- 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 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.
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older

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 (HIPPA) and applicable Federal and State regulations. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

MEDICAL RECORDS TRANSFER FOR NEW MEMBERS

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

MEDICAL RECORDS AUDITS

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

RIGHTS & RESPONSIBILITIES

PROVIDER RIGHTS AND RESPONSIBILITIES

1. Be treated by their patients and other health care workers with dignity and respect.
2. Receive accurate and complete information and medical histories for members' care.
3. Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
4. Expect other network providers to act as partners in members' treatment plans.
5. Expect members to follow their directions, such as taking the right amount of medication at the right times.
6. Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments
    - Provide information regarding the nature of treatment options
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered

- Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment

7. Make a complaint or file an appeal against CountyCare and/or a member.
8. File a grievance with CountyCare on behalf of a member, with the member's consent.
9. Have access to information about CountyCare's quality improvement programs, including program goals, processes, and outcomes that relate to member care and services. This includes information on safety issues.
10. Contact CountyCare's Provider Services with any questions, comments, or problems, including suggestions for changes in the QIP's goals, processes, and outcomes related to member care and services.
11. Treat members with fairness, dignity, and respect.
12. Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
13. Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
14. Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
15. Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
16. Allow members to request restriction on the use and disclosure of their personal health information.
17. Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
18. Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
19. Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
20. Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
21. Respect members' advance directives and include these documents in the members' medical record.
22. Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
23. Allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
24. Collaborate with other health care professionals who are involved in the care of members.
25. Obtain and report to CountyCare information regarding other insurance coverage.
26. Follow all state and federal laws and regulations related to patient care and patient rights.
27. Participate in CountyCare data collection initiatives, such as HEDIS and other contractual or regulatory programs.
28. Review clinical practice guidelines distributed by CountyCare.
29. Comply with CountyCare's Medical Management program as outlined in this manual.
30. Notify CountyCare in writing if the provider is leaving or closing a practice.
31. Contact CountyCare to verify member eligibility or coverage for services, if appropriate.
32. Disclose overpayment or improper payments to CountyCare.
33. Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.

34. Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
35. Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
36. Only provide members with HFS approved health plan marketing materials, including flyers and letters.
37. Not be excluded, penalized, or terminated from participating with CountyCare for having developed or accumulated a substantial number of patients in the CountyCare with high-cost medical conditions.
38. Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
39. Disclose to CountyCare, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice, even if there is no substantial financial risk between CountyCare and the physician or physician group.

MEMBER RIGHTS AND RESPONSIBILITIES

1. To receive information about CountyCare, its benefits, its services, its practitioners and providers and member rights and responsibilities.
2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
3. To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law.
4. To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services.
5. To participate with their providers and practitioners in making decisions regarding their health care, including the right to refuse treatment.
6. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
7. To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
8. To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
9. To receive assistance from both Illinois Department of Healthcare and Family Services and CountyCare in understanding the requirements and benefits of CountyCare.
10. To receive family planning services from any participating Medicaid doctor without prior authorization.
11. To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
12. To receive information on the Grievance, Appeal and Medicaid Fair Hearing procedures.
13. To voice grievances or file appeals about CountyCare decisions that affect their privacy, benefits or the care provided.
14. To request and receive a copy of your medical record.
15. To make CountyCare's member rights and responsibilities policy.
16. To request that your medical record be corrected.
17. To expect their medical records and care be kept confidential as required by law.
18. To receive CountyCare's policy on referrals for specialty care and other benefits not provided by the member's PCP.

19. To privacy of health care needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
20. To exercise his or her rights, and that the exercise of these rights does not adversely affect the way CountyCare and its providers treat the members.
21. To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.
22. To choose a PCP and to change to another PCP in CountyCare's network.
23. To receive timely access to care, including referrals to specialists when medically necessary without barriers.
24. To file for a Medicaid Fair Hearing.
25. To receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc., in a manner and format that may be easily understood.
26. To make an advance directive, such as a living will.
27. To choose a person to represent them for the use of their information by CountyCare if they are unable to.
28. To make suggestions about their rights and responsibilities.
29. To get a second opinion from a qualified health care professional.
30. To information about your rights and responsibilities, as well as the CountyCare providers and services.
31. To receive oral interpretation services free of charge for all non-English languages.
32. To be notified that oral interpretation is available and how to access those services.
33. As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and CountyCare responsibilities for coordination of care in a timely manner in order to make an informed choice.
34. To receive information on the following:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements
    - Cost sharing requirements. Service area
    - Names, locations, telephone numbers of and non-English language spoken by current
    - CountyCare providers, including at a minimum, PCPs, specialists and hospitals
    - Any restrictions on member's freedom of choice among network providers
    - Providers not accepting new patients
    - Benefits not offered by CountyCare but available to members and how to obtain those benefits, including how transportation is provided.
35. To receive a complete description of disenrollment rights at least annually.
36. To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
37. To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, emergency services, and post stabilization services?
    - Emergency services do not require prior authorization.
    - The process and procedures for obtaining emergency services.
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
    - Member's right to use any hospital or other setting for emergency care.
    - Post-stabilization care services rules in accordance with Federal guidelines.

38. To inform CountyCare of the loss or theft of their ID card.
39. To present their ID card when using health care services.
40. To be familiar with CountyCare procedures to the best of their ability.
41. To call or contact CountyCare to obtain information and have questions clarified.
42. To provide information (to the extent possible) that CountyCare and its practitioners and providers need in order to provide care.
43. To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers.
44. To inform your provider on reasons you cannot follow the prescribed treatment of care recommended by your provider.
45. To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
46. To keep your medical appointments and follow-up appointments.
47. To access preventive care services.
48. To follow the policies and procedures of CountyCare and the State Medicaid program.
49. To be honest with providers and treat them with respect and kindness.
50. To get regular medical care from their PCP before seeing a specialist.
51. To follow the steps of the appeal process.
52. To notify CountyCare, Illinois and your providers of any changes that may affect your membership, health care needs or access to benefits. Some examples may include:
    - If you have a baby
    - If your address changes
    - If your telephone number changes
    - If you or one of your children are covered by another plan
    - If you have a special medical concern
    - If your family size changes
53. To keep all your scheduled appointments; be on time for those appointments and cancel twenty-four (24) hours in advance if you cannot keep an appointment.
54. If you access care without following CountyCare rules, you may be responsible for the charges.

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

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

1. 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.
2. 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 follows:
   - Finding and making needed services and resources available
   - Assuring the health and safety of the member
3. 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.
4. Freedom of choice of member's providers for waiver services.
5. The right to choose not to receive waiver services.
6. The right to transfer from one provider to another provider.
7. The right to report instances to his or her provider's supervisor or any CountyCare care coordinator when the member does not believe his or her personal care worker:
   - Does not come to the member's home as scheduled
   - Is not following the care plan
   - Is always late
   - Any other issues or concerns with the personal care worker
8. 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.
9. 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
10. To notify the member's CountyCare care coordinator if the member is entering a hospital, nursing home or other institution for any reason. The member's services will be temporarily suspended until he or she returns home.
11. Notify the member's care coordinator in advance of his or her return home.
12. If the member is hospitalized or in a nursing home or other institution for more than 60 calendar days, the member's services may be terminated.
13. If the member becomes ineligible for waiver services for any reason, he or she must contact the Illinois Department of Human Services to reapply.
14. Notify the member's CountyCare care coordinator if the member is away from his or her home, for any reason, for over 60 calendar days. Services cannot be provided if the member is not at home. If this is the case, services may be terminated.
15. Must notify the provider and the member's CountyCare care coordinator if the member intends to be absent from his or her home when scheduled services are to be provided. The member must notify the provider when you are leaving and when the member is expected to return. The provider will resume services upon the member's return.
16. Must cooperate in the delivery of services. The member must:
   - Notify the provider agency at least one day in advance if the member will be away from home on the day services are to be rendered
   - Allow the authorized worker into the home
   - Allow the worker to provide the services included in the care plan/service plan
   - Do not require the worker to do more or less than what is in the care plan
   - If the member wants to change the care plan, he or she must contact a CountyCare care coordinator. The worker is unable to change it

- The member or other persons in his or her home must not harm or threaten to harm the worker or other participants, or display any weapon

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

1. Be free from mental, emotional, social and physical abuse, neglect and exploitation.
2. All housing and services for which the member has contracted and paid.
3. Have member records kept confidential and released only with the member's consent or in accordance with applicable law.
4. Have access to member records with 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 other 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. 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.
19. Design or accept a representative to act on the member's behalf.
20. 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.
21. Be free to file grievances according to supportive living facility policy and be free from retaliation from the facility.

GRIEVANCES & APPEALS

MEMBER GRIEVANCES AND PROVIDER COMPLAINTS

CountyCare's Grievance System includes an informal complaints process and a formally structured grievance and appeals process. CountyCare's Grievance System is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Section 438 Subpart F., including procedures to ensure expedited decision

- FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

ADDITIONAL CONTRACT TERMS

NO WAIVER OF RIGHTS

Except as specifically waived in writing, failure by a Party to exercise or enforce a right does not waive that Party's right to exercise or enforce that or other rights in the future.

INDEPENDENT CONTRACTOR

Providers shall act as independent contractors and not an agent, employee of or in joint venture with CountyCare. All payments made to providers by the CountyCare shall be made on this basis.

COMPLIANCE WITH THE LAW

Providers and their employees, agents and subcontractors shall comply with all applicable federal, state and local laws, rules, ordinances, regulations, orders, federal circulars and license and permit requirements in their performance under this contract.

Providers shall be compliant with applicable tax requirements and shall be current in payment of such taxes. Providers shall obtain, at their own expense, all licenses and permissions necessary for their performance under this contract.

Providers shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, sexual orientation, gender identity, national origin, ancestry, age, or physical or mental disability, including the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, Executive Orders 11246 and 11375, and 42 CFR 438.3(d)(4).

Providers further agree to take affirmative action to ensure that no unlawful discrimination is committed in any manner, including during or surrounding the delivery of services under this contract.

Providers shall not discriminate against plan members on the basis of their insurance, health status or need for health services.

CONSENT DECREES

Providers shall comply with and assist the plan in its efforts to comply with and assist HFS in complying with all consent decrees, including Colbert v. Quinn, No. 07 C 4735 (N.D. Ill.), and *Williams v. Quinn*, No. 05 C 4673 (N.D. Ill.).

CONFLICT OF INTEREST

Provider certifies that neither they nor any party directly or indirectly affiliated with them, including officers, directors, employees, and subcontractors, and the officers, directors, shall have or acquire any conflict of interest in performance of this contract.

Conflict of interest means an interest of a provider, or any entity described above, that may be direct or indirect, professional, personal, financial, or beneficial in nature; that, at the sole discretion of the Department, compromises, appears to compromise, or gives the appearance of impropriety with regard to provider's duties and responsibilities under this contract. This term shall include potential conflicts of interest. A conflict of interest may exist even if no unethical or improper act results from it, or may arise where provider becomes a party to any litigation, investigation, or transaction that materially affects their ability to perform under this contract. Any situation in which a provider's role under this contract competes with their professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a conflict of interest.

Providers shall disclose in writing any conflicts of interest to the plan no later than seven (7) days after learning

of the conflict of interest. HFS or the plan may initiate any inquiry as to the existence of a conflict of interest. Providers shall cooperate with all inquiries initiated pursuant to conflict of interest.

Providers shall have an opportunity to discuss the conflict of interest with HFS or the plan and suggest a remedy.

Notwithstanding any other provisions under this contract, HFS or the plan shall, at their sole discretion, determine whether a conflict of interest exists or whether a provider failed to make any required disclosure. This determination shall not be subject to appeal by the provider. If HFS or the plan concludes that a conflict of interest exists, or that the provider failed to disclose any conflict of interest, they may impose one or more remedies, including the elimination of the conflict of interest or termination of this contract.

LOBBYING

Providers are prohibited from using federally appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Provider shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at the Provider's request from Provider Services or the HFS Bureau of Fiscal Operations.

This certification is a material representation of fact upon which reliance is placed when any provider agreement is executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, US Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than US $10,000 and not more than US $100,000 for each such failure.