performance of certain providers, as well as to identify the needs for population health programs and interventions.

Calculation of HEDIS Rates

HEDIS rates may be calculated using two methodologies: administrative and hybrid. The administrative methodology data is calculated from claims or encounter data submitted to the health plan by providers. Measures typically calculated using administrative data methodology include breast cancer screening, chlamydia screening, annual PCP, and well-child visits. Accurate and timely claims submission and the use of appropriate CPT and diagnosis codes are of paramount importance for the accuracy of these measures.

The hybrid methodology data consists of both administrative data and a sample of medical records. It requires the review of a random sample of members' medical records to abstract data for services rendered that are not reported through claims or encounter data. Measures are typically calculated using administrative data, and medical record review: diabetic HbA1c screening, diabetic retinal exam, controlling high-blood pressure, and prenatal and postpartum care.

Medical Record Reviews for HEDIS

CountyCare contracts with a HEDIS-certified medical record review (MRR) vendor to conduct the hybrid medical record reviews on its behalf (see Medical Record Criteria below). Annual MRR audits for HEDIS are conducted from February through May. During this time, providers may be contacted by MRR representatives to provide medical records for patients within the HEDIS samples. Prompt cooperation with these requests is required and appreciated. HIPAA allows the release of patient information to health plans for treatment, payment, and health care operations, without specific signed consent or authorization. The MRR vendor is covered under this provision as well.

What Providers Can Do to Improve HEDIS Scores

- Understand the specifications for each HEDIS measure.
- Recognize that accurate and timely submission of claim/encounter data is the cleanest and most efficient way to report for HEDIS and can reduce the number of medical record reviews required for HEDIS rate calculation.
- Submit claims or encounter data for each and every service rendered. All providers must bill or report by encounter submission, for services delivered according to their contract status.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as blood pressure readings and HbA1c screening result.

Please contact the Population Health and Performance Improvement Department by phone at 312-864-8200 or by email at countycarepophealth@cookcountyhhs.org with any questions, comments, or concerns related to the annual HEDIS project.

Provider Satisfaction Survey

At least annually, CountyCare conducts a provider satisfaction survey which includes questions to evaluate providers' experience with plan services such as claims, communications, UM and Provider Relations. The survey is conducted by a certified national vendor. Participants meeting specific requirements outlined by CountyCare are randomly selected by the vendor and are kept anonymous. We encourage providers to respond timely to the survey, as the results of the survey are analyzed and used as a basis for forming provider- related quality improvement initiatives.

Consumer Assessment Of Health Care Provider Systems (CAHPS) Survey

The CAHPS survey is the national standard for measuring and reporting on the experiences of consumers with their health plan and the services provided. It is a standardized survey administered annually, each spring, to members by an NCQA-certified survey vendor as part of HEDIS and NCQA accreditation. The survey provides information on member satisfaction with their personal doctor and services provided, getting needed care, the health plan, and customer service. The CAHPS survey results are shared with large provider groups and used in various aspects of the quality program to drive performance.

Provider Profiles

CountyCare produces provider profiles as a tool to encourage providers to promote appropriate care and services for members, which has been shown to lead to better health outcomes.

Provider profiles support efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable), as well as recommendations from other national agencies such as CMS, American Medical Association (AMA), Physician Consortium, NCQA, and National Quality Forum (NQF). Additionally, the program encourages accurate and timely submission of preventive-health and disease-monitoring services in accordance with evidence-based clinical practice guidelines. Providers who meet a minimum panel threshold receive a quarterly profile report with refreshed data for each measure. Scores are benchmarked per individual measure to the network average and, as applicable, to the annual NCQA Medicaid Quality Compass percentiles.

Provider profile indicator data may be risk-adjusted, and scoring is based on provider performance within the service area range. PCPs who meet or exceed established performance goals or who demonstrate continued excellence or significant improvement over time may receive monetary bonuses and be recognized by CountyCare in publications such as newsletters, bulletins, press releases, and highlighted in our provider directories.

MEDICAL RECORD CRITERIA

Medical Records

Providers must keep accurate and complete medical records. Such records will help enable providers to render the highest-quality health care service to members. To ensure the member's privacy, medical records should be kept in a secure location.

Required Information

'Medical record' is defined as the complete, comprehensive member record including, but not limited to, x-rays, laboratory tests results, examinations, and notes. All medical records are to be accessible at the site of the member's participating primary care or another provider and document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care. They are to be prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number are on all chart pages.
- Personal or biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Notation of any spoken language translation or communication assistance is prominent.
- Significant illnesses and/or medical conditions and all past and current diagnoses are documented on the problem list.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA, or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in the chart for adults.
- Evidence that preventive screening and services are offered in accordance with CountyCare's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three (3) or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger), medical history relating to prenatal care, birth, surgeries and or childhood illnesses.
- Working diagnosis is consistent with findings. The treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.

- Documentation of prenatal risk assessment for pregnant members or infant risk assessment for newborns.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries are initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented including follow-up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and or counseling is documented.
- For members ten (10) years and over, appropriate notations concerning the use of tobacco, alcohol, and substance use (for members seen three or more times, substance abuse history should be queried).
- Documentation of failure to keep an appointment is present.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Evidence that an advance directive has been offered to adults 18 years of age and old.
- All entries are legible and maintained in detail.
- All entries are dated and signed or dictated by the provider rendering the care.
- Required consent forms are signed and dated.
- Confidentiality of member information and records protected.

Medical Records Release

All member medical records shall be confidential and shall only be released in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable Federal and State regulations. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned CountyCare members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

CountyCare may conduct random medical record audits as part of its QAPI program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services, also may be assessed during a medical record audit. CountyCare will provide verbal or written notice prior to conducting medical record reviews.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights:

- Be treated with respect and dignity at all times.
- Have personal health information and medical records kept private except where allowed by law.
- Be protected from discrimination.
- Be free from any form of restraint or seclusion used as a way to force, control, and ease of reprisal or retaliation.
- Receive information, including the Member Handbook from CountyCare in other languages, audio, large print or Braille.
- Have use of an interpreter when needed including during any complaint or appeal process.
- Have a candid discussion with providers about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information on available treatment options and alternatives. This includes the right to ask for a second opinion.
- Providers must explain treatment options in a way the member understands.
- Receive information necessary to be involved in making decisions about health care treatment and choices.
- Refuse treatment and be told what may happen to the member's health if treatment is refused.
- Receive a copy of their medical records and in some cases request that they be amended or corrected.
- Choose and change their primary care provider (PCP) from CountyCare.
- File a complaint (sometimes called a grievance), or appeal about CountyCare or the care they received without fear of mistreatment or backlash of any kind.
- Appeal a decision made by CountyCare on the phone or in writing.
- Request and receive in a reasonable amount of time, information about CountyCare Health Plan, and its providers, services and polices.
- Receive information about CountyCare Member Rights and Responsibilities. Members also have the right to suggest changes in this policy.
- Receive health care services in ways that comply with federal and state law. CountyCare must make covered services accessible to members. Services must be available twenty-four (24) hours a day, seven (7) days a week.

Member Responsibilities:

- Treat doctors and the office staff with courtesy and respect.
- Carry their CountyCare ID card with them when they go to doctor appointments and to the pharmacy to pick up prescriptions.

- Keep appointments and be on time for them.
- If members cannot keep appointments, to cancel them in advance.
- Provide as much information as possible so that CountyCare and their providers can give the best care possible.
- Know own health problems and take part in making decisions about treatment goals as much as possible.
- Follow the instructions and treatment plan agreed upon by member and doctor.
- Tell CountyCare and care coordinator if address or phone number changes.
- Tell CountyCare and care coordinator if they have other insurance and follow those guidelines.
- Read member handbook to know what services are covered and if there are any special rules.

Members who are part of the **Disability, HIV/AIDs or Brain Injury waivers** have specific rights and responsibilities, which include:

- Apply or reapply for waiver services.
- Receive an explanation about waiver services that the member may receive.
- Partner with care coordinator in making informed choices for waiver services care plan.
- Be assured of the complete confidentiality of case records.
- Participate with care coordinator in any decision to close member's case.
- Be informed of the Client Assistance Program (CAP).
- Be provided with a form of communication appropriate to accommodate the member's disability.
- Fully participate in the waiver services care plan with the care coordinator.
- Set realistic goals and participate in writing.
- Follow through with member's plan for rehabilitation.
- Communicate with a care coordinator and ask questions when the member does not understand services.
- Provided a copy of the care plan and any amendments related to the plan.
- Notify the care coordinator of any change in personal condition or work status.
- Be aware of the eligibility requirements, including financial for services as applicable.
- Keep original documents and send only copies to the care coordinator's office.

Members who are part of the **Aging waiver** have specific rights and responsibilities, which include: (these apply to the other waivers as well and most if not all in the other waivers apply to aging)

- To not be discriminated against because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge, or age.
- All information about the member and his or her case is confidential, and may be used only for purposes directly related to the administration of his or her aging waiver services as:
    - » Finding and making needed services and
    - » Assuring the health and safety of the member
- Information about the member and his or her case cannot be used for any other purpose as indicated above, unless the member has given his or her consent to release that information.

- Freedom of choice of member's providers for waiver services.
- The right to choose not to receive waiver services.
- The right to transfer from one provider to another provider.
- The right to report instances to his or her provider's supervisor or any CountyCare care coordinator when the member does not believe his or her personal care worker:
    - » Does not come to the member's home as scheduled
    - » Is not following the care plan
    - » Is always late
    - » Any other issues or concerns with the personal care worker
- To not discriminate against the member's personal care worker because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age. To do so is a Federal offense.
- The member must report changes that affect them. This includes
    - » Change of address, even if temporary.
    - » Change in number of family members
    - » Changes needed in waiver services
- To notify the member's CountyCare care coordinator if the member is entering a hospital, nursing home, or other institution for any reason. The member's services will be temporarily suspended until he or she returns home.
- Notify the member's care coordinator in advance of his or her return home.
- If the member is hospitalized or in a nursing home or other institution for more than sixty (60) calendar days, the member's services may be terminated.
- If the member becomes ineligible for waiver services for any reason, he or she must contact the Illinois Department of Human Services to reapply.
- Notify the member's CountyCare care coordinator if the member is away from his or her home, for any reason, for over sixty (60) calendar days. Services cannot be provided if the member is not at home. If this is the case, services may be terminated.
- Must notify the provider and the member's CountyCare care coordinator if the member intends to be absent from his or her home when scheduled services are to be provided. The member must notify the provider when you are leaving and when the member is expected to return. The provider will resume services upon the member's return.
- Must cooperate in the delivery of services. The member must:
    - » Notify the provider agency at least one day in advance if the member will be away from home on the day services are to be rendered.
    - » Allow the authorized worker into the home.
    - » Allow the worker to provide the services included in the care plan/service plan.
    - » Do not require the worker to do more or less than what is in the care plan.
    - » If the member wants to change the care plan, he or she must contact a CountyCare care coordinator. The worker is unable to change it.
    - » The member or other persons in his or her home must not harm or threaten to harm the worker or other participants, or display any weapon.

Members who reside in **supportive living facilities** have specific rights, which include:

1. Be free from mental, emotional, social and physical abuse, neglect and exploitation.
2. All housing and services for which the member has contracted and paid.
3. Have member records kept confidential and released only with the member's consent or in accordance with applicable law.
4. Have access to member records with forty-eight (48) hours' notice (excluding weekends and holidays).
5. Have member's privacy respected.
6. Refuse to receive or participate in any service or activity once the potential consequences of such refusal have been explained to the member and a negotiated risk agreement has been reached between the member, his or her designated representative and the service provider, so long as others are not harmed by the refusal.
7. Remain in the supportive living facility, forgoing recommended or needed services from the facility or available from others.
8. Arrange and receive non-Medicaid covered services not available from the contracted facility service provider at the member's own expense so long as he or she does not violate conditions specified in the resident contract.
9. Be free of physical restraints.
10. Control time, space, and lifestyle to the extent the health, safety and well-being of others is not disturbed.
11. Consume alcohol and use tobacco in accordance with the facility's policy specified in the resident contract and any applicable statutes.
12. Have visitors of the member's choice to the extent the health, safety and well-being of others is not disturbed and the provisions of the resident contracts are upheld. Have roommates only by the member's choice.
13. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality.
14. Participate in the development, implementation, and review of their own service plans.
15. Make and act upon decisions (except those decisions delegated to a legal guardian) so long as the health, safety and well-being of others is not endangered by your actions.
16. Maintain personal possessions to the extent they do not pose a danger to the health, safety and well-being of themselves and others.
17. Store and prepare food in the member's apartment to the extent the health, safety and well-being of the member and others is not endangered, and provisions of the resident contract are not violated.
18. Design or accept a representative to act on the member's behalf.
19. Not be required to purchase additional services that are not part of the resident contract; and not be charged for additional services unless prior written notice is given to the member of the amount of the charge.
20. Be free to file grievances according to supportive living facility policy and be free from retaliation from the facility.

GRIEVANCES AND APPEALS

Member Grievances and Provider Complaints

A grievance is any expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by CountyCare to make an authorization decision.

CountyCare encourages members to submit grievances and has processes in place to address them through the Grievance System. CountyCare works with the involved parties to achieve resolution and prevent further grievances. CountyCare providers are expected to help members report their dissatisfaction and cooperate with CountyCare's grievance investigations.

The grievance process allows the member, or the member's appointed representative (guardian, caretaker, relative, or Provider) acting on behalf of the member, to file a grievance either verbally or in writing using any medium, at any time. CountyCare will provide a form and instructions on how a member may appoint an authorized representative. CountyCare values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf.

CountyCare's Grievance System includes a structured grievance process. CountyCare's Grievance System is compliant with Section 45 of the Managed Care Reform and Patient Rights Act, ILCS 134, and 42 CFR §431 Subpart E and §438 Subpart F. CountyCare will acknowledge receipt of each grievance within forty-eight (48) hours of receipt of grievance. CountyCare will resolve all grievances as soon as possible but no later than forty-five (45) calendar days from receipt of a grievance. For grievances related to discrimination, resolution shall be within thirty (30) calendar days from receipt of a grievance. For grievances related to clinically urgent situations are expedited and will be resolved as soon as possible, but no longer than ten (10) calendar days from receipt of the request. The member will be informed of the resolution orally or in writing. When a member submits a grievance about a Provider, CountyCare will notify the provider either verbally or in writing. Regardless of the nature of the issue, the provider is expected to resolve the grievance. Resolution is achieved when the appropriate parties are informed of the grievance either orally or in writing, learning opportunities are identified and shared, and, if warranted, actions are taken to rectify the situation and prevent future situations that may lead to a similar grievance. CountyCare Grievance Coordinators require appropriate and complete information from the provider to confirm the resolution. If a grievance pertains to quality of care, it is investigated by the Quality team and may result in peer review if necessary.

Providers may be required to submit medical records and/or other information pertinent to the investigation and/or the resolution.

Grievances may be submitted verbally or in writing to:

CountyCare Health Plan
CCH A&G Department
P.O. Box 21153
Eagan, MN 55121

866-200-5031
312-864-8200, 711 (TDD/TTY)

Appeals

An appeal is a request for review of an Adverse Benefit Determination. An Adverse Benefit Determination is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of the payment for a service; the failure to provide services in a timely manner; the failure to respond to an appeal or grievance in a timely manner; or the denial of an Enrollee's request to dispute a financial liability, including cost sharing. An Enrollee may file an oral or written appeal within sixty (60) days following the date of the Adverse Benefit Determination that generates such appeal.

An Enrollee may appoint any authorized representative, including a guardian, caregiver relative, or Provider, to represent the Enrollee throughout the appeal process. CountyCare will provide a form and instructions on how an Enrollee may appoint a representative.

If an Enrollee does not request an expedited appeal, CountyCare will notify the filing party, within three (3) business days of receipt of any additional information required to evaluate the appeal request. Appeals will be fully investigated without deference to the denial decision. The appeal will be reviewed by an appropriately licensed clinical peer who was not involved in any previous level of decision making regarding the request.

CountyCare will make its decision on the appeal within fifteen (15) business days after submission of the appeal. CountyCare may extend this time frame for up to fourteen (14) days and will make reasonable efforts to give Enrollee prompt oral notice of delay, give Enrollee written notice within two (2) days, and resolve the appeal expeditiously.

If an Enrollee files for continuation of benefits on or before the latter of ten (10) days of Contractor sending the Adverse Benefit Determination, or the intended Effective Date of the proposed Adverse Benefit Determination, Contractor must continue the Enrollee's benefits during the appeal process. A Provider, serving as Enrollee's authorized representative for the appeal process, cannot file for continuation of benefits. If the final resolution of the appeal is adverse to the Enrollee, Contractor may recover the cost of the services that were furnished to the enrollee.

Expedited Appeals

Expedited appeals may be filed when either CountyCare or the member's provider determines that the timeframe for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. CountyCare does not deny expedited appeals. The appeal may be reclassified from expedited to standard if expedited criteria is not met.

CountyCare will notify the filing party within twenty-four (24) hours of receipt of any additional information required to evaluate the appeal request. CountyCare will render a decision and provide notification within twenty-four (24) hours after receipt of required information, not to exceed seventy-two (72) hours of receipt of the initial request. CountyCare will make reasonable efforts to provide the member, PCP and any health care provider who recommended the service with prompt verbal notice of the decision followed by written notice within two (2) calendar days after the initial verbal notification not to exceed three (3) calendar days from receipt of the appeal.

Appeals Contact Information

Medical and Behavioral Health	Mail: CountyCare Health Plan P.O. Box 21153 Eagan, MN, 55121-0153 Phone: 312-864-8200 Fax: 866-200-503
Pharmacy	Mail: MedImpact Healthcare Systems, Inc. Appeals and Grievance 10181 Scripps Gateway Ct. San Diego, CA 92131 Phone: 1-888-402-1982 Fax: 1-858-790-6060
Vision	Email: Pre-Service and Post Service Appeals and Grievances AG@avesis.com Phone: Avēsis Customer Service (855) 214-6777
Dental	Email: Post Service Appeals and Grievances AG@avesis.com Pre-Service Appeals PSA@avesis.com Phone: Avēsis Customer Service (855) 214-6777

Appeals should include the information indicated on the instructions within the Adverse Benefit Determination letter.

Notice of Appeal Resolution

Written appeal resolution notice shall include the following information:

- The decision reached by CountyCare.
- The date of the decision.
- For appeals not resolved wholly in favor of the member, the information will be provided on the member's right to request a State Fair hearing.
- The right to request to receive benefits while the State Fair hearing is pending.
- Member may be held liable for the cost of those services if the hearing decision upholds the CountyCare decision.

State Fair Hearing Process and External Independent Reviews

Final decisions of appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its fair hearings system within one hundred twenty (120) days after the date of CountyCare's decision notice. For expedited appeals, the request for external review must be made within thirty (30) calendar days of the date of the appeal decision notice. Also, if CountyCare fails to meet notice and timing requirements, the Enrollee is deemed to have exhausted the appeals process and may initiate a State Fair Hearing. A State Fair Hearing may be requested within one hundred twenty (120) calendar days of the appeal decision notice.

To request a State Fair Hearing please contact:

HFS Bureau of Administrative Hearings Plan
401 S. Clinton, 6th Floor
Chicago, IL 60607

800-435-0704, TTY: 877-734-7429

CountyCare is responsible for providing to HFS an appeal summary describing the basis for the decision. CountyCare will comply with the HFS fair hearing decision. Except for a denial of Waiver services, which may not be reviewed by an external independent entity, CountyCare allows an Enrollee to request an external independent review, at no cost to the Enrollee, on both standard and expedited time frames, of appeals that are denied by CountyCare within thirty (30) days after the date of the decision notice.

Reversed Decision Resolution

In accordance with 42 CFR §438.424, if CountyCare or the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, CountyCare will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, if services were continued while the appeal was pending, CountyCare will provide reimbursement for those services in accordance with the terms of the final decision rendered by HFS and applicable regulations.

Provider Complaints

CountyCare has established a provider complaint system that allows a provider to dispute the policies, procedures, or any aspect of the administrative function. CountyCare takes all complaints very seriously, and all provider complaints are thoroughly investigated. CountyCare has designated a Provider Complaints Coordinator (PCC) to process provider complaints. The PCC will provide written notice of resolution to the provider within thirty (30) days from the decision date.

NOTE: The process for appeals of medical necessity decisions (actions) is outlined in the Utilization Management section of this manual.

Provider complaints may be submitted verbally by calling Provider Relations at 312-864-8200 or in writing to:

CountyCare Health Plan
P.O. Box 21153
Eagan, MN 55121

In addition to communicating the provider complaint process through this manual, CountyCare communicates the provider complaint process during provider orientation and on its website.

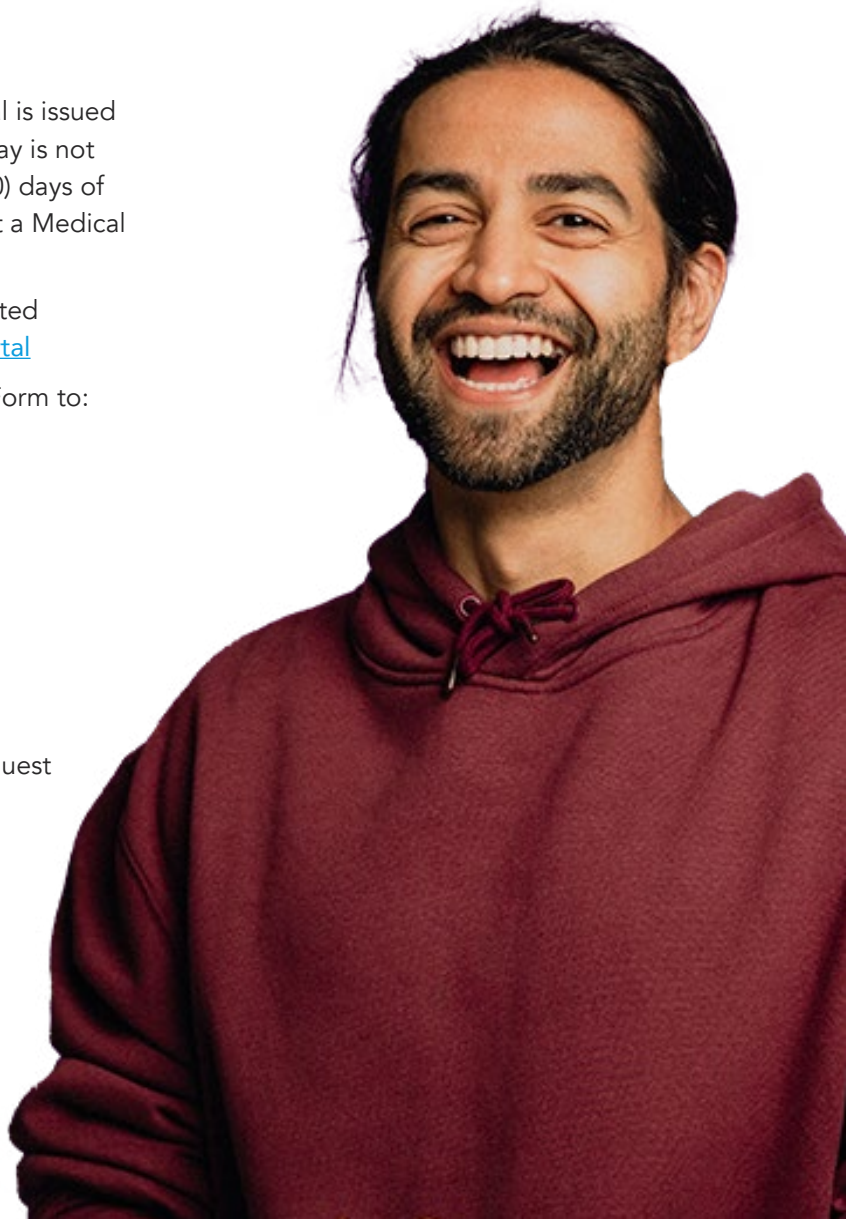
Medical Necessity Reviews

A medical necessity review is performed when a denial is issued for a pre-certification, authorization, or extension of stay is not approved. Reviews must be submitted within thirty (30) days of UM denial or date of service, whichever is first. Submit a Medical Necessity Review form via:

- Online through the Provider Portal for contracted providers www.countycare.com/providers/portal
- Mail a Claims and Medical Necessity Review Form to:

CountyCare Health Plan
P.O. Box 21153
Eagan, MN 55121

All necessary documentation must accompany the request for the review.



PROGRAM INTEGRITY AND FRAUD, WASTE AND ABUSE (FWA) EFFORTS

Fraud, Waste, Abuse, Misconduct and Mismanagement

CountyCare takes the detection, investigation, and prosecution of fraud, waste, abuse, misconduct, and mismanagement very seriously and has a Fraud, Waste, and Abuse (FWA) Plan that complies with Illinois and federal laws. CountyCare, in conjunction with its delegated vendors, successfully operates the FWA Program.

Obligation To Report Suspicious Activity

A provider who becomes aware of suspected fraud, waste, abuse, mismanagement, or misconduct shall report the activity to CountyCare. If you suspect or witness a provider inappropriately billing for Medicaid services or a member receiving inappropriate services, please call our anonymous and confidential hotline at 844-509-4669. CountyCare takes all reports of potential fraud, waste, abuse, mismanagement and/or misconduct very seriously and will investigate all reported issues.

Obligation To Report and Return Overpayments

Providers are also required to notify CountyCare in a timely manner of any potential overpayments they have received from the health plan. Providers must return any overpayment to CountyCare within sixty (60) days of identifying the overpayment. Providers must also submit a written description to CountyCare outlining the specific reason for the overpayment and how the overpayment was identified.

FWA Education and Training

All CountyCare providers are required to complete FWA training annually, in order to understand how to prevent, detect and report fraud, waste, abuse, mismanagement and misconduct. This training can be found on CountyCare's website at: https://countycare.com/providers/provider-training/.

Program Integrity Policy Updates and Revisions

CountyCare will review, update, and communicate relevant information regarding requirements related to fraud, waste, abuse, misconduct, and mismanagement at least annually, and as needed, to reflect changes in laws, regulations, the health care industry, any amendments to CountyCare's Program Integrity and FWA-related contract requirements.

Confidentiality

Issues reported or reviewed are considered confidential regardless of how the issue under review was identified. CountyCare staff will only discuss the details or issues under review with individuals who may have direct knowledge of the potential area of concern or those individuals with Program Integrity oversight responsibility.

Lines Of Communication

CountyCare has systems in place to receive, record, and respond to inquiries or reports of potential or suspected fraud, waste, abuse, mismanagement or misconduct by employees and vendors. The key aspects of CountyCare's Lines of Communication are outlined below:

- All concerns are handled and investigated in a confidential and anonymous manner and to the fullest extent allowed by law.
- Retaliation against employees, vendors and Providers for good faith reporting of concerns is prohibited. Any attempted retaliation will result in disciplinary action.

Prevention And Detection Practices

CountyCare conducts monitoring activities to ensure the suspicious activity is identified and performs front- and back-end audits to ensure compliance with medical record documentation standards and billing requirements. CountyCare also uses a sophisticated code editing software to perform systematic audits during the claim's payment process.

CountyCare utilizes a Special Investigation Unit (SIU) to perform audits and investigations which may result in taking the appropriate actions against providers, at the individual or practice level, where issues related to fraud, waste, abuse, mismanagement, or misconduct are identified.

Some of the most common issues identified are:

- Unbundling of codes.
- Assigning an incorrect code to increase payment (Up-coding).
- Assigning add-on codes without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age/gender.
- Use of exclusion codes.
- Excessive use of units.
- Misuse of benefits.
- Submitting claims for services not rendered.
- Submitted claims with cloned or ineligible medical record entries.

Requests For Medical Records

When providers receive a document/medical records request from CountyCare, it is expected that they will respond to the request within the requested timeframe. Failure to respond to the request within the requested timeframe will likely result in adverse findings and recoupment of previously paid monies related to the medical record request.

CountyCare does not reimburse for medical records requested in connection with an audit or investigation.

Medical Record Documentation Guidelines

CountyCare performs regular audits to confirm that provider documentation supports claims billed. The guidance below outlines several issues identified during our provider audits, including what is and is not acceptable forms of medical record documentation.

- Cloned records are not acceptable.
- Documentation is considered cloned when it is worded exactly like or similar to previous entries.
- Cloning also occurs when the documentation is exactly the same from patient to patient.
- Simply changing the date on the medical record without reflecting what occurred during the actual visit is not acceptable.

Please remember that individualized patient notes for each patient encounter are required. Medical record documentation must reflect the patient condition necessitating treatment, the treatment rendered and if applicable the overall progress of the patient to demonstrate medical necessity. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter.

Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services, due to the lack of specific individual information for each unique patient, regardless of the reason it was used. Where records contain cloned documentation, it will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.

Provider medical records must be completed in a timely matter. All medical records should be completed, with signature, within forty-eight (48) hours of an encounter. Regulators have stated that twenty-four (24) to forty-eight (48) hours is a reasonable timeline for the completion and signature of medical records.

Investigation

CountyCare will follow an established procedure for investigation of all potential issues involving fraud, waste, abuse, mismanagement, or misconduct. Cooperation with the investigation is required. Investigations involving potential fraud, waste, abuse, mismanagement or misconduct (otherwise referred to as Program Integrity investigations) and any associated recoupment activities are not required to follow the 12-month lookback requirements outlined in Section 368d of the Illinois Insurance Code (215 ILCS 5/368d).

Corrective Action, Sanctions, Prosecution, and Recovery

CountyCare will implement the appropriate corrective action required, including but not limited to the following:

- Remedial education and/or training to attempt to eliminate the action or issue identified.
- Providers may be placed on increasingly stringent utilization review or a corrective action plan.
- Recoupment of previously paid monies from a provider/practice.
- Termination of provider agreement or other contractual arrangement.
- Civil and/or criminal prosecution.
- Any other remedies are available to rectify the issue identified.

Member “Lock-in” Program

CountyCare employs data analytics to identify members who consistently utilize multiple pharmacies and/or physicians to obtain multiple medications or medical services. Members who consistently misuse their pharmacy or medical services may be enrolled in a lock-in or restriction program. Additionally, members are identified and recommended to CountyCare from the Office of Inspector General for the "Lock-In Program."

If a provider believes a member may benefit from the “Lock-In Program,” they should contact our confidential hotline at 844-509-4669.

Letters to Verify that a Member Received Services

CountyCare randomly selects a sample of members to receive a Verification of Services Rendered letter. These letters are sent to members to help ensure that CountyCare is paying for services that are actually provided to members. Any services that are reported as billed but not received by the member are referred to the Claim Audit Department for further review and investigation to determine if fraudulent activity is occurring. Findings from the original review and the investigation will be forwarded to the Special Investigation Unit if warranted.

HEALTH, SAFETY AND WELFARE INCIDENTS, INCLUDING CRITICAL INCIDENTS

CountyCare has developed a systematic approach to promote the identification of Health, Safety and Welfare (HSW) incident(s). Any concerns identified as abuse, neglect, exploitation, and other potential incidents must be promptly reported, reviewed, investigated, and appropriate actions must be taken as necessary to protect the safety of the member. Providers must participate in health plan training to recognize potential concerns related to abuse, neglect, and exploitation, and their responsibility to report suspected or alleged abuse, neglect, or exploitation. Retaliatory action is prohibited against the reporting personnel by the affiliated provider, an employee, and/or another person affiliated with CountyCare.

Providers' primary responsibility is in their role as mandated reporters. While HSW reporting may coincide with mandated reporting to Investigating Authorities, CountyCare is not itself an Investigating Authority. HSW follow-up is not an investigation; rather it is a function of care coordination, a plan of action to support the Member/family by providing resources and interventions to decrease risks and improve the member's health, safety, and welfare.

Incidents differ in reporting requirements depending on the member impacted by the incident. Identifying an incident requires the provider to be aware if the member participates in specific programs or demographic groups, for which very specific types of incidents are reportable. Specific health, safety and welfare incidents are established for:

a. Members who receive Home and Community Based Services through the Division of Rehabilitation Services. These incidents are called Critical Incidents and are listed in Appendix A of this manual. Examples of Critical Incidents include but are not limited to:

- **a.** Death.
- **b.** Physical abuse.
- **c.** Verbal or emotional abuse.
- **d.** Sexual harassment.

b. Members who are over the age of sixty (60) and adults with disabilities age eighteen (18) to fifty-nine (59). These incidents are listed in Appendix B of this manual. Examples of these incidents include but are not limited to:

- **a.** Confinement.
- **b.** Emotional, physical, or sexual abuse.
- **c.** Passive neglect.

c. Members residing in Supportive Living Facilities. These incidents are listed in Appendix C of this manual, which is Attachment XIX of the Plan-Department Contract. Examples of these incidents include but are not limited to:

- **a.** Abuse or suspected abuse of any nature by anyone, including another resident, staff, volunteer, family, friend, etc.
- **b.** Allegations of theft when a resident chooses to involve local law enforcement.
- **c.** Any crime that occurs on facility property.

d. Members who are DCFS Youth in Care or Former Youth in Care. These incidents include but are not limited to:
    a. Incidents of child or youth deaths, suspected child abuse or neglect and human trafficking.
    b. Incidents involving children or youth missing or abducted from their placement.

For the above groups of members, and all other members, any concern about abuse, neglect and exploitation shall be reported. All specific groups and incident types are listed on CountyCare's HSW Incident Form on the CountyCare.com website. Providers are encouraged to use this form as a guide for reporting and confirming completion of mandated reporting and actions taken to ensure the member's safety.

Each situation must be considered based on the member, the members enrollment in specific programs, the members specific needs and risks and the circumstances of the incident. When unsure, an individual may report any potential incident and CountyCare may make a determination as to whether it will be included as a HSW incident and/or provide other direction to Reporter. If the incident is not related to abuse, neglect, exploitation, a listed incident type for specific member groups described above or otherwise directly related to health, safety and welfare, the individual shall consult with a supervisor to determine if and how to report the incident. When considering incidents that do not rise to the level of abuse, neglect or exploitation, providers should report incidents in which the member's health, safety or welfare is or has been at risk, and further action is or was needed to address the ongoing risk or the cause(s) of the incident. Incidents are unusual and not reasonably expected. Reports of poor service, access to care, or member rights issues, shall be reported as a Grievance by contacting Member Services.

How To Report an Incident

Mandated reporting is the responsibility to the person who identifies an incident that requires reporting to investigating authorities. In addition to making mandated reports, and for other incidents that do not require mandated reporting, all suspected incidents should be reported by contacting Member Services at 312-864-8200, or by completing the Incident Reporting form at http://www.countycare.com/ providers/criticalincidents.

The form may be completed electronically or printed and completed manually. Upon completion, the Incident Reporting form should be faxed to 312-637-8312 or emailed to countycarequalityofcare@cookcountyhhs.org. Reports should be made within one (1) business day of becoming aware of an incident.

If the incident involves a criminal act, local law enforcement must be notified immediately. If an incident involves abuse, neglect, and exploitation, the reporter is required to report to the applicable agency or agencies below:

- Reports regarding members ages 18-59 with a disability, or age 60 and older and living in the community, are to be made to the Illinois Department on Aging by using the Adult Protective Services Hotline at 866-800-1409 or TTY 800-206-1327.
- For members under the age of 18 years old, contact the Illinois Department of Children and Family Services (DCFS) Hotline at 800-252-2873 or TTY 800-358-5117. If you believe a child is in immediate danger of harm, call 911.
- Reports regarding members in nursing facilities must be made to the Department of Public Health's Nursing Home Complaint Hotline at 800-252-4343.
- Reports regarding members aged 18-59 receiving mental health or Developmental Disability services in DHS-operated, -licensed, -certified or -funded programs are to be made to the Illinois Department of Human Services Office of the Inspector General (OIG) Hotline at 800-368-1463 (voice and TTY).
- Reports regarding members in Supportive Living Facilities (SLFs) must be made to the HFS SLF Complaint Hotline at 844- 528-8444.
- Reporting for all populations is mandated when the incident involves child abuse, elder abuse, law enforcement, incidents occurring at nursing facilities, and fraud reports to OIG.

Review and Follow-up of Incidents

CountyCare's Health, Safety, and Welfare Program staff will ensure:

- Timely and comprehensive response in the protection of members.
- Interventions and/or education are in place to prevent more serious or future incidents.
- Medical assessments and/or treatment has been initiated as appropriate.
- The appropriate state agencies/authorities were contacted, as applicable.
- The resolution process is documented, updated, and tracked as the investigation proceeds, indicating actions taken on behalf of the member, care coordinator and other relevant parties.
- Any proposed corrective action is documented, including proposed interventions/education.
- All corrective action and recommendations by state agencies/external authorities have been followed up on and/or implemented.

Authority and Responsibility

CountyCare's Compliance Officer has overall responsibility and authority for operating CountyCare's Compliance Program. CountyCare is committed to meeting all Program Integrity requirements set out by HFS and the HFS Office of Inspector General (OIG), including identifying, investigating, sanctioning, reporting, and prosecuting suspected fraud, waste, abuse, mismanagement, and misconduct.

CountyCare providers must cooperate fully in producing documentation and making employed personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations and audits.

Disclosure of Ownership and Control Interest Statement

The federal regulations outlined in 42 CFR 455.105 require providers entering into or renewing a provider agreement to disclose to the US Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency certain business transactions. Failure to submit the accurate, complete information requested promptly may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.42 CFR 455.105 states in relevant part:

a. Provider agreements. A Medicaid agency must agree with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions following paragraph (b) of this section.

b. Information that must be submitted. A provider must submit, within thirty-five (35) days of the date on a request by the Secretary or the Medicaid agency, complete information about:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-months ending on the date of the request.

2. Any significant business transactions between the provider and any wholly-owned supplier, or between the provider and any subcontractor, during the 5-years ending on the date of the request.

Providers should note that:

- Federal Financial Participation (FFP) is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under 42 CFR 455.105(b) or under 42 CFR 420.205 (Medicare requirements for disclosure).
- FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the data was supplied.

Thank You for Choosing CountyCare

IF YOU HAVE QUESTIONS, PLEASE CALL PROVIDER RELATIONS.

312-864-8200, 711 (TTY/TDD)

CHOOSE THE PLAN THAT UNDERSTANDS

APPENDIX A

Plan-Department Contract Attachment XVII

Illinois Department Of Human Services, Division Of Rehabilitation Services, Critical Incident Definitions

Incident Name	Description
Death, HSP customer	Contractor shall report deaths of an unusual nature to HFS OIG. Criteria for reporting deaths of an unusual nature include, but are not limited to, a recent allegation of abuse, neglect or exploitation, or that customer was receiving home health services at time of passing Contractor shall cooperate in any investigation conducted by HFS OIG.
Death, other parties	Events that result in significant event for customer. For example, customer's caregiver dies in the process of giving customer bath, thereby leaving customer stranded in home without care for several days. Passing of immediate family members is not necessary unless the passing creates a resulting turn events that are harmful to customer.
Physical abuse of customer	Non-accidental use of force that results in bodily injury, pain or impairment. Includes but not limited to being slapped, burned, cut, bruised, or improperly physically restrained.
Verbal/Emotional abuse of customer	Includes but is not limited to name calling, intimidation, yelling, and swearing. May also include ridicule, coercion, and threats.
Sexual abuse of customer	Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities.
Exploitation of customer	The illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.
Neglect of customer	The failure of another individual to provide an adult with disabilities with, or the willful withholding from an adult with disabilities of the necessities of life including but not limited to food, clothing, shelter, or medical care.
Sexual harassment by provider	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.

Incident Name	Description
Sexual harassment by customer	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive work environment.
Sexually problematic behavior	Inappropriate sexual behaviors exhibited by either the customer or individual provider which impacts the work environment adversely.
Significant medical event of provider	A recent event to a provider that has the potential to impact upon a customer's care.
Significant medical event of customer	This includes a recent event or new diagnosis that has the potential to impact on the customer's health or safety. Also included are unplanned hospitalizations or errors in medication administration by provider.
Customer arrested, charged with or convicted of a crime	In instance where the arrest, charge, or conviction has a risk or potential risk upon the customer's health and safety should be reported.
Provider arrested, charged with or convicted of a crime	In instance where the arrest, charge, or conviction has a risk or potential risk upon the customer's health and safety should be reported.
Fraudulent activities or theft on the part of the customer or the provider	Executing or attempting to execute a scheme or ploy to defraud the Home Services program, or obtaining information by means of false pretenses, deception, or misrepresentation in order to receive services from our program. Theft of customer property by a provider, as well as theft of provider property by a customer is included.
Self-neglect	Individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to medical conditions.
Customer is missing	Customer is missing or whereabouts are unknown for provision of services.
Problematic possession or use of a weapon by a customer	Customers should never display or brandish a weapon in staff's presence. Any perceived threat through use of weapons should be reported. In some cases, persons with SMI are not allowed to possess firearms and this should be documented if observed.

Incident Name	Description
Customer displays physically aggressive behavior	Customer uses physical violence that results in harm or injury to the provider.
Property damage by customer of $50 or more	Customer causes property damage to in the amount of $50 or more to provider property.
Suicide attempt by customer	Customer attempts to take own life.
Suicide ideation / threat by customer	An act of intended violence or injurious behavior towards self, even if the end result does not result in injury.
Suspected alcohol or substance abuse by customer	Use of alcohol or other substances that appears compulsive and uncontrolled and is detrimental to customer's health, personal relationships, safety of self and others. Social and legal status.
Seclusion of a customer	Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others.
Unauthorized restraint of a customer	Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
Media involvement/ media inquiry	Any inquiry or report/article from a media source concerning any aspect of a customer's case should be reported via an incident report. Additionally, all media requests will be forwarded to the DHS Office of Communications for response.
Threats made against DRS/ HSP staff	Threats and/or intimidation manifested in electronic, written, verbal, physical acts of violence, or other inappropriate behavior
Falsification of credentials or records	To falsify medical documents or other official papers for the expressed interest of personal gain, either monetary or otherwise.
Report against DHS/HSP employee	Deliberate and unacceptable behavior initiated by an employee of DRS against a customer or provider in HSP.
Bribery or attempted bribery of a HSP employee	Money or favor given to an HSP employee in exchange to influence the judgment or conduct of a person in a position of authority.
Fire / Natural Disaster	Any event or force of nature that has catastrophic consequences, such as flooding, tornados, or fires.

APPENDIX B

Plan-Department Contract Attachment XVIII

Illinois Department On Aging, Elder Abuse And Neglect Program

The program provides services to people over the age of sixty (60) and to adults with disabilities age eighteen (18) to fifty-nine (59) who may be victims of abuse as prescribed below:

- **Confinement** means restraining or isolating, without legal authority, an older person for reasons other than medical reasons ordered by a Physician.

- **Emotional Abuse** means verbal assaults, threats of maltreatment, harassment, or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.

- **Financial Exploitation** means the misuse or withholding of an older person's resources by another person to the disadvantage of the older person or the profit or advantage of a person other than the older person.

- **Physical Abuse** means causing the inflictions of physical pain or injury to an older person.

- Sexual Abuse means touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual activity.

- **Passive Neglect** means a caregiver's failure to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, and medical care. This definition does not create any new affirmative duty to provide support to eligible adults, nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.

- **Willful Deprivation** means willfully denying medications, medical care, shelter, food, therapeutic devices, or other physical assistance to a person who, because of age, health, or disability, requires such assistance and thereby exposing that person to the risk of physical, mental, or emotional harm because of such denial; except with respect to medical care or treatment when the person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.

APPENDIX C

Plan-Department Contract Attachment XIX

Illinois Department Of Healthcare And Family Services Incident Reporting For Supportive Living Facilities

Examples of incidents that must be reported to the Department include, but are not limited to the following:

- Abuse or suspected abuse of any nature by anyone, including another resident, staff, volunteer, family, friend, etc.
- Allegations of theft when a resident chooses to involve local law enforcement.
- Elopement of residents/missing residents.
- Any crime that occurs on facility property.
- Fire alarm activation for any reason that results in on-site response by local fire department personnel. This does not include fire department response that is a result of resident cooking mishaps that only cause minimal smoke limited to a resident's apartment and that do not result in any injuries or damage to the apartment. Examples of what do not need to be reported include, but are not limited to: burnt toast or burnt popcorn.
- Physical injury suffered by residents during a mechanical failure or force of nature.
- Loss of electrical power in excess of an hour.
- Evacuation of residents for any reason.