Welcome to CountyCare Plus

A MEDICARE-MEDICAID PLAN

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

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

November 2021

About Us

This MMAI plan is born out of the partnership between CountyCare Medicaid plan and Medicare Advantage plan with strong provider partners to improve health equity and reform care delivery for Cook County residents who are eligible for both Medicaid and Medicare Services (called "dual eligibles").

What is MMAI?

- Medicare-Medicaid Alignment Initiative (MMAI) is a Medicare-Medicaid (MMP) dual health plan with benefits plus additional supplemental benefits, including dental and vision. Hospital and ancillary staff orientation.
- Illinois' MMAI program is jointly administered by CMS and HFS.
- Includes all Medicaid services and all Medicare services, with an integrated administration of both.

Member Eligibility and Enrollment

Beneficiaries who wish to enroll in the CountyCare Plus's Medicare-Medicaid plan should reach out to their local Department of Health and Human Services office. CountyCare Plus's does not actively submit enrollment or disenrollment for Medicare-Medicaid plans (MMAI) to the State or to CMS. Members who wish to enroll in CountyCare Plus MMAI must meet the following criteria:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Parts B and D
- Are eligible for full Medicaid benefits
- Are ages 21 or older
- Permanently reside in the Illinois, Cook County – CountyCare Plus service areas
- Be a U.S. citizen or lawfully present in the United States

The following populations will be excluded from enrollment in the demonstration:

- Individuals under the age of 21
- Individuals previously disenrolled because of Special Disenrollment from Medicaid managed care
- Individuals not living in a Demonstration region
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)
- Individuals without full Medicaid coverage (spend-downs or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated

- Individuals who have Presumptive Eligibility
- Individuals receiving developmental disability institutional services or participate in the HCBS waiver for Adults with Developmental Disabilities
- Individuals in the Illinois Medicaid Breast and Cervical Cancer program
- Individuals who have Comprehensive Third-Party Insurance

CountyCare Plus will accept all members without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status. Additionally, we will not limit or condition coverage of plan benefits based on any factor that is related to the member's health status including but not limited to medical condition, claims history, receipt of health care, medical history, genetic information, evidence of insurability or disability.

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

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

About This Provider Manual

CountyCare Plus is committed to our providers and strives to create a positive working experience. This Provider Manual is your comprehensive source of information for our product, offerings, member benefits, care coordination, quality of care, operations, and related policies and procedures for MCCN organization contracted with the State and the Centers for Medicare and Medicaid Services (CMS). The Provider Manual is updated periodically and designed to be a resource for you.

Changes to CountyCare Plus 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 Network Contracting Team at MMAI@Cookcountyhhs.org if you have any questions about the Provider Manual or need additional assistance.

Contact Information and Quick Reference Guide

General Contact Information

	Notes	Contact Information
CountyCare Plus Website	Visit for documents, forms, important health plan information, and provider and member resources.	www.CountyCarePlus.com
HFS MEDI System	Utilize the system to verify Medicaid eligibility.	https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx
Universal Provider Roster	Submit any provider additions, changes, or terminations *monthly* and send a complete IAMHP universal roster quarterly.	MMAIRosterSubmission@cookcountyhhs.org
Fraud & Abuse Hotline	Use our anonymous and confidential hotline to report concerns.	844-509-4669

Communicating With CountyCare Plus

Provider Relations

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

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

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

Website

www.CountyCarePlus.com

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

The following information can be found on the CountyCare website:

- Billing resources and guidelines
- Clinical guidelines
- Health, Safety, and Welfare Incidents including Critical Incident reporting guidelines
- Fraud, Waste and Abuse reporting guidelines
- Prior authorization lookup by CPT code
- Provider complaints, member grievances, and appeals training
- Provider Directory
- Provider manual and forms
- Provider newsletters and notices
- Provider training modules
- Member benefits
- Member communications
- Preferred Drug List (PDL or formulary)
- Population Health and Care Management Program Information
- Wellness information

Secure Provider Portal

CountyCare Plus's web portal service allows providers to access many tools and resources, which makes giving care to CountyCare Plus members more manageable and more efficient. Contracted providers and their office staff can register for the secure provider portal.

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

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

Verifying Eligibility

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

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

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

Medicare Overview

Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers 43 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay provider bills, outpatient hospital care and other medical services not covered by Part A.

Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in Medicare-covered employment, is age 65 or older, and a citizen or permanent resident of the United States. Certain younger disabled people and kidney dialysis and transplant patients qualify for premium-free Part A. When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Part B

Medicare Part B pays for many medical services and supplies, including coverage for provider's bills. Medically necessary services of a provider are covered no matter where received — at home, in the provider's office, in a clinic, in a nursing home or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services
- Internal Medicine
- X-rays and laboratory tests
- Diagnostic services and tests
- Certain ambulance services
- Durable medical equipment
- Services of certain specially qualified practitioners who are not providers
- Physical and occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental health care
- Mammograms and pap smears
- Home health care if a beneficiary does not have Part A

Part C

The Balanced Budget Act of 1997 (BBA) established Medicare Part C, also referred to as **Medicare Advantage**. Prior to January 1, 1999, Medicare HMOs existed as Medicare Risk or Medicare Cost plans. The BBA was intended to increase the range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included HMOs and Preferred Provider Organizations (PPOs).

Under the Medicare Modernization Act of 2003 (MMA), Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. **Special Needs Plans (SNPs)** are allowed

to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Dual eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from higher risk to lower risk on the care continuum.

Primary Care Providers (PCPs) And Medical Home

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

PCP Specialties And Provider Types

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

- Family Medicine/General Practice
- 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 Plus does not reimburse for medical records requested in connection with an audit or investigation.

Specialist As PCP

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

PCP For Homebound Members

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

Specialty Care Providers

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

Provider Responsibilities

- Be enrolled as a qualified provider in the HFS Medical Program's IMPACT or CMS 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.
- Comply with CountyCare Plus's credentialing and re-credentialing requirements.
- Have admitting (and delivery, where applicable) privileges at a participating hospital or other inpatient facility or a written referral agreement with a provider who has inpatient privileges and provides for transfer of medical records and coordination of care between providers.
- Submit a complete Illinois Association of Medicaid Health Plans (IAMHP) roster quarterly. Any provider additions, changes in name, address, office hours, spoken languages, patient age ranges, accessibility status, tax ID, taxonomy, education, hospital affiliation or admission status, licensure or board certification, or terminations must be sent every month to: CountyCarePlusProviderRosterSubmission@cookcountyhhs.org.
- Confirm members' eligibility before providing services.
- Obtain authorizations for selected inpatient and outpatient services as listed on the current Prior Authorization List.
- 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 Plus to coordinate specialized services (e. g., interpreters and accommodations for members with cognitive limitations).
- Communicate all appropriate treatment options to CountyCare Plus 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 the CountyCare Plus website.
- Adhere to the CountyCare Plus Cultural Competence Plan.
- Adhere to Access and Availability requirements, including linguistic and physical accessibility standards, appointment availability and after-hours coverage.
- Communicate in a manner that accommodates the member's individual needs.
- Assist CountyCare Plus 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.

- Cooperate with CountyCare Plus quality improvement activities and participate in the CountyCare Plus Quality Improvement (QI) Program. Cooperation with the QI Program includes, but is not limited to:
    - Cooperate with the CountyCare Plus data-collection process by reviewing medical and administrative records for identified members and submitting requested documentation to CountyCare Plus;
    - Assist and accommodate CountyCare Plus 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 Plus quality improvement initiatives and activities related to the appropriateness of service and quality of care;
    - Respond timely 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 Plus;
    - Providers may not charge CountyCare Plus for copy fees related to requests for medical records;
    - Permit CountyCare Plus 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 and CMS provider requirements and public-health initiatives;
    - Refer to your CountyCare Plus 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 Plus 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 Plus for payment and health care operations purposes (i.e., care coordination/ management, quality metrics, etc.).
- Comply with the CountyCare Plus Fraud, Waste and Abuse policies 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 Plus training.

HCBS Waiver Provider Responsibilities

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

- Work collaboratively with the CountyCare Plus 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 the CountyCare Plus 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 Plus if you are or become a provider that administers the DON or Pre-Admission Screening (PAS) required under the HCBS waiver programs. CountyCare Plus must notify HFS of any contracted provider that administers these tools.
- Important note related to HCBS Providers Stopping Services for HCBS Members:
    - » Providers are expected to notify CountyCare Plus Health Plan prior to stopping services with the reason and effective date. It is not acceptable, at any time, for a provider to stop services due to an issue with claims payment without prior notification to CountyCare Plus and arrangements made for members to continue receiving service without interruption..

Supportive Living Program And Long-term Care Facility Responsibilities

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

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

Outpatient Laboratory Responsibilities

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

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

Hospital Responsibilities

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

- Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list.
- Notify UM of emergency hospital admissions, elective hospital admissions and newborn deliveries within twenty-four (24) hours of admission.
- Notify UM of member emergency room visits for the previous business day via fax or electronic file. The notification should include the member's name, member 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.

Inpatient Psychiatric Network Provider Responsibilities

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.
- Review discharge plan with member prior to discharge including all scheduled follow-up appointments.
- Notify CountyCare Plus or the Mobile Crisis Response team, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stay.

Mobile Crisis Response Provider Responsibilities

Provide a face-to-face crisis screening within ninety (90) minutes of notification, to all members experiencing a Behavioral Health Crisis.

- Ensure that Mobile Crisis Response services are available every day of the year, twenty-four (24) hours per day.
- Provide immediate crisis and stabilization services when a member in crisis can be stabilized in the community.
- Ensure that staff responsible for providing the services hold the following credentials: Mental Health Professional (MHP) with direct access to either a Qualified Mental Health professional (QMHP) or Licensed Practitioner of the Healing Arts (LPA).
- 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.
- Facilitate the member's admission to an appropriate inpatient institutional treatment setting when the member in crisis cannot be stabilized in the community.
- Inform the member's parents, guardian, caregivers, or residential staff about all the available Network Providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

- Use the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) instrument as the standardized mental health assessment and treatment plan for all members requiring mental health services.
- Complete an IM+CANS on all members who require mental health services within thirty (30) days of initiation of services.
- Establish an individualized Crisis Safety Plan in collaboration with the member and the member's family that includes concrete interventions and techniques to address the crisis.
- Provide members and families of members with physical copies of the Crisis Safety Plans prior to the completion of the Crisis screening for any member stabilized in the community and prior to the member's discharge from an inpatient psychiatric hospital setting.
- Educate the member's family to the components of the Crisis Safety Plan and review the plan regularly.
- Share the Crisis Safety Plan with all necessary medical professionals, including Care Coordinators, consistent with the authorizations established by consent or release.

Advance Directives

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

Terminating Care Of A Member

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

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

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

1. Incidents have been appropriately documented in the member's medical record.
2. A certified letter has been sent to the member, with a copy to CountyCare Plus 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. 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 Plus will auto-assign the member to a PCP.

Suspending, Stopping, or Terminating HCBS Waiver Services

A 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 Plus before stopping services with the reason and effective date.

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

Leaving The Network and Continuity Of Care Requirements

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

Providers must continue to render covered services to members who are:

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

CountyCare Plus 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 Plus will request that the member select a new PCP. If a member does not select a PCP before the provider's termination date, CountyCare Plus will automatically assign one to the member.

Provider Accessibility

Appointment Access Standards and Annual Audit

CountyCare Plus 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 Plus 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)	Within five (5) weeks
	Routine Care (infant <6 months old)	Within two (2) weeks
	Non-Urgent Problem or Complaint	Within three (3) weeks
	Urgent Care	Within twenty-four (24) hours
Prenatal Care	Prenatal – 1st Trimester	Within two (2) weeks
	Prenatal – 2nd Trimester	Within one (1) week
	Prenatal – 3rd Trimester	Within three (3) days
Behavioral Health	Care for non-life-threatening emergency	Within six (6) hours (or directed to ER or BH crisis unit)
	Urgent Care	Within forty-eight (48) hours
	Initial Visit for Routine Care	Within ten (10) business days
	Follow-up Routine Care	Within thirty (30) days
Specialty Care	Initial Visit for Routine Care	Within four (4) weeks
	Follow-up Routine Care	Within four (4) weeks
All Provider Types	Average Office Wait Time	Less than one hour
All Provider Types	All Appointment Types	No more than six 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 Plus network provider during scheduled or unscheduled time off. Covering providers are compensated following the terms of their contractual agreements.

PCP Member Panel

PCP panel sizes cannot exceed 600 enrollees. CountyCare Plus 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 Plus 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 Plus 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 Plus monitors provider compliance with the ADA by:

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

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

Cultural Competence

Overview

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

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

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

Effective Care successfully restores the client to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions. For health services to be effective, the clinician must accurately diagnose the illness, discern the correct treatment for the individual, and negotiate the treatment plan successfully with the member.

Understandable Care focuses on the need for patients to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff. To be understandable, the concepts must "make sense" in the cultural framework of the individual.

Respectful Care includes considering the values, preferences, and expressed needs of the member and helping to create an environment whereby patients from diverse backgrounds feel comfortable discussing their individual needs with any staff member.

Training Goals and Requirements

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

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

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

Covered Services

CountyCare Plus covers services offered under Illinois Medicaid- Medicare Alignment Initiative. CountyCare Plus network providers deliver a variety of medical benefits and services.

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

Services not covered by CountyCare Plus include:

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

The chart below summarizes services covered by CountyCare Plus for MMAI.
Some services require prior authorization.

Covered Services

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

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

Telehealth

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

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

Rewards and Extra Benefits

CountyCare Plus offers a variety of extra benefits to members. Detailed information is available on our website.

Covered Services For Members Eligible For Home And Community Based Services (HCBS)

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

Covered Services For Members Living In Long Term Care Facilities

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

HCBS Covered Services

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

Covered Services For Members In The Supportive Living Program

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

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

Utilization Management (UM)

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

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

Overview

The CountyCare Plus UM department hours of operation are Monday through Friday from 8:30 a.m. to 8:00 p.m. (excluding holidays)..

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 Plus does not require a referral from the PCP for payment of 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 Plus.

Medical Necessity

Medical necessity is defined for CountyCare Plus members as health care services, supplies or equipment provided by a licensed health care professional 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 the CountyCare Plus clinical practice guidelines
- 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 Plus has adopted the medical necessity criteria of its Benefits Managers. These criteria are established and periodically evaluated and updated with appropriate involvement from appropriate clinicians, and providers may obtain the criteria at the time of request or notification to the requesting practitioner/facility of an adverse determination.

Prior Authorizations For Medical And Behavioral Health Services

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

The CPT look-up tool has the most up-to-date requirements, however, below are general services that require authorizations:

- Any services related to any type of inpatient confinement
- Any services rendered by a non-contracted (out-of-network) provider unless related to emergency services
- All DME rentals (regardless of purchase price)
- All transplants
- Some pharmaceuticals

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

Inpatient Admissions

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

Emergency Services

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

Second Opinion

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

Clinical Decisions

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

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

Review Criteria For Medical And Behavioral Health Services

CountyCare Plus has adopted InterQual, developed by Change HealthCare®, and the American Society of Addiction Medicine utilization review criteria to determine medical and behavioral healthcare services' medical necessity.

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

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

New Technology

CountyCare Plus 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 Plus population. CountyCare Plus 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 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 Plus 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 Eligability	# of Days Continued from Enrollment Date
Ongoing Course of Treatment for members new to MMAI	180 days
Ongoing Course of Treatment for members transitioning from another MCO	90 days
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. Postop 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 one-hundred-and-eighty (180) days or ninety (90) days as applicable. 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 one-hundred-and-eighty (180) days or ninety (90) days as applicable.
Oncology	COC continues up to after completion of the initial treatment plan.
Diagnostic	Honor existing auths x1st one-hundred-and-eighty (180) days or ninety (90) days as applicable for any service already scheduled.
DME	Honor existing auths x1st one-hundred-and-eighty (180) days or ninety (90) days as applicable 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 one-hundred-and-eighty (180) days or ninety (90) days as applicable to transition to an INN provider.
Other ancillary services including therapies (PT, OT, ST)	Honor existing auths x1st one-hundred-and-eighty (180) days or ninety (90) days as applicable for any service already scheduled.
INN Providers with members newly effective with CountyCare Plus	Follow normal PA rules above.
Inpatient on effective date	Previous payor is Medicaid: Professional fees are paid by CountyCare Plus, facility charges are paid by the previous payor, providers must notify UM for an authorization; if previous payor was Commercial/No insurance: CountyCare Plus reviews for bed days and professional fees on the member's effective date; Providers must notify UM and submit clinical for a medical necessity review before the claim is submitted.
Hospice	Terminal illness life expectancy </=6 months COC will continue for that period.

Exclusions – What Does Not Qualify for COC:

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

Discharge Planning

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

Pharmacy

CountyCare Plus is committed to providing appropriate, high-quality, cost-effective drug therapy to all members. CountyCare Plus 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 Plus clinician. CountyCare Plus collaborates with a Pharmacy Benefits Manager (PBM), MedImpact, to administer pharmacy benefits, including the prior authorization process.

Covered OTC Medications

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

Generic Substitution

CountyCare Plus encourages generic substitution when a generic equivalent is available.

Specialty Medications

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

Specialty medications may be covered under the Pharmacy or Medical benefits. Often, these medications require a Prior Authorization.

Maintenance Medications

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

Pharmacy Prior Authorization (PA) Process

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

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

Quantity Limits

Quantity limitations apply to certain medications to ensure their safe and appropriate use. Quantity limitations are approved by the CountyCare Plus 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 Plus requires evidence of Step Therapy for certain medications. The PBM claims system will automatically check the member profile for evidence of prior or current use of the required agent. If there is evidence of the required agent on the member's profile, the claim will process automatically. If not, the claims system will notify the pharmacist that a PA is required.

Age Limits

Some medications on the CountyCare Plus 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 Plus PDL by the CountyCare Plus P&T Committee following the first six (6) months of product availability on the market.

Behavioral Health

CountyCare Plus 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 Plus 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.

Coordination And Communication Between Behavioral Health Providers And PCPs

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

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

Examples of some of the information shared include:

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

CountyCare Plus 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).

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 Crisis Line

CountyCare Plus has two behavioral health crisis lines, which are answered twenty-four (24) hours a day, seven (7) days a week. The crisis lines are available by dialing the CountyCare Plus Customer Service line and following the prompts connecting callers to each line for adults and children, respectively, or by contacting Member Services where representatives will direct calls to the appropriate crisis line or network behavioral-health resource.

Crisis Safety Plan

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

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

Providers shall collaborate with CountyCare Plus Care Coordinators staffing and assist with member communication for members who are being treated by an inpatient hospital provider following a crisis event. This includes allowing care coordinators access to members by phone, in person during visitation hours, and ICT participation.

Providers are responsible for sharing the crisis safety plan with all necessary medical professionals, including care coordinators, consistent with authorization established by consent of release.

Discharge Planning and Transitional Services

Providers should encourage the member and their family to contact the member's care coordinator. Providers shall ensure that referrals are made to other service providers effectively, efficiently, and, when possible and appropriate, within CountyCare Plus's network.

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.

Member Follow-up

Providers shall facilitate members attending all post-discharge appointments for follow-up care. Providers shall also collaborate with care coordinators in their efforts to provide appropriate care management based on concurrent assessment.

Notification of Discharge

Hospitals and other facilities must notify CountyCare Plus 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.

CountyCare Plus 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 Plus 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.

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.

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.

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 Plus has processes and procedures in place to ensure smooth transitions to and from CountyCare Plus 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 Plus assures one-hundred-and-eight (180) 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 Plus 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 Plus providers must communicate with the member and facilitate the transition to another PCP should they no longer serve them as their chosen PCP (for example, transition a pediatric patient when he or she reaches adulthood). Practices serving pediatrics should have a written policy for the transition of care of adolescents from pediatric to adult health care that addresses the needs of adolescents with and without chronic medical or behavioral health conditions and adolescents who become pregnant.

Health Risk Screening And Assessment

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

The HRS tool assesses:

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

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

Billing and Claims Submission

CountyCare Plus is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. CountyCare Plus follows the Centers for Medicare and Medicaid Services (CMS) and Illinois HFS billing requirements.

General Billing Guidelines

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

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

Claims will be rejected or denied if billed with:

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

Claim Requirements

The following information much be included on every claim:

- Name and appropriate TIN number of the health professional or facility that provided treatment or service, with a matching NPI number based on the billing guidance for the IMPACT provider type.
- Patient (RIN and/or MCO-specific Plan ID, address, and date of birth).
- Date (mm/dd/yyyy) and place of service.
- If necessary, include any applicable prior authorization number provided by the MCO.
- A valid Diagnosis, Procedure, Modifier, and Location Codes (Ensure all Diagnosis Codes are to their highest number of digits available - 4th, 5th, and 6th character requirements and 7th character extension requirements).
- Ensure all other insurance resources (e.g., Medicare or other third-party coverage) have been exhausted before submission. Include any coordination of benefit (COB) documentation (e.g., a copy of the primary insurance explanation of benefits (EOB) – including pages with run dates, coding explanations and messages) with the claim submission. Medicaid is always the payer of last resort.

- Be certified by the provider that the claim:
    - » Is true, accurate, prepared with knowledge and consent of the provider.
    - » Does not contain untrue, misleading, or deceptive information.
    - » Identifies each attending, referring, or prescribing physician, dentist, or another practitioner.

Timely Filing

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

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

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

- A clearinghouse electronic acknowledgment indicating claim was electronically accepted by CountyCare Plus
- 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 Plus product name or line of business

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

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

Clean Claims

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

Clean claim processing requirements are:

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

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

Claim Forms

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

Paper Claim Forms:

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

Electronic Claims:

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

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

Claim Submission

Claim Type	Submission Information
Professional CMS 1500 and Institutional UB04 *Electronic Claim Submission*	Clearinghouse: Change HealthCare Payor ID: 06541 For additional detail on claim submission, view our Provider Billing Resources on the CountyCare Plus website.
Professional CMS 1500 and Institutional UB04 *Paper Claim Submission*	Mail Paper Claim to: CountyCare Plus Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Dental Claims	**Vendor:** Avēsis **Portal:** www.avesis.com/commercial3/providers/index.aspx **Electronic:** Payer Identification Number: 86098 **Paper:** Avēsis Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Vision Claims	**Vendor:** Avēsis **Portal:** www.avesis.com/commercial3/providers/index.aspx **Electronic:** Via Clearinghouse – Payer ID 86098 **Paper:** Avēsis Third Party Administrators, Inc. PO Box 38300 Phoenix, AZ 85069-8300

The following information much be included on every claim:

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

Coordination Of Benefits

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

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

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

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

Billing Guidelines For LTSS Providers

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

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

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

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

Claims For HCBS Waivers

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

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

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

Claims For Long Term Care Facilities

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

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

Corrected Claims

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

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

Corrected/replacement claims can be submitted via

1. EDI - see process/guidelines noted below
2. Paper submission

Electronic Funds Transfer And Electronic Remittance Advice

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

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

Recoupment Of Overpayments To Providers

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

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

Billing The Member

Providers are prohibited from billing members for any covered services provided (also called "balance bill"), even if the provider's usual and customary charge for the covered services is greater than what is allocated in the CountyCare Plus fee schedule. Payments made to providers by CountyCare Plus for Medicaid covered services for CountyCare Plus 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 Plus members for copayments, participation fees, deductibles, coinsurance, or any other form of patient cost sharing related to CountyCare Plus 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 Plus reimbursement would have been available. A reduction in payment because of claims policies or processing procedures is not an indication that the service provided is a non-covered service. Providers also cannot ask the member to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees. Providers may not make arrangements to provide more costly services or items than those covered by CountyCare Plus on the condition the member supplement payments are made by CountyCare Plus.

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 Plus will require additional provider enrollment documents including the Disclosure of Ownership and Control Interest Statement, W-9 Form, and the Universal IAMHP Roster.

CountyCare Plus 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 Plus reserves the right to initiate actions as specified in the provider agreement, up to and including termination of the contract or participation status. The right of appeal is available to providers whose participation in our network has been limited or terminated for quality reasons.

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

Quality Improvement

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

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

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

Program Structure

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

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

Practitioner Involvement

CountyCare Plus, 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 Plus 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

The CountyCare Plus 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 Plus Health Plan. Initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service.

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

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

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

Calculation Of HEDIS Rates

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

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

Medical Record Reviews For HEDIS

CountyCare Plus 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.

Provider Satisfaction Survey

At least annually, CountyCare Plus conducts a provider satisfaction survey which includes questions to evaluate providers' experience with plan services such as claims, communications, UM and Provider Relations. The survey is conducted by a certified national vendor. Participants meeting specific requirements outlined by CountyCare Plus 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 Plus 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 Plus in publications such as newsletters, bulletins, press releases, and highlighted in our provider directories.

Medical Record Criteria

Medical Records

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

Required Information

Medical record is defined as the complete, comprehensive member record including, but not limited to, x-rays, laboratory tests results, examinations, and notes. All medical records are to be accessible at the site of the member's participating primary care or another provider and document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care. They are to be preparedin 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 Plus 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 or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Working diagnosis is consistent with findings. The treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Unresolved problems from previous visits are addressed in subsequent visits.

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

Medical Records Release

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

Medical Records Transfer For New Members

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

Medical Records Audits

CountyCare Plus may conduct random medical record audits as part of its QAPI program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services, also may be assessed during a medical record audit. CountyCare Plus 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 Plus in other languages such as audio, large print or Braille.
- Have use of an interpreter when needed including during any complaint or appeal process.
- Have a candid discussion with providers about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information on available treatment options and alternatives. This includes the right to ask for a second opinion.
- Providers must explain treatment options in a way the member understands.
- Receive information necessary to be involved in making decisions about health care treatment and choices.
- Refuse treatment and be told what may happen to the member's health if treatment is refused.
- Receive a copy of their medical records and in some cases request that they be amended or corrected.
- Choose and change their primary care provider (PCP) from CountyCare Plus.
- File a complaint (sometimes called a grievance), or appeal about CountyCare Plus or the care they received without fear of mistreatment or backlash of any kind.
- Appeal a decision made by CountyCare Plus on the phone or in writing.
- Request and receive in a reasonable amount of time, information about CountyCare Plus Health Plan, and its providers, services and polices.
- Receive information about CountyCare Plus Member Rights and Responsibilities. Members also have the right to suggest changes in this policy.
- Receive health care services in ways that comply with federal and state law. CountyCare Plus must make covered services accessible to members. Services must be available twenty-four (24) hours a day, seven (7) days a week.

Member Responsibilities:

- Treat doctors and the office staff with courtesy and respect.
- Carry their CountyCare Plus 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 Plus and their providers can give the best care possible.
- Know own health problems and take part in making decisions about treatment goals as much as possible.
- Follow the instructions and treatment plan agreed upon by member and doctor.
- Tell CountyCare Plus and care coordinator if address or phone number changes.
- Tell CountyCare Plus and care coordinator if they have other insurance and follow those guidelines.
- Read member handbook to know what services are covered and if there are any special rules.

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

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

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

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

- Information about the member and his or her case cannot be used for any other purpose as indicated above unless the member has given his or her consent to release that information.
- Freedom of choice of member's providers for waiver services.
- The right to choose not to receive waiver services.
- The right to transfer from one provider to another provider.
- The right to report instances to his or her provider's supervisor or any CountyCare Plus 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 Plus 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 Plus 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 Plus 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 Plus 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. 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.
15. Participate in the development, implementation, and review of their own service plans.
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.

Program Fraud, Waste and Abuse (FWA)

Fraud, Waste, Abuse, Misconduct and Mismanagement

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

Obligation To Report Suspicious Activity

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

Obligation To Report And Return Overpayments

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

FWA Education And Training

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

Program Integrity Policy Updates And Revisions

CountyCare Plus will review, update, and communicate relevant information regarding requirements related to fraud, waste, abuse, misconduct, and mismanagement at least annually, and as needed, to reflect changes in laws, regulations, the health care industry, any amendments to the CountyCare Plus 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 Plus 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 Plus has systems in place to receive, record, and respond to inquiries or reports of potential or suspected fraud, waste, abuse, mismanagement or misconduct by employees and vendors. The key aspects of the CountyCare Plus Lines of Communication are outlined below:

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

Prevention And Detection Practices

CountyCare Plus conducts monitoring activities to ensure the suspicious activity is identified and performs

front- and back-end audits to ensure compliance with medical record documentation standards and billing requirements. CountyCare Plus also uses a sophisticated code editing software to perform systematic audits during the claim's payment process.

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

Some of the most common issues identified are:

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

Requests For Medical Records

When providers receive a document/medical records request from CountyCare Plus, 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.

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

Investigation

CountyCare Plus will follow an established procedure for investigation of all potential issues involving fraud, waste, abuse, mismanagement, or misconduct. Cooperation with the investigation is required.

Corrective Action, Sanctions, Prosecution, And Recovery

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

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

Member "Lock-in" Program

CountyCare Plus employs data analytics to identify members who consistently utilize multiple pharmacies and/or physicians to obtain multiple medications or medical services. Additionally, members are identified and sent to the MCO from the Office of Inspector General. Members who consistently misuse their pharmacy or medical services may be enrolled in a lock-in or restriction program. If a provider believes a member may benefit from the "Lock-In Program," they should contact our confidential hotline at 844-509-4669. When a member is enrolled in the "Lock-In Program," they will only be able to utilize a specific pharmacy or physician for their medication or medical service needs (excluding emergency services).

Member Verification Of Services Received Process

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

Health, Safety And Welfare Incidents, Including Critical Incidents

CountyCare Plus 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 Plus.

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

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

A. Members who receive Home and Community Based Services through the Division of Rehabilitation Services. These incidents are called Critical Incidents and are listed in Appendix A of this manual. Examples of Critical Incidents include but are not limited to:
   a. Death.
   b. Physical abuse.
   c. Verbal or emotional abuse.
   d. Sexual harassment.
B. Members who are over the age of sixty (60) and adults with disabilities age eighteen (18) to fifty-nine (59). These incidents are listed in Appendix B of this manual. Examples of these incidents include but are not limited to:
   a. Confinement.
   b. Emotional, physical, or sexual abuse.
   c. Passive neglect.
C. Members residing in Supportive Living Facilities. These incidents are listed in Appendix C of this manual, which is Attachment XIX of the Plan-Department Contract. Examples of these incidents include but are not limited to:
   a. Abuse or suspected Abuse of any nature by anyone, including another resident, staff, volunteer, family, friend, etc.
   b. Allegations of theft when a resident chooses to involve local law enforcement.
   c. Any crime that occurs on facility property.

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 the CountyCare Plus HSW Incident Form on the CountyCare Plus.com website. Providers are encouraged to use this form as a guide for reporting and confirming completion of mandated reporting and actions taken to ensure the member's safety.

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

How To Report An Incident

Mandated reporting is the responsibility to the person who identifies an incident that requires reporting to investigating authorities. In addition to making mandated reports, and for other incidents that do not require mandated reporting, all suspected incidents should be reported by contacting Member Services

Reports should be made within one (1) business day of becoming aware of an incident.

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

- Reports regarding members 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.
- 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 Plus Health, Safety, and Welfare Program staff will ensure:

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

Compliance Program

Authority And Responsibility

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

CountyCare Plus providers must cooperate fully in producing documentation and making employed personnel and/ or subcontractor personnel available in person for interviews, consultation, grand jury proceedings,

pre-trial conferences, hearings, trials and in any other process, including investigations and audits.

Disclosure Of Ownership And Control Interest Statement

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

a. Provider agreements. A Medicaid agency must agree with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions following paragraph (b) of this section.
b. Information that must be submitted. A provider must submit, within thirty-five (35) days of the date on a request by the Secretary or the Medicaid agency, complete information about:
    1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-months ending on the date of the request.
    2. Any significant business transactions between the provider and any wholly-owned supplier, or between the provider and any subcontractor, during the 5-years ending on the date of the request.

Providers should note that:

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

Thank you for choosing CountyCare Plus

A MEDICARE-MEDICAID PLAN

Appendix A

Plan-Department Contract Attachment XVII

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

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

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

Appendix B

Plan-Department Contract Attachment XVIII

Illinois Department On Aging, Elder Abuse And Neglect Program

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

- **Confinement** means restraining or isolating, without legal authority, an older person for reasons other than medical reasons ordered by a Physician.
- **Emotional Abuse** means verbal assaults, threats of maltreatment, harassment, or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- **Financial Exploitation** means the misuse or withholding of an older person's resources by another person to the disadvantage of the older person or the profit or advantage of a person other than the older person.
- **Physical Abuse** means causing the inflictions of physical pain or injury to an older person.
- **Sexual Abuse** means touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual activity.
- **Passive Neglect** means a caregiver's failure to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, and medical care. This definition does not create any new affirmative duty to provide support to eligible adults, nor shall it be construed to mean that an eligible adult is a victim of neglect because of healthcare services provided or not provided by licensed healthcare professionals.
- **Willful Deprivation** means willfully denying medications, medical care, shelter, food, therapeutic devices, or other physical assistance to a person who, because of age, health, or disability, requires such assistance and thereby exposing that person to the risk of physical, mental, or emotional harm because of such denial; except with respect to medical care or treatment when the person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.

Appendix C

Plan-Department Contract Attachment XIX

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

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

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