



Provider Manual

PROVIDER RELATIONS
312-864-8200, 711 (TTY/TDD)
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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 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 non-profit Medicaid 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))
- Individuals eligible for health benefits for immigrant seniors (HBIS)

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 optimal outcomes
- 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 positive working experiences. 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.

Provider Services

CountyCare Website	Find documents, forms, important health plan information, and provider and member resources.	 countycare.com
Provider Portal	Provides access to member eligibility, important documents, forms, authorization submission and status, claim status, claim review requests, and panel rosters.	 essentials.availity.com
HFS MEDI System	Utilize system to verify Medicaid eligibility.	 illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx
Universal Provider Roster	Submit any provider additions, changes, or terminations monthly and send a comprehensive Universal IAMHP Roster, quarterly. Please note 'comprehensive roster' in request.	 iamhp.org/providers  CountyCareProviderRoster Submission@cookcountyhhs.org
Member & Provider Services	Mon. - Fri.: 8:00 a.m. - 6:00 p.m. CT Sat.: 9:00 a.m. - 1:00 p.m. CT	 312-864-8200, 711 (TTY/TDD)
Transportation Scheduling	Contact Modivcare to request a ride 3 business days prior to member need.	 312-864-8200  855-444-1661 (toll-free) / 711 (TDD/TTY)  member.modivcare.com/en/login
Fraud, Waste and Abuse Hotline	Use our confidential hotline to report concerns.	 844-509-4669
Critical Incidents	Complete a critical incident form:  countycare.com/wp-content/uploads/CC-Health-CI-Incident-Reporting-Form012125.pdf	 312-864-8200, 711 (TTY/TDD)  countycarequalityofcare@cookcountyhhs.org

Claims Submission (Medical and Behavioral Health)

Clearinghouse Vendor	Availity	 essentials.availity.com
Paper Claims Mailing Address		 CountyCare Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Payer ID	06541	

Claims Timely Filing Requirement

Claims must be submitted within 180 calendar days from date of service or discharge date.
Submit corrected claims sixty (60) calendar days of the Explanation of Payment (EOP) and within 180 days from the date of service or discharge date.

Claims Review Process

Claim Request for Reconsideration	Submit within sixty (60) calendar days of EOP. Submit reconsiderations via 'Message the Payer' within the Availity portal.	 essentials.availity.com
Provider Claim Disputes	Submit dispute within sixty (60) calendar days of EOP. Submit via Identifi (access Identifi through Availity portal).	 essentials.availity.com
Post-Service Authorization Disputes	Submit disputes within sixty (60) calendar days from EOP. Must include extenuating circumstance for not obtaining prior auth within the required timeframe.	 essentials.availity.com

Prior Authorization

Prior Authorization (PA) Look-up Tool	Use PA Look-up Tool to determine if an authorization is required.	 https://countycare.com/providers/#prior-authorizations
Medical Necessity Appeals	Submit appeals within 30 days of an Authorization denial. Medical Necessity appeals may only be submitted on behalf of the member with a completed Authorized Representative Form. Access Identifi on Availity portal via 'Payer Spaces.'	 essentials.availity.com  CountyCare Health Plan P.O. Box 21153 Eagan, MN 55121
	 bit.ly/CCAuthorizedRep	

Medical and Behavioral Health

Complete the authorization request form:

-  **Inpatient PA Form**
-  **Outpatient PA Form**
-  **Behavioral Health PA Form**

 **essentials.availity.com**

Specialty Services

Musculoskeletal surgery for the spine, interventional pain management (IPM), physical, occupational and speech therapy, advanced imaging* and diagnostic cardiology

Submit authorization request to Evolent Specialty Services (formerly National Imaging Associates).
*For cardiac imaging refer to the PA Look-up Tool for authorization submission information.

 **RadMD.com**

Cardiology/Oncology

Cardiology and oncology imaging, radiology, related medications and hospital review

Submit authorization requests to Evolent Specialty Services (formerly New Century Health).

 **carepro.evolent.com**

Neonatal/NICU

Maternity & NICU Care Management

Submit authorization requests to Progeny Health.

 **progenyhealth.com**

Dental

Request at the Avesis Provider Portal.

 **myavesis.com/providers**
 **855-337-1594**

Vision

Request at the Avesis Provider Portal.

 **myavesis.com/providers**
 **855-337-1594**

Pharmacy (including Specialty)

Submit the CVS Caremark medication request form:

 **caremark.com/portal/asset/Medicaid_PA_request_form.pdf**

 **866-255-7569**
 **800-364-6331**

Inpatient Admissions

Contact Member Services within **24 hours** of patient admission.

 **312-864-8200, 711 (TTY/TDD)**
 **866-209-3703**

Medical Management

Care Management Referrals for Members in HCBS Waivers

 **312-864-0200, 711 (TTY/TDD)**
 **countycarewaivers@cookcountyhhs.org**

Referrals to Care Coordination

Complete the care coordination referral form:

 **countycare.com/referral-to-care-coordination/**

 **countycarereferrals@cookcountyhhs.org**

Communicating With CountyCare

Provider Relations

The Provider Relations Representative plays a key role in ensuring a positive experience for providers partnering with CountyCare, serving as a primary liaison between providers and the health plan. Provider Relations supports CountyCare contracted providers through the following responsibilities:

- Serve as the primary point of contact for provider inquiries, concerns, and issue resolution
- Conduct orientation for newly contracted providers and office staff
- Deliver ongoing provider education, including distribution of provider notices and systems training
- Educate providers on CountyCare policies, procedures, and operational updates
- Facilitate claims research and assist with timely resolution of claims-related issues
- Promote compliance with regulatory and contractual requirements
- Liaise with CountyCare's contracting team to address contract-related matters
- Collaborate with internal departments to resolve provider issues and improve processes
- Support provider satisfaction and engagement initiatives

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

Website

[CountyCare.com](https://www.countycare.com)

Visiting the "[For Providers](#)" link on CountyCare's website provides you with comprehensive resources to help create efficiencies for you and your team. The website is continuously updated with the latest health plan news and information. We encourage you to save www.countycare.com to your internet "Favorites" list and visit the site often.

The following information can be found on the CountyCare website:

- Provider billing resources
- Clinical guidelines
- Health, Safety, and Welfare Incidents including Critical Incident reporting guidelines
- Fraud, waste and abuse reporting guidelines
- Prior authorization look-up tool
- Provider complaints, member grievances and appeals
- 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

Secure Provider Portal

<https://essentials.availity.com>

CountyCare's secure portal provides access to many tools and resources to aide providers in the care for CountyCare members. Any contracted providers and their office staff can register for the secure provider portal. On the [home page](#), select the 'Portal Login' 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 through 'Identifi SSO'
- View claims payment history
- Verify member eligibility
- Contact us securely and confidentially through 'Message the Payer'
- Access the provider directory
- Request a claim reconsideration through 'Message the Payer'

Please contact Provider Relations at countycareproviderservices@cookcountyhhs.org, or by phone at 312-864- 8200.

Get the Assistance You Need

Where	When	How	For What?
Secure Provider Portal	Twenty-four (24) hours a day, seven (7) days a week	essentials.availity.com	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 reconsideration through 'Message the Payer'
Provider Services	Monday – Friday: 8 a.m. – 6 p.m. CT Saturday: 9 a.m. – 1 p.m. CT	P: 312-864-8200 countycareprovider@cookcountyhhs.org	Live Representative Service • Verify member eligibility • Understand member benefits • Check claims status • Request authorizations • Report Health, Safety and Welfare Incident(s) including Critical Incidents • File appeals or grievances
Your Provider Relations Representative	Monday – Friday 8 a.m. – 6 p.m. CT	Via phone and email	• Discuss escalated issues, concerns, or questions • Request training (products offered, claims, etc.) • Check provider status • Schedule meetings to partner with CountyCare on optimizing programs and processes
Provider Data Management (PDM)	Twenty-four (24) hours a day, seven (7) days a week.	Via email: CountyCareProviderRosterSubmission@cookcountyhhs.org	• Provider roster submission • Check provider roster status

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 third-party administrator fraud hotline at 844-509-4669 immediately.



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

Secure Provider Portal	Contracted providers can log onto the secure provider portal at essentials.availity.com. 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 secure 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.
MEDI System	Medicaid providers can also utilize the state's MEDI system.
Interactive Voice Response (IVR) Phone System	To access the IVR system, providers must self validate using: • National Provider Identifier (NPI) • ZIP code associated with the billing provider record Eligibility Status • Confirms current member eligibility • Required information: » Member ID » Member Date of Birth (DOB) • No limitation on the number of member eligibility checks per call 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 a.m. and 6 p.m., Monday-Friday, and follow the menu prompts to speak to a Provider Services 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 members. 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. 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 certain criteria and individual factors.

PCP For Homebound Members

If a member is determined to be homebound by the PCP or care coordinator, they may be assigned, either temporarily or permanently, to a PCP who will see the member in their 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 certain 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 comprehensive 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 Look-up Tool](#).
- 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 Humility and Competency Plan](#).
- Adhere to Access and Availability requirements, including linguistic and physical accessibility standards, appointment availability and after-hours coverage (see page 26 of this manual for details)
- 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.
- Should not accept referrals or deliver services to a waiver population or within a service area for which you are not approved by IDoA or DRS.
- Important note related to HCBS providers stopping services for HCBS Members:
 - » Providers are expected to notify CountyCare 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 Utilization Management 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 look-up tool.
- Notify Utilization Management within one (1) business day for notification of admits under emergent needs. Elective hospital admissions require prior authorization approval in advance of services being rendered.
- Notify Utilization Management 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 Utilization Management 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 seven (7) 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, video conference, 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 should collaborate with CountyCare Care Coordinators staff 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 of Healthcare and Family Services 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. *(Note, this is changing to 60 minutes effective July 1, 2026.)*
- 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 members information about advance directives in the CountyCare Member Handbook. PCPs and other providers rendering services to CountyCare members provide counseling for advanced directives (living will and health care power of attorney), collect those documents, if available, and store them in their medical record.

Terminating Care of a Member

Any provider may request to terminate the care of a member under the following circumstances:

- Member repeatedly fails to keep scheduled appointments.
- Member fails to comply with the treatment plan.
- Member is abusive to the provider or staff (physically or through words).
- Member impedes operations of the practice through disruptive behavior unrelated to their medical condition.

The provider may request to terminate the care of a 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 for stopping services and an effective date.

It is not acceptable, at any time, for a provider to stop services due to claims or payment related issues without prior notification to CountyCare and a plan and/or appropriate alternative services in place for members to continue receiving service without interruption.

Leaving the Network and Continuity of Care Requirements

Providers must give CountyCare written notice of termination in accordance with the terms of their participating provider agreement and submit a termination IAMHP roster to CountyCareProviderRosterSubmission@cookcountyhhs.org subject to CountyCare's approval. Providers must supply copies of medical records to CountyCare upon request and facilitate the impacted 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 according to 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 Humility and Competency

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 and Humility 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 Humility and Culturally and Linguistically Appropriate Services (CLAS) Plan is based on adopting the National Standards for 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 and humble 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 goals that include but are not limited to:

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

Although CountyCare will provide a Cultural Competency and Humility training, provider offices should also have their own specific cultural sensitivity and competency training. In addition, providers should comply with Illinois Public Act 102-0004 and complete any state mandated training for health care professionals, including implicit bias 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:

- Elective cosmetic surgery
- Diagnostic or therapeutic procedures related to infertility/sterility
- Services that are experimental or investigational in nature
- Intermediate Care Facility for Developmentally Disabled (ICF/DD Facility)
- Services that are provided without required prior authorization
- Non-emergency services provided by an out-of-network provider and not authorized by CountyCare
- Any service that is not medically necessary
- Services provided through local education agencies

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 [Prior Authorization Look-up Tool](#) on CountyCare's website or contact Provider Relations at countycareproviderservices@cookcountyhhs.org.

Medicaid Covered Services

Following is a list of some of the medical services and benefits that CountyCare offers:

- Abortion services are covered by Medicaid (not CountyCare) by using your Illinois Healthcare and Family Services (HFS) medical card
- Advanced practice nurse services
- Applied Behavior Analysis (ABA) therapy and services
- Ambulatory surgical treatment center services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic coverage for members ages 21 and over

- Dental services, including oral surgeons
- Doula services
- EPSDT services for members under age 21
- Family planning services and supplies
- Federally Qualified Health Centers, rural health centers and other encounter rate clinic visits
- Gender-affirming care
- Genetic counseling and testing
- Home health agency visits
- Hospital emergency department visits, inpatient services and ambulatory services
- Laboratory and X-ray services
- Lactation counseling services
- Medical supplies, equipment, prostheses and orthoses
- Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option and Targeted Case Management Option
- Nursing facility services
- Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for members under age 21
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pharmacy services
- Physical, occupational and speech therapy services
- Physician services
- Podiatric services
- Post-stabilization services
- Practice visits for members with special needs
- Renal dialysis services
- Respiratory equipment and supplies
- Services to prevent illness and promote health
- Skilled nursing
- Subacute alcoholism and substance abuse services, residential day treatment and detox day treatment
- Transplants*
- Transportation to covered services
- Vision services

* CountyCare Access (HBIS) coverage is limited to stem cell transplants and kidney transplants. No other transplant organ is covered for this group.

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. 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.

Institution for Mental Diseases (IMD) Services

CountyCare may cover medically necessary inpatient psychiatric and substance use disorder services provided in an Institution for Mental Diseases (IMD) as an in lieu of service, consistent with applicable federal and Illinois Medicaid requirements. Coverage is limited to eligible members ages 21 through 64 for IMD stays of no more than 15 days in a calendar month. Eligibility and the allowable length of stay are determined based on the member's IMD admission status on the first day of each calendar month. Providers should refer members to the treatment setting that best meets their clinical needs. CountyCare does not require members to receive services in an IMD.

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 Visa Rewards Card in the mail after we receive a claim for that qualifying service. The card will have cash credit on it and can be used as a debit card at most merchants/locations that accept Visa. Visit the [website](#) for the most up-to-date information on the CountyCare Rewards Card Program.

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 at almost any merchant that accepts Visa on things such as groceries, transportation, utilities, and more. Find more examples of what members can buy with their Rewards Card at our [website](#).

For complete details about CountyCare rewards and extra benefits, scan the QR code 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

NOTE: Members in CountyCare Access do not qualify for Long Term Care. Please visit the CountyCare [website](#) for more information.

For Long Term Care Facilities, CountyCare covers room and board for qualified members.

HCBS Covered Services

NOTE: Members in CountyCare Access do not qualify for Home and Community Based Waiver Services (HCBS). Please visit the CountyCare [website](#) for more information.

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				✓	

NOTE: Personal Emergency Response System that includes GPS and/or Fall Detection is covered under the Aging Waiver, only.

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
- Meals and Snacks

Note: Providers must also regularly assess each resident's health status and consult with the resident on an ongoing service plan that promotes health and wellness.

Transportation Services for Members

CountyCare offers transportation to and from covered services. Members can:

- Request passes (Ventra and PACE) two (2) weeks before their appointment.
- Schedule a ride. Members will need to schedule at least 72 hours (3 days) before their appointment by calling Member Services at 312-864-8200/855-444-1661 (toll-free) / 711 (TDD/TTY) or check our [website](#) for additional ways to schedule a ride.

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 Transdev 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 Transdev 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)

Overview

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 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.

CountyCare's UM department hours of operation are Monday through Friday from 8:30 a.m. to 8:00 p.m. (excluding holidays). If you have any questions, please 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 additional information on CountyCare's [website](#).

Medical Necessity

Medical necessity is defined for CountyCare members as health care services, supplies or equipment needed to diagnose or treat a medical condition according to accepted standards of medicine. Medical necessity is determined by providers who:

- Provide appropriate and consistent diagnosis or treatment of the patient's condition, illness, or injury
- Follow the standards of good medical practice consistent with evidence-based care and CountyCare's [clinical practice guidelines](#) as found on our website.
- Act not primarily for the convenience of the member, family, or provider
- Recommend the most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Work 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 or notification 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 [Prior Authorization Look-up Tool](#) to determine if authorization is necessary. The [Prior Authorization Look-up Tool](#) has the most up-to-date requirements, however, below are general services that require or notification:

- 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 [pharmacy section under prior authorization](#)).
- All elective cardiology or oncology service authorizations should be requested and performed by specialists within Evolent Specialty Services. Call 888-999-7713 for more details.
- The following specialties should be requested through Evolent Specialty Services via RadMd or telephone at 1-800-424-1732
 - All PT/OT/ST
 - All Musculoskeletal (MSK) Surgery and Interventional Pain Management (IPM)
 - All outpatient Advanced Imaging and Diagnostic Cardiology services

Providers can check authorization status using our IVR system.

To access the IVR system, providers must **self validate** using:

- **National Provider Identifier (NPI)**
- **ZIP code** associated with the billing provider record

Then, to check authorization status:

- To verify status of submitted authorization requests
- **Required information:**
 - Authorization number

Inpatient Admissions

All inpatient hospital admissions require notification within one (1) business day of admission to CountyCare.

Emergency Services

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

Prior Authorization and Notification

Complying with prior authorization and with notification is a mandatory condition for payment of claims for inpatient admissions for which prior authorization or timely notification is required.

Prior Authorization

Prior authorization from CountyCare is mandatory for:

- a. All elective inpatient admissions and other inpatient admissions requiring prior authorization as listed in the current [Prior Authorization Look-up Tool](#) posted on the CountyCare website; and
- b. All out-of-network services. Prior authorization is required for inpatient admissions, including for hospitals, behavioral health facilities and other facilities, must be requested at least 14 calendar days before the scheduled inpatient admission.

Notification

Notification to CountyCare is mandatory within the later of 24 hours or the next business day after inpatient admissions following medical emergencies, pregnancies, observations, or other events not requiring prior authorization as listed in the current [Prior Authorization Look-up Tool](#) posted on the CountyCare website.

Clinical Information

Prior authorization requests and required notifications must include the demographic information to identify the member and all relevant clinical information to evaluate the medical necessity of the inpatient admission, including without limitation:

- Member's name, date of birth and CountyCare ID number
- Member's diagnosis
- Requesting provider's name and telephone number
- Servicing provider's name, TIN and NPI, telephone number, fax number and location
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past and/or proposed treatment plan, surgical procedure, diagnostic procedures to support the appropriateness and level of service proposed)
- Discharge plan
- Notification of newborn deliveries should include the mother's name, the mother's date of birth, the mother's CountyCare ID number, date of delivery, route of delivery, and the newborn's birth weight.

If additional clinical information is required, a CountyCare nurse or medical management representative will notify the provider of the specific information needed to complete the authorization process or the notification.

Determining Need and Requesting or Obtaining Prior Authorization

The need for prior authorization may be verified in the [Prior Authorization Look-up Tool](#) posted on the CountyCare website or by calling Medical Management at 312-864-8200 or 855-444-1661. Prior authorization may be requested or obtained by calling Medical Management at 312-864-8200 or 855-444-1661, through the secure provider portal, or by faxing to:

Inpatient Medical: 800-856-9434

Outpatient Medical: 866-209-3703

Behavioral Health: 800-498-8217

Click to view and download the prior authorization forms:

[Inpatient PA Form](#) [Outpatient PA Form](#)

[Behavioral Health PA Form](#)

Reviewed By	Service Type	Phone	Fax	Portal
Evolent	Physical Health	855-444-1661	866-209-3703	Identifi via the Availity portal
	Behavioral Health		800-498-8217	
	Medical Pharmacy		866-209-3703	
Evolent Specialty Services: Formerly New Century Health	Cardiology	1-888-999-7713	1-800-573-1906	CarePro
	Imaging		1-800-915-3450	
	Radiation Oncology		1-800-752-3448	
	Medical Oncology		1-800-616-2076	
Evolent Specialty Services: Formerly National Imaging Associates	Non-Cardiac Advanced Imaging/Radiology	1-800-424-1732	1-800-784-6864	RadMD
	Diagnostic Cardiology			
	Interventional Pain Management			
	Musculoskeletal - Spine Surgery			
	Physical Medicine			
Progeny	Maternity-NICU	888-832-2006	877-868-9679	NA
Evicore	DME	866-525-5029	866-663-7740	Evicore
CVS Caremark	Prescription Drug Services	833-845-4702	1-866-255-7569	CVS Caremark
	Specialty Pharmacy Services			
Avesis	Dental	1-866-337-1594	n/a	Avesis
	Vision		n/a	

CountyCare renders decisions on routine prior authorization requests within five (5) calendar days following receipt of the request. CountyCare renders decisions on urgent requests within 48 hours following receipt of the request. Requests for expedited prior authorization must be directed to the member's care coordinator or, if the member is not assigned a care coordinator, to the supervisor or director of the department. CountyCare addresses requests for expedited prior authorization in the timeframe appropriate to the situation, which can be as timely as minutes or hours.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which prior authorization was not obtained from or timely notification was not given to CountyCare due to extenuating circumstances related to the member. Requests for retrospective review must be submitted to CountyCare promptly, but no later than 90 days from the first date of the service to which the request for retrospective review applies. CountyCare makes decisions on timely requests for retrospective review within 30 calendar days following receipt of all necessary information for a qualifying service case.

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.

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 authorizations x1st ninety (90) days (180 for SNC) for any service already scheduled.
DME	Honor existing authorizations 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 in-network provider.
Other ancillary services including therapies (PT, OT, ST)	Honor existing authorizations 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	<i>Previous payor is Medicaid:</i> 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 <i>Commercial/No insurance:</i> 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, Transitional Care 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.

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 ten (10) 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), CVS, 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 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 formulary/PDL does not include all medications. Some medications require prior authorization (PA) or have limitations on previous therapies, age, dose, and quantity. Some drugs have a generic equivalent or a brand-name drug from a different manufacturer that is included.

For more detailed information, please visit the CountyCare [website](#).

Covered OTC Medications

The CountyCare pharmacy prescription benefit covers some OTC medications. 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 health care 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 [prior authorization medication request form](#) 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 CVS Pharmacy Help Desk at 1-833-845-4702.

Maintenance Medications

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

Pharmacy Prior Authorization (PA) Process

The formulary/PDL 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 the request. If a PA request is denied, information about the denial and appeal rights is provided to both the member and the provider.

Electronic Prior Authorization (ePA)	Prescribers may submit requests for PA online via the CVS Portal .
Phone	Prescribers can initiate a PA by calling 1-877-433-7643. 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 CVS at 866-255-7569.
Peer-to-Peer Services	Prescribers can initiate a Peer-to-Peer review by calling 877-433-7643. Please have available the following needed information: member name/ID, PA #, provider contact info. If needed a return phone call to complete the review should be received within eight (8) business hours. Peer-to-Peer services hours of operation are Monday through Friday 9 a.m. to 6 p.m.

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.

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 can automatically check the member's 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 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 is 800-345-9049, TTY: 773-523-4504. The crisis line can also be reached by calling CountyCare's Member Services line at 312-864-8200 and following the prompts connecting callers to the line or waiting for a Member Services 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 members aged 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))
- Sick 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 and submit the online [Referral to Care Coordination form](#) on our website.

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. There is member incentive with completion of Health Risk Screening, whether it is done online, via text campaign or telephonically with a Health Plan Representative.

The HRS tool assesses a member's involvement with their PCP focusing on the following scope of needs:

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

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 CountyCare 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](#).

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 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 must 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.
 - Providers must be registered in IMPACT with the appropriate category and subcategory for the services provided.
- Appropriate taxonomy for provider based on provider type and category of service.
- 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.
- All providers must certify that a 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.

For a full review of billing requirements, please see IAMHP's [Comprehensive Billing Manual](#) for more information.

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 (EOP).

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

The following are 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 are not accepted 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 rendered services that can be processed without obtaining additional information from the provider 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 medical 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 these requirements are for claims processing, also known as claims adjudication. Claims processing/adjudication does not indicate that a payment is made. It indicates that a determination has been made as to the outcome of the claims process. These determinations can include pending the claim, denying the claim, or claims payment.

Claim Forms

Claims can be submitted to CountyCare via paper or electronic claims submission:

Paper Claim Forms	• Original CMS1500 (red form) • UB-04 • ADA Dental 2019 Claim Form (Avesis)
Electronic Claims	• 837P or 837I • 837D for dental claims • NDCDP electronic format for pharmacy claims (CVS)

Claim Submission

Claim submissions are accepted electronically via the [Availity Provider Portal](#).

Claim Type	Submission Information
Professional CMS 1500 and Institutional UB04 <i>Electronic Claim Submission</i>	Clearinghouse: Availity Payor ID: 06541 For additional detail on claim submission, view our Provider Billing Resources on the CountyCare website.
Professional CMS 1500 and Institutional UB04 <i>Paper Claim Submission</i>	Mail Paper Claim to: CountyCare Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Dental Claims	Vendor: Avēsis Portal: myavesis.com/providers/ Electronic: Payer Identification Number: 86098 Paper: Avēsis Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Vision Claims	Vendor: Avēsis Portal: myavesis.com/providers/ Electronic: Via Clearinghouse – Payer ID 86098 Paper: Avēsis Third Party Administrators, Inc. PO Box 38300 Phoenix, AZ 85069-8300
Transportation Claims <i>Emergent Claims and Non-Emergent Ambulance Claims</i>	Paper: CountyCare Health Plan P.O. Box 211592 Eagan, MN 55121-2892 PAYOR ID 06541
Transportation Claims <i>Non-Emergent Non-Ambulance Claims</i>	CountyCare c/o Modivcare 798 Park Ave. NW Norton, VA 24273 Fax: 866-528-0462 Claims Helpline: 800-930-9060 Electronic claims can be submitted to support.claims@modivcare.com

Interactive Voice Response (IVR)	CountyCare offers an IVR system that allows providers to securely obtain real time information without waiting for a Customer Service representative. Providers are encouraged to use IVR self-service options for routine verification and status inquiries. Provider Self Validation Requirements To access the IVR system, providers must self validate using: • National Provider Identifier (NPI) • ZIP code associated with the billing provider record Claims Status • Claim processing and payment status • Ability to check multiple claims for the same member during a single IVR session • Required information: • Claim number • Date(s) of service (DOS)
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Payment for services is contingent upon compliance with prior authorization requirements, 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 and active 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 rendered 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. Please note, MEDI is not the source of truth for TPL.

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.

Corrected Claims

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

Corrected/replacement claims may be submitted one hundred eighty (180) calendar days from the date of service or date of discharge, whichever is later. A provider can resubmit a corrected/replacement claim as many times as necessary if it is within one hundred eighty (180) calendar days from the date of service or date of discharge, whichever is later.

Failure to mark the claim as a resubmission, corrected or replacement claim 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 via Instamed to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access to remittance information, and straightforward reconciliation of payments. More information on InstaMed can be found on CountyCare's [website](#).

Providers that bill electronically have the same timely filing requirements as providers filing paper claims; one hundred eighty (180) calendar days from the date of service or date of discharge. 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 are mistakenly paid due to retroactive member termination or other systemic issues, CountyCare will request a refund from the provider.

The provider has sixty (60) calendar 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.

For additional details on the reason for overpayment, please visit the [secure provider portal](#) to review claim details.

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

CountyCare Health Plan



Department 7870
P.O. Box 4110
Woburn, MA 01888-4110

Other Claim Type Instructions

MLTSS Billing Guidance

MLTSS members are dual-eligible and Medicare is 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 Medicaid FFS)
- MLTSS coverage under CountyCare 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

Billing Guidelines for HCBS Providers

A variety of HCBS waiver providers contract with CountyCare. HCBS waiver providers are considered 'Atypical' providers.

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 or 837P file. 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](#). 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 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

For additional billing guidance for HCBS Waiver providers, please reference the [IAMHP Billing Manual](#).

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.

For additional billing guidance for LTC providers, please reference the [IAMHP Billing Manual](#).

Claim Reviews and Provider Disputes

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

Review Type	Description	Process
Provider Claim Request for Reconsideration	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 reconsideration requests must be submitted within sixty (60) calendar days of the EOP.	- Providers can submit online through the secure provider portal - Providers can request a claim reconsideration review by calling Provider Services at 312-864-8200 - Providers can contact a Provider Relations Representative at countycareproviderservices@cookcountyhhs.org
Provider Claim Dispute	A provider claim dispute is a formal dispute related to claims, payment, contracting, eligibility, prior authorization, enrollment or system errors. Provider claim disputes must be submitted within sixty (60) calendar days of the EOP.	The CountyCare Provider Dispute System link can be accessed in the Provider Dispute User Guide on the CountyCare website under Provider Resources/Training Materials. Attach all applicable documentation before submitting. Failure to include all necessary documentation may result in dispute closure. Availability Provider Portal
Provider Post Service Dispute	Provider post service disputes must be submitted within sixty (60) calendar days from EOP. Providers must include the extenuating circumstance for not obtaining prior auth within the required timeframe.	The CountyCare Provider Dispute System link can be accessed in the Provider Dispute User Guide on the CountyCare website under Provider Resources/Training Materials. Attach all applicable documentation before submitting. Failure to include all necessary documentation may result in dispute closure. Availability Provider Portal

Billing the Member

Providers are prohibited from billing members for any covered services provided (also called “balance billing”), 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 cannot provide more costly services or items than those covered by CountyCare on the condition the member supplement payments 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 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 current [Universal IAMHP Roster](#). Rosters not in the current Universal IAMHP Roster format will be returned and can delay new provider additions or updates which could affect claims adjudication and payment. Changes to a provider's Tax Identification Number and/or address, including pay-to addresses 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 monthly. The most updated Universal IAMHP Roster Template and IAMHP roster validation tool are located on the [IAMHP website](#).

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 mechanisms to continuously monitor the quality and appropriateness of care provided to members, 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 Health'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
- Grievances and Appeals Committee
- Delegated Vendor Oversight Committee
- Peer Review Committee
- Family Leadership Council
- Enrollee Advisory and Community Stakeholder Committee
- Provider Quality Review Committee
- Customer Quality Management Committees
- Regulatory Compliance 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. 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. Consumers 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. The HEDIS Measure Reference Guide can be found on our [website](#) under Provider Resources/Clinical.

Calculation of HEDIS Rates

HEDIS rates may be calculated using three methodologies: administrative, hybrid and electronic clinical data systems (ECDS). 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 diabetic eye exams, 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 utilizes both administrative data and a sample of medical records to calculate rates. 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. Some examples of measures that use the hybrid methodology are diabetic HbA1c control, controlling high-blood pressure, and prenatal and postpartum care.

The electronic clinical data systems (ECDS) methodology utilizes administrative data as well as additional clinical data sources including data from electronic health records, care management systems and health registries. Calculated rates include data from these diverse data sources. As NCQA moves to retire the hybrid reporting methodology, measures will shift to the ECDS methodology. Examples of measures that use the ECDS methodology include childhood immunizations, adolescent immunizations, and colorectal cancer screening.

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 Pay-for-Performance (P4P) Program

CountyCare is pleased to offer a P4P Program that provides a simple, focused, and rewarding bonus structure for high-quality performance. Specifically, in-network primary care and women's health care providers, without value-based contracts, are eligible for annual incentives for achieving quality targets and closing care gaps. Details regarding the current P4P Program can be found on CountyCare's [website](#). Providers may also contact their Provider Relations Representative to request additional information.

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, Utilization Management 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. Medical record entries must not be cloned or illegible.

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 and 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

PCPs are required to document attempts to obtain historical medical records in the member's medical record for all newly assigned CountyCare members. If the member or member's guardian is unable to provide information on where they obtained previous medical care or are unable to provide addresses for the previous providers, 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 and quality 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 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, and its providers, services and policies
- 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, e.g., CountyCare must make covered services accessible to members and those 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 their 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 the 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



312-548-9940



**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, toll free 855-444-1661  Fax: 866-200-5031
Pharmacy	 Mail: CVS Appeals Appeals MC 109 CVS/Caremark P.O. Box 52084 Phoenix, AZ 85072-2084  Phone: 833-845-4702  Fax: 844-802-1405
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 was 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 the CountyCare [website](#).

Program Integrity and Fraud, Waste and Abuse (FWA) Efforts

Fraud, Waste and Abuse

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

Obligation To Report Suspicious Activity

A provider who becomes aware of actual or suspected fraud, waste and abuse 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 or report this issue via email to countycarecompliance@cookcountyhhs.org. CountyCare takes all reports of potential fraud, waste and abuse 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 incidents related to fraud, waste and abuse. 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 and abuse on an as needed basis, to reflect changes in laws, regulations, the health care industry, and 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 and abuse by employees and vendors. The key aspects of CountyCare's Lines of Communication are outlined below:

- All reports of potential fraud, waste and abuse are reviewed and investigated to the extent possible given the information reported
- All concerns and reports are handled and investigated in a confidential manner 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 identify suspicious activity and performs front- and back-end audits of providers to ensure compliance with medical record documentation standards and billing requirements. CountyCare investigators use sophisticated data analytics and code editing software programs to identify potential issues and perform systematic monitoring reviews and audits throughout the different stages of claim submission and payment.

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/entity level, where issues related to fraud, waste and abuse 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 illegible medical record entries
- Submitted claims where medical record documentation does not support the level of service billed

Requests for Medical Records

Providers must provide CountyCare with access to provider records, physical premises and facilities, equipment, and personnel in order for CountyCare to conduct compliance reviews in connection with the terms of the network agreement between the provider and CountyCare.

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 unique 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 and abuse. Cooperation with the investigation is required. Investigations involving potential fraud, waste and abuse (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 for each issue investigated, 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, prepayment review or a corrective action plan
- Recoupment of previously paid monies from a provider/practice, including the use of extrapolation techniques if deemed appropriate
- 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, which means that the member is only able to receive prescriptions written by one prescriber and/or at one pharmacy location. Additionally, members are identified and recommended to CountyCare from the Office of Inspector General for the “Lock-In Program” or by members of CountyCare operational team (for example, by the care management team or by the pharmacy benefit manager).

If a provider believes a member may benefit from the “Lock-In Program,” they should submit a Recipient Restriction Program Referral form. The form can be found [here](#).

Letters to Verify that a Member Received Services

CountyCare randomly selects a sample of members each month 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 by a provider but not received by the member are referred to the Compliance 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 for additional review and investigation 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/Unexpected Death
 - b. Abuse (physical, verbal, emotional, sexual)
 - c. Neglect (passive, willful deprivation)
- 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. Restraint, seclusion, or other restrictive interventions
 - b. Exploitation
 - c. Neglect (passive willful deprivation)
 - d. Abuse (physical, verbal, emotional, sexual)
- 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 members, 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 of 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 completing the [Incident Reporting online form](#). 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 immediately to the applicable agency or agencies below:

- Reports regarding members aged 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 have 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

Compliance Program

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.

Providers are also required to implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in federal laws, regulations and enforcement agency guidance, including, without limitation, the Federal Sentencing Guidelines, and that address the scope of services that are provided by the Provider to CountyCare members.

Incidents of Suspected Non-Compliance

Providers must promptly investigate any potential and/or suspected incidents of non-compliance with federal and state laws, or fraud, waste, or abuse, in connection with the administration or delivery of services provided to CountyCare members as soon as reasonably possible, but in no instance later than 30 calendar days after the Provider becomes aware of such incident. Written notice to CountyCare must include a statement regarding the Provider's efforts to conduct a timely, reasonable inquiry into the incident, proposed or implemented corrective actions in response to the incident and any other information that may be relevant to CountyCare.

Providers must cooperate with any investigation by CountyCare, HFS, the Department of Health and Human Services (HHS) or their authorized designees relating to the incident. 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.

Failure to cooperate with any investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under federal or state laws or regulations.

The Provider must also require its subcontractors and downstream entities to promptly report to the Provider, who shall report to CountyCare, any incidents in accordance with this section.

Sanctions Under Federal Health Programs and State Law

Providers are required to check the appropriate databases specified in the Provider Contract on hire and at least monthly to ensure that no Providers, management staff or other persons who have been convicted of criminal offenses related to their involvement with Medicaid, or other federal health care programs, are employed or subcontracted by the Provider.

Providers must disclose to CountyCare whether the Provider or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicaid laws, the rules or regulations of the State of Illinois or any government sponsored program.

Providers must notify CountyCare immediately if any such sanction is imposed on a Provider, a staff member or subcontractor.

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. The regulations at 42 CFR 455.105 state 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-month period ending on the date of the request; and
 2. Any significant business transactions between the provider and any wholly-owned supplier, or between the provider and any subcontractor, during the 5-year period 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 information was supplied.

Thank You for Choosing CountyCare

IF YOU HAVE QUESTIONS, PLEASE CALL PROVIDER RELATIONS:

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

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:

A. Definition/Criteria for Critical Incidents (REFERENCE PAGE)

Abandonment	The Desertion or willful forsaking of an eligible adult by an individual responsible for the care and custody of that eligible adult when a reasonable person would continue to provide care and custody. Nothing in this act shall be construed to mean that an eligible adult is the victim of abandonment because of health care services provided or not provided by licensed health care professionals. Abandonment was added to the APS Act in January 2022.
Abuse	The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Generally used in conjunction with neglect. Abuse includes physical abuse, verbal abuse, sexual abuse, or harassment, mental or emotional abuse.
Fraud	A manner of operation that results in an excessive or unreasonable cost to the Federal or State health care programs.
Neglect	Neglect includes: passive neglect (a non-malicious failure to provide the necessities of life including but not limited to food, clothing, shelter, or medical care), willful deprivation (a willful denial of 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 exposes 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 dependent person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences).
Exploitation	The misuse or withholding of a member's assets and resources (belongings and money). 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.
Behavioral Health	Serious behavioral health incident that results in emergency treatment-this can include self-neglect, self-injury, property damage, verbal aggression, suicidal ideation, attempted suicide, sexually problematic behavior, uncontrolled problematic alcohol or substance abuse, or any other mental health emergency.

Death	Deaths due to a new or existing medical condition made unusual because they are related to: a treatment error, medication or omission of medication, poor care, or there was a recent allegation of abuse, neglect, or exploitation, or the member was receiving home health services at the time of passing. Any death of an individual occurring within 14 calendar days after discharge or transfer of the individual from a residential program or facility, within 24 hours after deflection from a residential program or facility, at an agency or facility or at any Department-funded site.
Unexpected Death	Death of a Home and Community Based Service customer that could not have been anticipated or predicted. Examples include but are not limited to: accidental death, death resulting from suicide, death that occurs in questionable circumstances, resulting from any other unexpected or unknown reason.
Legal/Criminal Activity	Involves State, Local or Municipal Law Enforcement - includes problematic possession or use of a weapon, arrest, property damage greater than \$50, or other criminal activity. Any illegal activity that is allegedly committed by the waiver participant in which there is law enforcement involvement; Examples include, but are not limited to: arrests, incarceration, criminal court appearances/charges, illegal drug use, and shoplifting. Violation of probation or parole that potentially will result in the revocation of probation/parole. Any criminal offense that is committed by a waiver participant results in immediate incarceration.
Medication Management	When there is a discrepancy between what a physician prescribes and what an individual actually takes such as an individual taking the wrong medication, which includes taking medication after it has been discontinued or taking the incorrect medication because it was improperly labeled. Could also be due to an individual taking the wrong dose of medication, an individual omitting and not taking a prescribed dose of medication within the 24-hour period of a calendar day, or an individual's refusal to take prescribed medication. Also refers to issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care. Missing medication (i.e., stolen medication) should also be reported here.
Restraint, Seclusion, or other Restrictive Intervention	Unauthorized restraint is 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. Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others. Confinement means restraining or isolating, without legal authority, a person for reasons other than medical reasons ordered by a physician.

Medical emergency/ injury/illness	Any recurring injury or illness that requires treatment beyond first aid which included lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, pneumonia, urinary tract infections, etc. An injury or illness requiring immediate emergency medical treatment to preserve life or limb. An emergency medical treatment that results in admission to the hospital. An emergency medical treatment that results in admission to the hospital. Medical Emergency: Admission of an individual to a hospital or the provision of emergency medical services (treatment by EMS) that results in medical care which is unanticipated and/or unscheduled for the individual and which would not routinely be provided by a PCP.
Missing Person/ Elopement	A person who is identified as missing by law enforcement, hospital elopement or leaving against medical advice, staff, family, caretakers, or other natural supports. A person is considered missing if they cannot be located and are lost or in danger.
Environmental/ Unsafe Housing/ Displacement	Unsafe housing is any home or living space which does not provide a safe and healthy environment. Loss of utilities, structurally unsafe, etc. Displacement is the removal of the client from a home or living space due to natural disaster (fire, flooding, tornado, etc.) or eviction. Social environment hazards are the culture that the waiver participant lives in and the people and institutions with whom the waiver participant interacts, would include family, roommates, facility staff and providers.

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