Introduction

Welcome to CCAI

Thank you for choosing to participate in the Community Care Alliance of Illinois (CCAI) Network. We value your partnership. We will make every effort to keep you informed and educated as to the opportunities, resources and policies of CCAI, as well as update you regarding changes in the HFS rules, definitions and requirements as they relate to our products and providers.

This Provider Manual

Please refer to this manual online at www.ccaillinois.com/files/provider_manual.pdf, for answers to any questions you may have about working with our Enrollees or our staff under your participation Agreement. We will update this manual as need arises, so the online version will always be the most current. We will notify you via the Provider Newsletter whenever material changes are made.

You can print any section or the entire manual online at www.ccaillinois.com/files/provider_manual.pdf in the Provider Resources section. Or call us at (866)871-2305, and we will send you a CD.

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SECTION I: Integrated Care Program Overview

CCAI participates in the Illinois Department of Healthcare and Family Services' (HFS) Integrated Care Program (ICP). Part of Illinois Medicaid, the ICP covers adults (aged 19 and over) and seniors (60 and over) with disabilities living in Boone, McHenry and Winnebago Counties. Enrollees receive a comprehensive range of medical care, behavioral health, pharmacy, and Home and Community Based Services (HCBS).

For more information on the ICP, please visit the HFS website at http://www2.illinois.gov/hfs and click the Integrated Care Program button.

SECTION II: Participating in the Illinois Medical Assistance Program

Contracting

CCAI will contract with any licensed, qualified Medicaid or State medical or LTSS/HCBS provider who agrees to our business terms and company policies.

To avoid unnecessary duplication of efforts, CCAI contracts with providers through our parent company, Family Health Network. When a provider wishes to be part of our Network, they contract with FHN and may choose which products they participate in with either company if more than one opportunity is available.

MAP

Interested providers not already enrolled in the Illinois Medical Assistance Program (MAP) must complete a Provider Enrollment Application. MAP is the program which implements Title XIX of the Social Security Act (Medicaid). Requests for enrollment applications may be made by mail, email or phone to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, IL 62794-9114

Phone: 217-782-0538
Fax: 217-557-8800
E-mail: hfs.PPU@illinois.gov
Website: http://www.hfs.illinois.gov/enrollment

To join the CCAI Network, please contact Network Management at (866)871-2305 or email us at network@ccaillinois.com. A representative will be happy to give you all the relevant information and can arrange a meeting if desired.

SECTION III: CCAI Contact List

Please contact us at one of the numbers or email addresses listed. You can also communicate with us through our website www.ccaillinois.com.

Department	General Email (answered daily)	Phone	Fax
Main Office Switchboard (administration, all employees)		(312)932-8181	(312)491-1175
Provider Services/Network Management	network@ccaillinois.com	(866)871-2305	(312)491-1175
Behavioral Health—PsycHealth		(800)753-5456	
Care Management		(866)871-2305	(312)491-9856
Enrollee Services General TTY (hearing impaired) NurseNow (24-hour nurse line) Pharmacy—CVS Caremark Customer Care TDD (hearing impaired)	enrollees@ccaillinois.com	(866)871-2305 (888)491-8534 (855)265-7258 (855)248-3446 (800)231-4403	(312)492-9707

SECTION IV: About Community Care Alliance of Illinois

Formed in 2012, the Community Care Alliance of Illinois is a not-for-profit Managed Care Community Network (MCCN) that focuses on disabled and disadvantaged populations. CCAI is a wholly owned subsidiary of the Family Health Network, also a MCCN, serving the Medicaid TANF population. Detailed information about the CCAI's history and management team can be found in the About Us section of our website at www.ccaillinois.com.

SECTION V: CCAI Mission, Vision & Values

Mission

The Community Care Alliance of Illinois is a health plan dedicated to consumer-directed, community-based innovative health services specializing in the care of seniors and people with disabilities.

Vision

To be the leader in Choice, Access, and Quality of Health Services for the people we serve

Values

- Respect
- Integrity
- Teamwork
- Service
- Stewardship
- Transparency

Objectives

- To implement robust primary and preventive care
- To ensure accessible health and wellness services
- To mitigate access barriers
- To provide the right care at the right time

SECTION VI: CCAI Model of Care

CCAI has based our Model of Care on improving Enrollees' quality of care and quality of life through wrap-around, "all-in" care. We, along with our provider partners, take into account the Enrollee's overall medical, psychological, socioeconomic and functional status and circumstances, to offer an integrated, coordinated approach to care for the whole person.

More detailed information on the Model of Care can be found in the Resources section of our website at www.ccaillinois.com.

Anchor Health Homes
One of the innovations that CCAI offers to better serve persons with disabilities or chronic illness, who are Medicaid beneficiaries, is a type of patient-centered medical home which we identify as an "Anchor Health Home." There are currently two Anchor Health Homes in the Rockford area:

- Crusaders Clinic (a FQHC)
- Rockford Health System

Anchors utilize specialized primary care teams at geographically dispersed locations, which are fully accessible, disability-competent sites of care. Nurse practitioners are employed by the Anchor Health Homes and dedicated to serving the CCAI population. Although it is anticipated that much of the locus of care will be in the home setting, Anchor Health Homes allow patients to be seen in various settings as needed.
The disability-specific cohesive care teams collaborate across the Anchor Health Homes. They have regular meetings of representatives during which new patient scenarios and cases may be discussed for sharing of successful approaches to care. Such meetings also allow review of quality metrics and enhancements to the clinical model of care.

The Anchor Health Home is enabled through technology to include capabilities such as Electronic Medical Records, e-Prescribing, as well as Health Information Exchange (when available), telemedicine and telemonitoring.

Anchor Health Homes receive a Gold Star designation which means they are fully accessible with disability-competent specialized primary care teams.

Anchor Health Home Criteria include the following:

- Fully committed to the CCAI philosophy and Model of Care
- Fully accessible and user-friendly environment for people with disabilities
- Physical access (parking, entrance, clinic space, bathrooms, etc.)
- Communication access including interpreting services available

- Accessible medical equipment including exam tables, wheelchair accessible scales, transfer equipment and staff training
- Knowledgeable staff regarding disability care and accommodations
- Dedicated specialized disability-competent primary care team (primary care providers are MDs, DOs or NPs), Care Coordinator (RN), Home and Community Based Services Coordinator (social worker), and behavioral health provider
- Committed to the model of consumer-directed, person-centered services
- Committed to working with CCAI nurse care coordinators/intake specialists who will do screening, triage, risk stratification, and communicate with the PCP about initial contact for new beneficiaries. Once a care plan is developed by the PCP and the Enrollee, the PCP communicates the plan back to the care coordinator to incorporate into CCAI care coordination tools, and to assist in arranging all appointments, services and follow-up of all ordered tests, consults, etc.
- Committed to incorporating CCAI care coordination tools, health information technologies and enhancements into anchor site health information systems
- Committed to using the care coordination tools, clinical pathways, quality metrics and provider networks of CCAI
- Participation in team meetings, case reviews, care management pathways review, quality indicators, and disability/ chronic illness continuing activities across the anchor sites
- Agree to jointly hire, developing collaborative agreements, and provide back up for primary care NPs with specialized training in disability/complex conditions
- Willing to provide 24/7 access and participate in call for CCAI Enrollees

Other providers are preparing to meet the Anchor requirements and achieve the designation.

Providers interested in being designated a CCAI Anchor Health Home should contact Network Management for full information.

SECTION VII: Network Management Department Overview

CCAI's Network Management staff is here to ensure that your experience as a CCAI Network provider is a positive one. They can answer questions concerning contract provisions, policies, programs, etc. They will provide you with resources and materials and will travel to meet with you and your staff for orientation and education regarding CCAI and its programs. Please feel free to call or email them at any time.

Website and Provider Portal

Other resources for your use are available through our website: www.ccaillinois.com.

CCAI has developed a Secure Web Portal available to Providers, so that they may verify eligibility, submit referrals and claims, check payment status, receive important plan information and news and contact us electronically.

Providers can obtain a login and password from one of our Network Management Specialists or right on the CCAI website. The site has information on it to answer a variety of questions that Providers might have. It also offers reference resources, polies and procedures, and the CCAI Model of Care. The subjects on the website range from benefits information, care management and HEDIS resources to Enrollees and provider materials, useful links, contact information and etc.

The web address is under a secure domain and can be accessed at https://www.ccaillinois.com

CCAI will continually update our website with new information and resources, be sure to check back often to remain up-to-date on all areas of CCAI.

Please go to the Providers section, where you can find:

- Covered Services
- Eligibility
- Provider Manual
- Provider Directory
- Referral/Authorization rules and forms
- Provider Portal for claims and payment status
- Enrollee Materials
- Provider Newsletters
- Information on standards of care and best practices

SECTION VIII: Provider Responsibilities

ICP Enrollees have a wide range of needs from a variety of service providers. These services must be fully coordinated in order to best serve this population.

All Network providers are expected to participate in CCAI's care-management, quality-assurance and utilization-management programs, as well as meet all relevant reporting requirements. These programs require regular communication with CCAI's Care Management nurses and social workers. Most services outside the primary-care office do require a documented referral or prior authorization per nationally recognized care pathways and accepted standards of care.

Providers will accept the determination of such programs concerning approval for payment for services subject to the rights of appeal or dispute resolution through processes established by CCAI. CCAI will not be liable to pay for any health care service which is determined through the applicable Utilization Management or Quality Assurance Program to be medically unnecessary or outside the scope of covered services.

Responsibilities of PCPs

The Primary Care Provider (PCP) is an integral part of our Model of Care. CCAI and its Enrollees rely on the PCP to provide truly coordinated care. This includes but is not limited to:

- Assistance with completing the Health Risk Assessment (HRA)
- Engaging the Enrollee in their own care
- Acting as the Enrollee's main service provider
- Driving access to all non-primary services
- Eliminating wasteful or repetitive services
- Playing an integral part of the Enrollee's interdisciplinary Care Team

Every Enrollee is guaranteed 24-hour access to medical care. Office hours must be adequate to meet the needs of a primary-care population. If a PCP is temporarily unavailable to provide necessary medical services, qualified coverage must be provided to ensure Enrollee access to care is not interrupted.

Assignment of Primary Care Provider
All Enrollees choose a PCP with HFS Enrollment Services Provider (Maximus) when they select our plan. The PCP's name and phone number will be listed on the front of the Enrollee ID card. Their name should be reflected in the PCP's Eligibility List within a month or two of their enrollment. Eligibility is available online through the provider portal at www.ccaillinois.com or from our Enrollee & Provider Services staff at (866)871-2305.

Enrollees Changing PCPs
Enrollees are allowed to change their PCP assignment at any time by calling Enrollee Services. Changes are reflected the first day of the month following the Enrollee's request, and updated ID cards are mailed within a few days.

The maximum allowable Enrollee panel for any PCP is 600.

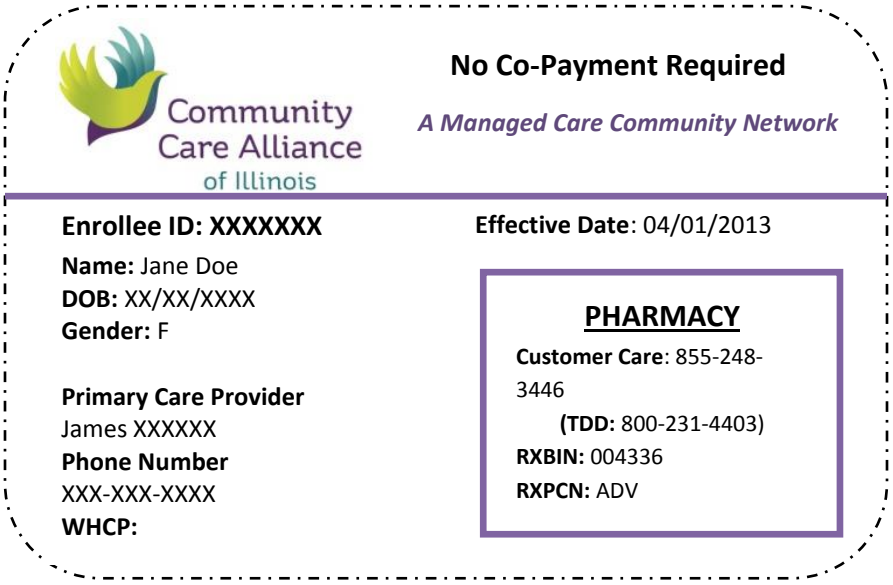
SECTION IX: Eligibility

Member ID Cards
All CCAI Enrollees receive a CCAI Member ID card. Enrollees should present their ID card, at the time of Service. *The CCAI Member ID card is not proof of eligibility.* Providers should verify eligibility upon and even after the date of service. See Verifying Eligibility.

A sample of the CCAI Enrollee ID card is provided below.

The front of the ID card contains:
- Member ID number and effective date
- Name, Date of Birth, and Gender
- Primary Care Provider Name and Phone Number (Woman's Health Care Provider Name and Number if designated)
- Pharmacy Information

The back of the ID card contains:
- Enrollee Services (Toll-free and TTY), 24-hour nurse advice line and PsychHealth phone numbers
- Claims billing address
- Provider Services Phone number and Website address

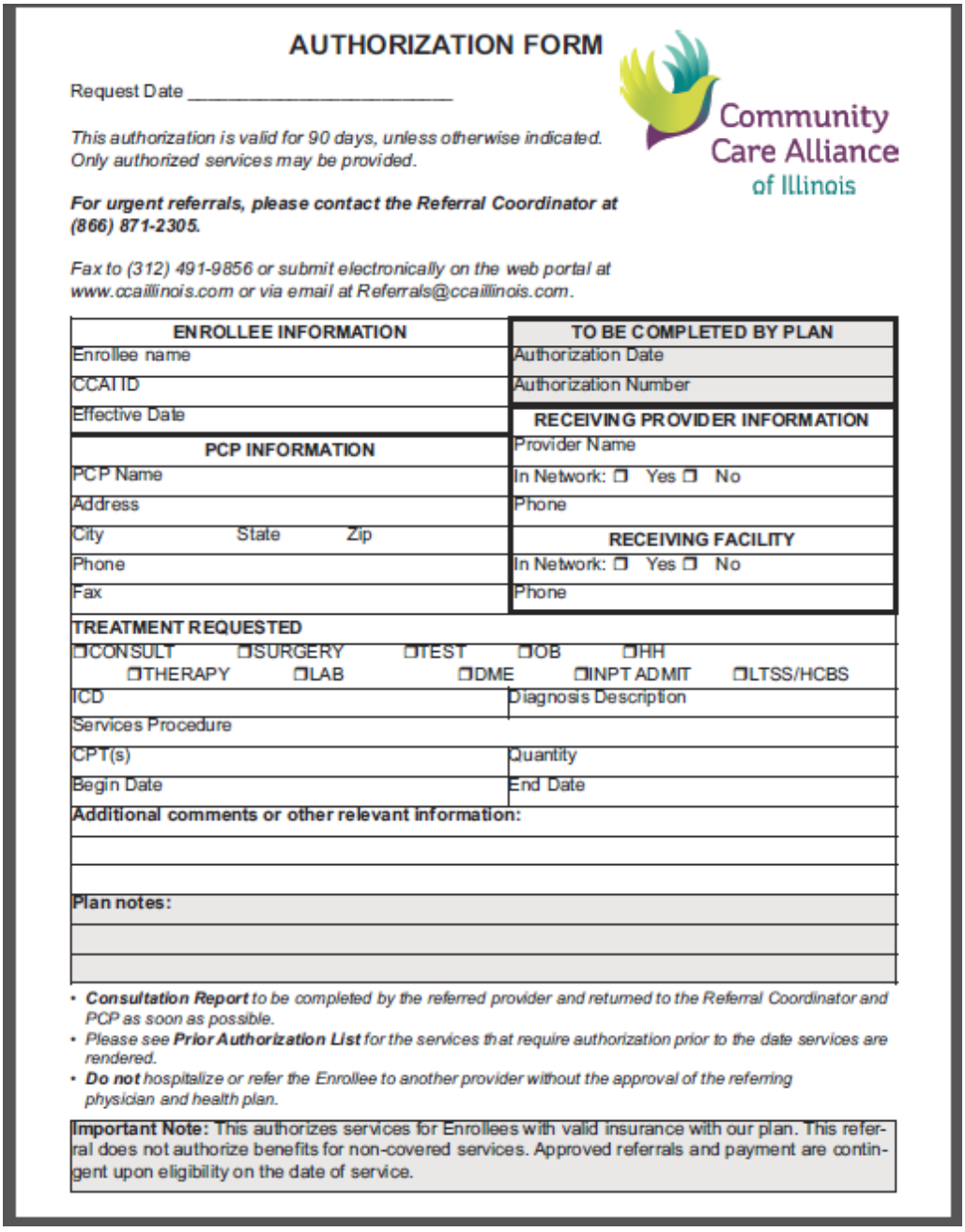


(Front of Card)

(Back of Card)

Referrals/Prior Authorization

Referrals to specialists, second surgical opinions, hospital admission or any services which requires prior authorization, are initiated by the PCP. Requests for authorization shall include written documentation of medical necessity for the service or procedure. The requested service provider must be within the CCAI Network, unless the Network does not have a provider for that service. Referral requests must be completed on the Authorization Request Form either in the Provider Portal at www.ccaillinois.com or via fax at (312)491-9856.



AUTHORIZATION FORM

Request Date _____

This authorization is valid for 90 days, unless otherwise indicated. Only authorized services may be provided.

For urgent referrals, please contact the Referral Coordinator at (866) 871-2305.

Fax to (312) 491-9856 or submit electronically on the web portal at www.ccaillinois.com or via email at Referrals@ccaillinois.com.

ENROLLEE INFORMATION	TO BE COMPLETED BY PLAN
Enrollee name	Authorization Date
CCAID	Authorization Number
Effective Date	**RECEIVING PROVIDER INFORMATION**
PCP INFORMATION	Provider Name
PCP Name	In Network: ❒ Yes ❒ No
Address	Phone
City State Zip	**RECEIVING FACILITY**
Phone	In Network: ❒ Yes ❒ No
Fax	Phone

TREATMENT REQUESTED

❒CONSULT ❒SURGERY ❒TEST ❒OB ❒HH
❒THERAPY ❒LAB ❒DME ❒INPT ADMIT ❒LTSS/HCBS

ICD	Diagnosis Description
Services Procedure	
CPT(s)	Quantity
Begin Date	End Date

Additional comments or other relevant information:

Plan notes:

- ***Consultation Report*** *to be completed by the referred provider and returned to the Referral Coordinator and PCP as soon as possible.*
- *Please see* ***Prior Authorization List*** *for the services that require authorization prior to the date services are rendered.*
- ***Do not*** *hospitalize or refer the Enrollee to another provider without the approval of the referring physician and health plan.*

Important Note: This authorizes services for Enrollees with valid insurance with our plan. This referral does not authorize benefits for non-covered services. Approved referrals and payment are contingent upon eligibility on the date of service.

Verifying Eligibility

It is wise to verify Enrollee eligibility in order to ensure that you are working with the most updated information—and to assure payment. Since eligibility information can change, we suggest that verification be done:

- At the time an appointment is scheduled
- The day of the Enrollee's appointment
- When a bill is submitted

CCAI will always give you the most updated information we can access. To check an Enrollee's eligibility:

- Log-on to the secure Provider Portal at www.ccaillinois.com. You can search by Enrollee name, date of birth or CCAI ID number (the same as their Medicaid identifier).
- Contact CCAI's Enrollee & Provider Services at (866)871-2305. We can check our latest eligibility, as well as that of the State.

If it is the Enrollee's first visit in your office, you are unfamiliar with them, or you suspect fraud, ask for photo Identification.

SECTION XII: Network Participation

All practitioners in the CCAI Network undergo a review of their qualifications, including education and training, licensure status, board certification, hospital privileges and malpractice history. The CCAI Peer Review Committee makes final decisions regarding Network status. In order to participate in the CCAI Network, a practitioner must:

- Be enrolled in the Illinois Medical Assistance Program
- Be a qualified practitioner in their respective discipline. PCPs should be licensed (MD, DO or NP) and practicing Family Medicine, General Internal Medicine, Obstetrics & Gynecology or Pediatrics (CCAI does not currently serve the pediatric population)
- Maintain active admitting privileges or demonstrate adequate admitting arrangements at one or more participating network hospital
- Be willing to collaborate and cooperate with CCAI to coordinate the delivery of high-quality, appropriate care to Enrollees
- Comply with all Federal, State and local regulations and requirements, including those defined in the *Contract for Furnishing Health Services by a Managed Care Organization* between HFS and CCAI. A copy is posted at http://www.hfs.illinois.gov/assets/mco.pdf
- Meet the credentialing requirements of CCAI
- Have an executed participation agreement or participate in a group with an executed participation agreement with FHN/CCAI or an authorized affiliate (e.g., a contracted Medical Group.

Credentialing Process

Family Health Network (FHN), the parent company of CCAI, does the credentialing for CCAI's Network. FHN may delegate credentialing/re-credentialing responsibilities to contracted physician/hospital organizations (PHOs), independent physician associations (IPAs), and qualified hospitals or medical groups. If you participate in the CCAI or FHN Network through one of these entities, peer review and credentialing is conducted by that organization.

Even in delegated arrangements, FHN/CCAI retains responsibility for credentialing its Network providers (except LTSS/HCBS providers—see that section below) and must ensure compliance with State requirements. We do this through ongoing oversight, auditing and monitoring of delegated credentialing/re-credentialing activities.

FHN/CCAI accepts credentialing information electronically from the Council for Affordable Quality Healthcare (CAQH) or as a paper application. The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that the *Health Care Professional Credentialing and Business Data Gathering Form* be used to collect information for credentialing. A completed form includes required documents and attachments with a signed and current date *Affirmation of Information.*

CAQH

CAQH allows practitioners to fill out one set of credentialing information for health plans and healthcare organizations to access. There is no cost to the practitioner. Completing an application online with CAQH can be done by registering at https://caqh.geoaccess.com/oas/ or by using the link available at www.ccaillinois.com. Please make sure to allow access to Family Health Network, CCAI's parent company, if you do not grant global access to your CAQH application.

Incomplete Applications cannot be accessed on CAQH. Please work with CAQH to complete.

Paper Application

The *Health Care Professional Credentialing and Business Data Gathering Forms* are available in Word and PDF versions at http://www.idph.state.il.us/about/credentialing.htm.

If you submit a paper credentialing application please make sure to provide

- Complete responses
- Attachments which contain all of the information requested in the relevant section
- Copies of all documents listed under CONFIDENTIAL INFORMATION
- Signature and date on page 2 of the *Affirmation of Information*

Incomplete applications cannot be processed. If we receive an application which is missing information, a Network Management Specialist will notify the applicant of what is needed. Three attempts will be made over a 60-day period to obtain the requested information. Failure to submit the information after that period will be considered a voluntary withdrawal of the application.

Primary Source Verification

Upon receipt of a complete application, FHN will obtain primary-source verification of the following information:

- Current Professional License: Valid Illinois licensure is verified by the appropriate State Department of Regulation.

- Current Malpractice Coverage: Professional liability insurance is verified via face sheet including dates and amount of coverage. Minimum coverage requirements are $1,000,000 per incident and an aggregate of $3,000,000. Certificate of Waiver under the Federal Tort Claims Act (FTCA) is acceptable for practitioners of a federally qualified health center (FQHC).
- Malpractice Claims History: A request for professional liability claims history for at least the past ten (10) years is required. Affirmative responses require additional information. FHN will query the National Practitioner Database (NPDB) for verification of professional liability claims history.
- Drug Enforcement Agency (DEA) Certificate: Any restrictions will require further investigation. Practitioners that do not dispense medication in the course of practice are exempt from verification.
- Education and Training: Verified directly via school or on-line education verification or American Medical Association (AMA) Provider Profile
- Board Certification: Verified with the applicable specialty Board
- Non-Board Certified Practitioners: Completion of residency verified by residency training program, and/or graduation from medical school verified by the medical school, or AMA Provider Profile. The Education Commission for Foreign Medical Graduates Certificate (ECFMG) serves as verification for non-boarded certified practitioners who are foreign educated and therefore residency and medical school cannot be verified.
- Review of Work History**:** Examination of the applicant's work history, practice, and/or employment. Work history for the past five (5) years. Work history must reflect month and year of employment to identify any gaps in excess of six (6) months. Explanation is required for gaps in work history in excess of six (6) months.
- Hospital Admitting Privileges**:** Clinical privileges in good standing at a Network hospital designated by applicant as primary admitting facility

Practitioner Rights re: Credentialing

Practitioners have the right to:

- Review the information submitted in support of their credentialing application, except information that is peer review protected by law and plan policy
- Respond to information obtained during the credentialing process that varies substantially from the information provided by the provider
- Correct erroneous information supplied by another source during the credentialing process
- Be informed of the status of their credentialing application at any time
- Receive notification of credentialing decisions within 60-days of the Peer Review/Credentialing Committee's decision

Re-Credentialing

Re-credentialing is performed every three (3) years based on the last digit of the practitioner's Social Security number.

FHN re-verifies the information that is subject to change over time in order to identify any issues with in licensure, certification, clinical privileges, health status, sanctions status, clinical competence or any other area that may affect the practitioner's ability to render quality healthcare services to Enrollees.

In addition, the re-credentialing process incorporates an assessment of prior performance with CCAI or FHN, including but not limited to, medical-record review, Enrollee complaints, Enrollee satisfaction, and information gained through quality and medical-management activities.

Between re-credentialing cycles FHN/CCAI performs ongoing monitoring for adverse events, sanctions or member complaints.

Long-Term Services & Supports/Home & Community Based Services
Providers of Long-Term Services & Supports or Home & Community Based Services (Waiver Services) need only have a Medicaid number with the State of Illinois to enter into a contract with CCAI, as the State handles their credentialing.

While they are not considered medical providers, LTSS/HCBS providers are integral to the CCAI Network and have the same participation Agreement. This means they agree to CCAI's business terms, participate in programs and reporting processes, and adhere to the policies of CCAI.

Benefits and Services

The following services are provided an Enrollee if, as determined by the Enrollee's PCP or WHCP, they are medically necessary and appropriate.

Covered Benefits/Services:

- Advanced Practice Nurse services
- Ambulatory Surgery
- Audiology
- Chiropractic services
- Dental services for Enrollees under 21
- Diagnosis and treatment of an illness or injury
- Durable Medical Equipment
- EPSDT services for Enrollees under age twenty-one (21) pursuant to 89 Ill. Admin. Code Section 140.485, excluding shift nursing for Enrollees in the MFTD HCBS Waiver for individuals who are medically fragile and technology dependent (MFTD)
- Family planning
- FQHC, RHC and other Encounter Rate Clinic services
- General health maintenance
- Home health
- Emergency care

- Emergency care out of the service area
- Hospice care
- Hospital inpatient services
- Hospital outpatient services
- Laboratory services
- Long Term Services & Supports or Home & Community Based Services (e.g. services under the Elderly, HIV, Physical Disabilities, Supportive Living and Traumatic Brain Injury Waivers)
- Medical supplies and equipment
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option
- Nursing care for Enrollees under age twenty-one (21) not in the HCBS Waiver for individuals who are MFTD, pursuant to 89 Ill. Admin Code Section 140.472
- Nursing Facility services for the first ninety (90) days (Excludes Enrollees who are Residents of a Nursing Facility on the date of enrollment)
- Oral surgery due to injury or illness
- Orthotics
- Palliative care
- Pharmacy
- Physical, Occupational and Speech Therapy
- Physician services, primary care or specialist
- Podiatry
- Post-Stabilization services
- Practice Visits for Enrollees with special needs
- Prosthetics
- Renal Dialysis
- Sub-acute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090
- Transportation to obtain Covered Services
- Wellness care
- X-rays

If the PCP determines that the Enrollee needs to see another Physician (a Specialist), they will refer the Enrollee to such Physician.

Non-emergent services obtained outside the PCP office may require prior health-plan authorization.

Emergency Services
Emergency services are covered anywhere in the United States and do not require a referral or prior plan authorization.

A *medical emergency* is defined as a medical condition with acute symptoms of sufficient severity, including but not limited to severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in:

- Serious jeopardy to the person's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Enrollees calling CCAI Enrollee Services during normal business hours for permission to go to the Emergency Room will be immediately connected with the Primary Care team, the CCAI Healthcare Management Staff or CCAI Medical Director as indicated.

Enrollees who reach CCAI's after-hours answering service will be instructed to use their best judgment in determining whether to go to the Emergency Room or contact their PCP.

The CCAI Enrollee Handbook, sent to new Enrollees at their initial effective date with CCAI, lists the following conditions as medical emergencies:

- Broken bones
- Chest pain
- Convulsions or extreme bodily shaking
- Difficulty breathing
- Extreme pain in the stomach or chest areas
- Heavy, uncontrolled bleeding from a wound
- Miscarriage
- Poisoning
- Severe burn
- Shock
- Vomiting blood

Post Stabilization Services

Post-Stabilization medical services provided by a non-contracted provider will be covered in any of the following situations:

- The services are authorized by CCAI
- The services were administered to maintain the member's stabilized condition within one (1) hour of a request to CCAI for authorization of further post-stabilization services
- If CCAI does not respond to a request to authorize further post-stabilization services within one (1) hour, CCAI or Primary Care Team not be contacted, or CCAI or Primary Care Team and the treating provider cannot reach an agreement concerning the member's care and a contracted provider is unavailable for consultation. If a contracted provider is unavailable, the treating provider must be permitted to continue the care of the member until a contracted provider is reached and either concurs with the treating provider's plan of care or assumes responsibility for the member's care

Bonus Benefits (in addition to Standard Medicaid Benefits)

- No copayments
- Chronic Disease Self-Management*
- Diabetic Care Program*
- Debit Card Incentive Program for healthy behaviors
- Jewel/Osco Coupons
- 90-day supply of prescription drugs via mail order
- Medical and Psychiatric After-Care Incentives
- 24-Hour Nurse Line for medical questions
- Practice visits for dental services*
- Practice visits for gynecological visits as needed *
- Semi-Annual dental cleaning and examination
- Transportation to pharmacy for prescription fill following health care visit
- Vision rebate
- Weight Watchers membership

*For those who meet the criteria as determined by CCAI Care Management

The availability of interpretive services; should any employee receive a phone call from a non-English speaker, the Language Line is available for us to use. Employees are taught the procedure and have reference material.

SECTION XIII: Healthcare Management

Overview

CCAI's Healthcare Management department hours of operation are Monday through Friday from 8:00 am to 5:00pm. Healthcare Management services include the areas of Care Coordination, Case Management/Disease Management, Utilization Management, Pharmacy Management and Quality Assurance.

Health Risk Surveys and Health Risk Assessments

CCAI is committed to delivery and coordination of the highest-quality care and starts the process by completing a Global Health Risk Assessment, which consists of an initial Health Risk Survey and subsequent Comprehensive Health Risk Assessment for every Enrollee.

Once a person is in the Enrollment report provided by HFS, CCAI mails them a Welcome Packet, which contains an Initial Health Risk Survey (HRS). Every effort is made to complete the HRS within sixty (60) days of enrollment. The HRS is a self-reported general view regarding the Enrollee's overall health status. The HRS can be submitted by the Enrollee via fax, mail or telephone, and is entered into the Clinical Care Management System (CCMS).

If the Enrollee is being treated at or has been admitted to an acute-care facility or emergency department before CCAI has reached them for initial assessment, the HRS and HRA may be completed by the Care Coordinator at the same time.

Based on the Enrollee's responses to the HRS, a risk score will be assigned as follows:

- High: risk score of 10 or greater
- Moderate: risk score of 5-9
- Low: risk score of 4 or less

Once the risk score is determined, the Comprehensive Health Risk Assessment (HRA) is performed by a Care Coordinator in an appropriate timeframe. The HRA may be completed telephonically or face-to-face, with the Enrollee or their designated representative. The HRA includes but is not limited to:

- General health status
- Identification of chronic conditions
- Medical history
- Medications
- Utilization
- Psychosocial needs
- Mental health history
- Functional status
- Current needs

The Care Coordinator relies upon clinical pathways which are based on nationally recognized guidelines to conduct the HRA and to guide the care and ongoing management of Enrollee's overall health.

Based on the HRA findings, Enrollees are stratified into the following categories:

- Tier one: High Risk
- Tier two: Moderate Risk
- Tier three: Low Risk

The Enrollee's HRA stratification will determine the Risk Tier component of the PCP's per member per month Management Fee. The full HRA must be completed in order for the Enrollee's PCP to receive that portion of the fee.

Upon completion of the HRA, the assessment and care plan are developed, approved by the PCP and shared with the Integrated Care Team (ICT) via email, fax or team meetings. Team meetings are scheduled based on Enrollee's needs and risk stratification. Once the

individualized Plan of Care is established, it is updated at least annually or with any change in the Enrollee's condition, whichever is sooner.

Care Coordination and the Interdisciplinary Care Team
The individualized Plan of Care and Interventions (POC) is proactive and preventive in nature and focuses on stabilization of the chronic medical conditions, or slowing of their impact, and will help optimize quality of life. Additionally, such plans identify opportunities to prevent acute episodes.

The Care Coordinator coordinates the services provided to the Enrollee in collaboration with the PCP and ICT. They communicate with the Enrollee, their family and or responsible parties in accordance with HIPAA privacy and confidentiality requirements. Ongoing communication with the PCP, ICT, caregivers and other facility partners is based on Enrollee's health status and preferences. The Care Coordinator reviews clinical status for all reported changes in condition and follows-up with the Enrollee until their condition change has returned to baseline or new baseline is established. The Care Coordinator also monitors changes in health status in order to identify need for transition of care. When planned or unplanned transitions of care occur, the Enrollee, PCP, and ICT are involved in the development of the appropriate POC.

The ICT is designed to ensure that the Enrollee's needs are identified and managed by an appropriately composed team. Composition of the ICT is aligned with the Enrollee's condition and health-risk status. Essential members of the ICT are the Enrollee, if feasible, the PCP, a nurse Care Coordinator, and a Long Term Services and Supports (LTSS) Coordinator. Other members will participate on the ICT as needed and may include specialists, the CCAI medical director, health educators, a clinical pharmacist, a dietician, and long-term-care facility providers.
ICT functions will include, but are not limited to:

- Development, implementation, and monitoring of the Individualized Care Plan, including LTSS/HCBS services where applicable
- Assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system
- Explaining alternative care options to the Enrollee
- Maintaining frequent contact with the Enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to the member's needs and risk-level, or upon the member's request

Care Management/Disease Management:
Care Management (CM) is the coordination of care and services provided to Enrollees who have experienced a critical event or illness that requires the extensive use of resources and who need help navigating the healthcare system. CM is initiated as early as possible following onset or diagnosis and continues throughout the course of illness or injury.

Enrollees needing CM are identified through a variety of sources, including but not limited to: self-referral, claims information, inpatient utilization, ER utilization, provider referral, administrative data, the HRA, PCP referral, marketing/enrollment forms, and referral to or from the behavioral health provider.

All Enrollees in the CM program have active POCs on file. These treatment plans are developed by the ICT, with final approval by the PCP. Enrollees receiving CM are contacted as frequently as necessary to assure compliance with the treatment plan and progress toward overall treatment goals. (Please see the Care Management Policy at www.ccaillinois.com for full details on the program.)

Utilization Management

The Utilization Management (UM) Program systematically and objectively monitors and evaluates the healthcare services provided to Enrollees to ensure the provision of medically necessary care in the most appropriate setting with optimal outcomes, while achieving cost containment by

- Using and communicating established care pathways and clinical standards
- Enhancing awareness of medical necessity and appropriateness of services
- Organizing and coordinating services
- Identifying under- and over-utilization via concurrent and retrospective review

The UM Program monitors and oversees services provided to Enrollees in acute care, skilled nursing and rehabilitation facilities, outpatient centers, in the home and by others who render services and contribute to the POC. The UM Program also includes the review and evaluation of medical services, health education and support for the management of complex and long-term medical needs.

The UM Program also focuses on the evaluation of Emergency services. The UM Committee reviews over/under utilization data (ER, inpatient services and 30-day readmissions) and develops Corrective Action Plans as necessary.

Specific types of utilization review, the services reviewed within that type and the responsible parties are outlined below.

UM utilizes internal and external clinical review criteria that are evaluated annually by the Clinical Guidelines committee and approved by Quality Assurance/Utilization Review Committee within CCAI. External review criteria are based on applicable state/federal law, contract or government program requirements, InterQual criteria and guidelines and standards by professional organizations, as appropriate, such as ACOG, AAP, AAFP, etc.

Prospective Utilization Review

Prospective utilization review is the process by which medical care and services are assessed prior to their delivery. Pertinent clinical information is reviewed before a determination is

made. Prospective review processes apply to both inpatient and outpatient services. CCAI does prospective review of most outpatient and ancillary services including:, outpatient, radiology services, laboratory services, home health, hospice, DME, prosthetics/orthotics, transportation and other outpatient services, including outpatient surgery and observation admissions.

CCAI requires prospective approval or "prior authorization" of non-PCP services, including but not limited to:

- Dialysis
- DME
- Home health
- Inpatient admissions
- Lab
- Lithotripsy
- LTSS/HCBS
- Outpatient surgeries
- Physical, occupational and speech therapies after initial evaluation
- Prosthetics and orthotics
- Skilled nursing admissions
- Specialist referrals after initial consultation
- Sub-acute and Rehabilitation Facility admissions
- Transportation
- Urgent care
- High tech diagnostic Imaging

Authorization determinations are made no longer than 10 days following receipt of request.

Urgent referrals should be clearly marked as such or called in to the Referral Coordinator Management at (866)871-2305. Determinations on urgent referrals are made based on the clinical situation, but in no case later than 72 hours of receipt of request.

Non-urgent determinations will be given within ten (10) calendar days of the receipt of request.

Please use your Quick Reference Guide for a list of services that require prior authorization.

Concurrent Review
Concurrent Review is the process that evaluates the appropriateness and medical necessity of ongoing medical care and services. Concurrent review includes evaluation of the following:

- Medical necessity of services being rendered
- Enrollee's condition
- Place of service and/or level of care

- Quality of services being provided
- Anticipated discharge needs
- Changes that may necessitate modifications to the treatment plan

The frequency of Concurrent Review is case-specific.

Healthcare Management gathers appropriate clinical information for all ongoing services, both in the inpatient and outpatient settings. Documentation of ongoing reviews and determinations of service are documented in the Clinical Care Management System (CCMS) at CCAI.

For reductions in or termination of previously approved course of treatment, CCAI will issue the Determination of Reduction and allow the Enrollee to request a review and receive a decision before the reduction or termination occurs.

For requests to extend a current course of treatment, CCAI issues the determination within 72 hours of receipt of the request.

Retrospective Review
Retrospective Review is the process by which medical care and services are evaluated for medical necessity and appropriateness of care after the services have been rendered no later than ninety (90) calendar days after the services and in which Concurrent Review was not conducted.

CCAI collects all pertinent information regarding level of care, outpatient surgeries and twenty-three (23) hour observation stays upon notification and will make final determination of medical necessity and will determine final approval of services rendered within thirty (30) calendar days of the receipt of request for utilization management determination. This period may be extended one time by CCAI for up to ten (10) calendar days

Evidence-based criteria (InterQual Level of Care) is used by the UM Specialist to determine medical necessity and approval of requests for services. Prospective, Concurrent and Retrospective reviews are performed as necessary to provide a basis for decision making regarding claims payment.

Utilization Management decisions are made by qualified healthcare professionals, who have the knowledge and skills to assess clinical information and evaluate working diagnoses and proposed treatment plans. Inter-rater reliability (IRR) to assure consistent application of the utilization criteria is conducted on CCAI UM staff, the Medical Director and other provider reviewers quarterly, and results are reported to the QA/UM Committee. The CCAI Medical Director oversees all UM activities and makes final determinations on denial of services. All UM decisions are made within 72 hours of notification to minimize any disruption in the provision of health services and to accommodate the clinical urgency of the situation.

Non-Certification (Denial of Service)
A Non-Certification is a determination by the Medical Director that actual or proposed services do not meet medical necessity criteria or that insufficient information is available to apply criteria.

Providers are notified by the UM coordinator telephonically within 24 hours after the non-certification decision is made by the Medical Director. The CCAI Medical Director is available to any requesting provider to discuss determinations based on medical necessity/appropriateness. All non-certification decisions are communicated in writing to the Enrollee, the PCP and other affected providers within one business day. All adverse-determination letters state that the clinical review criteria upon which the non-certification determination was made are available upon request by the Enrollee and/or provider.

No CCAI staff or Medical Director conducting Utilization Review activities receives incentives to deny, limit or discontinue covered services.

Transition of Care/Continuity of Care
CCAI manages Transition of Care and Continuity of Care for new Enrollees and Enrollees moving from institutional settings to community living arrangements.

New Enrollees with ongoing services provided by out-of-network providers will receive services from those providers during a ninety (90)-day transition-of-care period. The Transition of Care/Continuity of Care policy has complete details on the CCAI website.

Out of Plan and Out of Area Services
Out of plan services are rendered by non-contracted providers. Utilization Management functions and processes are unchanged for this type of service. Enrollees are transferred to a contracted provider when the out-of-plan provider and the PCP agree they are stable for transfer. Trending of out-of-plan utilization will help determine the need for Network expansion.

Out-of-area services are those services provided outside the Service Area (Boone, McHenry, and Winnebago Counties). Again, Utilization Management functions and processes are the same. Elective care out of the area is not a covered benefit. Out-of-area urgent and emergent care is covered. All out-of-area services are reviewed and approved or denied for coverage and payment by CCAI using the processes and standards described above.

Discharge Planning
Discharge Planning is done by the UM staff, the ICT and the caregiver(s). It begins at the time of the pre-admission certification and/or admission to the hospital and continues through the Enrollee's stay. The objectives of discharge planning are to:

- Facilitate timely and appropriate discharge
- Evaluate alternative levels of care

- Provide information about available community resources
- Support the delivery of high-quality, cost-effective health services

Discharge Follow-Up
Within three days after discharge from hospital or ER visit, the Enrollee and PCP will receive follow-up calls from the Care Coordinator. The purpose of the calls is to ensure that:

- All needed services are in place (e.g. ordered DME has been delivered, etc.)
- The Enrollee's health status is known and stable
- Follow-up appointments with PCPs or specialists have been scheduled

Mental Health/Substance Abuse Services
All mental health and substance abuse (MHSA) services are sub-contracted to a PsycHealth. PsycHealth manages both inpatient and outpatient services, as well as all UM processes related to MHSA.

No referral or prior authorization is required for an Enrollee to seek MHSA. However, if any provider feels the Enrollee needs such services, they can refer them to PsycHealth at (800)753-5456.

Emergency Room Review
Appropriate use of emergency services is a significant concern for CCAI. Follow-up to ER care is conducted by the Interdisciplinary Care Team. ER utilization reports and findings are reviewed monthly. The CCAI Medical Director and VP of Healthcare Management will review each provider's ER utilization report and present identified issues to the QA/UM and/or Peer Review Committee. All ER services are approved following the prudent-layperson legislation.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
PCPs caring for Enrollees under age 21 must offer to provide periodic and medically necessary inter-periodic screens as defined by the *HFS Handbook for Providers of Healthy Kids*.

All Enrollees under 21 years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program. Children should receive comprehensive child health services, according to HFS' recommended periodicity schedule or more frequently, as appropriate. Well child visits shall consist of age-appropriate component parts including but not limited to:

- Initial/Interval medical history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations
- Laboratory procedures, including lead toxicity testing

- Periodic objective developmental screening using a recognized, standardized developmental screening tool, as approved by HFS.
- Periodic objective screening for social emotional development using a recognized, standardized tool, as approved by HFS
- Objective vision and hearing screening
- Risk assessment
- Childhood obesity assessment
- Anticipatory guidance
- Perinatal depression screening for mothers of infants in the most appropriate clinical setting (e.g., at the pediatric, behavioral health or OB/GYN visit)

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the scope of Covered Services. If, as a result of EPSDT services, the PCP determines a child is in need of services that are not Covered Services but are services otherwise provided for under the HFS Medical Program, the PCP will ensure that the child is referred to an appropriate source of care. FHN will not pay for services that are not Covered Services.

For more information please visit http://www.hfs.illinois.gov/assets/hk200.pdf; and http://www.hfs.illinois.gov/assets/032008hk200appendices.pdf

SECTION XIV: Pharmacy

CCAI has chosen CVS Caremark as its Pharmacy Benefits Manager. CVS Caremark has a national network of pharmacies of which CVS stores comprise about 20%. Enrollees and providers can call the ***Customer Care Line (855)248-3446*** (on the Member ID Card) or visit the CCAI website and click the CVS Caremark button on our Home Page to find a participating pharmacy nearby.

If a pharmacy preferred by the Enrollee or Provider is not in the CVS Caremark network, CCAI and CVS Caremark will make an effort to include them. Network Management can be reached regarding the pharmacy network at (866)871-2305 or provider@ccaillinois.com

It is also possible for a pharmacy to contact CVS Caremark at the Customer Care number to arrange a one-time 'emergency' agreement so that a member who is in need of medicine can get it expediently.

Mail Order
Prescriptions will be filled for up to a 30-day supply in the pharmacy. Enrollees who need longer-term medication can send their prescriptions to CVS Caremark's mail-order pharmacy at

CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

Formulary, PA and Step Therapy
CCAI utilizes a Preferred Drug List, which can be found on the CVS Caremark website by clicking the CVS Caremark button on the CCAI home page at:
https://www.ccaillinois.com/files/CCAI_Formulary_FINAL_eff_7_1_2013.pdf

There are medications that require Prior Authorization or are only accessible through Step Therapy. These, along with instructions for obtaining authorization, can also be found on the website or by calling the CVS Caremark Customer Care line at (855)248-3446.

Restrictions
The following drugs are not in benefit for CCAI Enrollees:

- Erectile dysfunction medications
- Drugs prescribed for cosmetic use
- Experimental therapeutics

SECTION XV: Billing and Claims

All CCAI Covered Services are reimbursed on a fee-for-service basis per the Provider Service Agreement with FHN.

Claims Submission
Claims for covered services provided to CCAI Enrollees can be submitted electronically on the Provider Portal accessible through the CCAI website or by mail.

Electronic filing may be done through Availity or directly via CCAI's Provider Portal. Providers wishing to submit claims through Availity should submit a short application which can be found on our website www.ccaillinois.com, or our Enrollee & Provider Services department will mail or fax one upon request. Call (866)871-2305 or email us at network@ccaillinois.com.

Claims submitted by mail should be sent to:

CCAI
4044 N. Lincoln Ave., Box 294
Chicago, IL 60618

Timely Filing
Claims should be filed within 180 days of the date of service. Clean claims will be paid within 30 days of receipt.

Clean Claims
CCAI will process claims submitted on standard CMS 1500, UB 04 or the commonly used claim form for the provider's services. The claims must contain correct information or codes in all applicable fields.

The following will cause a claim to be ***rejected prior to processing:***

- Enrollee unknown to CCAI
- Illegibility
- Illogical dates (e.g., future service date, etc.)
- Incorrect form
- Missing Enrollee information, such as name, date of birth, ID
- Missing Provider information, such as name, tax ID (or NPI number for Medical Providers)
- Missing any of the following fields:

    - ✓ Valid Diagnosis
    - ✓ Admission Type
    - ✓ Patient Status
    - ✓ Occurrence Code or Date

- ✓ Valid Revenue or CPT Code

Rejected claims will be returned to the provider along with applicable explanation. Rejected claims are considered closed and will not be revisited by the claims system or staff.

Prior Authorization
Non-emergent services which a PCP cannot perform in the office, services performed at a hospital or outpatient surgical center or facility other than a physician office, home health, DME and some diagnostics, and Long Term Services & Supports/Home & Community Based Services require Prior Authorization from CCAI's Healthcare Management Department.

Please reference the list of services which require Prior Authorization in this manual, or contact Healthcare Management or Network Management at (866)871-2305 or via email at network@ccaillinois.com with any questions.

Claims for services which require Prior Authorization from CCAI will not be paid. However, 180-day Transition of Care requirements will be observed for new Enrollees, and claims will be paid without prior authorization during that period.

Emergency Claims Payment
Emergency Department (ED) bills may be reviewed retrospectively. The professional fees will be paid at the prevailing CCAI rate applicable to the billed CPT code (99281-99285, 99288). Facility fees will be paid at the prevailing CCAI rate applicable to the billed revenue code (450, 451, or 456), unless there is a reason to request the medical record for review. In every case, the triage fee will be paid. Upon completion of the medical-record review, the applicable facility fee will be paid at the prevailing CCAI rate. In all cases of denial of payment, a clear explanation of the reason for not paying the billed code will be provided.

CCAI is responsible for provision of and payment for out-of-area ED and will review and pay per the same rules as for in-area.

Miscellaneous Codes
Use of miscellaneous codes will cause that line of the claim to go unpaid and the EOP issued with reduced or $0 payment. Additional information provided subsequently should be submitted with a Corrected Claim via the web portal for reconsideration.

Reimbursement
Clean Claims will be paid within 30 days of submission date, and Providers will be reimbursed consistent with the terms in their Participation Agreement.

Network Management staff can answer questions regarding contract terms and payment policies and can be reached during normal business hours at (866)871-2305 or via email at network@ccaillinois.com

Claims Payment Disputes and Corrected Claims
CCAI will consider claims-payment disputes received within 90 days of the date on the EOP. Disputes may be submitted through the Provider Portal at https://ccaiportal.chicagolanddrs.com/index.asp or by mail at the Claims address. All relevant documentation, including original CCAI claim number, must be submitted with the claim and clearly identified as a Payment Dispute, or it may be automatically rejected as a duplicate.

CCAI will process Claims Payment Disputes within 45 days of receipt. After consideration by CCAI, the resubmitted claim will be processed as a new claim. The resolution will be reflected in the EOP. The EOP may be accompanied by a letter, if further explanation is warranted.

Reversal of Claim Payment
In the event that CCAI determines a claim, or some portion of a claim, was paid in error, we will reprocess a claim at a future date and deduct the amount from the Provider's next claim payment. Likewise, payment may be made where it was previously denied. The EOP will contain the reason(s) for any reversal.

The main reasons for reversing a payment are:

- Updated member eligibility information for service date
- Incorrect payment amount
- Additional claim information obtained later changes the contract rate

Reversals may be disputed through the Claims Dispute process delineated above.

Electronic Funds Transfer
Electronic Funds Transfer (EFT) is available to CCAI Network Providers. In order to receive EFT, providers must submit a form for participation. The form can be found on our website in the Providers pages. A Network Management representative can also provide it via email, fax or mail upon request.

Balance Billing
CCAI Network providers have agreed to accept the CCAI contracted rate as payment in full for services provided to CCAI Enrollees. Under no circumstances is the Enrollee to be billed for any covered service that has been authorized or does not require authorization.

SECTION XVI: Cultural Competence

CCAI and all of its affiliated providers and vendors are committed to cultural awareness and inclusion. The following is a summary of our Cultural Competence Plan. All providers are educated on this plan as part of their orientation, and education is updated and repeated annually.

The CCAI Cultural Competence Plan for 2013 can be found on our website at www.ccaillinois.com in the Provider Resources Section.

Cultural Competence
It is our goal to provide culturally competent services which value diversity, support Enrollee communication, reduce barriers to the health care, and optimize health goals and outcomes. CCAI has developed a Cultural Competence Plan that implements the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards).

As a contracted provider, it is your responsibility to comply with the requirements of CCAI's Cultural Competence Plan. It is CCAI's responsibility to ensure that our provider network is delivering health care services that are respectful of and responsive to the cultural and linguistic needs of the communities we serve.

CCAI ensures the provision of culturally competent healthcare through its credentialing and re-credentialing process by confirming:

- Languages used by providers, including ASL
- Physical access to provider locations

To obtain a copy of CCAI's Cultural Competence Plan, or for information on how to address the challenges of meeting the healthcare needs of our Enrollees, please contact Enrollee & Provider Services at (866)871-2305.

SECTION XVII: Enrollee Rights and Responsibilities

CCAI Enrollees have the right to:

- Be treated with dignity and respect
- Privacy
- Receive quality healthcare
- Receive an explanation of their illness
- Receive an explanation of their treatment options
- Share in deciding the type of care they will receive.
- Refuse healthcare (to the extent of the Law) and understand what may happen if they do
- Ask for a summary of their records
- Request that their medical records be changed
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To be free to exercise these rights and the exercise of these rights does not adversely affect the way CCAI treats members
- Make a Living Will
- File Grievances and Appeals per the guidelines in that section below

CCAI Enrollees have the responsibility to:

- Treat members of their Care Team with dignity and respect
- Make and keep appointments and be on time. Call if they need to cancel an appointment or if they will be late
- Get referrals from their CCAI doctor
- Notify CCAI as soon as possible after receiving emergency room services
- Explain their health problem and symptoms to the doctor and to ask questions
- Follow their doctor's treatment plan
- Discuss with their doctor anything that could keep them from following his or her instructions
- Become involved in their health care
- Consider the outcome of refusing treatment
- Learn and follow the CCAI policies in their Member Handbook
- Carry their CCAI member ID card with them at all times
- Report any lost or stolen cards to CCAI Member Services
- Call Enrollee Services if they need help
- Respect the privacy of other people waiting for health care services

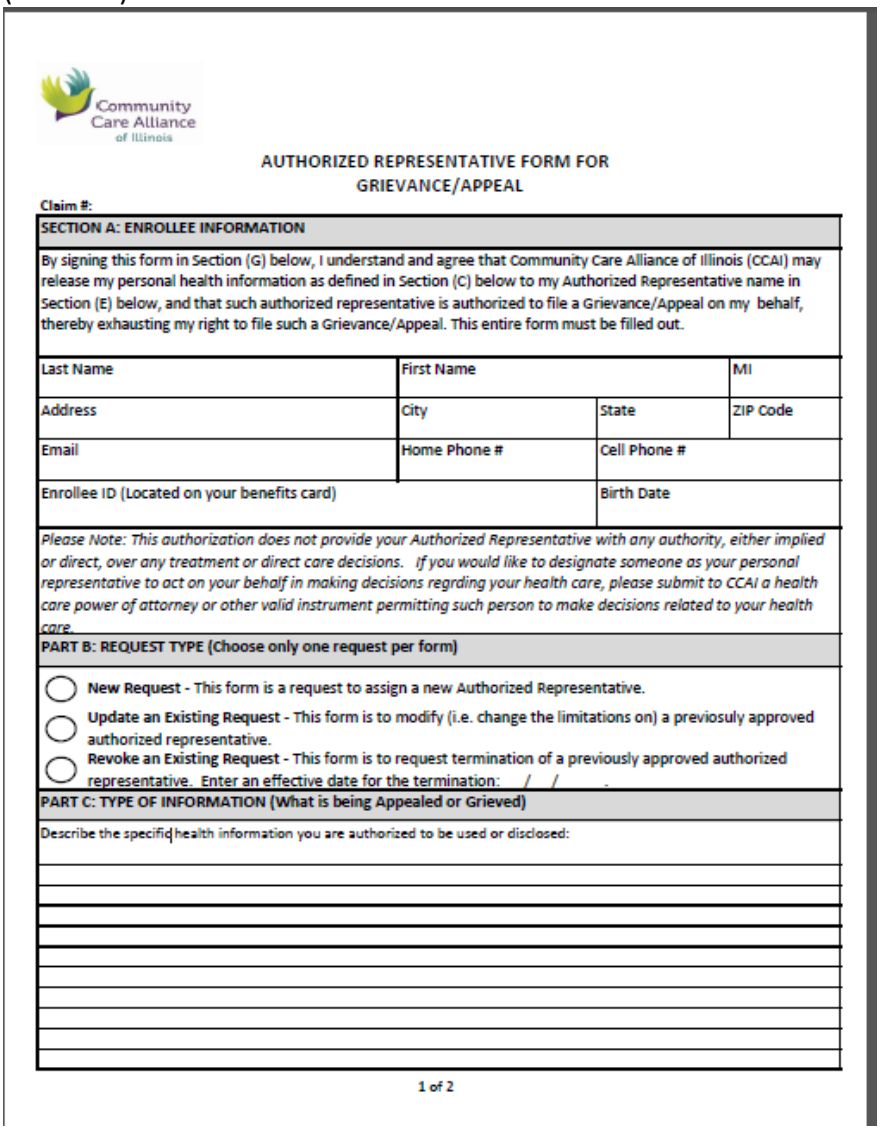
SECTION XVIII: Appeals and Grievances

Grievances

A ***grievance*** is defined as a complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which the health plan or delegated entity provides health care serves, regardless of whether remedial action can be taken.

Enrollees have the right to file a grievance. A grievance may be filed on the Enrollee's behalf by an Authorized Representative (which can be a provider) with the Enrollee's written consent. If the Enrollee wishes to use an Authorized Representative, they must complete an Authorized Representative Form at https://ccaillinois.com/files/CCAI_AUTHORIZED_REPRESENTATIVE_FORM_-_Appeals.pdf

(SAMPLE)



Community Care Alliance of Illinois

AUTHORIZED REPRESENTATIVE FORM FOR GRIEVANCE/APPEAL

Claim #:

SECTION A: ENROLLEE INFORMATION

By signing this form in Section (G) below, I understand and agree that Community Care Alliance of Illinois (CCAI) may release my personal health information as defined in Section (C) below to my Authorized Representative name in Section (E) below, and that such authorized representative is authorized to file a Grievance/Appeal on my behalf, thereby exhausting my right to file such a Grievance/Appeal. This entire form must be filled out.

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone #	Cell Phone #	
Enrollee ID (Located on your benefits card)		Birth Date	

Please Note: This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you would like to designate someone as your personal representative to act on your behalf in making decisions regrding your health care, please submit to CCAI a health care power of attorney or other valid instrument permitting such person to make decisions related to your health care.

PART B: REQUEST TYPE (Choose only one request per form)

◯ **New Request** - This form is a request to assign a new Authorized Representative.

◯ **Update an Existing Request** - This form is to modify (i.e. change the limitations on) a previosuly approved authorized representative.

◯ **Revoke an Existing Request** - This form is to request termination of a previously approved authorized representative. Enter an effective date for the termination: / /

PART C: TYPE OF INFORMATION (What is being Appealed or Grieved)

Describe the specific health information you are authorized to be used or disclosed:

1 of 2

Grievances may be submitted verbally or in writing and are reviewed by our Grievance Committee. Decisions are made within 30 days of receiving a grievance.

If the Enrollee remains dissatisfied after the determination of the Grievance Committee, they may request a review by the Illinois Department of Healthcare and Family Services.

Appeals

An ***appeal*** is defined as a request for review of a decision made by CCAI with respect to an adverse organizational determination (or denial).

As a provider, you have the right to file an appeal if you are dissatisfied with a decision made by CCAI to terminate, suspend, reduce or not provide Covered Services to an Enrollee. If an issue involves a Utilization Management decision, you must obtain the written consent of the Enrollee in order to act on their behalf (see Grievances section above).

If you believe that waiting the standard time to decide the appeal could seriously risk the life, health or well-being of the member, you may request an *expedited appeal*.

Requests are to be in writing, and must include an explanation of why the denial should be overturned, as well as any other relevant information. Standard appeals must be filed within 60 days from the date of the notice, and a decision will be rendered within 15 days of receipt of the filed appeal. Expedited appeal decisions will be rendered within 24 hours.

Submit pharmacy appeals to:

CVS Caremark
Prescription Claim Appeals
MC 109
P.O. Box 52084
Phoenix, AZ 5072-2084
Fax: 1-866-443-1172

Submit medical or LTSS appeals to:

Community Care Alliance of Illinois
Appeals and Grievances
322 S. Green Street, Suite 400
Chicago IL, 60607

SECTION XIX: Fraud, Waste & Abuse Program

CCAI is committed to ensuring that all employees (temporary and permanent), including management, First Tier, Downstream, or related entities comply with all applicable federal and state laws and regulations, and other contractual requirements designed to prevent fraud, waste, and abuse (FWA).

It is a federal crime to defraud the government under any of its programs. Individuals who commit fraud may be imprisoned, fined, or both. Criminal convictions typically result in restitution, fines, and or exclusion from federal programs such as Medicaid or Medicare.

Prevention, early detection, and timely resolution are essential to effectively discourage FWA activities. Therefore, CCAI will provide to all employees, governing body members, and FDR entities, information regarding various laws, regulations, and policies established to prevent, detect, and report issues applicable to FWA.

First Tier Entities are those who have contracted with CCAI to provide administrative or health care services to our CCAI Enrollees. They include contracted providers, delegated entities, consultants and vendors. Downstream Entities are companies that are contracted with a First Tier Entity to provide administrative or health care services on behalf of CCAI. A Related entity is a party that is connected to CCAI by common ownership or control and performs some of the management functions or delegation.

Fraud
Fraud is generally defined as the intentional deception, false statement, or misrepresentation in an effort to receive an unauthorized benefit. For example, fraud in the provision of health care can involve:

- Billing for medical services, procedures or supplies that were not ordered or provided
- Billing for durable medical equipment items that were not ordered or provided
- Providing services or items a person does not need based on their medical history
- Intentional misrepresentation by manipulating:
    - Dates on which services or treatments were rendered
    - Medical record of service
    - Condition treated or diagnosed
    - Charges or reimbursement
    - Identity of provider/practitioner or recipient of services
    - Coding of services provided (“unbundling” or “up-coding”)

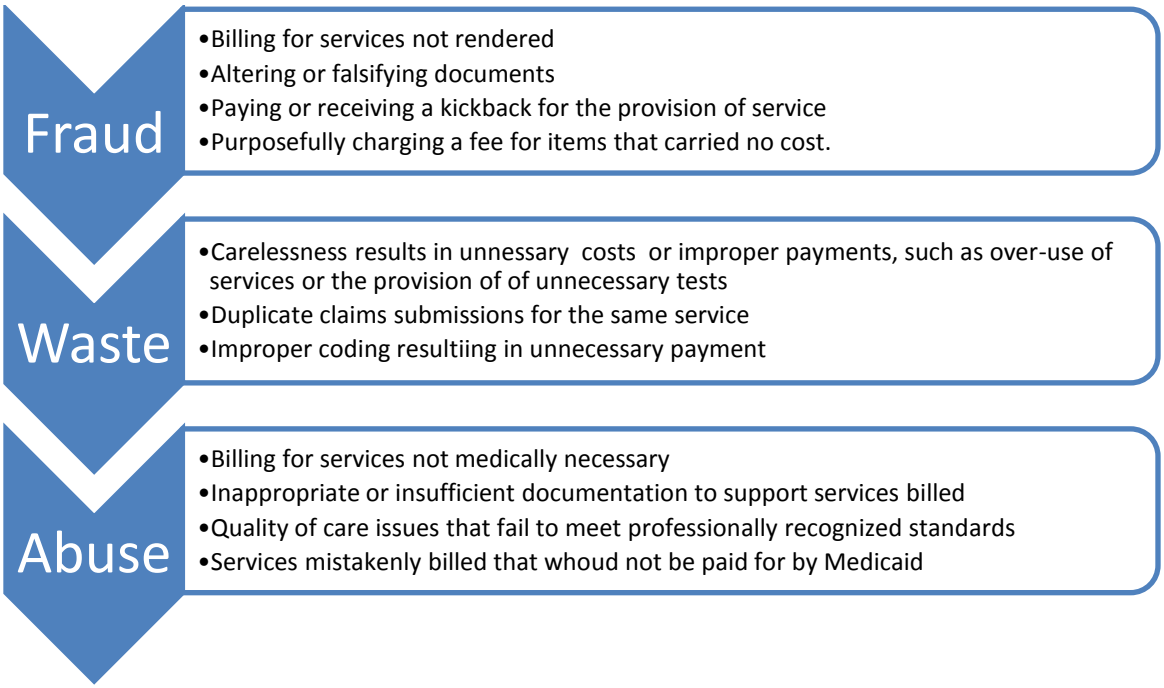
- Balance billing a Medicaid member for Medicaid covered services (e.g., asking a patient to pay the difference between discounted fees, negotiated fees, and the provider’s usual and customary charges)
- Concealing a patient’s misuse of CCAI’s identification card
- Failure to report a patient’s forgery/alteration of a prescription

- Failure to report "Doctor shopping" – when a patient who may or may not have a legitimate physical ailment goes from doctor to doctor to obtain multiple prescriptions for narcotic painkillers

Waste
Waste is defined as the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources owned and operated by CCAI to the detriment of CCAI. Waste involving the provision of heathcare refers to healthcare that is "ineffective." *It can also include fraud and abuse.*

Abuse
Abuse is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices.

The key distinctions of fraud and abuse are intent and knowledge. Waste and abuse allegations can escalate to a fraud investigation if a pattern of intent is determined.



Reporting Fraud, Waste, and Abuse
If you suspect cases of fraud, waste, or abuse you can report them to CCAI, and we will investigate.

No director, officer, employee, volunteer, or contractor who in good faith reports illegal, unethical, or otherwise inappropriate acts, such as violations of applicable laws and/or CCAI

policies shall suffer harassment, intimidation, retaliation or adverse employment consequences.

CCAI maintains a zero-tolerance policy for retaliation or retribution against anyone who reports or participates in an investigation of a compliance concern. Any employee who retaliates against someone who has reported a violation in good faith is subject to disciplinary action up to and including termination.

All FDRs are required to report actual or suspected fraud, waste or abuse. To report suspected fraud, waste, or abuse, you can contact the CCAI Compliance Department.

Community Care Alliance of Illinois
Attention: Chief Compliance Officer
CONFIDENTIAL
322 S. Green Street, Suite 400
Chicago, IL 60607

Telephone: 312-880-1635
E-mail: compliance@ccaillinois.com

You may remain anonymous if you prefer. All information received or discovered by CCAI will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information.

Fraud, Waste & Abuse Training and Education
To comply with the Centers for Medicare and Medicaid (CMS) requirements that all contracted entities provide Fraud, Waste & Abuse training to their employees, governing body members, and FDRs, CCAI will provide FWA training within 90 days of start date, as well as on an annual basis.

SECTION XX: Delegated Oversight

CCAI is accountable for all activities it delegates to any entity, including contracted Medical Groups, IPAs, and PHOs, the PBM, the MHSA provider and third-party administrator. The Delegated Oversight Committee manages oversight and monitoring activities to ensure that delegated entities maintain compliance with regulatory and contractual obligations.

There are four elements of delegation oversight:

1) Pre-delegation Assessment. Prior to formal delegation of any administrative or care-related function, CCAI will evaluate the ability of the entity to perform the activities in accordance with CCAI expectations and business practices, as well as all applicable state, and federal requirements.

2) Delegation Agreement. Once CCAI determines that the activity is able to be performed appropriately and effectively, CCAI will enter into a delegation agreement with the entity. The agreement specifies the responsibilities of both parties, including the delegated activities, reporting frequency, performance evaluation process, and the de-delegation of responsibilities.

3) Annual Oversight Audit. The performance of the delegated entity (delegate) is monitored on an ongoing basis and formally reviewed by CCAI on an annual basis. CCAI uses audit tools that are designed to assess the performance the entity based on the delegation agreement and required regulations.

   Any resulting problems or deficiencies identified will be addressed with a corrective action plan (CAP). A CAP is a formal written response that identifies deficiencies sited during the audit and/or monitoring activity. The CAP addresses each deficiency, and outlines the corrective action(s) and completion timeline required of the delegate. The Delegated Oversight Committee monitors CAP compliance. If the delegate remains non-compliant after the determined timeframe CCAI retains the right to take further action, which may include but is not limited to revocation of delegated responsibilities.

   CCAI will inform the delegated entity of expectations for compliance prior to the annual audit by distributing the content of the audit tool, and conducting compliance education, as necessary.

4) Ongoing Oversight. CCAI conducts ongoing oversight of all delegated entities throughout the year in accordance with a reporting timeframe whereby regular reports are reviewed. Additional oversight methods could include face-to-face meetings, email, and online and phone communications.