Thank you for participating in Health Alliance Connect. Health Alliance Connect is a health plan designed for individuals enrolled in the Family Health Plan (FHP), the Illinois Medicare-Medicaid Alignment Initiative (MMAI) and the Illinois Integrated Care Program (ICP) for Seniors and Persons with Disabilities.

- Family Health Plan (FHP) exists because the Affordable Care Act (ACA) raised the cap on income levels for people to be eligible for Medicaid to 138 percent of the federal poverty level. Its purpose is to improve the management and coordination of medical and support services for families, men, women and children not eligible for Medicare.

- The Medicare-Medicaid Alignment Initiative (MMAI) is a new program designed for members who qualify for both Medicare and Medicaid Benefits. Its purpose is to coordinate and manage the benefits of both public programs for members.

- The Illinois Integrated Care Program (ICP) is designed for State of Illinois Seniors and Persons with Disabilities (SPD) who qualify for full Medicaid benefits (but who are not dual eligible for Medicare). Its purpose is to improve the management and coordination of medical and support services for members.

This manual is intended as a reference and resource guide for participating Health Alliance Connect providers and office staff. It contains relevant policies and procedures of the program as well as accompanying explanations and exhibits.

The first goal in our association with our participating providers is to develop a mutually beneficial relationship that results in the delivery of the highest-quality care to our members. As a provider, you are integral to successfully coordinating and providing medical care to the Medicare and Medicaid beneficiaries who will be served through the FHP, MMAI and ICP/SPD programs. Their ability to work with members to coordinate care will be essential to program effectiveness. The better you understand these Health Alliance Connect programs and procedures, the greater the likelihood of success for practicing quality, cost-effective medicine with an emphasis on patient education, health promotion and integrated care management. However, this requires all our participating providers to cooperate and comply with the terms of the Participating Provider Agreement and to fulfill their responsibilities set forth in the agreement and this Provider Manual.

This manual will help maximize the value of the program to you and your Health Alliance Connect patients. Remember, members should be referred to Health Alliance Connect Client Services at the number on their member ID card for coverage issues.

Health Alliance Connect will update this manual from time to time based on experience and changes in our products. For your convenience, Health Alliance Connect will make the manual available on our website at HealthAllianceConnect.org. Your input and advice are appreciated. Please direct your comments to your Health Alliance Connect provider relations specialist.
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**Health Alliance Connect**

301 S. Vine St.
Urbana, IL 61801
Monday – Friday
8 a.m. – 5 p.m.
HealthAllianceConnect.org

<table>
<thead>
<tr>
<th>Department</th>
<th>Telephone Number/Email/ Web Address</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services (Claim, Coding or Timely Filing)</td>
<td>1-800-851-3379, extension 4668 <a href="mailto:PSC@healthalliance.org">PSC@healthalliance.org</a></td>
<td>(217) 365-7492</td>
</tr>
<tr>
<td>Electronic Claim Filing</td>
<td>1-800-851-3379, extension 8566</td>
<td>N/A</td>
</tr>
<tr>
<td>Client Services</td>
<td>1-877-933-8480 TTY 1-800-526-0844 or 711</td>
<td>N/A</td>
</tr>
<tr>
<td>Anytime Nurse Line</td>
<td>1-855-802-4612</td>
<td>N/A</td>
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<tr>
<td>Pharmacy</td>
<td>1-877-933-8480</td>
<td>N/A</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>1-800-851-3379</td>
<td>(217) 337-3438</td>
</tr>
<tr>
<td>Language Services</td>
<td>1-877-933-8480</td>
<td>(217) 337-3438</td>
</tr>
<tr>
<td>Illinois Department of Healthcare and Family Services</td>
<td>(217) 782-1200 TDD/TTY 1-800-526-5812 <a href="http://www.hfs.illinois.gov">www.hfs.illinois.gov</a></td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Suspected Abuse – Elder Abuse Hotline</td>
<td>1-866-800-1409 TTY 1-888-206-1327 <a href="http://www.state.il.us/aging/1directory/elder_abuse.pdf">www.state.il.us/aging/1directory/elder_abuse.pdf</a></td>
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Provider Resources

Provider Network

Health Alliance maintains a comprehensive network of medical providers and home and long-term support services to meet the needs of its membership. The Health Alliance Connect FHP, MMAI and ICP/SPD programs have a diverse network to ensure that all service needs of the membership can be met including those members who are participants in the Illinois Home and Community Based Waiver Program.

Health Alliance offers a comprehensive Provider Services function to assist in clarifying the requirements of Health Alliance Connect provider participation, answering questions as needed, providing education and training, and resolving issues as required.

Health Alliance Connect physicians, hospitals, and ancillary providers are a critical to meeting the needs of the Members who will be served through these innovative programs. A brief description of these Health Alliance Connect programs and service populations is provided below.

Family Health Plan (FHP)

Health Alliance Connect’s FHP exists as a result of the Affordable Care Act, which raised the cap on income levels for people to be eligible for Medicaid to 138 percent of the federal poverty level. FHP helps improve the management and coordination of medical and support services for families, men, women and children not eligible for Medicare. These support services include family planning services and supplies, well-child visits, coordination of community resources and more. Health Alliance Connect serves FHP members in the Central Illinois service area.

Medicare-Medicaid Alignment Initiative (MMAI)

The Health Connect MMAI program covers individuals who are dual eligible for Medicare and Medicaid benefits. There are approximately 17,000 dual eligible individuals in the Central Illinois service area that will be served by Health Alliance Connect and at least one other approved health plan. Approximately 50 percent of these individuals are over the age of 65 and will represent a senior care profile. Multiple chronic conditions and multi-systemic disorders will represent a significant percentage of the population to be served. Slightly more than half of the dual eligible population qualifies for the program due to their disabled status.

Integrated Care Plan: Seniors and Persons with Disabilities (ICP/SPD)

Health Alliance Connect also provides services to the ICP/SPD members. Individuals are Medicaid eligible and approximately 15,000 individuals reside in the Central Illinois service area. A significant portion of the ICP/SPD population will exhibit special needs that have to be taken into consideration in planning and delivery care. Individuals may, for example, require special interventions to effectively care for with a range of diagnoses and conditions including motor impairments, chronic mental illness and other chronic disabilities.
Provider Resources

Culturally Competent Care

Health Alliance Connect is committed to providing the highest quality, person centered care for all members. Members in the FHP, MMAI and ICP/SPD programs are a diverse population and by definition exhibit a high proportion of individuals with long term disabilities. It is the responsibility of Health Alliance Connect and our network of providers to deliver medical and Long Term Support Services (LTSS) in a manner that both recognizes and accommodates member needs.

Members represent diverse populations and cultural backgrounds that may also impact the member’s communication needs during the course of care planning and subsequent treatment. All Health Alliance Connect members understand that they will have access to interpreter, signer and TTY services as part of the care provided to them under the plan. It is each provider’s responsibility to help inform members that they have these services available to them at no cost. It is also essential that care be provided in a manner that takes into consideration the race, ethnicity and language needs of member and how these characteristics may impact member health, care planning and treatment. Members have access to Language Lines and Interpreter services 7 days per week, 24 hours per day. Health Alliance Connect will facilitate access to resources including language lines for providers to assist in the delivery of culturally competent care to members. For assistance with accessing available language services please call Client Services at 1-877-933-8480.

The training program, “A Physician’s Guide to Culturally Competent Care” is available through Provider Services and in an interactive educational program designed for physicians and nurse practitioners located at: https://cccm.thinkculturalhealth.hhs.gov/

Health Alliance Training and Education Resources

In order to assist providers Health Alliance Connect makes educational programs and materials available that focus on Cultural Competency and Disability Literacy. It is our goal to provide training opportunities for you and your staff for a range of related areas. In addition to the provision of educational and self-assessment materials, Health Alliance Connect will conduct periodic training sessions and providers including medical and LTSS providers will be required to participate.

The education programs will include information on:

a. The types of chronic conditions prevalent within the target population;
b. Awareness of personal prejudices;
c. Legal obligations to comply with the ADA requirements;
d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;
e. Types of barriers encountered by the target population;
f. Training on person-centered planning and self-determination, the independent living and wellness philosophies, and the recovery model;
g. Use of evidence-based practices and specific levels of quality outcomes; and
h. Working with members with mental health diagnoses, including crisis prevention and treatment.
**Americans with Disabilities Act (ADA)**

Accessibility of doctors’ offices, clinics, and other health care providers is essential in providing medical care to people with disabilities. Due to barriers, individuals with disabilities are less likely to get routine preventive medical care than people without disabilities. Accessibility is not only legally required, it is important medically so that minor problems can be detected and treated before turning into major and possibly life-threatening problems.

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services. These statutes require medical care providers to make their services available in an accessible manner. This technical assistance publication provides guidance for medical care providers on the requirements of the ADA in medical settings with respect to people with mobility disabilities, which include, for example, those who use wheelchairs, scooters, walkers, crutches, or no mobility devices at all.

The ADA requires access to medical care services and the facilities where the services are provided. Private hospitals or medical offices are covered by Title III of the ADA as places of public accommodation. Public hospitals and clinics and medical offices operated by state and local governments are covered by Title II of the ADA as programs of the public entities. Section 504 covers any of these that receive federal financial assistance, which can include Medicare and Medicaid reimbursements. The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504.

Health Alliance will provide information and training to physician offices, agencies and other providers on the importance of ADA-compliant facilities for members who have disabilities. As a resource, Health Alliance Connect Provider Services can provide the Health and Human Services publication “Access to Medical Care for Individuals with Mobility Disabilities.” The publication provides recommendations, including office, exam, furnishings and transfer techniques. A copy is also posted at HealthAllianceConnect.org under the Information for Providers section.

**Medical Homes**

A medical home, also referred to as a “health care home,” is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The medical home features a personal care clinician who partners with each member, their family and other caregivers to coordinate aspects of the member’s health care needs across care settings using evidence-based care strategies that are consistent with the member’s values and stage in life.

**Medicaid Provider**

Providers who provide services to Integrated Care Program members must be enrolled as a Medicaid provider with the State of Illinois and credentialed before they can provide health care to members. To access enrollment forms and other information about how to register with the state of Illinois, please refer to the Department’s website at www.hfs.illinois.gov/enrollment.

**Primary Care Provider (PCP)**

Many Health Alliance plans and products require that members designate a Primary Care Physician (PCP). This will also be true for Health Alliance Connect members in the FHP, MMAI and SPD programs. The PCP may be a Family Practice, General Practice, Internal (Adult) Medicine or Pediatric physician. The PCP is responsible for providing and coordinating the medical care of the member.
Physician Resources

Self-Referrals

Members may self-refer/directly access some services without an authorization from the PCP. These services include behavioral health care, vision care, dental care, family planning, and services provided by Women’s Health Care providers (WHCPs).

Member Assignment to a PCP

Upon enrollment, members choose a PCP for their medical home. If the member does not select a PCP, the Illinois Client Enrollment Broker (ICEB) will automatically assign a contracted PCP to the member. If the member is dissatisfied with the auto-assignment they have received from the ICEB, or wishes to change their PCP for any other reason, the member may choose an alternative PCP by calling Health Alliance Connect.

Reimbursement

Health Alliance Connect reimburses its contracted providers according to the Department’s fee schedule or other contracted rates. The type of reimbursement you receive and the services you are eligible to provide are part of their contract. To view the state of Illinois’ fee schedule for the Integrated Care Program visit http://www.hfs.illinois.gov/reimbursement.

Provider Orientation

Participating in Health Alliance Connect Orientation and Education Programs for Providers. One requirement of the FHP, MMAI and SPD programs is that providers and their staff participate in education programs on topics that will help serve the unique needs of members. These educational programs will include:

- Interdisciplinary Care Team management and coordination
- Member communications and cultural competency
- Special needs of patients with disabilities
- Patient Centered Medical Home development
- Access and ADA compliance training

Ongoing Provider Education

In follow up to provider orientation, Health Alliance Connect Provider Relations Representative will continue to provide ongoing provider training and education, such as routine visits, group or individualized training sessions on select topics (i.e., claims coding, member benefits, Health Alliance Connect website navigation), distribution of provider newsletters containing updates and reminders, and online resources through our website at HealthAllianceConnect.org.
Limited English Proficiency

Health Alliance Connect policies conform with federal government limited English Proficiency (LEP) guidelines stating that programs and activities normally provided in English must be accessible to LEP persons. Services must be provided in a culturally effective manner to members, including those with LEP or reading skills, those with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. To maintain members’ privacy, they must not be interviewed about medical or financial issues within hearing range of other patients.

In compliance with federal and state requirements:

Health Alliance Connect makes certain that LEP members have access to health care and benefits by providing a range of language assistance services at no cost to the member or the provider. Health Alliance Connect offers interpreter and translation services, including sign language interpreters and CART reporting, to providers and members free of charge. These interpreters are qualified and familiar with medical terminology. Participating health care subcontractors are required to provide services to multi-lingual Health Alliance Connect members, utilizing translators for non-English speaking members, telecommunications devices for deaf members, and TTY for blind members. Health Alliance Connect can assist in the provision of these multi-lingual services when requested by the provider or the member.

Health Alliance Connect is making interpretation services available to Integrated Care Program members and providers at no cost. Providers can also make advance arrangements with Health Alliance Connect for personal interpreters, sign language interpreters or CART reporting for the hearing impaired. Contact our Customer Services Department at 1-877-933-8480, TTY 1-800-526-0844 or 711 to learn more about the services.

Language interpretation services are available for use in the following scenarios:
- If a member requests interpretation services, Health Alliance Connect member services representatives will assist the member via a three-way call to communicate in the member’s native language.
- For outgoing calls, member services staff dial the language interpretation service and use an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Health Alliance Connects staff (e.g., care managers) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Health Alliance Connect to link with an interpreter.

Referrals

- Standing Referral: If a member has a condition that requires ongoing specialty care, he or she may ask his or her PCP for a standing referral. The standing referral can be effective for a time period up to one year or a specified number of visits, whichever is less.
- Woman’s Principal Health Care Provider (WPHCP): Female members may obtain services from their designated WPHCP (specializing in OB-GYN or Family Practice) without a referral from their PCP. A WPHCP is not authorized to refer to a specialist. All referrals to physicians for specialty services must be made by or approved by the member’s PCP.
- Before you refer to a specialist or make an appointment for a member, verify that the practitioner is affiliated. Visit our website, HealthAllianceConnect.org, or call the Health Alliance Connect Provider Services Department.
Communications

The Health Alliance Communications Department is happy to assist you in your communications needs as an affiliated provider. If you have questions, please call the department at 217-337-8083 or 1-800-851-3379, extension 8083.

Use of the Health Alliance name and logo
Health Alliance works continuously to maintain a positive brand identity. To this end, Health Alliance closely regulates the use of its name, logo and other identifying references. All providers and other entities must obtain written approval from the Health Alliance Communications Department prior to use of the Health Alliance or Health Alliance Connect name, logo and/or identifying references in publicly disseminated materials including, but not limited to, newspaper ads, fliers, direct mail, pamphlets, brochures, signage, radio and television broadcasts. We ask that you allow 48 hours for review.

Media Relations
HMOs, managed care and Medicare Part D are popular media topics and will continue to be so for some time to come. It is in the best interest of our providers and Health Alliance that all media relations be carefully coordinated for consistency.

If you are contacted by the media with inquiries related to Health Alliance Connect, before you respond:

• Tell the reporter that you are happy to help. Take his or her name and number and say that a representative will return the call promptly.
• Immediately call the Health Alliance Communications Department for guidance.
Counties in the Health Alliance Connect FHP, MMAI and ICP service area include: Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermilion.
Physician Responsibilities

Member Eligibility Verification and ID Cards

All Health Alliance Connect members receive a Health Alliance Connect member ID card (see examples). Members should present their ID at the time of service, but an ID card in and of itself is not a guarantee of eligibility; therefore, providers must verify a member’s eligibility on each date of service. Information such as member ID number, effective date, phone number for health plan, and PCP information is included on the card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. If you are not familiar with the person seeking care, please ask to see photo identification. If you suspect fraud, please contact Provider Relations immediately.

To verify member eligibility, please use one of the following methods:

Log on to the secure provider portal at HealthAllianceConnect.org. Using our secure provider website, you can check member eligibility. You can search by date of service, plus any one of the following: member name and date of birth, or Health Alliance Connect member ID number.
Physician Responsibilities

Call our Customer Service department at 1-877-933-8480, TTY 1-800-526-0844 or 711 from any touch tone phone and follow the appropriate menu options to reach a live Customer Service representative.

**Member Education**

Providers are responsible for educating members about their unique health care needs, sharing the findings of physical examinations, discussing potential treatment options, side effects, management of symptoms, disease prevention and the importance of regular health maintenance. In general, they must recognize that the member has the right to choose the final course of action among clinically acceptable options. Providers must also educate members on how to access emergency and urgent care providers.

**Non-Compliant Members**

It should be the provider’s goal to medically manage members so they comply with treatment plans and attend scheduled appointments, rather than to transfer non-compliant members to another provider. Providers may refer non-compliant members to our Care Management Department at 1-800-851-3379 to assist in promoting compliance by the member.

**Examinations to Determine Abuse or Neglect**

When a State agency notifies Health Alliance Connect of a potential case of neglect and/or abuse of an Integrated Care Program member, we work with the agency and the PCP to help the member to receive timely physical examinations for determination of abuse or neglect. In addition to conducting physical examinations upon request by the county, providers must proactively report suspected abuse and/or neglect of Integrated Care Program members.

**Information Disclosure to Members**

The Illinois Managed Care Reform and Patient Rights Act requires health care providers to supply the following information upon request from an member:

- Educational background, experience, training and board certification
- The names of facilities where the providers have privileges
- Continuing education and compliance with any licensure, certification or registration requirements.

**Physician-Patient Relationship**

Maintaining a conventional patient-physician relationship. Health Alliance Connect encourages open practitioner-patient communication regarding appropriate treatment alternatives and does not penalize practitioners for discussing medically necessary or appropriate care of the patient.

**Appropriate Conversations with Patients**

Health Alliance Connect encourages providers to have open and honest communications with patients. It is recommended that you advise their patients on any of the following:

- the patient’s health status
- medical care and treatment options
- the risks, benefits and consequences of treatment or non-treatment
- the opportunity for the patient to refuse treatment
- future treatment options

The patient has a right to know about all treatment options available and to have direct input into treatment alternatives. Please encourage patients with coverage questions to call Health Alliance Connect Member Services at the number listed on the back of their ID card, or to visit HealthAllianceConnect.org.
Physician Responsibilities

Inappropriate Conversations with Patients

It is inappropriate for you or your staff to initiate discussions with patients about disenrolling from any Health Alliance Connect plan. It is also inappropriate for you or your staff to quote benefit information to your patients; patients should obtain coverage information from Health Alliance Connect Member Services.

Office and Medical Record Requirements

Health Alliance Connect requires that all contracted providers meet our Office and Medical Record Requirements. If a member registers a complaint about one of the criteria listed here, a Provider Relations Specialist will visit the office within 45 calendar days and complete an Office Site Inspection. Offices failing to score 90 percent on the inspection will be resurveyed until the 90 percent threshold is reached. Office sites that fail to reach the 90 percent threshold may be terminated.

Goals and criteria for provider sites include:

- Physical accessibility
- Physical appearance/safety—professional, safe, clean and pleasant environment
- Access to care
- Limited or barred access to medications and medical records
- Equipment licensure and appropriate maintenance
- Confidentiality policy
- Medical record maintenance, availability and documentation of service rendered (see attached policy and procedure)

Each provider office will maintain a secured separate medical record for each patient. All medical information shall be maintained in a confidential manner except as required for medical treatment and care. Medical record keeping must meet Ambulatory Review criteria (see Ambulatory Review process p. 20) and focus on the following six critical elements:

1) Significant illnesses and medical conditions are indicated on the problem list.
2) Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
3) Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
4) Working diagnoses are consistent with findings.
5) Treatment plans are consistent with diagnoses.
6) There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
**Physician Responsibilities**

**Provider's Office Site Inspection**

*MAKE HEAVY DARK MARKS  ERASE CLEANLY TO CHANGE  USE #2 PENCIL OR BLACK PEN  EXAMPLE:

<table>
<thead>
<tr>
<th>Name of Provider/Applicant:</th>
<th>Specialty:</th>
<th>Date of visit:</th>
<th>Service Area:</th>
</tr>
</thead>
</table>

**Check Yes, No, or N/A for the following:**

### I. Physical Accessibility:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

- A. Is there adequate parking?
- B. Is there a ramp for handicapped access?
- C. Are there designated handicapped parking space(s)?
- D. Is there a handicapped accessible toilet or are facility employees available to assist handicapped patients in restroom if needed?

### II. Physical Appearance/Safety:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

- A. Is the exterior of facility presentable and the grounds well maintained?
- B. Is the floor or carpet in good repair?
- C. Is the waiting room clean and free of unnecessary clutter?
- D. Is there adequate space and seating available in the waiting room?
- E. Are the examination rooms clean and free of unnecessary clutter?
- F. Are prescription pads kept away from the public?
- G. Are there appropriate disposal containers available for sharps?
- H. Are the medical instruments, hazardous substances and other potentially dangerous materials kept out of patient areas when not being used/monitored by the physician or medical staff?
- I. Are autoclaves used and properly maintained for sterilization of medical equipment?

### III. Access to Care:(Medical Services)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

- A. Is a routine appointment available for a new patient within 10 working days?
- B. Is a routine appointment available for an established patient within 10-14 days?
- C. Can a new patient be seen for an urgent problem within 24 hours (same day or next day)?
  - If not, can the patient be seen elsewhere within 24 hours?
- D. Can an established patient be seen for an urgent problem within 24 hours (same day or next day)?
  - If not, can the patient be seen elsewhere within 24 hours?
- E. Can a new patient be seen for an emergent need immediately?
  - If not, can the patient be seen elsewhere immediately?
- F. Can an established patient be seen for an emergent need immediately?
  - If not, can the patient be seen elsewhere immediately?
- G. If the average wait time in the office is more than 15 minutes, are patients advised of the potential wait time?
- H. Are there an adequate number of examination rooms available per physician?

### IV. Access to Care:(Behavioral Health)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

- A. Is a routine appointment available for a new patient within 10 working days?
- B. Can a patient be seen for an urgent problem within 48 hours?
- C. Can a patient with a non-life threatening emergency be seen within 6 hours?
- D. Is a patient with a life-threatening emergency seen immediately?
**Physician Responsibilities**

### V. Medical Records:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Are medical records easy to access by staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Are medical records stored away from patient access?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Is there a single medical record for each patient with the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the medical record secured within the chart?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are all pages within the chart secured?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does each member of the family have his/her own medical record?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Are there designated sections in the medical record for notes, reports, diagnostic studies, correspondence, etc?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Is a current complete personal/biographical data sheet easily accessible in the medical record?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>Is a current complete diagnostic/problem list easily accessible in the medical record?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G.</td>
<td>Is there a Policy and Procedure that ensures the confidentiality of medical records?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.</td>
<td>If your Policy and Procedure is written, please attach a copy. If it is oral, briefly explain it below:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VI. Medications:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Are drugs, including manufacturer samples, stored away from patient access?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Are drugs maintained in original manufacturer packaging?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>If a crash cart is maintained, is the cart checked periodically for expiration dates and completeness?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Are all Schedule II drugs stored in a locked area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Are any medications stored in a refrigerator?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>Is the refrigerator with the medications free from food?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS:**

### VIII. Additional Comments:

__________________________

__________________________

**Percent Compliance:**

__________________________

Signature of Reviewer: __________________________

Date: __________

Signature of Provider/Office Representative: __________________________

Date: __________

**Please note:** deficiencies of any safety issue addressed in Section II (E-I) and Section V (A,B, & D) may result in cessation of the credentialing process. The practitioner must provide written substantiation that safety issues have been corrected within 30 days of the site visit date in order to reactivate processing of the Participating Provider application.
# Physician Responsibilities

## Appointment Scheduling Guidelines

<table>
<thead>
<tr>
<th>Access Descriptions (NCQA QI Standard 5)</th>
<th>Definition</th>
<th>Accessibility Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventive Care</td>
<td>Preventive care, annual physical, wellness visits, or gynecological exams</td>
<td>Within 5 weeks of request</td>
</tr>
<tr>
<td>2. Routine Primary Care</td>
<td>Primary care for non-urgent symptomatic conditions (differentiates it from wellness visits), such as chronic health problem or ongoing illness in which the member is experiencing no significant change in ADL’s; i.e., HTN, seasonal allergies, medication checks</td>
<td>Within 10-14 days of request</td>
</tr>
<tr>
<td>3. Prenatal Visits</td>
<td>Initial Prenatal visits without expressed problems the first trimester</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td></td>
<td>Initial Prenatal visits without expressed problems the second trimester</td>
<td>Within 1 week of request</td>
</tr>
<tr>
<td>4. Urgent Care</td>
<td>Sudden, severe onset of illness or health problem requiring medical attention; i.e., sore throat with fever, localizing abdominal pain</td>
<td>Within 1 business day</td>
</tr>
<tr>
<td>5. Emergency Care</td>
<td>Sudden severe injury or symptoms requiring immediate attention; i.e., chest pain with cardiac HX/unrelieved by NTG, uncontrolled bleeding</td>
<td>Provide and/or refer for emergency care immediately</td>
</tr>
<tr>
<td>6. After-hours Care</td>
<td>Practitioners are available to members 24 hours a day either directly or by call coverage*</td>
<td>Answering system that arranges access of: ER calls = 30 minutes Urgent = 24 hours Life-threatening = refer to appropriate health care facility</td>
</tr>
</tbody>
</table>

**Sources:** 2011 NCQA Standards and Guidelines and MMAI Requirements

* If you use an answering machine, please make sure the recording specifically includes the following information. NCQA requires messages include instructions for the terms urgent, emergency and life threatening. “If this is an urgent situation, please contact (appropriate contact). If this is an emergency or life-threatening situation, please call 911 or go to the nearest emergency room.”

## Accessibility Standards for Behavioral Health Issues

<table>
<thead>
<tr>
<th>Access Descriptions (NCQA QI Standard 5)</th>
<th>Maximum Allowable Waiting Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-Life-Threatening Emergency</td>
<td>6 hours</td>
</tr>
<tr>
<td>2. Urgent Care</td>
<td>48 hours</td>
</tr>
<tr>
<td>3. Routine Office</td>
<td>10 working days</td>
</tr>
</tbody>
</table>

**Sources:** 2011 NCQA Standards and Guidelines
PURPOSE OF THE POLICY

To provide guidelines for the maintenance of well-documented medical records at provider sites to facilitate communication, coordination and continuity of care and promote efficiency, safety and effectiveness of treatment, leading to better health outcomes.

STATEMENT OF THE POLICY

The medical records, whether electronic or on paper, communicate the member’s past medical treatment, family history, past and current health status, and treatment plans for their health care.

PROCEDURES

1. Contents and Organization

1.1 A single medical record should exist for each patient.
1.2 Attempts should be made to have all aspects of patient care reflected in the medical record. If some care options, i.e., home care, ambulance records, are not available for inclusion within the record, communication should exist as to the location of those specific care records.
1.3 Contents of the medical record should be secured-fastened.
1.4 Each entry should be indelibly added to the medical record.
1.5 Records should be organized for easy access by filing appropriate information together, i.e., biographical information, progress note, diagnostic studies, past medical history, etc.

- Contents should include, but are not limited to, the following:
  - All services provided directly by the PCP
  - All ancillary services and diagnostic tests ordered by the practitioner
  - All diagnostic and therapeutic services for which a member was referred
  - History and physical
  - Allergies and adverse reactions
  - Problem list
  - Current Medications
  - Documentation of clinical findings and evaluation for each visit
  - Preventive services/risk screening
  - BMI percentile or value
  - Family History
  - Smoking Status (exposure to second-hand smoke for children)
  - Alcohol Status (for those over 14 years of age)
1.6 Information should be kept in chronological order within each section.
1.7 Documentation on whether or not a member has executed an advance directive is included in the medical record.
1.8 Documentation of advance directives is placed in prominent part of a member’s medical record.
1.9 All clinical information filed into a patient’s chart should be signed by that patient’s provider in order to note that it has been reviewed prior to filing. For an electronic chart, a time/date stamp of the review date is sufficient.

2. Storage, Availability and Confidentiality

2.1 Each provider site determined and maintains a tracking system for medical record storage and retrieval for various routing needs, such as:
   • Scheduled appointments prior to time of service
   • Same-day scheduled appointments as soon as possible
2.2 In the event a medical record is not available at the time of service, there should be a mechanism to include any related documentation of a visit into the medical record in a timely manner.
2.3 Medical record organization and storage should allow for easy retrieval. Records should be stored on site, in a secure area away from patient/visitor access to ensure confidentiality of PHI.
2.4 Offices must ensure that staff receives periodic training in confidentiality of member information.

3. Follows standards as outlined in:

3.1 *Ambulatory Review for Primary Care Practitioners P&P* and Ambulatory Review For that support:
   • Specific medical record documentation criteria
   • Performance Goals
Physician Responsibilities

Health Alliance Ambulatory Review Process

**WHAT is an ambulatory review?**
An ambulatory review is a medical record review conducted by Health Alliance to ensure quality care is provided to our members. It is a process for evaluating a primary care physician’s (PCP) documentation of member visits.

**WHY do we conduct ambulatory reviews?**
The Illinois Department of Public Health (IDPH), per the Health Maintenance Organization Act, requires Health Alliance to have a program for the review and evaluation of medical record documentation of primary care physicians once every two years. In an effort to ensure quality care is provided to our members, Health Alliance scores each ambulatory review, and includes that score as part of the recredentialing process conducted every three years.

**WHO conducts an ambulatory review?**
Ambulatory reviews are conducted by our medical record review staff from the Quality and Medical Management Department. The medical record reviewer will contact the primary care physician’s office to coordinate a review date, which will include confirmation of the appointment and a list of charts identified for review.

If there are any questions or concerns at any time during the review process, feel free to contact your medical record reviewer at 217-337-8112 or qualitymanagement@healthalliance.org.

**WHEN is an ambulatory review conducted?**
New Primary Care Physicians are reviewed within their second year of affiliation with Health Alliance, as long as they have 50 or more members on their panel. Subsequent reviews are completed according to the following schedule:

<table>
<thead>
<tr>
<th>Compliance Rating</th>
<th>Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100%</td>
<td>Two Years</td>
</tr>
<tr>
<td>≤ 89%*</td>
<td>6 months</td>
</tr>
</tbody>
</table>

*If a compliance rating is ≤ 89%, a corrective action plan must be submitted to Health Alliance by the Primary Care Physician within 10 working days of receiving their compliance rating.

**HOW is the criteria applied?**
Our medical record reviewers utilize specific criteria based on record keeping, confidentiality and quality of care to evaluate 10–12 member visits for each Primary Care Physician. Some of the criteria may not be applicable for a review based upon the member’s age, gender and/or medical history. If the criteria are not applicable, it will not be factored into the compliance rate.

Health Alliance reviews criteria for ambulatory reviews each year to ensure the best quality of care is being provided to our members. Any changes to the ambulatory review, including new, deleted or modified criteria, will be communicated at least 30 days in advance in writing to the providers.

The following pages provide an overview of the categories.

**Indicates the following:** For monitoring purposes only. Questions will not be scored.

**Section I – Record Keeping/Confidentiality**

- Does staff receive annual training on confidentiality? – The primary care physician office is responsible for providing proof of a written policy regarding confidentiality to the reviewer.
- Does provider have a policy for record retention/retirement? – The primary care office is responsible for providing proof of a written policy regarding record retention and retirement of member records.
- Is biographical data in the record? – Current biographical data such as member name, address, DOB, etc. is recorded in a designated area.
- Electronic Medical Record?**
Physician Responsibilities

• Provider maintains an active record for each member? – A separate medical record should be maintained for each member.
• Are records organized/stored for easy retrieval?
• Are records stored securely and allows access to authorized personnel only?
• Are records current and complete, containing services by PCP?
• Are records legible?
• Is each entry permanently added to medical records? Information should not be entered in any method that can be removed, washed away or erased.

Section II – Information Specific to Date of Service
• Entry is dated? – The date of selected visit should be documented.
• Chief Complaint? – The reason the member sought care should be clearly documented.
• Was a blood pressure performed (≥ 18 years of age)? – A blood pressure ready for member who sought care should be clearly documented.
• Assessment noted? – Objective and subjective information regarding the member’s presenting complaint should be recorded.
• Current diagnosis present and consistent with findings? – Diagnosis for date of visit should be clearly documented and consistent with findings.
• Plan of treatment, including health education, documented? – The plan of treatment should be consistent with the diagnosis of visit. Health education should be noted for visit, including discussion of treatment, disease processes, diet, exercise, medication side effects, anticipatory guidance, and distribution of informational pamphlets. Follow up correspondence will also be reviewed.
• Is each entry signed/initialed by Primary Care Physician? – All entries should be signed or initialed by the provider. This includes both manual and electronic entries.

Section III – Preventative Care – Other
• Are allergies or NDKA documented? – Notation of allergies and the specific reactions should be noted. If there are no allergies, “NKA” or ‘NDKA” should be noted.
• Medical history, including any relative to current episode of care documented? – Notation of current, failed, past medications should be documented.
• Is current problem list documented? – Problem list for date of visit should be clearly documented.
• Are physicals documented? – Notation of routine physicals should be documented.
• Are medications documented? – Notation of pertinent medical history such as chronic conditions, malignancies, surgeries.
• Is family history documented? – Notation of pertinent family history of all members should be on a history form during a recent physical. If there is not significant history, a notation should be made. Notation of family history should be at least every five years.
• For members 65+, advanced care planning included? – For members 65+, evidence in the medical record of a living will or power of attorney should be present.
• If advanced care planning is included, is it in a prominent part of the member’s record? – Evidence in the medical record of a living will or power of attorney should be in a prominent part of member record.

Preventive Care – Preventive Services/Risk Screenings
• Notification of the use of tobacco? – The use of tobacco should be assessed on all members regardless of age. Because of the effects of second-hand smoke, infants and children should be assessed for the presence of a smoker in the home.
• Notation of smoking cessation counseling/referral?
• For members age 18–74 is BMI documented?
• If BMI is documented is it < 25%?***
• For members age 2–17, is BMI percentage documented?
• For members age 2–17, is counseling for nutrition and physical activity documented?
Physician Responsibilities

- For members age 50–80, did member have a discussion/counseling with physician on appropriate cancer screening for appropriate care?
  - If Y, did member have colorectal cancer test?***
  - If N, did member refuse colorectal cancer test?***
- Immunization Records – Providers should maintain an age appropriate immunization record for all members.
  - For patients two years old:
    ~ Appropriate immunizations completed by 2nd birthday - four DTap, three IPV, one MMR, three HiB, three HepB, one VZV, two Hepatitis A, three rotavirus and two influenza vaccinations.
    ~ If all immunizations are not present, were they refused?**
  - For patients 13 years old:
    ~ Appropriate immunizations completed by 13th birthday – two Hepatitis A, three rotavirus, two influenza, one meningococcal.
    ~ If all immunizations are not present, were they refused?**
  - For patients ≥ 65 years:
    ~ Appropriate immunizations to be completed? One pneumococcal within past 5 years and one influenza within the past 12 months.
    ~ If immunizations are not present, were they refused?**
- For female patients age 16–25, was sexual activity assessed? For females age 16–25, the chart should contain documentation that sexual activity is assessed, and if the patient is sexually active, a test for Chlamydia is conducted and/or discussed.
  - If Y and sexually active, test for Chlamydia was discussed?**
  - If Y and test was discussed, was it refused?**

Family Planning Services

Members can get family planning services from any qualified Medicaid provider in or out of our network and without preauthorization or a referral from their PCP.

Health Alliance Connect covers these family planning services:
- Birth control education and counseling
- Birth control pills
- Birth control shots (Depo Provera)
- “Morning after pill”—no preauthorization needed
- IUD (Intrauterine devices)
- Diaphragms
- Condoms
- Foams and suppositories
- Male and female sterilization for members ages 21 and older with completed consent form
- Natural family planning
- Medical and lab exams, including ultrasounds related to family planning
- Treatment of complications that come from using birth control
- Basic infertility counseling, consisting of medical/sexual history review and fertility awareness education
- Sexually transmitted disease screenings
- HIV testing
- These services are not covered family planning services:
- Infertility services, including diagnostic testing, treatment and medications
- Some methods of sterilization
PURPOSE OF THE POLICY

To evaluate medical record documentation by Primary Care Practitioners (PCP) as required by both the Illinois Department of Public Health (IDPH).

STATEMENT OF THE POLICY

Initial ambulatory reviews are conducted within the second year of a practitioner’s affiliation with Health Alliance if an appropriate panel of ≥ 50 members exists. Subsequent reviews are completed according to the schedule defined in the scoring section in the procedure. Practitioners include Pediatrics, Adult/Internal Medicine, Family/General Practice and Specialists designated as PCP’s. Practitioners with a panel size of less than 50 members are not reviewed. Ambulatory Review scores are included as part of the re-credentialing process.

PROCEDURES

1. HEDIS Coordinator

1.1 Generates monthly report for each in the Ambulatory Review database to obtain a list of due and overdue reviews, updated member panel size per provider, as well as a terminated provider listing, for each Medical Record Reviewer.

1.2 Sends copy of the report to assigned Medical Record Reviewer indicating new, overdue and terminated providers that need ambulatory review.

2. QMM Medical Record Reviewer

2.1 Coordinates date for review with practitioner office 3–4 weeks prior to review date.

2.2 Notifies HEDIS Coordinator of appointment date.

2.3 Generates a query of medical records to be reviewed from provider claims history in the Crystal Enterprise software.

2.4 Randomly selects visits/claims from the query report including acute illnesses, complete physical exams, and chronic disease visits for pediatric, adult and geriatric patients. If the query report does not list at least 10 visits (even with a query of visits for the past 12–24 months), request a new query from HEDIS Reporting Manager.

2.5 Prepares Ambulatory Review database input file prior to review and sends to Data Analyst to be loaded into database.
Physician Responsibilities

3. QI Coordinator I

3.1 Maintains Ambulatory Review database and makes changes to database structure, forms, programming and reports to reflect changes to Ambulatory Review criteria.

3.2 Upon notification that a database input file is prepared, examine file to validate data and verify that it was entered appropriately.

3.3 Imports data from input file into a database file. Verify that data imported correctly and run any data manipulations necessary (e.g. age calculation).

3.4 Place database file on J drive and notifies the Medical Record Reviewer that it is available.

4. Medical Record Reviewer

4.1 Sends a confirmation letter via fax or mail to physician office with an attached list of medical records with date of birth to be reviewed.

4.2 On the day of the review, Medical Record Reviewer shall review database for completeness prior to leaving a practitioner’s office.

4.3 Takes query report to the review. If any of the pre-requested medical records are not available at the time of the review, a different member/visit may be randomly selected and reviewed from the query report.

4.4 For those physicians with a small number of members assigned, it is critical the sample consist of all the visits requested. If the physician’s office cannot provide documentation to support evidence of a visit for which they billed Health Alliance, this should be noted on the Ambulatory Review form and a report will be made to the Credentialing Committee and included in the Provider Notification Letter.

4.5 If reviewer has any concerns that come to light during the review at the provider’s office, they should fill out the provider site concern form and forward form to the Credentialing Manager.

4.6 Provides feedback and preliminary score to the physician’s office prior to leaving.

4.7 Notifies HEDIS Coordinator of any scores that fall below passing, upon return from the visit.

4.8 Forwards the completed database reviews to the QI Coordinator I following completion of the review.

4.9 When the QI Coordinator I sends a report indicating the provider name, score and date, the Medical Record reviewer should review and approve the Provider Notification Letters being sent out.

5. QI Coordinator I

5.1 Upon notification that Record Reviewer has completed reviews, retrieves database file and cleans data by removing extra records and ensuring that the required number of records are completed and scored appropriately.

5.2 Creates and stores provider reports (PDFs) for each provider contained in the database file.

5.3 Updates main Ambulatory Review database by adding data from database file into the main database and entering provider scores and review information into the score tracking table.

5.4 Backs up files by exporting data in main Ambulatory Review database to storage files.

5.5 Notifies HEDIS Coordinator that processing is completed and sends the practitioner reports.

5.6 A report is sent to the Medical Record Reviewer indicating the provider name, date of review and score. The Medical Record Reviewer should approve prior to sending out the Provider Notification Letters.
6. **HEDIS Coordinator**

6.1 Formats result letter for each practitioner based upon compliance score upon receipt of provider reports from the QI Coordinator I.

6.2 Upon completion, files a copy of the letter and distributes letters with the Ambulatory Review Result Sheet to:
   - Practitioner
   - Medical Record Reviewer – Notified that letters are filed, and they can go to that file to review the result letters. A report is also sent to the Medical Record Reviewer indicating the provider name, date and score.
   - Credentialing Department to be filed in the practitioners credentialing file.

6.3 **Scoring**
   - New Primary Care Practitioners meeting minimum panel size requirements are reviewed within their second year of affiliation with Health Alliance. Subsequent reviews are completed according to the following review schedule:
     Compliance rating:
     - 90%-100% - Next review date 2 years
     - ≤89% - Next review date 6 months in conjunction with a corrective action plan from the practitioner.

6.4 If a practitioner receives <89%, sends memo to appropriate regional medical director with copy of practitioner letter and results.
   - Letter sent to practitioner via Certified Mail.
   - Coordinates communication to the appropriate regional Medical Director, via e-mail, if the practitioner has not submitted a response/action plan within ten (10) working days.
   - Forwards action plan to Credentialing to file.

7. **Regional Medical Director**

7.1 Contacts practitioner if action plan/response is not received within 10 working days from date of notification letter. An email will be generated from the HEDIS Coordinator if this is necessary.

8. **Credentialing Committee**

8.1 Reviews scores at six (6) month re-review results if prior scores ≤ 89% does not improve.

8.2 If problem cannot be corrected and the score does not improve, the Credentialing Committee will evaluate termination of the practitioner’s contract.
Physician Responsibilities

Credentialing Process
The credentialing process applies to all participating practitioners licensed in the states in which Health Alliance is qualified to do business.

The credentialing process is performed at the Health Alliance office in Urbana. Our internal goal is to complete the credentialing process in 35 business days depending on licensure, standing, medical malpractice history, board certification status, responses from references, affiliations and the Credentialing Committee’s review.

All participating practitioners are required by NCQA to complete the credentialing process before being added to the provider network. MDs, DOs and DCs in the state of Illinois will be recredentialed in accordance with the Illinois Department of Public Health regulations on recredentialing. All other providers will be recredentialed every 36 months.

Health Alliance adheres to standards set by the NQCA and Centers for Medicare & Medicaid Services (CMS) to ensure the quality of our provider network. Legal and accreditation requirements mandate a thorough credentialing process for all managed care plans. We have obtained Excellent Accreditation from NCQA for our HMO, POS and Medicare HMO products.

The following credentialing policies and procedures provide an overview of the process.
PURPOSE OF THE POLICY

The purpose of this policy is to establish the procedures which the Company staff will follow in:
1. processing initial applications from applicants to become Participating Practitioners, and reapplications by former Participating Practitioners and applicants who have either withdrawn prior applications or whose applications to become Participating Practitioners have been denied by the Company;
2. conducting credentialing activities of applicants referred to in Section 1;
3. conducting recredentialing activities required by the Company;
4. ensuring that the Company maintains the highest credentialing standards possible;
5. establishing the procedures to be followed by the Company’s staff in notifying applicants who fail to meet the Company’s criteria to become a Participating Practitioner; and
6. meeting the requirements of applicable NCQA Credentialing Standards, CMS Standards, and by applicable State law.

STATEMENT OF THE POLICY

It is the policy of the Company that:
1. formal procedures and criteria be established for the application, credentialing, and recredentialing of Participating Practitioners;
2. all applicants be treated in a courteous, professional manner, including individuals who do not meet the Company’s criteria to become a Participating Practitioner;
3. approval by the respective Departments of Public Health, or their equivalent, (in all states) in which the Company is qualified to do business, as required for primary care physicians be obtained when required;
4. recredentialing of Participating Practitioners be conducted, not more than once every 24 months unless indicated by quality of care concern(s) and at least every 36 months; and e) to implement procedures to ensure these policies comply, at all times, with all applicable state and federal laws and regulations relating to credentialing of Participating Practitioners.

APPLICABILITY

This policy applies to all physicians (Medical Doctors and Doctors of Osteopathy), podiatrists, dental practitioners who perform services under medical benefits, optometrists, chiropractors, licensed behavioral health practitioners, nurse practitioners and any other independent healthcare practitioners licensed in the states in which the Company is qualified to do business who are invited by the Company to complete and submit an application to the Company to become a Participating Practitioner, regardless of the product for which the provider is contracted.
Physician Responsibilities

PROCEDURES

1. The Credentialing Committee

1.1 The Credentialing Committee (Committee) will:
   • Evaluate potential applicants and make decisions regarding credentialing of applicants and Participating Practitioners.
   • Review and evaluate information received during the credentialing process to determine if the applicant possesses the skills, training, ethics and background necessary to provide care to members.
   • Determine if there is insufficient information on which to base a decision regarding an application, and request additional information from the applicant or other parties if needed.
   • Withhold processing of applications from applicants who do not provide requested information until information is received, or, in the event of substantial delay and after repeated requests, remove the application from further consideration.
   • Require a new application from any applicant who was removed from consideration prior to reconsideration.
   • Annually review and revise, if necessary, all credentialing applications, policies and procedures, and all other credentialing documentation.

1.2 The Committee shall have the final authority to approve applicants as new Participating Practitioners, and to renew, terminate, or suspend Participating Practitioners as a result of the credentialing process. The Committee’s authority to approve an application, or to renew or terminate a Participating Practitioner is limited to those applicants the Chief Executive Officer of the Company, or his or her designee, has determined applications should be extended to or renewed. The Committee shall hold bimonthly meetings, unless no applications are awaiting review and consideration. The Committee Chairman may call a special meeting of the Committee to review pending applications when the number of applications cannot be reasonably and timely considered by the Committee at its regularly scheduled meetings.

2. Initial Credentialing Process

2.1 The Credentialing process will begin when a complete application has been received. A complete application must contain:
   • A completed credentialing application, either the Illinois Health Care Professional Credentialing and Business Data Gathering form for MD/DO/DC’s in Illinois or the Health Alliance application or the application designated by the state in which the provider practices;
   • Languages (other than English), including American Sign Language, spoken by the applicant or office staff.
   • A complete educational and work history, broken down by month and year, with any gaps in excess of six (6) months explained in writing;
   • Copy of current, valid Drug Enforcement Administration (DEA) registration from all states in which the applicant currently practices;
   • Copy of current, valid certificate of insurance and
   • Written explanations of all malpractices actions.

2.2 The Committee, or its designee(s), will obtain and review verification of the following information from a primary source:
   • A valid license to practice in all states in which the applicant sees members. Company staff will verify with the appropriate state licensing agencies that the license is active and in good standing via the agency website, phone call, or facsimile. (Please refer to Inquiry of Adverse Action Against Applicants and Participating Practitioners Documented by State Regulatory Agencies policy).
Physician Responsibilities

- If applicable, clinical privileges in good standing at the hospital designated by the applicant as his or her primary admitting facility. Company staff will verify Clinical privileges with the facility via signed/dated letter, via telephone or via website designated by the hospital.
- A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, from all states in which the applicant sees members. The applicant must provide a photocopy of licenses. Company staff will verify one of the above-mentioned licenses with the appropriate licensing agency via the agency website, phone call, or facsimile.
- Completion of residency, graduation from medical school or graduation from professional school, as applicable. Education is verified via the school’s designated verification service, the educational facility directly, the AMA Masterfile, or the AOA.

2.3 Board certification status may be verified. The following sources are acceptable:
- MDs – Certifacts Online, AMA or the issuing board
- DOs – American Osteopathic Association Website or Certifacts Online
- Podiatrists – American Board of Podiatric Surgery
- Oral Surgeons – American Board of Oral and Maxillofacial Surgery or ABMS

2.4 If the applicant’s Board Certification is verified, Education is not verified.

2.5 Current malpractice insurance in accordance with the amounts established by the Committee. A copy of the applicant’s current malpractice insurance policy facesheet must clearly state the name of the company, coverage dates and amount(s) of coverage, and the covered entity.

2.6 Professional liability claims history. Applicants must provide detailed written information regarding past or pending claims for malpractice, whether or not submitted to their insurance carrier.

2.7 If requested by the Committee, the applicant must provide at least one reference from a peer who is not related to or in practice with the applicant.

2.8 The application shall also include statement by the applicant regarding:
- Reason for any inability to perform the essential function of the position, with or without accommodation
- Lack of present illegal drug use
- History of suspension and/or revocation of any license
- History of felony convictions
- History of loss or limitations of privileges or disciplinary activity
- Complete work history with any gaps of six months or more explained, in writing

2.9 The applicant must attest to the correctness and completeness of the information set forth in the application. Attestations must contain an original handwritten signature by the applicant. Signatures that are affixed by stamp, photocopied or electronically or mechanically produced will not be accepted.

2.10 The Committee, or its designee(s), will document requests for information and responses regarding the applicant from recognized monitoring organizations.

2.11 The Committee, or its designee(s), will query the National Practitioner Data Bank (NPDB) for all providers subject to credentialing.

2.12 The Committee, or its designee(s), will request information regarding sanctions or limitations on licensure from the appropriate state licensing agencies or other appropriate verification service(s). This information is to be obtained by Company staff from the appropriate state board of medicine at the time the applicant’s medical license is verified.

2.13 For applicants potentially providing care to Medicare members, documentation received from the NPDB also serves as confirmation that the applicant has no Medicare or Medicaid sanctions.

2.14 Applicants have the right to review information submitted by third parties in support of their credentialing applications, including, but not limited to: malpractice insurance carriers, state licensing boards. Documents available for review do not include references, recommendations, peer review reports or other peer review-related materials and information. Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

2.15 Information obtained during processing of the application that varies substantially from information provided to the Company by the applicant will be fully investigated. The Committee or its designee(s)
Physician Responsibilities

may contact any other sources it deems necessary, in its sole judgment, to verify the applicant’s response.

2.16 The Committee, or its designee(s), will contact the applicant regarding the conflicting information received. The applicant will be asked to substantiate the information received and will be allowed to make corrections to erroneous information (refer to the Notification of, and Process for, Applicants to Correct Erroneous Information Discovered in Credentialing Process policy). Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

2.17 The Committee may consider any other factors or information it deems, in its sole judgment, relevant (such as membership in good standing in professional societies, complaints to professional societies, etc.) in making their decision.

2.18 The Application, and all information and materials submitted by the applicant with it, together with all information and materials received in response to requests for information by the Committee, or its designee(s), will be maintained in strictest confidence. All paper information and materials relating to each applicant shall be maintained in a confidential locked file. Access to this file will be restricted to the Committee, or its designee(s). Access to the Credentialing Database and electronic credentialing files are restricted and entered only by pass code.

2.19 The Credentialing Department staff has the option, on a daily basis, to consult with a Health Alliance Medical Director if questions arise.

2.20 Providers who do not meet the Company’s criteria are reviewed by the Committee and either pended for additional information, approved for affiliation as a Participating Practitioner or denied as a Participating Practitioner. The Committee has final authority regarding the acceptance or rejection of all applications. Applicants who are approved for affiliation will be notified in accordance with the CPS New Provider Education policy.

2.21 No members shall be assigned to a provider until their credentialing is complete.

2.22 Health Alliance shall notify the Department of Healthcare and Family Services (HFS) when the credentialing process is completed and provide the results of the process.

2.23 The following shall apply to all applicants who do not meet the criteria to become a Participating Practitioner:

• Any applicant who does not initially meet the criteria for approval as a Participating Practitioner may, in the Committee’s sole discretion, be reevaluated by the Committee according to this policy before notice is given to the applicant that he or she has not been accepted as a Participating Practitioner.

• In conducting its reevaluation of an application under this part, the Committee may consider any factors it deems relevant in making its recommendation regarding final approval or disapproval of an applicant.

• All additional information gathered by the Committee in this process will be maintained in the confidential file.

• The Committee will make a decision regarding the reevaluation of the applicant.

• Applicants who, after the reevaluation, do not meet criteria and are not accepted for affiliation as a Participating Practitioner are to be notified in writing by the Chairman of the Committee within five (5) business days following the Committee’s final decision.

2.24 If a provider marks “yes” to Practice and Health History, question Q, “Have you ever been convicted of a felony?” the Credentialing Department will perform a criminal background check.

2.25 Applicants have the right to be informed of the status of their application. This information may be requested via phone, fax, email or postal mail. Request will be responded to within three business days. Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

3. Recredentialing Process

3.1 Four (4) months prior to the triennial anniversary date of all Participating Practitioners the Committee will recredential each Participating Practitioner. This applies to all practitioners except MD/DO/DCs, in
Illinois. These providers will be recredentialed in accordance with the State of Illinois single recredentialing cycle.

- The Credentialing Coordinator will request a Health Care Professional Recredentialing and Business Data Gathering Form from all MD/DO/DCs, in Illinois and will send a renewal application to all other Participating Practitioners.

3.2 The Committee, or its designee(s), will obtain and review the following information from a primary source:

- A valid state license to practice in all states in which the provider sees members. Company staff will verify with the appropriate state licensing agencies that the license is active and in good standing.
- If applicable, Clinical privileges in good standing at the hospital designated by the practitioner as his or her primary admitting facility. Company Staff will verify clinical privileges via the hospital’s designated web service, signed/dated letter or telephone.
- A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, from all states in which the provider sees members. The Participating Provider must provide a photocopy of licensure. Company staff will verify that one of the above is active and in good standing with the appropriate state licensing agencies, or appropriate verification service.
- Board certification, as applicable. Board certification status may be verified using one of the sources listed in Section 2.3.

3.3 Changes to languages, other than English and including American Sign Language, spoken by the practitioner or office staff

3.4 Current malpractice insurance in accordance with the amounts established by the Committee. A copy of the provider’s current malpractice insurance policy facesheet is to be submitted. The facesheet must clearly state the name of the company, coverage dates and amount(s) of coverage, and covered entity.

3.5 Professional liability claims history. Participating Practitioner must submit written detailed information regarding past or pending claims for malpractice, whether or not submitted to their insurance carrier.

3.6 In addition, the Committee shall obtain a new statement from the Participating Practitioner regarding:

- Reason for any inability to perform the essential function of the position, with or without accommodation
- Lack of present illegal drug use
- History of suspension and/or revocation of any license
- History of felony convictions
- History of loss or limitations of privileges or disciplinary activity
- The Participating Practitioner must attest to the correctness and completeness of the information set forth in the application. Attestations must contain an original handwritten signature by the applicant. Signatures that are affixed by stamp, scanned or electronically or mechanically produced will not be accepted.

3.7 The Committee will document triennial requests for information and responses regarding the Participating Practitioner from recognized monitoring organizations.

- The Committee, or its designee(s), will query the National Practitioner Data Bank (NPDB).
- The Committee, or its designee(s), will request information regarding sanctions or limitations on licensure from the appropriate state licensing agencies or other appropriate verification service.
- NPDB also serves as confirmation that the Participating Practitioner has no Medicare or Medicaid Sanctions.

3.8 During the recredentialing or performance appraisal process for Primary Care Physicians (PCPs) the Committee will review data as described in the Coordinate the Use of Quality Monitoring Information During the Recredentialing Process policy.

3.9 Recredentialing files are available to the Committee if additional information is needed for review.

3.10 The renewal application and all information and materials submitted by the Participating Practitioner with the application, together with all information and materials received in response to requests for information by the Committee, or its designee(s) will be maintained in the strictest confidence. All information and materials relating to each applicant and his or her application shall be maintained in a
confidential file for each Participating Practitioner. Access to this file will be restricted to the Committee, or individuals with the express approval of the Committee.

3.11 The Committee has final authority regarding the acceptance or rejection of all renewal applications. Denied applicants will be notified of the Committee’s decision in writing within 14 business days. Approved applicants will be notified via US mail within 5 business days of approval.

3.12 If a provider marks “yes” to Practice and Health History, question Q, “Have you ever been convicted of a felony?” the credentialing department will perform a criminal background check.

3.13 Recredentialing applicants are entitled to the rights outlined in Sections 2.14, 2.16 and 2.25. They are notified of these rights in the Provider Manual.

4. Documentation

4.1 In documenting verifications obtained during the credentialing and recredentialing processes, the following information is required:
   - Oral verifications – verifications taken over the phone must include a note stating the date the verification was completed, the first name or title of the person giving the verification, the information verified, and the initials of the Company staff member taking the verification.
   - Fax verifications – verifications accepted via facsimile must include the date the facsimile was received, the name or title of the person giving the verification, the information verified, and the initials of the Company staff member who received the verification.
   - Internet verifications – verifications obtained via website will include a print out of the verification screen and will be dated and initialed by the staff member who obtained it. If the verification is too large to print, the company staff member will note, on the document being verified, the date the verification was obtained, the status and expiration date, if applicable, of the document being verified, and the initials of the staff member. If the verification is not printed, the staff member will save the web page as an Adobe Acrobat document and affix a stamp to the document indicating time, date and recipient of the document.
   - Mailed verifications – verifications sent to the Company via mail will be initialed and dated by the person receiving the information.

4.2 All notations on documents must be completed either by computer generated date stamp or ink. Use of pencil on verifications is not permitted.

4.3 All information regarding provider demographics, education, licensure, specialty, and hospital affiliations is housed in a Visual Cactus database. Individual provider summaries and reports relating to credentialing providers are generated from this system. Visual Cactus is housed on a server in the Urbana office and technical support is provided by the Health Alliance Information Technology department with assistance from technical staff at Visual Cactus when needed.

4.4 Verification of applicable credentialing information should not occur, or be dated, more than 180 days prior to the Credentialing Committee’s decision.

5. Preparing Provider Files for Presentation to Credentialing Committee or Credentialing Committee Chair

5.1 After the steps outlined in Section 2 have been completed, the Credentialing Coordinator shall determine if the applicant meets Company criteria as defined in Criteria for Approval as a Participating Practitioner policy. If the applicant does meet Company criteria, the Credentialing Coordinator will print a Credentialing profile sheet and present it to the Credentialing Committee Chair, or his/her designee, for approval.

5.2 If the Applicant does not meet Company criteria, the Credentialing Coordinator will print a Credentialing profile sheet and copy all documentation relating to licensure actions, malpractice cases, hospital affiliation action, criminal history, or any other infractions. This documentation will be submitted to the Credentialing Committee for review at its bimonthly meeting.
5.3 After the steps outlined in Section 3 have been completed for a provider undergoing recredentialing, the Credentialing Coordinator adds the provider to the Recredentialing Checklist. The Recredentialing Checklist contains a summary of a provider’s board certification, malpractice history and quality program information. Any documentation related to the Checklist present in the provider file is copied and placed with the Recredentialing Checklist. The Checklist and supporting documentation are submitted to the Credentialing Committee for review at the bimonthly meeting.

6. Credentialing Providers Who Have Terminated Participation

6.1 A provider who has terminated participation and is otherwise eligible to re-affiliate must complete the initial credentialing process unless they rejoin within thirty (30) days of the effective date of their termination.

6.2 If there are data elements in the provider’s original credentialing/recredentialing file that are less than six (6) months old and can be presented to the Committee prior to expiration, company staff does not have to recollect or re-verify those elements.

7. Updating Provider Information

7.1 When provider information stored in the Credentialing database (Visual Cactus) changes, the database must be updated within thirty (30) days of receipt.

7.2 Updates to provider demographic information that are received by the Credentialing Department are forwarded to Contracting and Provider Services.

7.3 Contracting and Provider Services generates an electronic update.

7.4 Credentialing receives the electronic update and amends the information in the Credentialing Database.

7.5 Information to be updated includes:
   • provider demographic information
   • hospital affiliation
   • board status
   • licenses
   • specialties
PURPOSE OF THE POLICY

The purpose of this policy is to establish the procedures and professional criteria, which are to be followed in processing requests from practitioners to become Participating Practitioners and ensure that applications are complete, accurate and the process is completed in a timely manner.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to maintain standardized, formal criteria for approval as a Participating Practitioner and to provide guidance to the Credentialing Committee (the Committee) in the exercise of its authority to accept or reject application of practitioners to become Participating Practitioners as delegated by Health Alliance Board of Directors.

APPLICABILITY

All practitioners seeking to become Participating Practitioners of Health Alliance in the state of Illinois and all other states in which Health Alliance is qualified to do business.

PROCEDURES

1. Applicants

1.1 Applicants will have (as applicable):
   • Successfully completed professional education and training;
   • A current, valid license;
   • Clinical privileges in good standing at the hospital designated as the primary admitting facility or a referring relationship with an affiliated provider in the same or similar specialty
   • Current, adequate malpractice insurance in amounts determined by the Company;
   • A current, valid DEA certificate; and
   • A current, valid Controlled Substances license.
Physician Responsibilities

1.2 Applicants must meet the following criteria. In the event that an applicant does not meet any or all of the following criteria, the Committee may consider other information or factors that it, in its sole discretion, considers pertinent in making its determination to accept the applicant as a Participating Practitioner.

- Applicants will have had minimal professional liability claims or suits filed against him or her. The Committee will consider:
  - The number of cases (open and closed).
  - The nature of the cases (open and closed).
- Applicants will be physically and mentally able to practice in their profession, with or without accommodation, and have no impairment due to chemical dependency or substance abuse.
- Applicants will have no restrictions on any license to practice, no current disciplinary activity, or current loss or limitation of clinical/hospital privileges.
- Attainment of Board Certification is not itself a criterion, but may be taken into consideration by the Committee.
- Applicants will have no evidence of significant legal difficulties outside of the practice of medicine that may interfere with the ability of the Participating Practitioner to perform his or her duties under the agreement with Company (felony convictions, extensive civil litigation, etc.).
- Applicants must have no history of previous sanction activity by Medicare or Medicaid (if applicable).

1.3 The Committee may consider any other information and factors it deems relevant (such as membership in good standing of professional societies, complaints to professional societies, etc.) in making its decision.

1.4 The Committee has the right to approve new Participating Practitioners and sites. Subject to the Company’s general right to decide whether or not to renew a contract with any Participating Practitioner, the Committee has the duty to investigate matters brought to its attention it believes are relevant to a Participating Practitioner’s ability to perform his or her duties under the terms of their contract with the Company. In the event the Committee determines such facts exist with respect to a particular Participating Practitioner, the Committee may recommend to the Chief Executive Officer and the Chief Medical Officer that the contract between the Participating Practitioner and the Company not be renewed, be terminated, or the Participating Practitioner’s right to serve the Company’s members be suspended for a recommended period of time.

1.5 The Company does not make credentialing/recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, type of procedures the applicant specializes in, or types of patients the applicant specializes in. To ensure credentialing and recredentialing are conducted in a non-discriminatory manner, the Credentialing Committee will:

- Submit a biannual report of all providers denied or terminated to the Quality Improvement Committee. The report will include demographic information and basic academic information about the provider and the reason for denial. If QIC determines a pattern of discrimination may exist, a referral will be made to the Compliance department.
- Ensure that all members of the Committee have signed a non-discrimination statement.

1.6 Applicants that meet all of the Company’s criteria, have no history of malpractice or alleged malpractice, have no history of discipline on any license, have no history of discipline by any educational program, have no criminal history or alleged criminal history, have admitting privileges at an affiliated hospital, and meet the criteria for specialty designation, may be approved for affiliation by review of the Credentialing Committee Chair. In the absence of the Credentialing Committee chair, any physician member of the Credentialing Committee may approve providers for affiliation.

1.7 Company will not credential providers for participation in Federal health care programs if excluded pursuant to section 1128 or section 1128A of the Act.
Physician Responsibilities

2. Specialty Designation

2.1 Applicants requesting specialty designation in the provider directory must hold board certification in that specialty or have completed a residency or fellowship in that specialty. Education/Board certification will be verified.

• Providers who respond on the credentialing application that they hold are qualified in multiple specialties may choose any of the specialties to be listed under in the Provider Directory. Board certification or education will be verified.

2.2 Primary Care Practitioner Designation

• Primary Care Practitioners are defined as physicians who provide primary care services (including family practice, general practice, internal [adult] medicine, and pediatrics) and manage routine health care needs. For women, an obstetrician/gynecologist may be considered a PCP.

• Nurse Practitioners and Physician Assistants may be designated as Primary Care Practitioners in limited situations. Those include:
  • Participation in government programs where medical midlevels are designated as PCP’s (i.e. Medicaid) and/or
  • Practice location in a medically underserved area.

• General Medicine/General Practice. Applicants who are not board certified or otherwise qualified to be listed in a specialty must be listed in the credentialing database and Provider Directory under General Medicine/General Practice if they are approved to become a participating provider.

2.3 Requested change of status from specialist to PCP

• If a practitioner has been previously credentialed as a specialist and requests a change in designation to that of PCP they must demonstrate the following:
  • Applicable education to support request, or;
  • Adequate coursework/CME hours to support request, or;
  • Document that greater than 50 percent of their practice is in providing PCP related services.

• Final determination for requested change is at the discretion of the Credentialing Committee.

2.4 PCP with specialty request

• Primary Care Physician who request to be listed also as a medical sub specialist, must provide one of the following sources of information to support the request:
  • Documentation of completion of fellowship in requested subspecialty;
  • Documentation of board certification
  • Documentation of completion of residency in requested subspecialty;

• Surgical specialties are not eligible to be PCPs.

• Final determination for requested change is at the discretion of the Credentialing Committee.

2.5 No credentialed provider may be designated in a provider directory in a specialty that has not been approved by the Credentialing Committee. In order to ensure accuracy between the specialty designation in the provider directory data and Visual Cactus (credentialing data), the Credentialing Manager will perform a monthly audit of new providers in the provider directory data. Credentialing Manager will confirm that specialty designation is correct. Any inconsistencies will be referred to the Regional Operations Manager for correction.

2.6 No member shall be assigned to a PCP until credentialing process is completed.

3. Use of Practitioner Performance Data

3.1 Participating providers allow the plan to use practitioner performance data, including but not limited to, quality improvement activities and public reporting to consumers.

4. Office Location Change

4.1 A physician who has passed credentialing may change his/her office location within the Health Alliance networks subject to the approval by the Chairperson.
5. **Board Certification**

5.1 The Credentialing Committee encourages all participating providers to attain and maintain board certification in their specialty. For those providers who elect not to become board certified within five years of completion of residency training or let their board certification lapse, the following is required:
- Completion of 50 hours of CME annually, in the area of the provider’s specialty.

5.2 The Credentialing Committee, or its designee, will request this information during processing of credentialing/recredentialing application.

6. **High Volume Specialty Determination**

6.1 Data regarding high volume specialists and high volume behavioral health practitioners is used by the Quality Management Department for a variety of activities. Annually, the Credentialing Manager requests a report to determine which specialists are high volume based on data from the preceding year.

6.2 The methodology used is based on claims data by volume for all provider types for a 12-month period.
- High volume specialists for the most recent time period are: Cardiology, OB/GYN, and Orthopedics.
- High volume Behavioral Health Providers are: Social Work, Psychiatry, and Psychology.

7. **Assessment of Availability of Primary Care, High Volume Specialty Care, and High Volume Behavioral Healthcare Providers**

7.1 Annually, the Quality Improvement Committee assesses the supply of primary care, high volume specialty care and high volume behavioral healthcare providers in the network against geographic data and national physician supply numbers.

7.2 The goal for physician supply numbers is to exceed the minimum supply needed based on a data set supplied by a national vendor. The data set currently in use is from Thomson Reuters/Truven.

7.3 The goal for geographic distribution is for no member to have to travel more than 30 miles or 30 minutes to see a primary care provider. The goal for high volume specialty and behavioral health care is for no member to travel more than 60 miles or 60 minutes to see a provider.

7.4 To assess the supply numbers, the Credentialing Manager requests a report from the Health Alliance Market Intelligence department. An analyst from this department collects Health Alliance physician supply data from the Provider Directory and prepares the report comparing it against the national benchmarks.

7.5 To assess geographic distribution, the Contracting & Provider Services Director uses GeoAccess to map the distribution of Health Alliance providers.

7.6 All data is sent to the Credentialing Manager. The Credentialing Manager prepares a report summarizing all data to present to Quality Improvement Committee.

7.7 QIC reviews the data and makes recommendations to Contracting & Provider Services.
Physician Responsibilities

Midlevel Information

To ensure accurate and prompt claim reimbursements, Health Alliance Connect requires all practitioner offices to submit information about certain midlevel providers in their practice (see list, page 39). Please complete and return the Midlevel Provider Data Form (located on page 152) for each new midlevel practitioner employed by your practice, and be sure to include copies of the:

- midlevel practitioner’s state license
- state controlled substance license
- DEA registration certificate.

This information will be used by Health Alliance to verify the midlevel practitioner’s license. Please use the Provider Addition/Change Form (located on page 150) to notify Health Alliance Connect when a midlevel practitioner terminates employment.

Proper notification of midlevel practitioners will ensure timely payment of claims.

Midlevel supervision: By contracting with a physician, Health Alliance Connect assumes the physician is the primary provider of medical care for beneficiaries and therefore, should be present to see patients in the office at least 50 percent of the time the office is open. The Credentialing Committee must review exceptions to this requirement.

If you have any questions about requirements for midlevel credentialing, please contact a Health Alliance Connect contract coordinator at 1-800-851-3379, extension 3445.

Proper Credentials Ensure Quality Health Care
Midlevel providers play an important role in providing care for our members, and we want Health Alliance Connect members to receive appropriate, high-quality health care from certified or licensed midlevels.

We only reimburse claims submitted by contracted midlevel providers with valid and current state licensure. If you are a member of a contracted group practice, and a claim reimbursement is disallowed because these requirements are not met, by contract you cannot bill an HMO member.

Midlevel Service Billing Clarification
When billing for services provided by a midlevel, please use his or her provider number. Health Alliance Connect does not need the supervising physician’s provider number as long as the midlevel’s provider number is given. When a new midlevel joins your office, please be sure to complete and return the Provider Addition/Change Form and Midlevel Provider Data Form located on pages 150 and 152. Billing for services provided by an individual delivering care outside their scope of practice is considered fraudulent billing and subject to recovery, termination of contract and prosecution to the full extent of the law.
PURPOSE OF THE POLICY

To define which midlevel provider types Health Alliance recognizes for network participation.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to only allow midlevel providers who hold a valid license or certification in their profession to provide services to members. The Credentialing department verifies such licensure or certification in accordance with Verification of Licensure of Midlevel Providers policy and procedure.

PROCEDURES

1. Mental Health Midlevel Provider (must be credentialed)

1.1 Clinical Professional Counselor
   • LCPC, Licensed Clinical Prof. Counselor
   • LPC, Licensed Professional Counselor
   • LC, Licensed Counselor
   • LMHC, Licensed Mental Health Counselor (IA)
   • LP, Licensed Psychologist (IA)
   • LCPC, Licensed Clinical Professional Counselor

1.2 Social Worker
   • LCSW, Licensed Clinical Social Worker
   • LSW, Licensed Social Worker
   • LISW, Licensed Independent S.W. (Iowa)
   • LMSW, Licensed Masters S.W. (Iowa)
   • LBSW, Licensed Bachelors S.W. (Iowa)

1.3 Marriage/Family Therapist
   • LMFT, Licensed Marriage Family Therapist
   • LMFC, Licensed Marriage Family Counselor
   • NP, PA, APN, PA-C with a specialty in mental health
Physician Responsibilities

1.4 Autism
• BCBA Board Certified Behavioral Analyst (must have Master’s Degree, be certified by the Behavioral Analysts Certification Board and have completed 225 graduate classroom hours.
• BCaBA – Board Certified Assistant Behavioral Analyst (must have Bachelor’s Degree, be certified by The Behavioral Analysts Certification Board and have completed 135 classroom hours)

2. Medical Midlevel Provider

2.1 Nurse Practitioner/Physician Assistant
• PA, PA-C, Physician Assistant
• APN, Advanced Practice Nurse
• APRN, Advanced Practice Registered Nurse
• ARNP, Advanced Registered Nurse Practitioner
• CFNP, Certified Family Nurse Practitioner
• CGNP, Certified Geriatric Nurse Practitioner
• CNP, Certified Nurse Practitioner
• CNS, Clinical Nurse Specialist
• CPNP, Certified Pediatric Nurse Practitioner
• CRNA, Certified Registered Nurse Anesthetist
• FNP, Family Nurse Practitioner
• FNPC, Family Nurse Practitioner, Certified

2.2 Nurse Practitioner
• NP, Nurse Practitioner
• RNFA, Registered Nurse First Assistant
• RNP, Registered Nurse Practitioner

2.3 Nurse Midwife
• CNM, Nurse Midwife

3. Ancillary Midlevel Providers

3.1 Physical Therapist
• PT, Physical Therapist
• RPT, Registered Physical Therapist
• LPT, Licensed Physical Therapist

3.2 Occupational Therapist
• OT, Occupational Therapist
• OTRL, Occupational Therapy, Registered License

3.3 Speech Therapist
• ST, Speech Therapist
• SP, Speech Pathologist
• SLP-CCC, Speech Language Pathologist

3.4 Audiologist
• CCC-A

3.5 Dietitian
• RD, Registered Dietitian
• LD, Licensed Dietitian
• LNC, Licensed Nutrition Counselor
Physician Responsibilities

Risk Adjustment Coding and Documentation

Health Alliance Connect contracts with the Centers for Medicare & Medicaid Services (CMS) and Illinois Health and Family Services (HFS) to offer the Family Health Plan (FHP), the Medicare-Medicaid Alignment Initiative (MMAI) and the program for Seniors and Persons with Disabilities (SPD) plans. Both of these programs are being provided under the name Health Alliance Connect.

CMS payment for Health Alliance Connect plans is based on risk adjustment methodology that reimburses health plans based on the health of the individual member. The risk of the individual member is determined by the diagnosis codes included on the claim submitted to Health Alliance Connect and passed to CMS.

Medicare has classified about 3,000 of the 14,000 International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes into Hierarchical Condition Categories (HCCs) or categories designating higher-cost to conditions, such as diabetes, kidney failure, atrial fibrillation, etc. When patients are assigned these ICD-9 codes, Medicare sees those members as sicker than the “average” Medicare member, resulting in higher reimbursement from CMS. In this program we are reimbursed by diagnosis codes, not CPT codes.

The Provider’s role in this process is to submit medical record documentation that is clear, concise, consistent, complete and legible. All diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim. To that end, an increased emphasis is being placed by Health Alliance Connect on provider education and recommendations related to HCCs, diagnosis and documentation regulations.

Coding and Documentation

HCCs are given a severity ranking, the higher medical risk to the patient, the higher the ranking. It is important to accurately follow normal coding practices. Specificity is of utmost importance and all codes that apply to a particular visit must be documented. The medical record documentation must support that the diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient or physician) and an acceptable physician data source as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to ICD-9-CM Guidelines for Coding and Reporting. For example, if a patient is diabetic and has other problems associated or caused by the diabetes, use the more specific codes 250.4x or 250.5x, etc. instead of 250.0x

Scenario

This example provides an illustration of how coding specificity can impact risk adjustment payments.

Herny Smith is a 68-year-old male living in Champaign. He has a history of colon cancer, anemia and active adult onset diabetes, controlled by medication. The diabetes has caused progressive neuropathy with weakness in his extremities. He now presents to an Internal Medicine physician for weakness and headaches.

After an examination and blood count, the final impression is: weakness and headaches due to continued anemia and diabetic neuropathy.

When diagnoses are reported at the highest level of specificity consider these two scenarios:

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ICD-9-CM Code 280.9 – Anemia (Not an HCC)</td>
<td>• ICD-9-CM Code 280.9 – Anemia (Not an HCC)</td>
</tr>
<tr>
<td>• ICD-9-CM Code 250.00 – Diabetes (HCC)</td>
<td>• ICD-9-CM Code 250.60 – Diabetes with Neuropathy (HCC)</td>
</tr>
<tr>
<td>• ICD-9-CM Code 357.2 – Neuropathy (HCC)</td>
<td>• ICD-9-CM Code 357.2 – Neuropathy (HCC)</td>
</tr>
<tr>
<td>• ICD-9-CM Code V10.05 – Hx of Malignant Neoplasm, Colon (not an HCC)</td>
<td>• ICD-9-CM Code V10.05 – Hx of Malignant Neoplasm, Colon (not an HCC)</td>
</tr>
</tbody>
</table>

Scenario 2 would be coding to the highest level of specificity. The patient has diabetes with neuropathy, not just diabetes.
Physician Responsibilities

Risk Adjustment Data Validation
Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by Health Alliance Connect are supported by medical record documentation for a member. The primary goals of CMS through risk adjustment data validation are to:

- Identify
  - Confirmed risk adjustment discrepancies
  - MA organizations in need of technical assistance to improve risk adjustment data quality
- Measure
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- Improve/Inform
  - Quality of risk adjustment data
  - The CMS-Hierarchical Condition Category (CMS-HCC) model

Health Alliance Revenue Management Department
As a local FHP, MMAI and ICP/SPD plan providing coverage to members in our community, Health Alliance Connect is committed to maintaining affordable premiums and quality care. Correct diagnosis coding is critical to ensure we have an accurate assessment of the health status of and expected level of care for our membership. Our Revenue Department has Accounting, a Coding Consultant, Certified Coding Analysts and Advanced Practitioner staff to monitor ongoing issues related to our members’ needs where their chronic conditions are concerned.

In a sense, Health Alliance Connect has brought the return of the house call for targeted members by sending Nurse Care Managers into members’ homes for comprehensive physical assessment and complex case management. These assessments are then provided to the primary care physicians and Health Alliance Connect’s Care Management staff to assist in care coordination.

Member Care Managers evaluate the level of assistance needed by a member, whether skilled or non-skilled care is needed, as well as associated care hours and appropriate care setting.

Health Alliance Connect regularly performs provider medical record reviews to ensure correct diagnosis coding using a random sampling of claims submitted for members. Medical record documentation is compared to the diagnoses submitted on the claim. As such, our coding analysts request our members’ medical records or may need to come onsite to review a member or group of members’ chronic conditions. The information provided should include, but should not be limited to:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic reports
- Discharge summary

Reviews are conducted in accordance with CMS ICD9-CM Official Guidelines for Coding and Reporting found at www.cdc.gov/nchs/datawh/ftpserv/ftpied9/icdguide06.pdf.

All erroneous data identified in the audit process must be corrected by the health plan and sent to CMS; delay in reimbursement could occur in these situations.
Members’ Rights and Responsibilities

Under this plan, you have rights and responsibilities. You will not be treated differently or face negative responses for exercising your rights. You may use all of your member rights without losing any health care services.

- A right to receive all services that Health Alliance Connect is required to provide per our agreement with Illinois Health and Financial Services.
- A right to be treated with respect and with consideration for your dignity and privacy.
- A right to get information about Health Alliance Connect structure and operations, the covered services, doctors and member rights and responsibilities.
- A right to get information including enrollment notices and educational materials in an easy-to-understand way.
- A right to partner with doctors in making decisions about your health care.
- A right to have treatment options and alternatives given to you in a manner fit for your condition and ability to understand.
- A right to refuse treatment to the extent of the law and to be told of the outcome.
- A right to be free from any form of restraint or seclusion used as a means of coercion (force), discipline, convenience or retaliation (revenge).
- A right to voice concerns, complaints or appeals about Health Alliance Connect and to get quick answers.
- A right to create advance directives documents.
- A right to appeal to or file directly with the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) any complaint of discrimination, on the basis of race, color, national origin, age, or disability in getting health care services.
- A right to exercise your rights without retaliation (revenge).
- A right to get a copy of your medical records and request the records be amended or corrected.
- A right that you will not be balanced billed.
- A right to reasonable accommodations.

- A responsibility to treat your PCP and office staff with respect.
- A responsibility to give information (to the extent possible) to Health Alliance Connect and their doctors so they can give you correct care.
- A responsibility to follow plans and directions for care that you have agreed to with your doctors.
- A responsibility to understand your health problems and help in creating an agreed-upon plan for your treatment goals, to the degree possible.
- A responsibility to decide about having medical treatment or procedure before it begins.
- A responsibility to help your PCP get your medical records.
- A responsibility to not see a specialist, unless referred by your PCP.
- A responsibility to not go to the emergency room for problems that are not life-threatening without contacting your PCP first.
- A responsibility to show up for all appointments and be on time.
- A responsibility to follow the rules and regulations of Health Alliance Connect.

Second Opinions

You can get a second opinion from another doctor in our network. You can do this at no cost to you. If you need help finding a doctor, call Client Services toll-free at 1-877-933-8480, TTY 1-800-526-0844 or 711. A representative will help you find another doctor for a second opinion. If you go to a doctor who is not part of our network, you may have to get preauthorization before the visit.
Compliance Program

Guidance for Business Partners
Health Alliance Connect Business Partners are expected to:

- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance Connect and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided for in the contract between you and Health Alliance Connect.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance Connect. Medicare guidelines allow nominal giveaways of no more than $15. Gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance Connect ethical standards or violate a law or regulations.
- Respect the rights and dignity of our employees and members. Health Alliance Connect does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use for personal gain any information obtained as a business partner of Health Alliance Connect.
- Comply with all relevant government requirements regarding record, document and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations.
- Be free of inappropriate conflicts of interest.

If authorization by the member is required before releasing PHI (for example, for mental health records), Health Alliance Connect will obtain a completed and signed form from the member (see form on page 58) and send it to you along with our request for the PHI.

We have policies and procedures in place to protect our member’s information. We have provided a copy of our Notice of Privacy Practices which describes how we protect this information.

A copy of the Ethics and Compliance in the Workplace: A Guide to Employee Conduct is available to you upon request by calling 1-800-337-8100.
Reporting a Compliance Violation, Suspected Misconduct, Privacy or Security Incident or a Potential Fraud or Abuse Situation
If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it.

Lori Cowdrey Benso, SVP Corporate Affairs and General Counsel, Interim Compliance Officer
1-800-851-3379 ext 3238 or 217-365-3238

Traci Jensen, Compliance Programs Manager and Privacy Officer
1-800-851-3379 ext 3418 or 217-337-3418

Wyatt Scheiding, HIPAA Security Officer
1-800-851-3379 ext 3493 or 217-337-3493

Health Alliance Compliance Line (this avenue can be anonymous)
217-383-8304 or 1-855-371-4640

The Office of the Inspector General
1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950

The Center for Medicare and Medicaid Services (CMS)
1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048
Commitment to Compliance

Health Alliance is committed to maintaining a reputation for excellence by establishing the highest ethical principles and professional standards and ensuring compliance with applicable state and federal laws. These principles and standards apply to our relationship with members, providers, employer groups, vendors, consultants and regulatory agencies and coworkers.

In support of this commitment, and in conformance with the standards set forth in the U.S. Federal Sentencing Guidelines and the compliance program guidance for Medicare Advantage Organizations (MAO), Part D Plan Sponsors and Medicare-Medicaid plans published by the Center for Medicare and Medicaid Services, and applicable state requirements Health Alliance established a Corporate Compliance Program.

This Program includes an Employee Guide to Conduct and policies and procedures designed to assist Health Alliance employees achieve and maintain compliance.

Health Alliance fosters an environment in which compliance with laws, regulations and sound business practices are woven into the corporate culture.
Commitment to Compliance

The Compliance Program focuses on the prevention and detection of violations of federal and state laws as well as corporate policies and procedures and promotes reporting of suspected misconduct, compliance violations, privacy and security incidents and potential fraud or abuse situations.

There is no retribution for asking questions, raising concerns or reporting possible violations in good faith.

Commitment to Compliance

Your understanding of this commitment and your willingness to partner with Health Alliance in adhering to these principles and standards are essential to the well-being of our members and to the success of the business partnership.

A copy of the Health Alliance Ethics and Compliance in the Workplace: A Guide to Employee Conduct accompanies this education and is also available to you upon request by calling 1-800-851-3379, ext 3418.

Guidance for Business Partners

Health Alliance Business Partners are expected to:
- Maintain a compliance plan which includes policies and procedures addressing prevention, detection and correction of fraud, waste and abuse.
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided for in the contract between you and Health Alliance.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance. Medicare guidelines allow nominal giveaways of no more than $15. Gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulations.
- Respect the rights and dignity of our employees and members. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use for personal gain any information obtained as a business partner of Health Alliance.
- Comply with all relevant government requirements regarding record, document and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations to Health Alliance.
- Be free of inappropriate conflicts of interest.
The Center for Medicare and Medicaid Services (CMS) requires MAOs, Part D Sponsors and Medicare-Medicaid plans to provide Compliance and Fraud, Waste and Abuse (FWA) training to all entities and individuals who meet the definition of first tier, downstream or related entity. First tier, downstream and related entities that have met the FWA certifications through enrollment in the fee for service Medicare program or accredited as a DMEPOS suppliers are deemed to have met the FWA training and education requirement.

Citation: F.R. Vol. 72, No. 233, December 5, 2007
F.R. Vol. 75 No 19678 effective June 7, 2010

Key Terms and Definitions
- **First Tier entity** means any party that enters into a written arrangement, acceptable to CMS, with an MAO to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage (MA) program.
- **Downstream entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between the MAO and the first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- **Related entity** means any entity that is related to the MAO by common ownership or control and (1) performs some of the MAO management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAO at the cost of more than $2,500 during a contract period.

Fraud is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representation or promises) any of the money or property owned by or under control of any health care program.

Waste is the over-utilization of services or other practices that directly or indirectly result in unnecessary costs; misuse of resources.
Key Terms and Definitions
Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Health care fraud is a major reason why the cost of health care in the United States continues to rise at an alarming rate. Individuals who participate in fraud schemes and those who fail to report health care fraud contribute to those rising costs. Schemes and fraudulent billing practices not only cost taxpayers, they put beneficiaries health and welfare at risk.

For example: Two patients died because of a scan that involved recruiting homeless and other vulnerable adults for unnecessary heart catherizations and angioplasties. The doctors and administrators behind the scheme were caught and prosecuted.

Fraud is a criminal act, abuse is not
Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully and intentionally or with reckless disregard.
If fraud occurs, a crime has been committed and criminal prosecution may take place.
In most cases of abuse a crime has not been committed.

The major difference is the intent of deception from the person.
There are many ways fraud and abuse can occur. Examples include:
- Identity Swapping
- Identity Theft
- Kickbacks
- Marketing Schemes
- False Claims
- Duplicate Billing
- Abuse of the System

Who can commit fraud and abuse?
- Beneficiaries/members
- Providers, pharmacies and billing companies
- Pharmacy benefit management companies (PBMs)
- Insurance Companies
- Employees
- Brokers/Agents
- Employer groups

The following slides are some examples of potential fraud and abuse under the Medicare program.

This is not intended as a comprehensive listing of all possible fraud and abuse schemes.
Fraud, Waste and Abuse

Beneficiary / Member
- Use of another’s insurance card to obtain prescription drug benefits or medical services
- Loaning one’s ID card to someone else to obtain prescription drug benefits
- Adding ineligible dependents to the plan
- Falsifying information on the application
- Excessive trips to the emergency room to obtain controlled substances
- Submitting prescription drug receipts that are forged or altered for reimbursement
- Resale of drugs on the black market
- Identity theft

Fraud, Waste and Abuse

Provider or billing company – Medical Services
- Intentionally not giving the member the amount of drugs prescribed
- Intentionally dispensing a different drug than the doctor prescribed, for purposes of saving money (prescription drug switching)
- Billing for drugs that a member did not receive
- Billing under another provider’s Tax Identification Number (TIN) to obtain reimbursement for services
- Duplicate billing
- Billing for services performed by non-licensed persons
- Regularly prescribing unnecessary drugs
- Illegal remuneration schemes such as selling prescriptions
- Script mills
- Theft of prescribers prescription pads

Fraud, Waste and Abuse

Pharmacy Benefits Manager (PBM)
- Prescription drug switching
- Unlawful remuneration, such as remuneration for steering a beneficiary toward a certain plan or drug
- Inappropriate formulary decisions
- Prescription drug splitting or shorting
- Failure to offer negotiated prices
Compliance Program

**Insurance Company**
- Discriminating against an individual, including not allowing the individual to enroll in a plan because of age, health, race, religion or income
- Charging a member more than once for premium costs
- Not paying for covered medical services or drugs
- Making false statements in advertising materials that influence consumers to make buying decisions

**Employee or Broker**
- Encouraging an individual to enroll in a richer benefit plan to receive a higher commission and, once the individual is on the plan, switching him or her to a reduced benefit plan without the member being fully aware of the implications (bait and switch)
- Encouraging a member to disenroll from a plan
- Offering cash to enroll in a MA or Prescription Drug plan
- Offering a gift worth more than $15 to sign up for MA or Prescription Drug plan
- Making false statements to an individual or member
- Altering claims or medical records for a service to be covered that is not normally covered
- Fabricating claims

**Employer**
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group
- Providing false employer or group eligibility information to secure health care coverage
- Changing dates of hire or termination to expand dates of coverage
Your Role

As a business partner you must participate in compliance and FWA training on an annual basis.

Report any suspected misconduct, compliance violation, privacy or security incident or potential fraud and abuse activity.

Reporting

If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it.

Health Alliance Compliance Line
217-383-8304 or toll-free 855-371-4640

The Office of the Inspector General
800-HHS-TIPS (800-447-8477)

Non-Retaliation for Reporting

Good faith reporting of suspected fraud, waste and abuse is expected and accepted behavior.

Anyone who in good faith report a violation is protected from any retaliation.

A number of laws contain whistleblower protection including the False Claims Act.
The False Claims Act

The False Claims Act establishes a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the government.

Those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government’s damages for the false bills plus civil penalties from $5,000 to $10,000 per false claim.

A private citizen or “whistleblower” with knowledge of past or present fraud on the federal government is permitted to sue on behalf of the government to recover civil penalties and damages. The whistleblower has guaranteed job protection under the Act and is entitled to a share of the government’s total recovery.

The False Claims Act Enforcement

The Federal False Claims Act/Fraud Enforcement and Recovery Act of 2009

Penalties

Civil

• Not less than $5,500 and not more than $11,000 per false claim plus three times the amount of the false claim
• Exclusion from participation in federal health care programs
• Additionally, under the Patient Protection and Affordable Care Act, the Office of Inspector General (OIG) may impose civil monetary penalties of up to $50,000 for each false record or statement and for knowingly failing to report and return an overpayment within the required timeframe.

Criminal

• Courts can impose criminal penalties against individuals and organizations for willful violations

Anti-kickback

The Federal Anti-Kickback laws make it a criminal offense to knowingly and willfully offer, pay, solicit or receive remuneration of any kind to induce or reward referrals of items or services reimbursable by a Federal health care program.

Remuneration includes anything of value, directly or indirectly, overtly or covertly, in case or in kind.
**Anti-kickback Enforcement**

The Federal False Claims Act/Fraud Enforcement and Recovery Act of 2009

**Penalties**

**Criminal:**
- Violation is a felony
- Fine of up to $25,000 and/or prison for up to 5 years

**Civil:**
- Violation may result in civil monetary penalties of up to $50,000 for each violation of the statute plus damages of up to three times the total amount of the unlawful remuneration

**Exclusion:**
- Violation may result in exclusion from participation in the Medicare and Medicaid programs

**Conflicts of Interest**

Conflicts of interest arise when a member of the board, an officer, director, manager, Pharmacy and Therapeutics Committee member, employee or contractor is in a position to influence either directly or indirectly Health Alliance business decisions that could lead to gain for the individual, the individual’s relatives or others to the detriment of Health Alliance and its mission and integrity.

**Examples:**
- Ownership of a significant financial interest in any outside concerns that does business with, or is a competitor of Health Alliance.
- Provision of services for compensation to any outside concern that does business with, or is a competitor of Health Alliance.

**Excluded Entities or Individuals**

Health Alliance may not contract with or employ entities or individuals who are excluded from doing business with the government.

Health Alliance monitors the Office of Inspector General (OIG) Exclusion List and General Service Administration (GSA) List on a monthly basis.

Non-compliance and/or fraudulent behavior is unacceptable and subject to termination of the business relationship with Health Alliance.
Conflicts of Interest

Conflicts of interest arise when a member of the board, an officer, director, manager, Pharmacy and Therapeutics Committee member, employee or contractor is in a position to influence either directly or indirectly Health Alliance business decisions that could lead to gain for the individual, the individual’s relatives or others to the detriment of Health Alliance and its mission and integrity.

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Health Alliance monitors the Office of Inspector General (OIG) Exclusion List and General Service Administration (GSA) List on a monthly basis.

Non-compliance and/or fraudulent behavior is unacceptable and subject to termination of the business relationship with Health Alliance.
HIPAA Privacy Policy for Use, Protection and Disclosure of PHI

Health Alliance (covered entity) complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The Privacy Rule ensures a patient’s protection of privacy without hindering his or her access to quality health care.

As a health care provider (covered entity) you are required to comply with the HIPAA Privacy and Security Rules. As a contracted provider of Health Alliance Connect for our FHP, MMAI and ICP plans, you are also required to protect member/patient PHI based on the contract provisions, such as you must safeguard the privacy of any information that identifies a particular member; take reasonable precautions to maintain the confidential nature of and to prevent the disclosure of confidential records or information, including medical records, relating to members other than to individuals authorized to receive such information pursuant to valid releases, lawful court orders, lawful subpoenas or in accordance with federal or state laws. If required by law, you are responsible for obtaining and maintaining adequate release of information authorizations from members essential for the administration of benefits under the member’s plan.

As covered entities under HIPAA, we are allowed to use members’/patients’ Protected Health Information (PHI) as allowed by the Privacy Rule and we are allowed to disclose PHI to one another for treatment, payment and certain health care operations activities.

Payment and certain health care operation activities include:

- Submission and receipt of claims for reimbursement
- Billing and claims management
- Health care data processing
- Disclosure and receipt of medical record information for review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges
- Utilization review activities, including preauthorization, concurrent and retrospective review of services
- Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines
- Population-based activities relating to improving health or reducing health care costs
- Protocol development, case management and care coordination
- Contact with health care providers or patient/member with information regarding treatment alternatives
- Review of competence or qualifications of health care professionals and evaluate practitioner, provider or health plan performance
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

If authorization by the member is required before releasing PHI (for example, for mental health records), Health Alliance Connect will obtain a completed and signed form from the member (see form on next page) and send it to you along with our request for the PHI.

We have provided a copy of our Notice of Privacy Practices which describes how we protect this information.
Even though HIPAA does not require the use of this form for medical necessity review or appeals (except when mental health information is involved), a Provider may receive a copy of this completed authorization form signed by the Member. This occurs when Health Alliance requests medical records from the Provider.

HEALTH ALLIANCE
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH CARE INFORMATION

Member’s Name ___________________________ Birthdate ______________
Street Address ___________________________ Member Number # __________
City, State, Zip ___________________________ Clinic # ______________
Maiden/Other Names ________________________ ________________________
Telephone # (home) ________________________ (work) ________________________

I. Information About the Use and Disclosure of Protected Health Information

I hereby authorize the disclosure and use of my protected health information as described below:

Person(s) or organization(s) providing the information: ______________________________

Person(s) or organization(s) receiving/using the information: ______________________________

A detailed description of the specific type of protected health information to be disclosed and/or used (include dates and type of treatment):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The purpose for which protected health information will be disclosed and/or used:

________________________________________________________________________
________________________________________________________________________

If information below is stated above, release is authorized. Please circle Yes or No in the column below.

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable disease and infection information, as defined by statute and Illinois Department of Public Health rules (which include venereal disease, “VD,” tuberculosis, “TB,” hepatitis B, human immunodeficiency virus “HIV,” acquired immunodeficiency “AIDS,” AIDS related complex “ARC” and specify other if known)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. (See “Important Notice” on next page.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or mental health professional.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
II. Important Information About Your Rights

I have read and I understand and acknowledge the following statements about my rights:

• I may revoke this authorization at any time prior to the expiration date by notifying Health Alliance in writing. However, the revocation will not have any effect on actions taken before the revocation was received.
• If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
• Treatment, payment, eligibility or enrollment will not be conditioned on obtaining this Authorization except as specifically authorized by law.

This Authorization expires one year after the date signed below or upon the following specific date, event or condition:_______________________________________________

III. Signature of Member or Member’s Representative

I accept these terms and authorize the above use and disclosure:

____________________________________  _______________________________________
Member or Member’s Legally Authorized   Witness Signature and Date
Representative’s Signature and Date

______________________________________________________
Printed name of the member or Legally Authorized Representative

If signed by a Legally Authorized Representative, please indicate the relationship to the individual

If a representative signs on behalf of the member, Health Alliance must have a copy of the legal document declaring representation on file.

IMPORTANT NOTICE: Any information disclosed is protected by Federal Protection Rules (42 CFR Chapter I, Part 2) and State Mental Health Protection Laws and is prohibited from further disclosure unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. Federal Rules restrict use of the information to criminally investigate or prosecute any member receiving treatment for alcohol or drug abuse.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date of this notice: September 1, 2013

Protecting the privacy of information about your medical conditions and health is a responsibility we take very seriously. We understand that medical information about you and your health is personal, and it is important to you that we keep it confidential. We are committed to the practices and procedures we established to protect the confidential nature of information about your health under the Medicare-Medicaid Plan and the Integrated Care Program for Seniors and Persons with Disabilities.

This notice describes the way we may use and disclose information about your health to carry out treatment, payment and health care operations and for other purposes as permitted or required by law. It also describes your rights and duties regarding the use and disclosure of medical information.

INFORMATION THAT THIS NOTICE APPLIES TO
This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that could only be used to identify you.

We collect such personal information as name, address, telephone number, Social Security number, age, sex and medical diagnosis to coordinate medical care. This information is obtained from member enrollment forms, member surveys and claims.

OUR LEGAL RESPONSIBILITIES
- We are required to maintain the privacy of your medical information.
- We are required to provide this notice of privacy practices and legal duties regarding medical information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.
- We will not sell your protected health information.
- We will not use or disclose genetic information for underwriting purposes.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION
The following categories describe different ways that we may use and disclose protected health information without your authorization. For each category, we give some examples of uses and disclosures. Not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of these categories.

Treatment: We do not provide medical treatment or services. We may disclose information about your health to a physician or health care professional involved in making a decision that could affect your care. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription contradicts prior prescriptions.

Payment: We use and disclose information about your health to determine eligibility for benefits and payment of claims for medical treatment or services. For example, we may disclose information to your health care provider to verify coverage for medical treatment or services. Likewise, we may share medical information with a health care provider to assist in billing or filing claims for payment of treatment and services, including third-party liability claims and coordination of benefits. We may also send you information about claims we pay and claims we do not pay (called an “explanation of benefits”) for you and your covered dependents. Under certain circumstances, you may request to receive this information confidentially.
Health Care Operations: We may use and disclose your medical information for activities that are necessary for our HMO and health insurance operations. These uses and disclosures are necessary for our business and to make sure you are receiving quality services. Some examples of how we may use and disclose information about your health include: case management and care coordination conducting quality assessment and improvement activities such as outcomes evaluation and development of clinical guidelines; underwriting, premium rating and other activities relating to coverage; submitting claims for stop-loss or reinsurance coverage; conducting or arranging for medical review; fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities.

We may also disclose information about your health to our business associates to enable them to perform services for us or on our behalf relating to our operations. Some examples of business associates are our lawyers, auditors, accrediting agencies, consultants, pharmacy benefit managers, collection agencies and printing and mail service vendors. Our business associates are required to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT
We may use or disclose your protected health information in the following situations without your authorization or without allowing you to object or agree to the use or disclosure.

Legal Requirements: We may use and disclose your medical information when we are required to do so by law. This includes disclosing your protected health information to a government health oversight agency for activities authorized by law, including audits, investigations, inspections and licensure. For example, we may be required to disclose your medical information, and the information of others, if we are audited by the Illinois Department of Insurance. We will also disclose your medical information when we are required to do so by a court order or other judicial or administrative process.

To Report Abuse: We may disclose your medical information when the information relates to abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting or with your permission.

Law Enforcement: We may disclose your medical information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness, missing person or in connection with suspected criminal activity. We may disclose protected health information in response to court orders or in emergency circumstances related to a crime. We may also disclose your medical information to a federal agency investigating our compliance with federal privacy regulations.

Family and Friends: Unless you object or law prohibits it, we may disclose your medical information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim or what benefits you are eligible to receive.

To Avert a Serious Threat: We may disclose your medical information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Health Benefits and Services: We may use your medical information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers’ Compensation: We may disclose medical information to the extent authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs that provide benefits for work-related injuries and illnesses.
ORGANIZED HEALTH CARE ARRANGEMENTS
We may share information that we have about you within our organization and with Carle Physician Group, Carle Foundation Hospital and their affiliates; and with Springfield Clinic, Memorial Medical Center and their affiliates for purposes of health care operations under an organized health care arrangement. Sharing information enables us to:

- Determine our financial risk
- Resolve quality of care complaints
- Arrange for medical and clinical peer review
- Improve our methods of payment or coverage policies
- Arrange for legal services
- Perform utilization management services

YOUR RIGHTS
The following describes your rights regarding the protected health information we maintain about you. If you want to exercise your rights, please contact a member of our Client Services Department, who will give you the necessary information and forms for you to return to the address listed under “Whom to Contact” at the end of this notice.

Authorization: We may use and disclose your medical information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your medical information for any other reason without your authorization. If you authorize us to use or disclose your medical information, you have the right to revoke the authorization at any time. You may not revoke an authorization for us to use and disclose your medical information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization. We will receive an authorization from you for certain marketing activities.

Request Restrictions: You have the right to request that we restrict uses and disclosures of your medical information that we use for treatment, payment and health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment of your care, like a family member. We will consider your request, however, we are not required to agree to a restriction. We cannot agree to restrict disclosures that are required by law.

Receive Confidential Communications: If our normal communication channels could endanger you, you have the right to request that we send communications that contain your medical information by alternative means or to an alternative location. We will ask you the reason for your request, and we will accommodate all reasonable requests to the extent the request specifies an alternative location and allows us to continue to pay claims.

Inspect and Copy: You have the right to inspect the medical information that we maintain about you in our records and to receive a copy of it. This right is limited to information about you that is used to make decisions such as claims, payment and enrollment records. Under state and federal law, this right does not include psychotherapy notes or information about your health compiled in reasonable anticipation of litigation, administrative action or administrative proceedings. To inspect your records or to receive a copy, send your written request to the address listed under “Whom to Contact” at the end of this notice. We may charge a fee for the cost of copying and mailing the records. We will respond to your request within 30 days.

We may deny you access to certain information if it would reasonably endanger the life or physical safety of you or another person. If you are denied access to information about your health, we will explain how you may appeal the decision.

Amend: You have the right to request that we amend your medical information for as long as we maintain such information if you believe that the information is incorrect or incomplete. This right is limited to information about you that is used to make decisions such as claims, payment and medical case management records. Your written request must include the reason or reasons that support your request. We will respond to your request in writing within 30
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Accounting of Disclosures: You have the right to receive an accounting of certain disclosures of your medical information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; disclosures made with your authorization; communications with family and friends; disclosures made for national security or intelligence purposes; disclosures to correctional institutions or law enforcement officials; or disclosures made prior to April 14, 2003. We will provide the first list of disclosures you request at no charge. A reasonable, cost-based fee may be imposed for each subsequent request. You must tell us the time period you want the list to cover. If a breach of your unsecure protected health information occurs, we will notify you within 60 days.

Receive a Paper Copy: You have the right to obtain a paper copy of this notice at any time.

Complaints: You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with our Medicare Services Department. (See “Whom to Contact” at the end of this notice.) You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services. We will not take any retaliation against you if you file a complaint.

Maintaining Confidentiality of Member Information: The security of our members’ personal information is very important to us. Member information is never sold to anyone, for any purpose. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your privacy.

All Health Alliance employees are educated on our standards and are required to sign a confidentiality and security agreement annually. Any employee found to be in violation of our privacy practices is subject to disciplinary action. Employees are encouraged to report violations of confidentiality using the Health Alliance compliance hotline.

CHANGES TO THIS NOTICE
We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any medical information that we already have, as well as to medical information we receive in the future. Before we make any change in the privacy practices described in this notice, we will mail a revised notice to you within 60 days of the effective date.

WHOM TO CONTACT
You may contact a member of our Client Services Department at 1-866-951-0264 or TTY/TDD 711 or 1-800-526-0844 (Illinois Relay) for the hearing impaired. Representatives are available from 8 a.m. to 8 p.m. Monday through Friday. You may also write to the address below for the following requests:

- For more information about this notice
- For more information about our privacy policies
- If you want to exercise any of your rights, as described in this notice
- If you want to request a copy of our current notice of privacy practices

Health Alliance Connect
301 S. Vine St.
Urbana, Illinois 61801

This notice is also available on our website at: HealthAllianceConnect.org

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Compliance Program

The HITECH Act of 2009
(including Breach Notification Rules)

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (“ARRA”). Within this Act is Title XIII, the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act” or the “Act”). The HITECH Act contains the most significant changes with respect the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) since the issuance of the final Privacy and Security Rules.

Health and Human Services (HHS) issued Breach Notification for Unsecured PHI Rule on August 19, 2009. The Breach Rule requirements have been incorporated into this summary.

Health Information Technology
Health and Human Services’ Office of the National Coordinator for Health Information Technology is charged with the responsibility to establish and evaluate annually guidance on the most effective and appropriate technical safeguards for use in carrying out the HIPAA security standards. Currently, the HIPAA Security Rule does not mandate use of any particular technical system, standards or safeguards.

Effective Date: Not later than December 31, 2009, the Secretary shall through published interim final rule, adopt an initial set of standards, implementation specifications and certification criteria on the most effective and appropriate technical safeguards.

Breach Notification
Covered entities are required to notify individuals whose “unsecured PHI” (whether electronic or paper) has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a breach.

Definition of Breach
HITECH Act definition – A “breach” is defined as the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of such information, except where an unauthorized person to whom the information is disclosed “would not reasonably have been able to retain such information.” The meaning of that last phrase is a bit ambiguous, but it could apply to a situation in which a laptop containing PHI is stolen, but recovered almost immediately without any real opportunity for the thief to extract the PHI.

Breach Notification Rule definition – Breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the protected health information. For purposes of this definition, compromises the security or privacy of PHI means poses a significant risk of financial, reputational, or other harm to the individual.

A breach does not include unintentional acquisition, access or use of PHI by an workforce member or other individual acting under the authority of a covered entity or business associate if the acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by the Privacy Rule.

A breach also does not include an inadvertent disclosure from an individual authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity, business associate or organized health care arrangement in which the covered entity participates, provided that the information is not further used or disclosed in a manner not permitted by the Privacy Rule.

Harm Threshold
To determine if an impermissible use or disclose of PHI constitutes a breach where notification is required covered entities and business associates are required to perform a risk assessment to determine if there is a significant risk of financial, reputational or other harm to the individual as a result of the impermissible use or disclosure.
Compliance Program

HHS has added this harm threshold as stated above for purposes of the definition of “breach”. HHS agreed that the statutory language allowed for a harm threshold and agreed with the many comments received which noted that “failure to include a harm threshold for requiring breach notification may diminish the impact of notifications received by individuals, as individuals will be flooded with notifications for breaches that pose no threat to the security or privacy of their PHI or alternatively, may cause unwarranted panic in individuals, and the expenditure of undue costs and other resources by individuals in remedial action.”

Two examples included in the Rule: 1) PHI is impermissibly disclosed to another entity governed by the HIPAA Privacy and Security Rules or to a business associate and there is less risk of harm to the individual. 2) A disclosure of PHI where a covered entity or business associate has a good faith belief that the unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Unsecured PHI Guidance
On April 27, 2009, HHS released a Rule that contains specific guidance specifying the technologies and methodologies that render PHI unusable, unreadable or indecipherable to unauthorized individuals for purposes of the breach notification requirements.

HHS has identified two methods for rendering PHI unusable, unreadable or indecipherable to unauthorized individuals: (1) encryption; and (2) destruction.

If electronic PHI is encrypted and presumably not accessed or if PHI both in paper and electronic form is destroyed prior to disposal in accordance with the guidance, no breach notification is required.

Unsecured PHI means PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technology and methodology specified by the Secretary in guidance issued under section 13402(h) (2) of Pub L. 111-5 on the HHS website.

Business Associate notification
Business associates must notify a covered entity of any breach of which they become aware.

Notice requirements
Timing of Notice – Notification of a breach must be made “without unreasonable delay and in no case later than 60 calendar days after the discovery of a breach.” Covered Entities will have the burden of demonstrating that a notification meets this timing requirement, including presenting evidence to support the necessity of any delay. A breach is deemed to be “discovered” as of the first day that the breach is known, or by exercising reasonable diligence would have been known, Covered Entity or one of our business associates.

Individual Notice – Notification to an individual must be made in writing and sent to the individual via first class mail unless the individual has specified a preference for electronic mail. If the Covered Entity has insufficient or out-of-date contact information, notice must be given in a substitute form, including posting notice of the breach on our website (for a period of 90 days) or in major print or broadcast media (if insufficient information for more than 10 individuals affected). For fewer than 10 the individual may be contacted by telephone or other means. If the individual is deceased the notice must be mailed to the next of kin or personal representative.

Media Notice – If the breach involves the PHI of more than 500 individuals in a state, notice of the breach must be given to prominent media outlets in that state.

HHS Notice – Covered entities must notify HHS of any breach. If the disclosure involves the PHI of more than 500 individuals, HHS must be notified immediately. If less than 500 individuals are affected, the covered entity may maintain a log to be produced to HHS annually.

Content of Notice – 1) a brief description of what happened, including the date of the breach and the date of the
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discovery of the breach, if known; 2) a description of the types of unsecured PHI that were involved in the breach (such as whether full name, SSN, DOB, address, account number, diagnosis, disability code, or other types of information were involved; 3) any steps individuals should take to protect themselves from potential harm resulting from the breach; 4) a brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and 5) contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website or postal address. The notice shall be written in plain language.

Administrative requirements
A covered entity must:
- Develop or update policies and procedures to reflect changes
- Train all member of its workforce (employees, temps, contracted individuals, etc.) on the new or revised policies and procedures
- Provide a process for individuals to make complaints regarding a breach
- Apply appropriate sanctions against members of its workforce who fail to comply with the Privacy policies and procedures
- Refrain from intimidating or retaliatory acts

Effective Date: September 24, 2009

Breach Notification and State law
The security breach notification provisions will largely supersede compliance with existing state notification laws. However, certain more stringent state notification requirements will not be preempted, such as state laws that require notification to certain state agencies in the event of a breach.

Business Associates
Prior to the enactment of the HITECH Act, HIPAA applied to business associates only indirectly by way of the business associate’s contractual obligations to the covered entity. Similarly, the penalty for a violation of these obligations was merely damages that resulted from any contractual breach (unless the business associate also happened to be a covered entity). The Act, however, has expanded both the application of HIPAA requirements and penalties to business associates.

The definition of business associate has been expanded to include organizations that provide data transmission of PHI for covered entities and who require routine access to the PHI. While many of these organizations already qualify as business associates the Act seems intended to clarify that the exception for “conduit” organizations that are solely responsible for transmission of PHI should not exempt these enumerated organizations from business associate status.

Business associates are required to comply with the Security Rule’s administrative, technical and physical safeguard requirements and require business associates to implement security policies and procedures in the same manner as a covered entity. If the business associate violates any of these Security Rule provisions, the business associate may be subject to the same HIPAA civil and criminal penalties as a covered entity.

Business associates are required to only use or disclose PHI consistent with its obligations under its business associate agreement with a covered entity. However, the Act does increase the potential liability for a business associate who breaches its contractual obligations. That is, if a business associate violates the terms of its business associate agreement, the business associate may be subject to the same HIPAA civil and criminal penalties as a covered entity that violated the Privacy Rule.

Effective Date: February 17, 2010.
Restrictions
An individual may request and the provider must agree to restrict PHI to a health plan for payment or health care operations if the individual has paid for treatment out of pocket at the time of service.

Effective Date: Immediately.

Minimum Necessary
The Act states that a covered entity will be in compliance with the minimum necessary requirements if a covered entity uses a limited data set; or only the minimum PHI is used to the extent is necessary to accomplish the intended purpose of the use, disclosure or request.

HHS is required to publish guidance on what constitutes “minimum necessary.”

Limited Data Set
All de-identifiable information with the exception of city, state and zip code and date elements such as age, birth date, admission or discharge date and date of death.

A limited data set is information that excludes the following: names, postal address (other than city, state and zip code), telephone and fax numbers, email addresses, social security number, medical record, health plan or other account numbers, certificate or license numbers, vehicle identifiers and serial numbers including license plate numbers, device identifiers and serial numbers, URLs, IP addresses, biometric identifiers and full face photographic images.

Effective Date: HHS must publish guidance on what constitutes “minimum necessary” under the privacy rules no later than 18 months from the date ARRA was enacted (August 17, 2010).

Accounting of Certain PHI Disclosures
The following is a list of disclosures of PHI in a Designated Record Set covered entities (and BAAs) would be required to provide the individual upon their request:

- Disclosures not permitted by the Privacy Rule unless the individual has received a breach notification.
- For law enforcement purposes
- For judicial or administrative proceedings
- For public health activities (except child abuse or neglect reports)
- To advert a serious threat to health or safety
- For military or veterans activities
- For workers compensation

The maximum time period to report will be reduced from six years to three years.

The timeframe to provide the information to the individual has reduced from 60 to 30 days, which is consistent with State law. A 30 day extension may be requested with a written statement of the reason for the delay.

The first accounting must be provided to the individual without cost. A reasonable, cost-based fee may be imposed for subsequent requests within a 12 month period, as long as the individual is notified of the fee for subsequent requests at the time of the first request.

The following must be included in the written disclosure:

- Date of the disclosure, if known, or if not, the approximate date or period of time (at a minimum month and year)
- Name of the entity or person who received the PHI (except when such information is another patient in which case we can state “another patient”)
- Address of entity or person, if known
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- A brief description of the type of PHI disclosed
- A brief description of the purpose of the disclosure

Effective Date: 180 days after the effective date of the final rule.

Right to an Access Report
This is a new requirement.

An individual would have the right to receive a report of who has accessed his or her PHI (e.g. employees, business associates and other covered entities) upon request.

This applies uses and disclosures of all electronic PHI in any designated record set (this would not be limited to an electronic health record as initially intended in the HITECH Act). This does not apply to PHI in paper form.

The following must be included in the report:
- Date of access
- Time of access
- Name of the person who accessed the information, if available, otherwise the name of the entity
- Description of what information was accessed
- A description of the user’s action (e.g. create, modify, access, delete)

The information must be available up to three years prior to the request. The report must be in an understandable format and must provide it in an electronic or hard copy format requested by the individual.

The first report must be provided to the individual without cost. A reasonable, cost-based fee may be imposed for subsequent requests within a 12 month period, as long as we the individual is notified of the fee for subsequent requests at the time of the first request.

The timeframe to provide the information to the individual is 30 days.

In addition, the Notice of Privacy Practices must be revised to add the statement describing the individual’s right to receive an access report.

Effective Date: January 1, 2013 for electronic designated record set systems acquired after January 1, 2009. For electronic designated record set systems acquired before January 1, 2009, the effective date would be January 1, 2014.

Prohibition on the sale of EHR or PHI obtained from EHR
Covered Entities are prohibited from direct or indirect remuneration for sale of PHI from an EHR unless there is a valid authorization from the individual. Certain exceptions apply (i.e. research or public health purposes; exchange is for treatment subject to HHS regulation for inappropriate access, use or disclosure; specific types of health care operations; in exchanges for services from a business associate, provide an individual with a copy of their PHI; and in regulations promulgated by HHS).

Effective Date: HHS shall release a regulation on the sale of PHI from EHRs no later than 18 months after the enactment of ARRA (August 17, 2010). The compliance date will be 6 months after the promulgation of the final Rule.

Access to Certain Information in Electronic Format
If a covered entity uses or maintains an EHR an individual shall have the right to receive a copy of such information in electronic format.

Effective Date: February 17, 2010.
Marketing
The provision of the Privacy Rule that states that a communication by a covered entity about a product or service that encourages the recipient of the communication to purchase or use the product or service is not a marketing communication, but rather, a health care operation, if that communication is: (1) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication; (2) for treatment of that individual; or (3) for case management, care coordination or to recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

However, if the covered entity receives payment for making these communications, the communication is no longer a health care operation (and, presumably, is a marketing communication that requires an individual’s authorization) unless: (1) the communication describes only a drug or biologic currently being prescribed for the individual and the amount of payment received for making the communication (if any) is reasonable in amount; (2) the communication is made by the covered entity and the covered entity has received a valid HIPAA authorization from the individual to whom it is making the communication; or (3) the communication is made by a business associate and is consistent with the terms of its business associate agreement with the covered entity.

Effective Date: February 17, 2010.

Opportunity to Opt Out of Fundraising
An individual has the right to opt out of fundraising. When an individual opts out of fundraising such election should be treated as a revocation of authorization.

Effective Date: February 17, 2010.

New Regulation of Personal Health Record Vendors
The recent movement to adopt personal health records (“PHRs”), spurred by the efforts of large employers, has led to concerns that vendors of PHR products are not necessarily required by law to report breaches involving PHR data. Most state security breach notification laws do not define “personal information” to include medical information, focusing instead on information that may be used to commit financial fraud. The HITECH Act addresses that perceived deficiency by extending the security breach notification provisions described above to (1) PHR vendors, (2) businesses that offer products or services through a website of a PHR vendor or a covered entity that offers PHRs, and (3) entities that access information in, or send information to, a PHR (collectively “PHR businesses”).

Notification of PHR Breach – Because PHR businesses are not covered entities under HIPAA subject to regulation by HHS, the HITECH Act provides for regulation of such businesses by the Federal Trade Commission (FTC). PHR businesses are required to notify the FTC and each affected individual who is a citizen or resident of the United States of a privacy or security breach of unsecured individually identifiable information in a PHR (“PHR Information”). If a PHR vendor utilizes the services of a third-party service provider in performing the PHR service, then that service provider must notify the PHR vendor of any breach upon its discovery. The FTC will notify HHS upon receiving notice of a PHR breach.

FTC Regulatory Authority – The FTC will have the authority to take action against violations of the notification requirements related to PHR Information as unfair and deceptive acts or practices under the Federal Trade Commission Act.

Effective Date: The FTC must issue interim final regulations regarding PHR breach notification requirements within 180 days from the enactment of the HITECH Act. The new breach notification requirements will apply to breaches that are discovered on or after 30 days from the publication of the FTC’s interim final regulations.
New Enforcement Provisions
The Act substantially increases HIPAA enforcement risk through 1) increasing civil monetary penalties (CMP) and civil settlement amounts; 2) adding provisions on willful neglect violations; and 3) allowing State Attorney Generals to enforce HIPAA Privacy and Security violations.

The Act provides a tiered system for assessing the level of penalty of each violation. CMS and OCR can supersede the limits, but with a cap of $50,000 per violation and $1.5 million for the calendar year for the same type of violation.

Tier A is for accidental breach “offender did not know”:
• Minimum per violation is $100
• Maximum per calendar year is $25,000

Tier B is for reasonable cause but not willful neglect. HHS needs to define “reasonable cause”:
• Minimum per violation is $1,000
• Maximum per calendar year is $50,000

Tier C is for willful neglect but the organization corrected:
• Minimum per violation is $10,000
• Maximum per calendar year is $250,000

Tier D is for willful neglect but the organization did not correct:
• Minimum per violation is $50,000
• Maximum per calendar year is $1.5 million

Effective Date: Tiered penalties are effective immediately. Enforcement for “willful neglect” is effective February 17, 2011.
The Quality and Medical Management (QMM) Program integrates the primary functions of Quality, Medical Management and Pharmacy. These departments work in tandem to establish, coordinate and execute a structure to support Health Alliance members/enrollees as they work to improve their health and assess and evaluate the care and service provided. Note: the following are used interchangeable throughout the document; Health Alliance and Health Alliance Medical Plans; and case and care management.

**Definition of Quality:**
- **Clinical quality** is defined as minimum variation from evidence-based practice or expert consensus.
- **Service quality** is defined as meeting or exceeding the valid service requirements of our customers.

**Purpose**
Quality Improvement (QI) at Health Alliance is an integrative process of continuous assessment and monitoring that strives to improve care and service provided to Health Alliance members/enrollees for all products. Activities are monitored according to a variety of quality indicators and regulatory requirements as outlined in the annual QI Plan. These indicators assess the healthcare programs delivered within the Health Alliance system. Based on quality indicator measurements and continuous evaluation of the program components, opportunities for improvement are identified. These opportunities enhance the quality of care and service provided to our members/enrollees by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided. Components of the QI Program include all products and plan types for Commercial HMO/POS, Commercial PPO, Medicare HMO, Medicare PPO, SNP, MMAI, SPD and FHP unless otherwise specified. The Quality and Medical Management Department is committed to ensuring that the care delivered to our members/enrollees is of the highest “value.” Value = Quality + Service / Cost.

**Goals**
The goals of the Health Alliance QMM program include:
- A. Identify special needs of the target populations served through annual population assessment data.
- B. Establish standards of clinical care and service for the target populations and measure performance outcomes adhering to NCQA, HPMS, CMS, and State and health plan requirements.
- C. Identify opportunities to enhance clinical care and service for the target populations.
- D. Respond with appropriate interventions to prioritized opportunities to improve clinical care and service.
- E. Measure the effectiveness of interventions and implement actions as needed to improve.

**Objectives**
The objectives of the Health Alliance QMM program include:
- A. Utilize a population-based approach to measuring and addressing continuous quality improvement for clinical care and service for the target populations.
- B. Develop, refine, and maintain data systems capable of providing systematic, reliable, and meaningful structure and process measures in the QMM program.
- C. Facilitate a partnership between practitioners, providers, members/enrollees, and Health Alliance for the purpose of maintaining and improving plan-wide services.
- D. Annually measure access, availability, and trends in member/enrollee satisfaction for improving service.
- E. Develop and maintain approaches to providing high-quality clinical care, including disease management, practice guidelines, utilization criteria and guidelines, complex case management, peer review, medical technology review, pharmaceutical management procedures, medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers.
- F. Involvement of designated behavioral health care practitioners to address behavioral health issues, including continuity and coordination of care, preventive health, clinical practice guidelines, appropriate triage and referral, customer service, clinical care including pharmaceutical management and all aspects of the QMM program. Health Alliance does not have a centralized triage and referral process for behavioral health services.
- G. Develop and maintain a utilization management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member/enrollee and practitioner appeal rights, and appropriate handling of denials of service. Through the UM process, each case is evaluated against established
medications to determine medical necessity. In the case of Medicare plans, the reviewer complies with national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contractors. Individual patient circumstances and the capacity of the practitioner and provider delivery systems are considered. Factors such as age, co-morbidities, complications, progress of treatment, psychosocial situations, and home environment (when applicable) are reviewed when applying criteria. Department policies and procedures further define these processes in detail.

H. Measurement of the effectiveness of the model of care for designated populations.

I. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety including medication therapy management data, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.

J. Develop and maintain a credentialing and recredentialing program for individual practitioners and provider organizations that adheres to federal and state regulations, as well as standards for accreditation.

K. Provide access to information about patient safety to members/enrollees and practitioners through our website while encouraging accountability for patient safety with contracted providers through our Adverse Events and Quality of Care processes.

L. Assess cultural and linguistic needs of member/enrollee population at least annually and report findings to the Members Rights and Responsibilities/Quality Improvement Committee. Annual assessment includes evaluation of CAHPS® and new member/enrollee survey demographic data, Language Line translation requests for oral translation services with documentation available upon request, complaint data, CACTUS credentialing system data for provider language spoken, CCMS case management cultural need responses, and data provided by Health Alliance’s four major provider systems.

M. Provide members/enrollees with information regarding rights and responsibilities, health plan policies and procedures, benefit and coverage information, and ensure appropriate oversight of procedures that protects the privacy and confidentiality of member/enrollee information and records.

N. Develop and promote preventive health standards, family planning services and programs to encourage members/enrollees and practitioners to utilize appropriate guidelines and early detection services for prevention of illness.

O. Provide an appeals process designed to protect the rights of the member/enrollee, physician and hospital as fully as possible. Ensure that any member/enrollee, provider or practitioner who is affected by an adverse determination is given the opportunity to appeal through a verbal or written request for medical and administrative review.

P. Establish standards and processes for maintenance and oversight of delegated activities, if applicable.

Q. Establish an annual QMM Plan that describes specific activities undertaken each year to address the components of the QMM program.

R. Annually review the program activities to determine effectiveness and focused priorities for the coming year. The QMM department prepares an annual evaluation that is reviewed and approved by the CMO, Department Director, and the Quality Improvement Committee. The annual evaluation contains a summary of the year’s program activities, an assessment of the effectiveness of the various components of the program as well as recommended program modifications and activities planned for the coming year are included. The annual assessment of effectiveness includes a review of the SPD/MMAI/SNP/FHP Integrated Care Team model and Model of Care. The annual evaluation highlights significant changes in the operation of the Quality Management, Medical Management, Pharmacy and Case and Utilization Management Programs based on review and recommendations from QMM leadership. Member/Enrollee and practitioner satisfaction with program activities is assessed as part of the evaluation. The impact of activities is reviewed by using the program evaluation to identify opportunities for improvement and to revise the programs as needed.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
**Program Scope**
The scope of the Health Alliance QMM program is designed to fulfill the goals and objectives of the program, while efficiently utilizing resources to promote and enhance integration of quality activities internally (within Health Alliance) and externally with practitioners, providers, members/enrollees, employers, state and federal agencies, and appropriate parties. The scope of the QMM program includes, but is not limited to:

A. Clinical Care
   1. preventive health activities
   2. family planning services
   3. clinical quality improvement activities
   4. clinical management criteria and guidelines
   5. disease management
   6. credentialing and recredentialing
   7. inpatient care review for inpatient, surgical and behavioral health care admissions
   8. discharge planning
   9. preauthorization review for medical necessity
   10. case management, including complex case management

B. Service
   1. Member/enrollee complaints and appeals
   2. trends in member/enrollee dissatisfaction/satisfaction (including CAHPS® surveys)
   3. appointment and afterhours access monitoring
   4. practitioner availability monitoring
   5. telephone access
   6. written and verbal communications with members/enrollees
   7. concurrent review

C. Behavioral Health Services
   1. preventive health
   2. mental health and substance abuse quality improvement activities
   3. behavioral management criteria and guidelines
   4. telephone and appointment access monitoring
   5. credentialing and recredentialing
   6. utilization management
   7. care transitions

D. Patient Safety
   1. continuity and coordination of care between practitioners and providers
   2. tracking and trending of adverse events
   3. evaluation of clinical care against aspects of evidence based guidelines that improve safe practices by detecting under- and over-utilization
   4. implementation of health management systems that support timely delivery of care
   5. medication management evaluation through case management program

**Structure of Program**
The Quality and Medical Management Program provides a comprehensive structure to identify, evaluate and improve clinical care and service provided to members/enrollees individually and collectively. The Health Alliance Board, has designated the day-to-day accountability of the quality and medical management program to the Chief Medical Officer and Quality and Medical Management Directors with reporting accountability to the Quality Improvement Committee (QIC). Subcommittees of the QIC provide a focus on initiatives involving quality improvement such as utilization management, members’ rights and responsibilities, credentialing and pharmacy. In addition to committees, multiple departments and individual staff members/enrollees have key roles and responsibilities in the QMM program.
Medicare Advantage/Special Needs Plan (SNP)

In addition to objectives, scope and program structure previously described, the following are specific to the Health Alliance Medicare Advantage/SNP enrollees, defined as a Medicaid subset D-SNP:

1. Implement chronic care improvement programs (CCIP) through methods that identify enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in the program. In addition, establish mechanisms for monitoring these enrollees that are participating in the chronic care improvement program. The program also addresses additional populations identified by CMS based on a review of current quality performance.

2. Quality improvement projects (QIP) that can be expected to improve health outcomes, enrollee satisfaction, and addresses areas identified by CMS.
   a. The projects are specific initiatives that address clinical and non-clinical areas and involve measurement of performance, system interventions including the establishment or alteration of practice guidelines, improving performance and systematic and periodic follow-up on the effect of the intervention.
   b. The projects assess performance under the plan use quality indicators that are objective, clearly and unambiguously defined, and are based on current clinical knowledge or health services research.
   c. The performance assessments on the selected indicators are based on systematic ongoing collection and analysis of valid and reliable data.
   d. Interventions identified in the annual work plan strive to achieve demonstrable improvement and improvement is documented in the annual evaluation.
   e. Each QIP project status and results of each project are reported to CMS as requested.

3. Encourages providers to participate in CMS and Health and Human Service (HHS) QI initiatives.

4. Contracts with approved Medicare CAHPS® vendor to conduct the Medicare CAHPS® survey.

5. Complies with and monitors the activities reflected in the Medicare domain program table which includes:
   a. Safer Patient Care (Medication Events, Health Care Associated Infections and Other Preventable Conditions)
   b. Patient Centered Care (Cultural Competency, Decision-Marking Partnerships and Integrated Care Delivery)
   c. Effective Care Coordination (Care Management, Effective Discharge Planning and Multidisciplinary Coordination)
   d. Effective Prevention & Treatment (Current Quality Initiatives, Early Detection & Intervention and Appropriate Treatment Modalities)
   e. Promotion of Healthy Living (Evidence Based Medicine, Clinical Preventive Services and Education & Counseling for Risk Behaviors)
   f. Effective Communication (Electronic Health Records, e-Prescribing and Telemedicine)
   g. Improving Affordability (Utilization of Products & Services, Payment and Service Models and Administrative Simplification)

6. Complies with CMS requirements for Medication Therapy Management programs. The goal is to optimize therapeutic treatment of specified chronic disease states by increasing compliance and providing education to enrollees and prescribers.
   a. Health Alliance contracts with Medimpact (MI) to perform the Medication Therapy Management functions.
   b. Health Alliance policy 1233 – Medicare D Medication Therapy Management Program outlines the identification of beneficiaries, intervention and reporting processes and policy 1753 for Medicare D Reporting Requirements – Medication Therapy Management further outlines reporting.
   c. Health Alliance provides Medimpact eligibility data files as well as beneficiary plan start/end dates. Members are selected based on criteria identified within the policy. All eligible members are included unless the member chooses to opt out of participation.
   d. Medimpact provides services including determination of eligibility, telephonic CMR, medication action plan, personal medication list, targeted medication review and other interventions identified in the policy. Health Alliance reviews all interventions and provides feedback and further education/assistance as necessary.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
e. Health Alliance stratifies members selected for MTMP into case management per chronic disease state.

f. CMS data validation standards are used to validate accuracy of reporting data. Data is uploaded to CMS annually via HPMS.

To support CMS regulations, Health Alliance maintains a health information system that collects, integrates, analyzes and reports data necessary to implement its QI program:

- Health Alliance has policies and procedures in place on the requirements for reporting data to CMS. Updates to the Reporting Requirements are reviewed upon publication and updates to policies, procedures and systems are completed.

- Health Alliance collects data on the following:
  a. Provider characteristics – via Visual CACTUS Credentialing System for provider and the MC400 as the primary member system of record for member characteristics.
  b. Services furnished to members – via McKesson Compliance Reporter and Risk Manager (HEDIS®*), CAHPS®* survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.
  c. Data to guide the selection of quality improvement project topics and meet the data collection requirements for quality improvement projects – via McKesson Compliance Reporter and Risk Manager (HEDIS®*), CAHPS®* survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.

- Health Alliance ensures that information and data received from providers are accurate, timely and complete – via MC400 Claims processing system and MedImpact PBM.

- Health Alliance has information systems that integrate data from various sources, including member concerns and complaints – via SalesForce.

- Health Alliance has a formalized process to analyze data – via McKesson Compliance Reporter and Risk Manager (HEDIS®), Statistical package for Social Sciences (SPSS), and Access data bases as needed, as reported to QIC.
  - Health Alliance addresses identified deficiencies in reported data through provider feedback or other corrective action – via QMM Program through McKesson Compliance Reporter (HEDIS®**) and Risk Manager, ambulatory and inpatient reviews.
  - Health Alliance complies with HIPAA and privacy laws and professional standards of health information management through the Compliance Committee.

- Health Alliance conducts a pre-assessment on the Part C measures and has checks and balances in place for data submission. Corrective actions are put into place for all findings from the data validation audit or CMS notification.

Formal evidence of the impact and effectiveness of the QI program is documented in the quality and medical management annual evaluation. The evaluation includes measurement tools required by CMS and is made available to CMS to enable beneficiaries to compare health coverage options and select among them based on quality and outcomes measures.

The process of integrating the quality improvement initiatives with various Health Alliance departments and committees is accomplished, in part, through appointment of representatives to the committees listed in the structure of the quality improvement program with a diversity of knowledge and skills. These individuals support the development and continuous evaluation of the QMM Program, through the plan, do, study and act cycle. It is the primary responsibility of the QMM Department to diffuse quality initiatives throughout the organization.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Quality Management

Key Personnel

a. Chief Medical Officer (CMO) provides medical leadership for all Health Alliance products in all service areas. Oversees the successful implementation of medical management, pharmaceutical, Medicare Advantage revenue management and quality programs. The pharmacy, quality and medical management, Medicare Advantage revenue management, and contracting/provider network director’s report to the CMO. The Senior and Regional Medical Directors report to the CMO; and to the director of quality and medical management for administrative functions. The CMO chairs the Medical Director Committee and Adverse Events Committee; and participates on the Quality Improvement, Medical Policy, Pharmacy and Therapeutics, Compliance and Members’ Rights and Responsibilities committees.

b. Medical Directors are key resources for the quality and medical management team. These medical directors are members of the Quality Improvement Committee and obtain feedback on quality and medical management initiatives throughout the Health Alliance network. Physicians and pharmacists make all UM denial determinations for medical necessity through daily reviews for medically necessary services at all levels and appeal reviews, they are key to the following areas:

- The Senior Medical Director is an Adult Medicine/Geriatric Provider by training, and a 100% medical director. He chairs the Medical Policy Committee, participates in the Quality Improvement Committee, Medical Director Committee and leads the preauthorization review process, medical policy development and annual review, tech topic reviews, out of area concurrent review, and supports the CCMS system enhancements and embedded criteria, including the provider portal link to Clear Coverage.
- A Regional Medical Director, a Psychiatrist, is a 50% medical director and practices 20% for Carle. He chairs the Quality Improvement Committee, is a member of the Behavioral Health Workgroup, Credentialing Committee, Medical Director Committee and is integral in the management of acute care for mental health and case management to integrate behavioral with medical needs. He leads meetings with the providers in the local service area to share utilization reports and obtain feedback on improvements in the reporting/feedback process.
- Two Regional Medical Directors are Family Practice Physicians. One is an 85% medical director for the Bloomington/Peoria and surrounding markets. He chairs the Credentialing Committee, participates in the Adverse Event Committee, OSF Joint Venture team, leads acute and non-acute concurrent review activities and interrater reviews. The other leads initiatives in the Springfield market and chairs the Pharmacy and Therapeutics Committee, participating in the Needs Assessment Committee, and the Springfield Joint Venture team. Four additional Medical Directors provide day-to-day support at least 20% time for medical necessity reviews. Their specialties include Allergy, Emergency Medicine, Pediatrics and Otolaryngology/Head and Neck Surgery.
- Additional medical directors (5), including one designated to the MMAI product, perform daily reviews for utilization management, as well as participate in MDC to review medical policies and provide guidance and support to the QMM department.

c. Quality and Medical Management Director provides oversight for the quality and medical management department and is a key resource to the model of care for the FHP/SPD/MMAI/SNP population. Responsible for identifying, implementing monitoring and evaluating quality and medical management activities to improve care and service provided to all Health Alliance members/enrollees. Responsible for overseeing the areas of credentialing and re-credentialing for all providers (individual and facilities); wellness; enhance Joint Venture and community partnerships; member/enrollee appeal and grievance monitoring to meet regulatory agency requirements; clinical guidelines for acute, chronic, preventative and behavioral health services; population-based disease management programs with the goal of improving health outcomes; case management to ensure engagement and improvement in quality of life; utilization management to focus on reducing medical spend while maintaining or improving quality; and ensuring appropriate document and reporting systems are utilized to maximum efficiency.

d. Pharmacy Director is responsible for drug formulary design and development, implementation and risk management to improve quality, control cost and contain costs. Responsible for the supervision of the pharmacy network, pharmacy staff, pharmacy-related contracting and pharmacy benefit manager. Evaluates and implements interventions that address clinical, administrative, financial and regulatory challenges involved in managing pharmaceutical costs and utilization.
** e. **Contracting and Provider Services Director** oversees the contracting and provider services department. Responsible for the overall direction and coordination of Network Development, Contracting and Provider Relations. Duties include planning, directing, organizing, controlling, and evaluating the implementation of strategic and tactical plans that ensure effective provider interactions and network development, and their continued viability to the organization.

f. **Utilization Management Manager**, for inpatient and outpatient services, is a registered nurse who oversees the utilization management activities for all products. She oversees the preauthorization process using established criteria to determine coverage, ensures that questionable cases or any potential denials based on medical necessity are forwarded to a Medical Director for review, ensures utilization management coordinators determine denials based on benefits only; and support the Intake Coordinators who are the front line staff for the preauthorization process. Three senior nurse coordinators report to the manager, one leads inpatient and two lead outpatient activities.

g. **QMM Data Reporting Manager** ensures the successful and accurate completion of all HEDIS** reporting for all products and the impact on the results to NCQA; develops innovative solutions around disease management reporting and links all affected systems. Manages the HEDIS** Supervisor, and key QMM staff for data reporting and system operations for the QMM department.

h. **Corporate Quality Manager** develops, implements and monitors a corporate quality improvement plan that includes interventions to improve care and service for all members/enrollees, including expansion areas and products. The position manages applicable staff as well as collaborates with and supports the Data Reporting staff around HEDIS** and Star ratings with the goal of attaining excellent NCQA accreditation for all products and 5 Star rating for Medicare Advantage products.

i. **Accreditation and Credentialing Manager** oversees the day-to-day credentialing and re-credentialing for all practitioners and providers, as well as manages the delegated credentialing program. Key contact to coordinate NCQA activities and facilitates completion of NCQA onsite activities.

j. **Case and Disease Management Manager** is a registered nurse and certified rehab counselor who oversees the integration of case and disease management to ensure a focus on the continuum of care. She leads the case management team, which consists of senior case managers, nurses, social workers and administrative staff. Designed case managers lead an integrated care team (ICT) to address specific needs and obtain input from the enrollee’s primary care physician, in addition, a person-centered Care Plan is developed and maintained for designated enrollees.

k. **Member Relations Manager** oversees the staff and management of the appeals process, DOI complaints, ERO reviews and Peer reviews for all products and service areas.

l. **Wellness Administrator** develops implements and oversees all wellness activities internal to Health Alliance as well as offerings and supporting employer groups.

m. **Quality and Health Management Services Coordinators**, through accountability for assigned quality initiatives, facilitate solutions to improve care and service through population based disease management and patient safety programs, HEDIS** data collection, complete tasks that support activities defined in the QI work plan and prepare routine reports to the Quality Improvement Committee (QIC).

n. **Star Coordinators** focus on improving star rating measures. Oversees population disease management programs for all populations and Medicare specific NCQA/CMS requirements.

o. **Systems and Operations Specialist** is the technical resource for the McKesson products that support the quality and medical management department. Primary responsibilities include the analysis, testing and integration of the organization’s software and information systems as it relates to quality and medical management functions. Ensures supplemental products/upgrades within the system, released for production, contain no identified defects. Provides technology expertise to the department and collaborates with other departments for data collections and system upgrades and maintenance. Functions as a liaison and resource to the IT Department related to medical management systems and software.

p. **Utilization Management Coordinators** include inpatient and outpatient nurses. Outpatient focus in on preauthorization of designated medical services and procedures. Inpatient Coordinators perform concurrent review, with a key focus on discharge planning, in the inpatient acute setting and at non-acute skilled nursing facilities. Retrospective reviews are conducted within each area, as appropriate. Established clinical criteria

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** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
are used to determine coverage based on medical necessity. Questionable cases or potential denials based on medical necessity are forwarded to a Medical Director for review. Utilization Management Coordinators (previously called medical management coordinators) may determine denials based on benefits only.

q. **Outpatient Case Managers** facilitate care transitions and complex member/enrollee needs through motivational interviewing techniques and approved scripting. An initial clinical assessment, screening for changes in health status, care transitions, and coaching and monitoring behavior changes for improved self-management are the performance expectations. Members/enrollees are also reminded about necessary testing and follow-up care as determined by clinical guidelines. Patient information sources include medical and pharmacy claims, medical record documentation, discussion with appropriate physicians and information gleaned from the member/enrollee.

r. **The Communications Specialist** is dedicated to quality management to provide consultation for material presentation and coordinate material distribution, as needed.

**Technical Resources/Systems**

There are a number of technical resources/systems available to support and implement the QI program:

a. **McKesson Vitals Platform** is a McKesson system that provides, condition identification, program identification/work list, risk levels/risk profile, identification of gaps in care, system alerts and messaging capabilities to support medical management services including utilization management, case management, disease management, management of members/enrollees at risk (complex case management) and documentation of appeals. The system allows evaluation of care management by tracking and measuring goals, interventions and outcomes. Health Alliance migrated to the McKesson Vitals platform from the McKesson CCMS system in the fall of 2013.

b. **InterQual** is embedded in CCMS and is an industry-leading evidence-based tool for determining the appropriateness of health care interventions and levels of care across the continuum. This program supports preauthorization, concurrent review and retrospective analysis of clinical appropriateness. The following guidelines are used:

**Inpatient Services**
- InterQual® Level of Care: Acute Criteria, Adult
- InterQual® Level of Care: Acute Criteria, Pediatric
- Prest & Associates, Inc. Review Criteria - Mental Health

**Outpatient Services**
- InterQual® Care Planning: Procedures Criteria, Adult and Pediatric
- InterQual® Care Planning: Imaging Criteria, Adult and Pediatric
- InterQual® Care Planning: Molecular Diagnostics

InterQual is a nationally respected vendor with clinical criteria based on best practice, clinical data and medical literature. Prest & Associates, Inc. is a nationally respected independent review organization that provides behavioral health criteria along with consultation and review services with board certified physicians in mental health and substance abuse. ASAM guidelines are a nationally accepted standard of care for the treatment of substance abuse disorders.

Where vendor guidelines are incomplete or absent, internal medical policies that reflect current standards or medical practice are developed by the Medical Director Committee and reviewed by the Medical Policy Committee. All Health Alliance criteria and medical policies are reviewed annually to determine whether updates/revisions are warranted. The designated Senior Medical Director and the medical management project coordinator receive and research all requests for policy revisions and for new policy development. Annual criteria reviews are conducted through the Medical Directors Committee and Medical Policy Committee as indicated. Coordinators utilize the medical policies to evaluate medical necessity and authorize services if appropriate. Medical Technology reviews are performed on new technologies to ensure that the Health Plan is staying current with the latest standards of care. Medical necessity reviews beyond the scope of current
coverage criteria are referred to a Medical Director, who is then accountable for review and determination of coverage. Decisions made using any criteria are based on each member/enrollee’s clinical status and assessment of the local delivery system. Clinical Peers are used as needed. Medical Directors and Coordinators are evaluated at least annually for consistency of applying criteria, and corrective actions are implemented when needed.

c. **McKesson Risk Manager** is an integrated performance platform that enables better management to reduce medical management costs and improve physician efficiency and quality profiling.

d. **McKesson Compliance Reporter** is used to gather and report HEDIS. This includes data reported annually to NCQA, as well as at the provider and employer levels annually and quarterly. The system integrates with VITAL and Risk Manager.

e. **MC400 (Managed Care 400)** is a claim processing system from OAO Healthcare Solutions retains member/enrollee eligibility information, applies provider contract and payment terms and adjudicates claims based on specific rules established for employer benefit packages.

f. **PBM (Pharmacy Benefit Manager)** – MedImpact for Medicare Advantage and MMAI, and Catamaran for the ICP/FHP/SPD populations offers customized products and uses an evidence-based approach to manage costs.

g. **Visual CACTUS** – houses all data for credentialed providers and drives the recredentialing process.

h. **Ambulatory Review Database** – an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.

i. **Adverse Events Database** – an Access based system developed by Health Alliance staff enables to tracking, documentation and reporting of adverse events (never events and sentinel events).

j. **Wellness Vendor (Currently WorldDoc/moving to Audax/Zensey 7/1/14)** – available to all Health Alliance member/enrollees and providers free of charge via the Health Alliance/Health Alliance Connect-SNP website. WorldDoc offers around-the-clock access to information that can make challenging health decisions a little easier. Tools and information on health risks, illnesses, treatment options and medications are included. The organization will be moving to Audax.

k. **SPSS (Statistical Package for the Social Sciences)** allows users to sample, manipulate, and analyze data including statistical testing, correlations, and regression analysis.

l. **SQL Query Analyzer** allows users to query data from the data warehouse for reporting or producing mailing lists.

m. **Crystal Reports** allows users to query data from the data warehouse for reporting or producing mailing lists

n. **MCNet** pulls member/enrollee information for the customer service representative from the member/enrollee number entered into the Cisco Systems IVR by the caller or when accessed manually by the representative. MCNet combines access to a call tracking process from another system by Onyx called Customer Center with data housed in the MC400. Calabrio’s Work Force Management and Quality Management software are used for staff scheduling, call recording, and call monitoring. They are fully integrated with the phones by Cisco Systems.

o. **Cisco Systems** – phone system that provides reporting on telephone utilization.

p. **Onyx Customer Center** tracks complaints and feeds into our data warehouse. Reports are run using Crystal Enterprises.

q. **Salesforce** – a customer relationship management (CRM) service. Broadly, this CRM service is used to manage our customer service, provider relations and member services. Salesforce also provides easy access to complete member information that is used to ensure more “one and done” service calls. The Custom Cloud allows the creation of powerful custom functionality in Salesforce, which works along with other services like DocuSign, Conga, etc. to automate many of our manual processes.

r. **CMS Medicare Coverage Guidelines** – For Medicare plans, national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contracts is used. Individual patient circumstances and the capacity of the practitioner and provider delivery system are considered. This includes the consideration of alternate settings when needed. Factors such as age, co-morbidities, complications, progress of treatment psychosocial situations, and home environment (when applicable) are reviewed when applying criteria.

The following pages contain descriptions of the quality improvement program committee structure.
QUALITY IMPROVEMENT COMMITTEE (QIC)

a. **Role:** Primary responsibility is to provide direction, implementation, oversight and coordination of quality improvement initiatives throughout Health Alliance for all products.

b. **Chairperson:** Chief Medical Officer, Health Alliance Medical Plans

c. **Membership:**
   - Regional Medical Director, Health Alliance, and Participating Psychiatrist
   - Regional Medical Director, East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
   - Senior Medical Director, Health Alliance, Family Practice, Board Certified
   - Associate Medical Director, Allergy, Carle; Participating Practitioner, Allergy, Carle
   - Medical Director, Population Health, Carle
   - Vice President of Quality, Carle
   - Director of Quality and Medical Management, Health Alliance
   - Director of Government Relations, Health Alliance Medical Plans
   - Manager of Case and Disease Management, Health Alliance
   - Accreditation and Credentialing Manager, Health Alliance
   - Corporate Quality Management, Health Alliance

d. **Reporting:** Reports to the Health Alliance Medical Plans Board.

e. **Responsibilities:**
   - Identify and initiate quality improvement activities for care and service as they relate to the enrolled Health Alliance population.
   - Continuously monitor data from quality improvement activities as outlined in the annual work plan and recommend appropriate action.
   - Evaluate and allocate resources for quality improvement activities, including resources needed to impact Star ratings and NCQA rankings.
   - Evaluate the quality improvement structure and complete a formal QI Plan and QI Evaluation on an annual basis.
   - Monitor sub-committee and work group activities through review of meeting minutes and reports.
   - Delegate any of the above activities to sub-committees with appropriate oversight.
   - Review reports of delegated activities at least annually.
   - Adopt, develop, and implement overall preventive health and clinical guidelines.
   - Oversee all quality improvement initiatives as described in the annual plan.
   - Review reports around pay for performance initiatives.
   - Review new NCQA standards and make recommendations, as needed.
   - Review HEDIS rates by product, reporting findings from the annual HEDIS audit, and assess actions based on results.
   - Review Part C and Part D Report Cards (Star Ratings)
   - Monitor Quality Improvement Project (QIP)
   - Monitor Chronic Care Improvement Program (CCIP)
   - Oversee pay for performance programs

f. **Meets:** Monthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.
a. **Role:** To assure the appropriate management of healthcare services for the elderly and disabled population utilizing evidence based clinical criteria and guidelines. Collaborate with other committees such as the Medical Policy Committee, the Pharmacy & Therapeutics Committee, the Behavioral Health Committee and the Consumer Advisory Committee. Function as the Grievance Committee to review member grievances.

b. **Chairperson:** Medical Director, Health Alliance Connect

c. **Membership:**
   - Medical Director, Health Alliance Medical Plans and Health Alliance/SNP
   - Chief Medical Officer, Health Alliance Medical Plans
   - Director of Client Services, Health Alliance/SNP
   - Director of Pharmacy, Health Alliance/SNP
   - Director of Pharmacy, Health Alliance Medical Plans
   - Director of Quality and Medical Management, Health Alliance Medical Plans
   - Director of Government Relations, Health Alliance Medical Plans
   - Quality Manager, Health Alliance Connect
   - Manager of Utilization Management, Health Alliance Medical Plans

d. **Reporting:** Reports to the Health Alliance Quality Improvement Committee and Health Alliance Connect Board.

e. **Responsibilities:**
   - Reviews utilization patterns and trends for inpatient, outpatient and LTSS services
   - Evaluates for over/under utilization of services
   - Evaluates and analyzes inpatient utilization
   - Reviews utilization reports to assist joint venture partners in identifying opportunities to improve service and quality of care as related to cost
   - Reviews Vendor involvement in utilization decisions
   - Reviews member grievances that cannot be handled informally and are not appropriate for standard internal processing
   - Reviews and analyzes satisfaction with UM staff and processes
   - Reviews care coordination oversight activities referenced in policy “Health Alliance 5430 Care Coordination Oversight”

f. **Meets:** Bimonthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.
   - Reported to the Health Alliance Quality Improvement Committee and Health Alliance Connect Board.
a. **Role:** Primary responsibility is to review all credentialing and recredentialing files and determine approval or denial of individual practitioners and facilities at the time of initial credentialing and recredentialing.

b. **Chairperson:** Regional Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine

c. **Membership:**
   - Senior Medical Director, Health Alliance
   - Regional Medical Director/Springfield Region, Health Alliance; Participating Practitioner Internal Medicine
   - Medical Director/Local Service Area, Health Alliance; Participating Practitioner, Psychiatry
   - Regional Medical Director/Peoria Region/Participating Practitioner, Adult Medicine-Urgent Care
   - A member of the LTSS provider community on an ad hoc basis
   - Non-Voting: Credentialing Manager or Designee

d. **Reporting:** Reports to the Quality Improvement Committee (aka Quality Assurance Plan Committee for purposes of MMAI plan.)

e. **Responsibilities:**
   - Review all materials, including patient safety/quality issues, relevant to an applicant regarding credentialing and recredentialing issues as identified in the Health Alliance credentialing policies and procedures.
   - Determine approval or denial status as a Health Alliance participating practitioner or facility.
   - Review and revise all policies and procedures related to credentialing and recredentialing activities at a minimum annually.
   - Oversee quality monitoring deficiencies for all providers outside the recredentialing cycle, including LTSS providers.

f. **Meets:** Bimonthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.
MEDICAL DIRECTORS’ COMMITTEE (MDC)

a. **Role:** Primarily responsible for oversight and review of medical management activities and strategic planning for initiatives that will enhance the provision of care

b. **Chairperson:** Chief Medical Officer, Health Alliance

c. **Membership:**
   
   **VOTING**
   - Senior Medical Director, Health Alliance
   - Regional Medical Directors, Health Alliance
   - Medical Directors, Health Alliance
   - Medical Director, Health Alliance/SNPH Health Alliance Northwest Medical Director
   - Director of Quality and Medical Management, Health Alliance
   - Director of Risk Adjustment Revenue Management, Health Alliance
   - Manager, Member Relations, Health Alliance
   - Manager, Utilization Management Health Alliance
   - Manager, Case and Disease Management, Health Alliance

   **NONVOTING**
   - Pharmacist, Health Alliance
   - Senior Case Coordinators/Case Managers, Health Alliance
   - Project Assistant, Medical Management, Health Alliance

d. **Reporting:** Reports to the Quality Improvement Committee for informational purposes only

e. **Responsibilities:**
   - Review medical policies at least annually
   - Oversee the review of information involving new technologies and/or treatments
   - For medical policy and new technology and/or treatment reviews, obtain input from participating providers, as needed
   - Reviews appeal decisions from External Review Organizations (EROs) to determine if changes in current criteria/medical policies are indicated
   - Oversees review of inter-rater reliability reports for applying UM criteria and validity including sampling methodology used when selecting records eligible for inter-rater reliability testing
   - Reviews and approves department policies presented for new or changed UM activities or processes
   - Discusses UM issues and may recommend further review by QMM Leadership and/or UM Committee

f. **Meets:** Monthly. Reports summary of activities to QIC

f. **Minutes:**
   - Generated for each meeting and approved by the committee
   - Reflect the activity, discussion, analysis and recommendations of the committee as well as follow-up and resolution of prior recommendations
MEDICAL POLICY COMMITTEE (MPC)

a. **Role:** Primary responsibility to review and provide practitioner input on new and updated criteria, medical policies, and policies and procedures.

b. **Chairperson:** Chief Medical Officer, Health Alliance

c. **Membership:**
   - Senior Medical Director, Health Alliance
   - Minimum of five Health Alliance participating practitioners representing primary and specialty care services including family planning services
   - Medical Director, Health Alliance/SNP

d. **Reporting:** Provides feedback to the Medical Directors’ Committee, as needed.

e. **Responsibilities:**
   - Review case requests for new technology based on literature with recommendations based on area of expertise
   - Review and updates to policy and procedures with recommendations based on area of expertise
   - Review inter-rater reliability reports for applying UM criteria and validity including sampling methodology used when selecting records eligible for inter-rater reliability testing.

e. **Meets:** Monthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis, and recommendations of the committee as well as follow-up and resolution of prior recommendations.
   - Reviewed by Corporate Medical Directors’ Committee monthly and shared with the Quality Improvement Committee.
PHARMACY AND THERAPEUTICS COMMITTEE

a. **Role:** Provides guidance for pharmacy utilization for Health Alliance providers.

b. **Chairperson:** Chief Medical Officer or Designee, Health Alliance

c. **Membership:**

   **VOTING**
   - Chief Medical Officer, Health Alliance
   - Medical Director/Springfield, IL, Health Alliance, Participating Practitioner, Internal Medicine
   - Medical Director/East Central Illinois Region, Health Alliance, Allergy
   - Medical Director/East Central Illinois Region, Health Alliance, Psychiatry
   - Medical Director, Adult Medicine, Ames, IA
   - Medical Director/East Central Illinois Region, ENT
   - Participating Practitioner, Pediatrics, Urbana, IL
   - Participating Practitioner, Family Medicine, Champaign, IL
   - Participating Practitioner, Emergency Medicine, Champaign, IL
   - Participating Practitioner, Rheumatology, Champaign, IL
   - Participating Practitioner, Neurology, Champaign, IL
   - Participating Practitioner, Family Med, Champaign, IL
   - Participating Practitioner, Internal Med, Springfield, IL
   - Participating Practitioner, Convenient Care, Springfield, IL
   - Participating Director of Pharmacy, Health Alliance

   **NONVOTING**
   - Compliance Officer or Designee, Health Alliance
   - Pharmacists, Health Alliance
   - Formulary and Communications Manager, Health Alliance
   - Client and Government Programs Manager, Health Alliance
   - Director of Pharmacy, Carle Hospital, Champaign, IL
   - Clinical Peers (consulted as needed, determination based on agenda)

d. **Reporting:** Reports to Medical Directors Committee for informational purposes only.

e. **Responsibilities:**
   - Annual review of the pharmacy program.
   - Maintain and establish a formulary.
   - Reviews and updates pharmaceutical management policies and procedures annually based on new technologies.
   - Approves or disapproves medications including biotechnology and medications. Medication on the formulary may be removed or have its status changed.
   - May, from time to time, determine that a prior approval guideline should be developed and implemented.
   - May establish guidelines for criteria based medications.
   - Establish and implement a Drug Utilization Evaluation (DUE) program.
   - Designate a Task Force or Subcommittee to study particular prior approval guideline.
   - Ensure an appeal process for pharmacy issues is maintained.

f. **Meets:** Bimonthly

g. **Minutes:**
   - Generated for each meeting and approved by the Chairman.
   - Reflects the activity, discussion, analysis, and recommendations of the committee as well as follow-up and resolution of prior recommendations.
   - Distributed to the Medical Director Committee and key directors and managers at Health Alliance.
   - Provided to Communications Department to include a summary of minutes to all Health Alliance practitioners.
BEHAVIORAL HEALTHCARE ADVISORY GROUP

a. **Role:** Identifies opportunities to improve the quality of behavioral health care delivered to members/enrollees of Health Alliance throughout all service areas. Reaches out to high volume behavioral health providers on a regular basis to identify interventions and coordinate efforts for medical and behavioral health care.

b. **Chairperson:** Regional Medical Director, Health Alliance/Practicing Psychiatrist

c. **Membership:**
   - Accreditation and Credentialing Manager, Health Alliance
   - Director of Quality and Medical Management, Health Alliance
   - Case and Disease Management Manager, Health Alliance
   - Senior Case Manager, Social Worker, Health Alliance
   - Inpatient Case Management for Behavioral Health, Health Alliance
   - Director of Care Management, Health Alliance/SNP

d. **Reporting:** Reports to the Quality Improvement Committee.

e. **Responsibilities:**
   - Advise Health Alliance on issues related to improving continuity and coordination of care between medical care and behavioral health care
   - Review HEDIS results for measures related to behavioral health care and advise Health Alliance on improvement opportunities and action plans
   - Addresses any identified patient safety improvement opportunities around behavioral health.
   - Identify and recommend actions to improve access to behavioral health services

f. **Meets:** Monthly (or as needed).

g. **Minutes:**
   - Generated for each meeting and approved by the committee
   - Reflect the activity, discussion, analysis and recommendations of the committee
MEMBERS’ RIGHTS AND RESPONSIBILITIES COMMITTEE (MRRC)

a. **Role:** To assist in maximizing the value of our members’/enrollees’ health care by monitoring available reports and information and making recommendations for improvement to the Quality Improvement Committee. Information reviewed may include: complaints and appeals data, policies and procedures, member/enrollee communications, prospective member/enrollee communications, member/enrollee satisfaction survey results (CAHPS® and new member/enrollee surveys), provider satisfaction survey results, employer satisfaction survey results, disenrollment survey results, cultural and linguistic service needs, service-related HEDIS measures, provider access data, and service-related Key Performance Indicators.

b. **Chairperson:** Senior Vice President of Corporate Communications, Health Alliance

c. **Membership:**
   - Chief Medical Officer, or designated Medical Director, Health Alliance
   - Director, Quality & Medical Management, Health Alliance
   - Director, Customer Service, Health Alliance
   - Vice President, Medicare & Individual Plans, Health Alliance
   - Director, Contracting and Provider Services, Health Alliance
   - Director, Communications, Health Alliance
   - Manager, Regulatory Compliance, Health Alliance
   - Manager, Member Relations, Health Alliance
   - Quality Improvement Coordinator, Health Alliance
   - Operations Management Representative, Health Alliance
   - Marketing Management Representative, Health Alliance
   - Pharmacy Director, Health Alliance
   - Senior QM Data Analyst
   - Director of Client Services, Health Alliance/SNP
   - Director of Care Management, Health Alliance/SNP
   - Director of Government Relations, Health Alliance Medical Plans

d. **Reporting:** Reports to the Quality Improvement Committee.

e. **Responsibilities:**
   - Facilitate mutually respectful relationships with members/enrollees and providers through an established statement of members’ rights and responsibilities.
   - Review member/enrollee complaints and appeals data and provider appeals (at least semi-annually) to identify trends, provide recommendations for improvement as needed. Monitor development, implementation and tracking of applicable policies and procedures.
   - Ensure member/enrollee and prospective member/enrollee communications clearly outline benefits and contain information needed to understand benefit coverage and how to obtain care via review of survey results.
   - Ensure cultural and linguistic needs of members/enrollees are assessed annually and addressed. Review findings of member/enrollee and practitioner satisfaction surveys (at least annually) to identify trends and opportunities for improvement.
   - Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.
   - Monitor service-related HEDIS measures and service-related organizational Key Performance Indicators to identify opportunities for improvement. Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.

f. **Meets:** Every other month starting June 2003 (quarterly prior to this time).

g. **Minutes:**
   - Generated for each meeting and approved by the committee
   - Reflect the activity, discussion, analysis and recommendations of the committee
   - Shared with the Quality Improvement Committee
CASE MANAGEMENT LEADERSHIP TEAM

a. **Role:** Provides oversight for the case management to ensure an integrated member/provider approach in the coordination of quality and cost effective health care services in the most appropriate setting. To identify differentiation for members’/enrollees’ needs, when applicable. To support NCQA standards around complex case management to members/enrollees following a critical event, have a diagnosis with the potential to require the extensive use of resources, or have a high forecasted risk index.

b. **Chairperson:** Director of Quality and Medical Management or Designee, Health Alliance

c. **Membership:**
   - Director of Risk Adjustment Revenue Management, Health Alliance
   - Manager of Case and Disease Management, Health Alliance
   - Senior Case Managers, Health Alliance
   - Director of Care Management, Health Alliance/SNP
   - Ad-Hoc Members, as needed, including the Chief Medical Officer

d. **Reporting:** Reports to the Quality Improvement Committee for activities around complex case management.

e. **Responsibilities:**
   - Conducts an annual population assessment to identify needs of the population
   - Defines new methods to identify members for case management, as appropriate
   - Develops and implements screening and engagement tools
   - Measures outcomes and program effectiveness
   - Integrates activities with provider specific initiatives
   - Ensure call monitoring of all case managers and action plans developed, if appropriate
   - Monitor CTI process and metrics
   - Ensure compliance with NCQA complex case management standard

f. **Meets:** Monthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.
CONSUMER ADVISORY COMMITTEE – COMMERCIAL PRODUCTS

a. **Role:** Identifies and reviews consumer concerns and makes advisory recommendations to Health Alliance. In addition, Health Alliance makes requests of the committee to provide feedback to proposed changes in plan policies and procedures, programs, materials and processes, which will affect enrollees.

b. **Chairperson:** Elected by the committee.

c. **Membership:** Eight enrollees selected as required by law. An enrollee may not serve on the committee if during the two years preceding service the enrollee: (1) has been an employee, officer, or director of the plan, an affiliate of the plan or a provider or affiliate of a provider that furnishes health care services to the plan or affiliate of the plan; or (2) is a relative of a person specified in item (1). Four enrollees will serve a two-year term and four enrollees a one year term. After the term expires, Health Alliance will re-appoint or appoint an enrollee to serve on the committee for a two-year term.

*Resources to the Committee:*
- Director of Compliance, Health Alliance
- Marketing Communications Specialist, Health Alliance
- Chief Medical Officer or Designee, Health Alliance

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee.

e. **Responsibilities:**
   - Identify and review consumer concerns and make advisory recommendations.
   - Provide feedback to proposed changes in plan policies and procedures which will affect enrollees.
   - Identify and recommend improvement of Health Alliance membership and educational materials.
   - Provide input and recommendations for coverage issues.

f. **Meets:** Quarterly

g. **Minutes:**
   - Generated for each meeting and reviewed/approved by the committee.
   - Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
   - Reported to the Members’ Rights and Responsibilities Committee.
MEDICARE ADVISORY BOARD

a. **Role:** The Medicare Advisory Board (MAB) for Health Alliance Medicare was established to provide beneficiaries a forum where ideas, concerns, and suggestions could be shared and discussed; and to have input into program planning and product development.

The primary mission of the Board is to facilitate open communication between management and members. The Board is a crucial source of insights about customer issues and concerns, MMAI product development needs and service requirements. Members have the opportunity to influence decision-making by providing feedback to proposed changes in plan policies and procedures which will impact MMAI beneficiaries.

b. **Chairperson:** Manager of Medicare Member Services

c. **Membership:** The Board shall consist of up to 12 members who hold active membership on a Health Alliance Medicare or Medicaid plan. To be selected for the Advisory Board, individuals must be articulate about issues and needs and be willing to commit to participation. There are no set terms of membership. Membership on the MAB will remain in effect until such time as the member or Chairperson deems otherwise. Health Alliance representatives include:
   • Member Relations/Education Coordinator
   • Administrative Office Coordinator

   **Resources to the Board:**
   • Director of Medicare and Individual Services
   • Consumer Product Sales Manager
   • Marketing Communications Project Coordinator

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee.

e. **Responsibilities:** The Board functions in an advisory capacity only. The Board will serve as a mechanism to:
   • Provide ongoing customer feedback on services, regulations, policies and procedures
   • Evaluate current products and services
   • Identify new/alternative services and products
   • Determine areas, products, or services that may need to be changed and/or improved
   • Serve as an issues forum
   • Determine customer priorities and needs

f. **Meets:** Quarterly, however meeting frequency may be altered to meet the needs of Board members and Health Alliance staff.

g. **Minutes:**
   • Generated for each meeting and reviewed/approved by the committee.
   • Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
   • Reported to the Members’ Rights and Responsibilities Committee.
MEDICARE-MEDICAID ADVISORY BOARD

a. **Role:** Provides members of the Medicare-Medicaid Plan (MMP) and Seniors and Persons with Disability (SPD) Plan a forum where ideas, concerns, and suggestions are shared and discussed; and to have input into program planning and product development.

b. **Chairperson:** Director of Client Services or Designee, Health Alliance Connect

c. **Membership:**
The Board shall consist of up to eight (8) members who hold active membership on a Health Alliance Medicare-Medicaid plan or Seniors and Persons with Disability Plan including members caregivers/family members that represent the dual and waiver populations, i.e. people with disabilities. To be selected for the Advisory Board, individuals must be articulate about issues and needs and be willing to commit to participation.

**Resources to the Committee:**
- VP Medicare and Individual Services, Health Alliance Medical Plans
- Director of Government Programs, Health Alliance Medical Plans
- Marketing Communications Project Coordinator, Health Alliance Medical Plans
- Medicare-Medicaid Outreach Coordinator, Health Alliance Medical Plans
- Compliance Programs Manager and Privacy Officer, Health Alliance

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee (MRRC); MRRC reports to the Quality Improvement Committee (QIC); and QIC reports to the Health Alliance Board of Directors.

e. **Responsibilities:**
   - Shall recommend program enhancements based on member and community needs.
   - Review provider and member satisfaction survey results.
   - Evaluate performance levels and telephone response timelines.
   - Evaluate access and provider feedback on issues requested by QIP.
   - Offer guidance on reviewing member materials and effective approaches for reaching members.
   - Identify key program issues; such as racial or ethnic disparities, that may impact community groups.

f. **Meets:** Quarterly

g. **Minutes:**
   - Generated for each meeting and reviewed/approved by the committee.
   - Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
   - Reported to the Members’ Rights and Responsibilities Committee.
a. **Role:** Provide feedback on the performance from community perspectives. Identify regional community health education opportunities, improve outreach and communication with community-based organization members, and actively promote healthy lifestyles such as disease prevention and health promotion.

b. **Chairperson:** Elected by the Committee

c. **Membership:**
Eight local representatives from key community stakeholders and advocates (i.e. such as churches, advocacy groups, and other community-based organizations). Representative may not serve on the committee if during the two years preceding service the representative: (1) has been an employee, officer, or direct of the plan, an affiliate of the plan or a provider or affiliate of a provider that furnishes health care services to the plan or affiliate of the plan; or (2) is a relative of a person specified in (1). Four representatives will serve two-year term and four representatives a one-year term. After the term expires, Health Alliance will re-appoint or appoint a representative to serve on the committee for a two-year term.

**Resources to the Committee:**
- Chief Medical Officer, Health Alliance
- Vice President of Medicare Advantage and Individual Services, Health Alliance
- Consumer Products Sales Manager, Health Alliance
- Marketing Communications Project Coordinator, Health Alliance
- Director of Government Relations, Health Alliance
- Director of Client Services, Health Alliance/SNP

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee (MRRC); MRRC reports to the Quality Improvement Committee (QIC); and QIC reports to the Health Alliance Board of Directors.

e. **Responsibilities:**
- Shall recommend program enhancements based on member and community needs.
- Review provider and member satisfaction survey results.
- Evaluate performance levels and telephone response timelines.
- Evaluate access and provider feedback on issues requested by QIP.
- Offer guidance on reviewing member materials and effective approaches for reaching members.
- Identify key program issues; such as racial or ethnic disparities, that may impact community groups.

f. **Meets:** Quarterly

g. **Minutes:**
- Generated for each meeting and reviewed/approved by the committee.
- Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
- Reported to the Members’ Rights and Responsibilities Committee.
COMPLIANCE COMMITTEE

a. **Role:** Provide direction and support in the ongoing oversight of the Compliance Program. The Compliance Committee acts on behalf of the Health Alliance Board of Directors to review and approve policies, procedures and activities of the Compliance Program.

b. **Chairperson:** Director of Compliance, Compliance Officer, Health Alliance

c. **Membership:**
   - Chief Medical Officer, Health Alliance
   - Chief Operating Officer, Health Alliance
   - Chief Financial Officer, Health Alliance
   - Chief Sales and Marketing Officer, Health Alliance
   - Senior Vice President, Corporate Affairs and General Counsel, Health Alliance
   - Senior Vice President, Corporate Communications, Health Alliance
   - Vice President, Operations and Information Technology, Health Alliance
   - Vice President, Medicare and Individual Services, Health Alliance
   - Director, Human Resources, Health Alliance
   - Director, Quality and Medical Management, Health Alliance
   - Director, Internal Audit, Health Alliance and Carle
   - Non-Voting:
     - Compliance Program Manager/Privacy Officer, Health Alliance
     - Security Officer, Health Alliance

d. **Reporting:** Reports to the Compliance Committee of the Board of Directors through meeting minutes and updates from the Compliance Officer or designee.

e. **Responsibilities:**
   - Assist with the development of the Compliance Program, which includes creation and implementation of standards, policies and procedures; effective training and education; effective lines of communication; effective system for auditing and monitoring, reports of non-compliance, the investigation process and well publicized disciplinary standards.
   - Develop strategies to promote compliance and the detection of any potential violations.
   - Review and approve standards of conduct and ensure up-to-date compliance policies and procedures are in place.
   - Ensure compliance and FWA training and education are conducted and appropriately completed by all employees, board members and Medicare Advantage and Part D business partners.
   - Recommend and monitor, in conjunction with internal departments, the development of systems and controls to carry out policies and procedures as part of its daily operations.
   - Review and approve the compliance risk assessment model.
   - Review and approve the monitoring and audit work plan(s).
   - Ensure a system is in place for employees and business partners to ask compliance questions and report suspected misconduct, compliance violations and potential instances of fraud, waste or abuse confidentially or anonymously without fear of retaliation.
   - Review reports of suspected misconduct and compliance violations, the investigation conducted and ensure corrective action plans are implemented and monitored.
   - Review and address at risk areas of fraud, waste or abuse and ensure that corrective action plans are implemented and monitored.
   - Support the Compliance Officer’s needs for sufficient staff and resources to carry out his or her duties.
   - Review effectiveness of internal controls and policies and procedures developed to ensure compliance with Medicare regulations and guidelines in daily operations.
   - Provide oversight and guidance for confidentiality and privacy issues within the organization including but not limited to:
     - Confidentiality, privacy and security policies for the organization.
     - Review and approve policies and procedures with material changes, as determined by the Compliance Officer.
Quality Management

- Mechanisms to ensure application of confidentiality and privacy policies
- Opportunities for reducing collection of unnecessary member data or using blinded and/or aggregate data
- Levels of user access to data across the delivery system, including practitioners and their staff as well as Health Alliance staff, i.e. claims, utilization management and customer service departments
- Mechanisms for adhering to specific requests to limit access to data
- Formal complaint process to address member/enrollee concerns regarding confidentiality, privacy and security of their information
- Ensure detection of potential identify theft and appropriate mitigation

The committee may also address other functions, as the compliance concept becomes a part of the overall operating structure and daily routine.

f. **Meets:** The committee shall meet on a quarterly basis and may hold special meetings as may be called by the Chairperson. A majority of the Committee shall constitute a quorum and the majority of a quorum is necessary for committee action.

g. **Minutes:**
   - Generated for each meeting and approved by the committee
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.
GOVERNMENT PROGRAMS WORKGROUP

a. **Role:** Identifies and reviews activities to ensure compliance with CMS and NCQA requirements for all Medicare-Medicaid products.

b. **Chairperson:** Director of Government Relations or designee, Health Alliance

c. **Membership:**
   - Chief Medical Officer, Health Alliance Medical Plans
   - VP of Medicare and Individual Services or Designee, Health Alliance
   - Director, Quality and Medical Management or Designee, Health Alliance
   - Director, Risk Adjustment and Revenue Management or Designee, Health Alliance
   - Director of Pharmacy or Designee, Health Alliance
   - Director of CPS or Designee, Health Alliance
   - Corporate Quality Management, Health Alliance
   - Compliance Program Manager, Health Alliance
   - Communications Manager or Designee, Health Alliance
   - Director of Client Services, Health Alliance/SNP
   - Director of Quality, Health Alliance/SNP
   - Director of Care Management, Health Alliance/SNP
   - Health Alliance Northwest Director of Managed Care Services, as needed

d. **Reporting:** Reports to the Quality Improvement Committee.

e. **Responsibilities:**
   - Ensures that the program domains prescribed by Medicare and Medicaid are addressed by the health plan and monitored. Domains include:
     - Safe patient care
     - Patient centered care
     - Effective care coordination
     - Effective prevention and treatment
     - Promotion of healthy living
     - Effective communication
     - Improving affordability
   - Review customer satisfaction, i.e. CAHPS®, complaints and appeals, and make recommendations to MRRC and/or act upon recommendations of the MRRC for Medicare-Medicaid beneficiaries.
   - Review Medicare-Medicaid HEDIS results annually and make recommendations to the QIC.
   - Oversee the HRA process and response rate for all products
   - Review HOS survey results to identify opportunities for quality programs including case manager involvement
   - Keep up-to-date on new Medicare-Medicaid/NCQA regulatory requirements specific to quality.
   - Monitor dashboards monthly for Medicare and Medicaid activities

f. **Meets:** Quarterly with dashboards distributed monthly

g. **Minutes:**
   - Generated for each meeting and reviewed/approved by the committee.
   - Reflects the activity, discussion, and decision of the committee, as well as, follow-up and resolution of prior recommendations.
Quality Management

ADVERSE EVENTS COMMITTEE

a. **Role:** Reviews aggregate adverse events identified through the Serious Reportable Adverse Event (CMS), Never Event and Sentinel Event Processes. The never events are defined by the National Quality Forum and delineated in provider contracts. Provide recommendations for patient safety interventions to QIC.

b. **Chairperson:** Chief Medical Officer, Health Alliance or Designee

c. **Membership:**
   - Chief Medical Officer, Health Alliance
   - VP of Corporate Affairs and General Counsel or Designee, Health Alliance
   - Regional Medical Director and Chair for Credentialing Committee, Health Alliance
   - Director for Quality and Medical Management, Health Alliance
   - Director of Risk Adjustment and Revenue Management, Health Alliance
   - Director of Contracting and Provider Services, Health Alliance
   - Manager of Claims, Health Alliance
   - Medicare Advantage Coding Consultant, Health Alliance
   - Quality Improvement/Member Relations Coordinator, Health Alliance
   - Quality Manager, Health Alliance/SNP
   - Ad-Hoc Members, as needed

d. **Reporting:** Reports events to Credentialing Committee, as needed; and annually to the Quality Improvement Committee.

e. **Responsibilities:**
   - Oversee the policy and procedure for SRAE and Adverse Events.
   - Trend and track events for annual reporting.

f. **Meets:** Biannually

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.
STAR STRATEGIC PLAN WORK GROUP

a. **Role:** Development and implementation of an ongoing quality improvement plan for improving Medicare star ratings

b. **Chairperson:** Star Ratings Coordinator

c. **Membership:**
   - Director, Risk Adjustment Revenue Management
   - Director, Quality and Medical Management
   - Manager, Risk Adjustment Revenue Management, Quality and Clinical Services
   - Manager, Case and Disease Management
   - Senior Case Coordinator, Quality and Medical Management
   - Star Ratings Coordinators
   - Clinical Pharmacist
   - Pharmacy Medicare Specialist
   - NCQA/HEDIS Specialist
   - Quality Improvement Coordinator

d. **Reporting:** Reports to the Quality Improvement Committee

e. **Responsibilities:**
   - Develop, implement, and monitor interventions based on:
     - Annual HEDIS data
     - Annual CAHPS® results
     - Annual HOS reports
     - Monthly Storan reports
     - Monthly Accumen data reports (PDE)
     - Other data sources as identified
   - Review Part C and Part D Star Ratings
     - Develop and implement interventions to achieve 5 star rated health plan
     - Review and develop intervention strategies that are directed towards members, providers, and internal staff
     - Monitor and review the CCIP and QIP plans
     - Analyze changes to future Star Ratings and Display Measures
     - Review new Health Plan benefits and analyze the impact to Star Ratings
     - Keep up-to-date on new Medicare/NCQA regulatory requirements specific to quality
     - Promote accountability and collaboration between departments
   - Promote collaboration with Carle, our largest provider network
   - Review and adjust plan and interventions based on market need

f. **Meets:** Monthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee at the next scheduled meeting.
   - Reflect the activity, discussion, analysis and recommendations of the committee as well as follow-up and resolution of prior recommendations.
Quality Management

QI OPERATIONAL TEAMS

Purpose: To review HEDIS, CAHPS and other pertinent data, monitor current interventions, identify areas to target for improvement, recommend specific actions to bring about that improvement and drive discussion to improve care and service to all members. Operational team activities are reported to the QIC as part of the day-to-day QMM program oversight and evaluation process.

Prevention and Screening Team

Focus:
1. BMI / Nutrition / Activity (program owner Karen Stefaniak)
   a. Adult BMI Assessment
   b. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
2. Immunizations (program owner Season Barrett)
   a. Childhood Immunization Status
   b. Immunizations for Adolescents
   c. Human Papillomavirus Vaccine for Female Adolescents
3. Lead Screening in Children
4. Women’s Health
   a. Breast Cancer Screening
   b. Cervical Cancer Screening
   c. Chlamydia Screening in Women
5. Colorectal Cancer Screening (program owner Karen Stefaniak)
6. Prenatal/Postpartum Care; and Prenatal program for FHP
7. Medicare Advantage only
   a. Improving or Maintaining Physical Health
   b. Monitoring Physical Activity

Respiratory Conditions Team

Focus:
1. Antibiotic Utilization
   a. Appropriate Testing for Children With Pharyngitis
   b. Appropriate Treatment for Children With Upper Respiratory Infection
   c. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
2. COPD
   a. Use of Spirometry Testing in the Assessment and Diagnosis of COPD
   b. Pharmacotherapy Management of COPD Exacerbation
3. Asthma
   a. Use of Appropriate Medications for People With Asthma
   b. Medication Management for People With Asthma
   c. Asthma Medication Ratio
4. Osteoporosis Management in Women Who Had a Fracture
5. Flu Vaccinations
   a. Adults Ages 18-64 (CAHPS)
   b. 65 and Older
6. Pneumococcal Vaccination Status for Older Adults(CAHPS)
7. Medical Assistance With Smoking and Tobacco Use Cessation (CAHPS)
Chronic Disease/Medication Management Team

Focus for Chronic Disease:
1. Cholesterol Management for Patients With Cardiovascular Conditions (HEDIS retired for 2015)
2. Controlling High Blood Pressure
3. Persistence of Beta-Blocker Treatment After a Heart Attack
4. Comprehensive Diabetes Care
5. Use of Imaging Studies for Low Back Pain
6. Management of Urinary Incontinence in Older Adults (HOS)
7. Fall Risk Management (HOS)
8. Plan All-Cause Readmissions

Focus for Medication Management:
9. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
10. Annual Monitoring for Patients on Persistent Medications
11. Potentially Harmful Drug-Disease Interactions in the Elderly
12. Use of High-Risk Medications in the Elderly
Quality Management

APPROVAL
The Quality Improvement Committee (QIC) approved the first QI Program on May 24, 1994. The QIC reviews and revises the QI/QMM Program document at least annually. After review and approval by the QIC, the program is submitted to the Health Alliance Medical Plans Board for final approval. As of August 2001, the Health Alliance Board designated this function to the newly formed Quality Committee. Approval dates are reflected in the following chart.

<table>
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<tr>
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<th>QIC Annual Approval Date</th>
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DELEGATION
If quality improvement, utilization management, or credentialing activities are delegated to another organization or provider group, strict procedures for assessing and monitoring the delegation relationship are followed, including:

- Pre-delegation agreement
- Pre-delegation site visit to determine scope and current capabilities
- Formal, written contract and description of roles and responsibilities for both parties
- Specified regular reporting by delegate to Health Alliance
- Annual oversight audit with appropriate follow-up for deficiencies
- Review and approval of delegates’ pertinent program descriptions, policies and procedures

At present, Health Alliance delegates Credentialing to eleven entities; the Health Information Line Services to McKesson’s Nurse Advice Line; the HRA and self-assessment tools to WorldDoc; and UM post-acute services for Medicare Advantage to naviHealth.

CONFIDENTIALITY AND CONFLICT OF INTEREST
QI information is considered confidential and handled in accordance with Health Alliance confidentiality policies and procedures. Health Alliance employees and committee members/enrollees sign a confidentiality and conflict of interest statement, as applicable, on an annual basis.
PURPOSE OF THE POLICY

The purpose of this policy is to ensure clinical guidelines promoted by the plan are based on reasonable medical evidence, made available to appropriate practitioners, and reviewed/updated at least once every two years.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to adopt and disseminate practice guidelines for the provision of prevention, acute, chronic and behavioral health care services that are relevant to its enrolled membership. Practice guidelines are defined as “statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.” (source: Institute of Medicine).

PROCEDURES

1. Designated Quality Management Coordinator

1.1 Supports the guideline process by:
   • Facilitating guideline implementation, measurement and review/approval for their designated area and Disease Management Program
   • Maintaining the Health Alliance and Carle web sites.
     • Check web sites quarterly for appropriate links and updates.
     • Problems with the website links and updates shall be corrected by the Communications Coordinator responsible for the website
   • Ensuring guidelines are consistent with Health Alliance UM criteria, member education materials and disease/case management programs.

1.2 Practitioners assess the National Guidelines Clearinghouse as the main resource available for new guidelines and updates, which includes but is not limited to, the Centers of Disease Control and Prevention (CDC), and American Congress of Obstetricians and Gynecologists (ACOG).

2. Approval

2.1 Guidelines are reviewed and approved at least once every two years. If not reviewed and approved at least every two years, then the guideline is void.

2.2 Guidelines are adopted for at least two medical conditions and at least two behavioral conditions. At least one behavioral guideline must address children and adolescents.
2.3 At least two of the guidelines provide the clinical basis for disease management programs for medical conditions.
2.4 The Quality and Medical Management Director or designee oversees review of the guidelines and makes these changes available to the Quality Improvement Committee.
2.5 Guidelines are sent to the Quality Improvement Committee (QIC) for review and approval annually.
2.6 QIC prioritizes guideline development, as needed, and is the Health Alliance approval body.

3. Distribution
3.1 After annual review of the guidelines, they are made available on the Health Alliance website.
3.2 Written notification of their availability is sent to all participating practitioners via an article in *inforMED*. The article includes instructions for obtaining a paper copy of the guidelines.

4. Measurement
4.1 The effectiveness of practice guidelines are “determined by scientific evidence; or by professional standards, in the absence of scientific evidence; or by expert option, in the absence of professional standards” (source: NCQA)
4.2 Health Alliance measures performance against two important aspects of at least four clinical guidelines annually to determine practitioner adherence.
4.3 Two of the four guidelines must focus on behavioral health care.
Filing Procedures
All claims are processed at the Health Alliance office in Urbana, Illinois. The mailing address for submission of claims is:

Health Alliance Medical Plans, Inc.
Attn: Claims Department
301 S. Vine St. Urbana, IL 61801-3347

A. Inquiries regarding claims payment should be directed to Health Alliance FHP/MMAI/ICP services in Urbana at 1-800-965-4022.

B. Health Alliance requires their National Provider Identification (NPI) prior to submitting claims electronically. Please note, it is extremely important that their NPI is submitted in its entirety, and is accurate, because an invalid submission may result in a match on another provider’s identification number. In addition, every provider location with a unique provider number must be submitted under their respective identification number. Please contact their billing system vendor and request they file their claims through Relay Health under payer ID 77950.

C. Health Alliance prefers all claims be submitted electronically. Services must be detailed on a HCFA 1500 or UB04 billing form. Minimum data requirements include:

1. Provider Name, Address and Telephone Number
2. Type of Bill
3. Federal Tax ID Number (employer identification number)
4. Statement Covers Period (beginning and ending service dates of the period included on the bill)
5. Patient Name, Address, Birth Date and Sex
6. Admission Date, Admission Hour, Type of Admission, Source of Admission
7. Discharge Hour
8. Patient Status
9. Condition Codes, if applicable
10. Occurrence Codes and Dates, if applicable
11. Occurrence Span Code and Dates, if applicable
12. Responsible Party Name and Address
13. Value Codes and Amounts, if applicable
14. Revenue Code
15. Revenue Description
16. HCPCS and/or CPT Codes and Modifiers/Rates
17. Medicare Specific Codes (HIPPS Codes)
18. Service Date required on outpatient series bills
19. Units of Service
20. Total Charges (by Revenue Code Category); includes covered and non-covered charges
21. Non-Covered Charges, if known
22. Payer Identification (primary/secondary)
23. Release of Information Certification Indicator
24. Prior Payment Information
25. Insured’s Name, Health Alliance Member Number (11 digits), and Insured Group Name
26. Principal, other, admitting/patient’s reason for visit, and E-code ICD-9-CM Diagnosis Codes (diagnosis codes must be coded to the highest degree of specificity)
27. DRG Code
28. Procedure Code(s)–ICD-9-CM and date
29. Attending Physician
30. Other Physician
31. Provider Representative Signature
32. Date Bill Submitted
33. Present on Admission
D. Full billed charges are to be submitted. Health Alliance will process claims according to member’s benefit plan and provider payment terms. Adjustments will be detailed on the “Remittance Advice” report.

E. Although the majority of Health Alliance Connect members have Medicare, Parts A, B, and D and Medicaid as their only insurance, in some instances members may have additional private health insurance. It is the provider’s responsibility to ask the member if they have additional coverage and to report this information to Health Alliance on the appropriate claims forms. Every member is issued a plastic, wallet-size identification card. As indicated, the face of the card includes the member’s PCP office visit copayment, specialty physician copayment, emergency room copayment, the member’s PCP and office telephone number, and a Catamaran PCN number.

F. An EOB is only issued to members covered by plans with deductibles and out-of-network benefits. A sample of the Health Alliance Medicare EOB is included, as well as an explanation of the EOB.

G. Clean Claims are defined as those that have no defect, impropriety, lack of any required, substantiating documentation or particular circumstances requiring special treatment that prevents timely payment and a claim that otherwise conforms to the clean claim requirement for equivalent claims if submitted to Medicare. Claims may be labeled non-clean if they have invalid or missing diagnostic or procedure codes, missing patient or procedure information, member’s eligibility has not been confirmed by CMS, missing accident flag or diagnostic pointers.

H. Claim adjustments (i.e., for duplicate payments, overpayments, etc.) are deducted from the provider’s next claim payment. The Remittance Advice report will provide detail of all claims being paid and will also indicate any claims being adjusted.

I. Health Alliance utilizes a claims analysis software program called iCES. This system provides an extensive set of rules that will utilize historical data to audit claims.

iACES identifies coding errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The system does this by utilizing a knowledge base containing more than 9 million government and industry rules, regulations and policies governing health care claims. The editing rules are built upon nationally recognized and accepted sources, including American Medical Association CPT guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

J. Health Alliance Connect members generally do not have copayments or deductibles and providers cannot balance bill members for any covered service.

K. Following are standard coding practices observed by Health Alliance:

Modifiers application: Health Alliance accepts all current CPT and HCPCS modifiers.

Most commonly used modifiers:
• 51—Multiple surgeries by the same physician performed the same day. The highest level procedure is paid at 100 percent; all subsequent procedures are paid at 50 percent (this applies to facility charges as well). Exception: Multiple Scopes. Health Alliance follows the same guidelines as Medicare for payment of multiple scopes.
• 50—Bilateral procedures. This modifier is used when unilateral procedures are performed bilaterally. Payment will be 150 percent.
• 80—Assistant surgeon. Health Alliance reimburses for assistant per CMS guidelines indicating procedures where an assistant is necessary. Reimbursement is 25 percent.
• 62—Two surgeons. Under certain circumstances, the skills of two surgeons may be required. Both surgeons will report the indicated code with the –62 modifier. Reimbursement will be 62.5 percent to each surgeon.
• Descriptive modifiers such as LT and RT will facilitate claims processing and often eliminate the need for additional documentation.
Claims Submission

**Anesthesia Payment**
Health Alliance uses Medicare guidelines in regards to the base units. Anesthesia services are calculated in fifteen (15) minute time units. Time is rounded to the nearest fifteen (15) minute time unit. If less than five (5) minutes no time unit will apply; five (5) minutes to fourteen point nine (14.9) minutes, one time unit will apply. In addition our calculator takes the base, time, modifiers and qualifying circumstances into consideration when calculating payments.

In addition to the time units calculation noted above, the National Coverage Provisions for Anesthesia Services established unique modifiers for anesthesia services that tell the payer if the services performed were medically supervised by a physician or performed without medical direction by or assistance from a physician. Those modifiers indicating services were provided by both anesthesiologist and Certified Registered Nurse Anesthetist (CRNA) will be entered in the modifier schedule at a 50 percent reduction (similar to modifier 51). The system will take the appropriate reductions at the time of service.

The four modifiers that are updated to 50 percent are:

- AD – Medically supervised by a physician for more than four concurrent procedures
- QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QX – CRNA with medical direction by a physician
- QY – Medical direction by one CRNA or by an anesthesiologist

**Multiple Scope Billing**
We follow the same guidelines as Medicare for multiple scope billing reimbursement. This applies different logic than a multiple procedure reduction with the 51 modifier.

Health Alliance refers to endoscopic Base code and Secondary codes when determining the correct allowable for multiple scopes performed during same session.

Medicare has created a list of the base codes used for paying secondary endoscopic procedures related to the primary scope.

The Base code has assigned secondary codes (family of codes).

When billing, each procedure would be reported. But because the value of the base code is included in each code in that particular “family of codes”, a different reduction logic is applied. All of this is outlined in Medicare guidelines.

If two unrelated endoscopic procedures are performed in the same session, but not within the same family of codes, then modifier 51 multiple procedure logic would apply. This is when the highest level procedure is paid at 100% of fee schedule or contracted rate, and all subsequent procedures as paid at 50%.

Some websites which may be helpful:


http://www.cms.hhs.gov/feeschedulegeninfo/ – physician fee schedule; PFS relative value files

Reimbursement for supplies billed in addition to a surgical procedure are considered to be inherent in the procedure. When reporting supplies, the appropriate HCPCS code must be indicated. Unlisted procedures/services: As industry standards, Health Alliance requires documentation for clarification.
Claims Submission

Annual Coding Changes
ICD-10 CM: Effective October 1 of this year, Health Alliance begins accepting new ICD-10 diagnosis codes.

CPT-HCPCS: Effective January 1 of each year, Health Alliance begins accepting new/revised procedure codes. There is no longer a 90-day grace period for discontinued codes in order to be compliant with HIPAA standards. Resubmission of a new/more appropriate code will be required.

Global surgery billing includes all necessary services normally furnished by the surgeon beginning with the day before surgery, the day of surgery and the designated post-op period. To indicate a service is not part of the global package, appropriate modifiers must be used, i.e. –24, –25, –57, –78, –79.

Ancillary Services Claims
Health Alliance Connect will reimburse providers delivering ancillary services in a hospital (either in-patient or out-patient) for the professional component of these services when Health Alliance Connect authorizes the primary service. Ancillary services include, but are not limited to radiology, pathology and anesthesiology. Claims for anesthesia services must indicate the minutes provided.

National Provider Identifier
Any claims submitted by a provider must be in compliance with HIPAA regulations regarding NPI numbers and the new claim forms. Any claims received not in compliance will be returned.

NPI Compliance
The new CMS-1500 form contains fields for the NPI numbers. Field 17 requires the NPI of the referring physician, if appropriate. Field 24J is available for the NPI number of the provider rendering service(s). Field 33 should be completed with the billing provider’s NPI number. The new UB-04 form requires the NPI number of the billing provider in field 56. The NPIs of the attending physician and the operating physician should be located in fields 76 and 77 respectively.

Provider Claims Disputes
Providers can submit claims disputes directly to Health Alliance Connect via mail to the following address:

Health Alliance Connect
Provider Appeals
301 S Vine St.
Urbana, IL 61801

The provider must include the following information:
• Nature of the request, i.e., timely filing, overpayment, underpayment.
• Member’s Name, date of birth and member identification number
• Date of Service
• Billed Amount
• Clinical Information and/or medical records/documentation supporting request (if applicable).

Timely Claims Submissions
As a reminder, Health Alliance requires claims to be submitted within 90 calendar days of the date of service. Except under rare circumstances, Health Alliance processes all claims within 30 days of receipt. If you have not received a payment or communication from Health Alliance for a claim within 45 days after the date of submission, please follow up with our Customer Service Department to verify the claim’s status at 1-800-851-3379. Or, you can access the status of a claim on the Health Alliance website at HealthAlliance.org. If you have not received their password, please contact us at 1-800-851-3379, extension 4668.
If you receive notification that we require more documentation for a claim, you must follow up with Health Alliance within 45 days from the date of the notification or the claim will be denied.

**Note:** Reimbursement appeals should be sent to the Health Alliance Claims Department.

**Electronic Filing**

Speed, accuracy and ease of processing are just a few of the reasons filing electronic claims is so popular. Health Alliance accepts both physician and hospital claims electronically. Medical offices and hospitals that use electronic filing also save money. All our multi-specialty groups and facilities are taking advantage of this technology. Isn’t it time you did the same?

Electronic filing eliminates double data entry – their staff are the only ones who enter claim information. Once the claim reaches Health Alliance, it is automatically loaded in our system, eliminating days of hand processing and sorting. Claim checks then can reach you in a fraction of the time of a traditional paper claim. Ensure the most accurate, rapid claims filing turn-around times by using an electronic filing system to file their Health Alliance claims. **Please contact their billing system vendor and request they file their claims through RelayHealth under payer ID 77950 to make sure claims reach Health Alliance.** You can also call RelayHealth directly at 1-877-411-7271 to discuss other cost-free options for submitting their claims to Health Alliance.

Health Alliance requires their ten-digit National Provider Identifier (NPI) for electronic claims.

No later than March 31, 2012, all electronic claims must comply with the HIPAA 5010 transaction set as required by the Centers for Medicare and Medicaid Services (CMS).

If you have questions, please have their office staff call the Health Alliance System Configuration Department at 1-800-851-3379, extension 8566.

**Electronic Claim Critical Error Message**

Please note that if a claim has a critical error, it is not stored in our system. You have 90 days to resubmit a claim. The following is a summary of the most common critical errors you may receive when attempting to submit claims electronically:

**Member Coverage Group not on file.**

- The most common reasons for this error message is the member’s date of birth does not match what is in our system, the entire member number does not match or the newborn claim has been submitted but the newborn has not been added to system. The claims must either be submitted with correct birth date or member number or the Health Alliance system must be updated to reflect the correct birth date. Often times the member number is simply “off” by the last two digits, which represent the dependent number in the family unit. Newborn claims cannot be processed until the newborn is added to the plan.

**Admitting Provider not on file or not submitted.**

- This error message is limited to inpatient claims because admitting provider is a required field. Often times these errors can be fixed internally after admitting provider record has been reviewed to determine UPIN and/or license number. However, if the information is unable to be verified, the claim will reject and have to be submitted on paper.

**DRG Code not submitted or is invalid.**

- The submission of the DRG is required even if the provider is not reimbursed by DRG. This error message is limited to inpatient claims because the DRG is a required field. This error indicates the DRG field was either blank or invalid (i.e., miss key, old code).

**Provider not on file.**

- Health Alliance requires your NPI for electronic claims. If this number is not submitted or doesn’t find a valid match in our system, you will receive this error message. Please note, it is extremely important that your NPI is submitted in its entirety and is accurate, because an invalid submission may result in a match on another
provider’s identification number. In addition, every provider location with a unique provider number must be submitted under their respective identification number.

**Vendor not on file.**
- This error message indicates the vendor number (tax ID) submitted does not match our system.

**Group and/or Member is not eligible.**
- This error message indicates the group coverage record or the member record is no longer effective.

**Contract history record not found.**
- This error message occurs when a provider has multiple records and the system is trying to read a record that has been terminated or marked as DO NOT USE. These errors can often be corrected internally so that resubmission is not required by removing the NPI and the tax ID from the header of the terminated records.

**G/L distribution code DEF not found.**
- This error message is completely an internal system issue at Health Alliance. These claims should be submitted in paper format for manual processing.

**Modifier not on file.**
- The two-digit modifier submitted on the claim is either miss keyed or invalid. The correct modifier must be submitted for the claim to load into the production system.

**Procedure code not on file.**
- This error tells the provider that they have submitted an invalid procedure code or a code that has been terminated. The correct procedure code must be submitted for the claim to be loaded into the production system.

**Price Category Record not found.**
- This often means procedure code is not found in the fee schedule for pricing and claim must be resubmitted.

**Express Line—Your Quick Link to Information**
We have priorities at Health Alliance – and superb customer service is at the top of the list. To enhance our ability to serve both members and providers better, Health Alliance offers Express Line. Using a touch-tone phone, you can call this virtually “round-the-clock” system to check patient eligibility. Express Line is not replacing the Customer Service Department. Callers will always have the option of speaking directly with a Customer Service representative.

Simply dial 1-800-851-3379 to be connected to the system. Express Line is available 24 hours on the weekend and all day Monday-Friday except from 10 p.m. to 2 a.m. This secure and easy-to-use system can be accessed using their provider number. If you call regarding a patient, you will need the patient’s member number and date of birth. Members also will be able to request an ID card and check eligibility.
Remittance Advice

Health Alliance
Attn: Cash Services
301 South Vine Street
Urbana, IL 61801

Electronic Service Requested

PAYMENT TRANSFERRED ELECTRONICALLY

PAY *****Six Thousand Seven Hundred Sixty Nine & 47/100 Dollars
PAY TO THE ORDER OF:

Busey Bank

EFT NO:

NON-Negotiable

VOID

NON-Negotiable

VOID AFTER 180 DAYS

COPY
**Payment Transfer Details**

**Claim #:**
- **Provider:**
- **Claim Comment:**

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**Plan:** HEALTH ALLIANCE F1

**Patient Id:**

**Account #:**

**Remittance Advice**

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- **EFT Date:**
- **EFT Amount:** 6,769.47
- **Tax ID:**
- **Provider ID:**
- **National Provider**

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**Claim #:**
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- **Claim Comment:**

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**Patient Name:** ANESTH, LENS SURGERY

**Plan:** HEALTH ALLIANCE F1

**Patient Id:**

**Account #:**

**Remittance Advice**

- **EFT #:**
- **EFT Date:**
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- **Tax ID:**
- **Provider ID:**
- **National Provider**

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**Claim #:**
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**Patient Name:** ANESTHESIA CESAREAN DELIVERY

**Plan:** HEALTH ALLIANCE F1

**Patient Id:**

**Account #:**

**Remittance Advice**

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</tr>
</tbody>
</table>

**Claim #3**

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>ALLOWED</th>
<th>DEDUCT/COPAY</th>
<th>ADJUST</th>
<th>ADJ CODE</th>
<th>NOT COVERED</th>
<th>NCV RSN</th>
<th>WITHHOLD</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER CONTRACT APPLIED</td>
<td>2,020.00</td>
<td>1,045.67</td>
<td>1,045.67</td>
<td>974.33</td>
<td>CO45</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

**Claim #4**

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>ALLOWED</th>
<th>DEDUCT/COPAY</th>
<th>ADJUST</th>
<th>ADJ CODE</th>
<th>NOT COVERED</th>
<th>NCV RSN</th>
<th>WITHHOLD</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER CONTRACT APPLIED</td>
<td>605.00</td>
<td>111.15</td>
<td>0.00</td>
<td>494.85</td>
<td>CO45</td>
<td>0.00</td>
<td>0.00</td>
<td>111.15</td>
<td></td>
</tr>
</tbody>
</table>

**PAYER TOTALS:**

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>ALLOWED</th>
<th>DEDUCT/COPAY</th>
<th>ADJUST</th>
<th>ADJ CODE</th>
<th>NOT COVERED</th>
<th>NCV RSN</th>
<th>WITHHOLD</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAYER TOTALS:</td>
<td>36,506.00</td>
<td>12,536.00</td>
<td>4,536.73</td>
<td>24,492.80</td>
<td>0.00</td>
<td>0.00</td>
<td>6,769.47</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any appeal of a recoupment must be made within 60 days after receipt of this remittance advice. Note: Reimbursement appeals from contracted providers should be sent to the Health Alliance Contracting and Provider Services Department: Health Alliance Contracting and Provider Services Department, 301 S. Vine St., Urbana, IL 61801. Reimbursement appeals from non-contracted providers should be sent to the Health Alliance Claims Department at: Health Alliance Claims Department, 301 S. Vine St., Urbana, IL 61801.

**Code Description:**

- CO45: Charges exceed your contracted/legislated fee arrangement.
- OA18: Duplicate claim/service.
- OA23: Payment adjusted because charges have been paid by another payer.
Claims Submission

Remittance Form Description

Section 1—Vendor Information Block
Includes Vendor (same as Federal Tax ID #), Vendor Name, amount of check and check number.

Section 2—Title Line for Claim Data
This line describes each data element printed per claim detail. The corresponding data for this line is found under the Patient Identification Line.

Section 3—Patient Identification Line
The claim data is sorted in alphabetical order by Patient Name. This line provides the patient’s name (last name, first name and middle initial) and the patient’s Health Alliance member number. Following the patient line is the detailed claim information.

Section 4—Claim Data Lines
This section provides claim data under the title lines described in each patient identification line. Claim data is entered in detail; therefore, multiple lines per invoice will be shown.
A. Provider Name
B. Provider Account #
C. Admission Data/1st Date of Service on Invoice
D. Form #
   • Health Alliance assigned claim
E. Proc Code
   • Each Revenue Code, CPT4 Code, or HCPCS Code on the Invoice will be listed in this column.
F. Description
   • A description of each Procedure Code will appear here.
G. Billed $
   • The charge corresponding to each procedure code
H. Allowed $
   • The Allowed $ for each detail line. Provider discounts, charges over usual and customary, etc. are deducted from Billed $ to arrive at Allowed $.
I. Adjust $
   • This is the difference between Billed $ and Allowed $.
J. Adj. Rsn
   • Adjustment Reason codes appear to define the difference between Billed $ and Allowed $. A legend of the codes prints with each remittance.
K. Not Cov $
   • This amount field includes charges and payments made by other carriers (Medicare, commercial, etc.)
L. Not Covered Rsn
   • This code defines the reason why dollars are in the not covered column. A legend of the codes prints with each remittance.
M. Copay + Deduct
   • This amount field includes copayments, coinsurance and deductibles.
N. Withheld $
   • This field contains $ withheld as part of the provider payment terms.
O. Paid $
   • This is the amount paid for this line.

The remittance report provides totals for each claim/invoices and provides grand totals at the end of the report for balancing with the check.
**Claims Submission**

**EXPLANATION OF BENEFITS**

THIS IS NOT A BILL
RETAIN COPY FOR YOUR RECORDS

<table>
<thead>
<tr>
<th>Date:</th>
<th>Claim #:</th>
<th>Member #:</th>
<th>Group:</th>
<th>Processed Date:</th>
<th>Check to be Issued To:</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>MEDICARE ADVANTAGE</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE SEE LAST PAGE FOR IMPORTANT INFORMATION**

**PROVIDER:**

<table>
<thead>
<tr>
<th>Date of Service / Description</th>
<th>Total Charges</th>
<th>Provider Discount / Adjust</th>
<th>Deductible</th>
<th>Copay/Coins</th>
<th>Non-Covered Charges</th>
<th>Other Insurance Paid</th>
<th>Paid by Health Alliance</th>
<th>Non-Covered Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>R300 - LABORATORY OR (LAB)</td>
<td>170.00</td>
<td>138.55</td>
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<td>0.00</td>
<td>0.00</td>
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<td>R300 - LABORATORY OR (LAB)</td>
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<td>89.65</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>20.35</td>
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</tr>
<tr>
<td>R300 - LABORATORY OR (LAB)</td>
<td>76.00</td>
<td>61.94</td>
<td>0.00</td>
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<td>0.00</td>
<td>14.06</td>
<td></td>
</tr>
<tr>
<td>R301 - LAB/CHEMISTRY</td>
<td>125.00</td>
<td>101.87</td>
<td>0.00</td>
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<td>0.00</td>
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<td>23.13</td>
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</table>
## Explanation of Benefits Description

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service</td>
<td>Date the patient received services.</td>
</tr>
<tr>
<td><strong>Service Code/Description</strong></td>
<td>Service code and description of services received.</td>
</tr>
<tr>
<td><strong>Total Charges</strong></td>
<td>Provider’s charge for services received.</td>
</tr>
<tr>
<td><strong>Provider Discount</strong></td>
<td>Contractual discount or amount provider must write off.</td>
</tr>
<tr>
<td><strong>or Adjustment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>The portion of the charges applied to your plan deductible.</td>
</tr>
<tr>
<td><strong>Copay/Coinsurance</strong></td>
<td>The portion of charges you are responsible for as copayments or coinsurance</td>
</tr>
<tr>
<td><strong>Non-Covered Charges</strong></td>
<td>Charges not covered by your plan.</td>
</tr>
<tr>
<td><strong>Other Insurance Paid</strong></td>
<td>The amount paid by another insurance carrier or Medicare.</td>
</tr>
<tr>
<td><strong>Amount Payable by</strong></td>
<td>The amount Health Alliance will pay for services received.</td>
</tr>
<tr>
<td><strong>Health Alliance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Covered Reason</strong></td>
<td>Refer to the reason code(s) printed at the end of this Explanation of Benefits</td>
</tr>
</tbody>
</table>
Health Alliance Connect Providers and Care Management

Health Alliance Connect members may only see contracted providers at offices within the service area (see service area map). Contracted providers with offices both in and out of the service area must be mindful of this requirement and not see Health Alliance Connect members out of the service area. There are special circumstances allowed for Family Planning Services. Health Alliance Connect covers family planning services whether provided by a contracted or non-contracted Provider.

The plan is structured to allow the member to receive the comprehensive benefits provided by HMO’s, including routine physicals, mammograms, prostate exams and routine vision care. Members must receive their care within the contracted network of providers to be eligible for benefits.

Out-of-Network benefits are available for emergencies and certain continuity of care services when the member will be transitioning to Health Alliance Connect from an existing out-of-network provider. Continuity of care benefits for members with established out of network provider relationships are available for up to 180 days after the member’s enrollment in a Health Alliance Connect program.

Health Alliance Connect members generally choose a PCP from Adult Medicine, Family Practice (or if indicated, obstetrics-gynecology) who will serve as the member’s “Patient Centered Medical Home” (PCMH). In some cases members with special needs or chronic health conditions may have a behavioral health specialist or other specialist act as the member’s PCP and PCMH.

The PCP is responsible for working with the member and the Interdisciplinary Care Team coordinating the member’s health care and directing specialty care services. Please note: the network of providers for Health Alliance Connect FHP, MMAI and ICP may vary and may also be different from the Health Alliance commercial and Medicare Advantage networks, so it is vital to consult the Health Alliance Connect Provider Directory when making referrals for specialty care.

Selected services may require preauthorization from the Health Alliance Connect Care Management Department. The preauthorization is obtained by the ordering physician’s office.

Health Alliance Connect Model of Care

The Health Alliance Connect Care Management department is responsible for the care coordination and utilization management function for members of the Health Alliance Connect FHP, MMAI and ICP programs. The Care Management Department is committed to a person centered approach to coordinate care by ensuring that the member receives appropriate medical and Long Term Support Services (LTSS) so that the member can maintain the highest quality of life possible.

Members, working with their care management team, will develop an Individual Plan of Care (IPOC) that helps with their health needs and activities of daily living. These services can include support services, such as personal care or meal deliveries, which keep the member independent and living in their own home. This individualized plan of care will be member directed wherever possible.

Interdisciplinary Care Team (ICT)

Each member will have a unique Interdisciplinary Care Team based on their individual medical and support service needs. The center of the team will be the member. At the minimum the ICT will consist of:

- Primary Care Provider (PCP)
- Nurse Care Manager (NCM)
- Member Resource Coordinator (MRC)
Medical Management

The team may include other healthcare disciplines including, but not limited to, behavioral health, medical specialties, pharmacy, physical therapy, and Long Term Support Services (LTSS) coordinators. The ICT members will collaborate with each other during assessments and plan of care design and updates to ensure the member is receiving all appropriate services and support in the least restrictive environment allowing for the highest possible level of independence.

Member Assessment

Each member is assigned a risk category—High, Moderate or Low—based on a health risk screening (HRS). Based on the member’s risk category, a comprehensive assessment is conducted and care plan developed with the member. Reassessment occurs when there is a change in the member’s status, expressed need and at minimum identified intervals.

Individual Plan of Care

All members will have an individualized plan of care (IPOC) which will be sent to the member’s PCP. Each member will be encouraged to assist in the design of their individualized plan of care which will incorporate their concerns and needs. The IPOC will include any waiver service plans if appropriate. The IPOC will be the roadmap for the ICT in maintaining good healthcare and independence for the member.

Communication

Communication between the member and members of the ICT will be open and two-way. Members will be encouraged to actively participate in their care. The NCM will function as the team lead and ensure in a timely manner that all members are aware of changes to the member’s status.

The member is the center of the Interdisciplinary Care Team (ICT) that coordinates and manages care. All members in the FHP, MMAI and ICP/SPD programs have the right to be informed of their treatment options and to actively participate in decisions regarding their health and well-being, including alternate courses of medical care.

Health Alliance Connect maintains a primary care network from which a member may choose a provider that acts as a medical home. Medical homes provide evidence-based primary care services, acute illness care, behavioral health care (where appropriate), chronic health condition management and referrals for specialty care and LTSS. Medical Homes are part of the Interdisciplinary Care Team to assist in coordinating care across the full spectrum of available services and manages transitions between levels of care.

Care Team Members

Primary Care Physician

The primary care provider (PCP), in most cases a physician, but perhaps a physician’s assistant (PA) or registered nurse practitioner (NP), is an integral part of every member’s care team. The PCP is responsible to direct and coordinate every member’s care, from performing regular health care assessments and physical examinations, to referring members for specialty care and ancillary testing, and to order additional home services and treatments. The PCP works very closely with nurse care managers and the rest of the care team. The PCP also sees members in person at regular intervals, such as for an annual physical exam, and at other times as a member’s condition warrants. In many ways the PCP serves as a leader of the healthcare team, but he or she will also work with every other team member to assure the goal is each member’s health and well-being.
Nurse Care Manager
Each member is assigned a Nurse Care Manager (NCM) who works with other members of the ICT to provide personal health coordination. The NCM will assess, coordinate and authorize services, and note any changes in health status. The nurses educate members on their medical condition and lifestyle changes that could impact or slow down the progression of the disease. There is a Nurse Line available for member, toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which members may obtain medical guidance and support from a nurse.

Nurse Care Managers respond to coverage requests by obtaining all necessary clinical information and applying Medicare criteria. Where Medicare criteria are absent, Care Management uses clinical medical necessity criteria from nationally respected vendors such as InterQual®, internal medical policies or medical technology reviews based on the latest standards. Decisions made using any criteria are based on the member’s clinical status and assessment of the local health care delivery system. You can access InterQual and internal medical policies on our website at HealthAlliance.org. A paper copy of any Health Alliance Connect medical or behavioral health criteria may be requested by calling their Provider Relations Specialist.

Member Resources Coordinator
A member Resources Coordinator (MRC) is represented on each member’s care team, with a particular focus on managing and arranging for Long Term Support Services (LTSS) and other support services as required. After enrolling, members receive a Welcome Phone Call from a member Resource Coordinator. During orientation, the member Resource Coordinator explains Health Alliance Connects key program features, helps members understand how to use the plan’s benefits and guides them through using the plan’s physicians and facilities. Members rely on the Member Resource Coordinator to answer questions and respond to concerns. Health Alliance Connect will meet the needs of members by being available maintains and operates a toll-free call center that operates seven days a week from 8 a.m. to 6 p.m. Central Time.

Access to Services
Health Alliance Connect is committed to providing members with efficient, cost-effective and quality health care coverage.

Health Alliance Connect employees never encourage decisions that result in underutilization of care. We do not give financial inducements or set quotas for issuing denials of coverage or care; nor do we keep statistics identifying individual providers and their denial rate. Utilization decisions made by our Medical Directors, Nurse Care Managers, Pharmacy Coordinators, and Pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to encourage barriers to care and services.

Turnaround Time Frames for Coverage Requests
The time frames explained below are our goals for notifying you of coverage decisions. Care Management adheres to Medicare regulations and takes into account the medical urgency of each member’s condition. Please note that more time (within Medicare requirements) will be taken if needed to perform a comprehensive review.

Standard (non-urgent) preservice requests: Our goal is to provide coverage decisions within five (5) business days of receiving a complete request that contains all the necessary medical documentation. Requests received after 4 p.m. Monday through Friday or on weekends or holidays are considered received on the next business day.

 Expedited (urgent) preservice requests: Our goal is to provide coverage decisions within one (1) business day of receiving a complete request. For patients in the MMAI program lease mark requests “urgent” only when there is a need for an expedited review as defined by Medicare, and indicate whether it is the member requesting or the physician certifying an expedited review. A member or physician may request an expedited review when either party believes that waiting for a decision under the standard timeframe (i.e., 14 days for pre-service review) could place the member’s life, health or ability to regain maximum function in serious jeopardy; and the member believes Health Alliance should arrange for services to be provided (when the member has not already received the services outside the Health Alliance network). If you feel the review should be expedited, please certify that you are requesting an expedited review.
because applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function. Expedited reviews may not be requested for services the member has already received. Expedited reviews may be submitted in writing via fax at 217-337-8440 or by calling the Care Management Department at 877-933-8481 for MMAI members and 877-933-8480 for FHP/ICP/SPD members.

**Please submit complete requests.** A complete request includes a Health Alliance request form with all pertinent sections filled in and either a completed InterQual SmartSheet or supporting documentation from the medical record. Please refer to the preauthorization list for the member’s plan to determine which requests always require supporting documentation. Supporting documentation is always helpful in making coverage decisions. If you submit inadequate information, the review may take longer to complete. In some situations when it could benefit the member, an extension may be initiated. You will receive a letter explaining the extension time frame and what specific information you will need to provide: the member will receive a copy of this letter. Once the information is received or the extension time frame is exhausted (whichever is first), we will complete the review and notify you of the coverage decision.

**Inpatient Admissions**
Health Alliance Connect requires notification for inpatient hospital medical, surgical, and behavioral health stays, whether they are elective or direct admissions. Concurrent on-site or telephonic review is conducted by Nurse Care Managers during the member’s stay. Medical necessity will always be the determining factor regarding additional inpatient days. We may consult the treating physician to discuss alternate care options at a lower level of care, such as skilled nursing facility, home care, or home infusion.

Health Alliance Connect will provide notice to members to notify them of their discharge rights, as well as the process for adjudicating appeals based on those rights. Hospitals are expected to comply with all valid and timely delivery requirements set forth by CMS, including issuing the notice within 2 calendar days of admission, obtaining signature of the member or representative and providing a copy at that time, as well as delivering a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge. Periodic auditing for compliance may be conducted. More information on these requirements as well as a copy of the current notice is available on the CMS website http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

**Skilled Care and Home Health Services**
Health Alliance requires preauthorization for skilled care and home health services. Telephonic review is conducted by Care Management Coordinators frequently during the member’s course of services.

Skilled care facilities (SNFs) and home health agencies (HHAs) are required by CMS to issue a “Notice of Medicare Non-Coverage” notice to Medicare Advantage members to notify them that services are ending, as well as the process for initiating an appeal if an member disagrees with the decision to discontinue services. Health Alliance will fax a copy of the notice for each member when the member is admitted for services, unless we agree to other arrangements for their facility or agency.

SNFs and HHAs are required to:

- Provide regular updates to Medical Management of the member’s progress and discharge planning activities
- Notify Health Alliance immediately of the anticipated discharge date
- Fill in pertinent date fields on the notice
- Obtain signature of the member or member’s representative on the notice **at least 2 days in advance of the services ending**
- Comply with all valid and timely delivery requirements set forth by CMS
- Fax a copy of both pages of the signed notice to 217-337-8440 within one week of services ending
Medical Management

**Long Term Support Services**

Long Term Support Services for non-waiver members generally require pre-authorization. Services, for example, include transportation services, use of personal care attendants, supportive living services and adult day habilitation services. Primary care providers should discuss the need for LTSS with the member’s care management team. Members who are current participants in the Illinois Home Community Based Services Waiver program can maintain existing services for a period of up to 180 days after joining Health Alliance Connect without the need for an additional referral and authorization.

**Illinois Home and Community Based Waiver Services**

Certain members of Health Alliance Connect are participants in the Illinois Home and Community Based Waiver Services program. A waiver is a program that provides services that allow individuals to stay in their own home or live in a community setting. These services, also known as Long Term Services and Supports (LTSS) are generally non-medical in nature and include such services as adult day health, personal care attendants, and transportation. Often these services are coordinated by Area Agencies on Aging.

LTSS service providers are an important part of the Health Alliance Connect Model of Care. It is anticipated that many non-Waiver members will have LTSS services authorized to help support the overall plan of care. Patients already in the Waiver program will have the ability to maintain all Waiver services and relationships without alteration during the first 180 days after their enrollment. Dependent upon the member’s waiver and severity, member’s will reassessed either monthly, quarterly or yearly.

Long Term Support Services may require preauthorization from the Health Alliance Connect Care Management Department.

**Denial of Certification**

For requests that do not meet medical necessity criteria, a Medical Director reviews all the medical information submitted to make a coverage determination. Additional information is requested if needed. The Medical Director may contact the requesting physician to discuss the case further. When necessary, the Medical Director confers with a board certified specialist. After review of the case facts and Medicare criteria, the Medical Director makes a coverage determination of approval or denial, using his/her medical judgment, experience and skill, as well as professionally recognized medical standards for treatment.

For all denials, the member, the member’s representative, and the requesting practitioner are notified in writing of the determination. The denial notice includes the instructions on how the practitioner can contact the Medical Director to discuss the denial. The practitioner may also contact 877-933-8480. Requests for benefits that clearly fall outside Health Alliance Connect benefits may be denied by the Nurse Care Manager. Any denial decision for services that are, or that could be considered, covered benefits are determined by the Medical Director as previously described. All appeals are handled by the Client Relations Department (see the Appeals Process section of this manual).

**How to Get More Information**

Please refer to the Health Alliance Connect Care Management policies included here for additional information on utilization management and the pre-authorization process for FHP, MMAI and ICP/SPD patients.

If you have questions about the status of a review or any other Care Management process, call Health Alliance Connect during normal business hours, Monday-Friday, 8 a.m. to 6 p.m., at 1-877-933-0264. After normal business hours, you may leave a message at this number, and it will be returned the next business day.
Preauthorization and the Web

We’ve recently changed the way our preauthorization process works on our website, and we hope it will make obtaining preauthorization for the services their patients need easier for you. Just follow these simple steps.

1. Log on to our website, HealthAlliance.org.
2. Sign in as a provider or office manager.
3. From the menu on the left, select “Preauthorization Information.”
4. Click on the appropriate category to see specific procedures.
5. Select the procedure to determine if you will need to get it preauthorized. The header information at the top of the criteria will tell you if preauthorization is required in their service area or for the member’s specific plan.
6. If the service is available to be authorized through Clear Coverage, the policy will have a link to take you to the Clear Coverage website.
7. For those not using Clear Coverage, InterQual Smart Sheets are still available and there will be a link to download these. Please complete and fax to 1-877-933-8223.

You can always do preauthorization over the phone by calling the Health Alliance Medical Management Department at 1-877-933-8480.

If you have any questions about Clear Coverage, please contact the Health Alliance Provider Service line at 1-800-851-3379, extension 4668.
Completion of all fields is required.

**URGENT REQUEST**
Per health care reform, urgent means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient’s life/health, or the patient’s ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

**REQUEST FORM**

Medicare records must accompany all requests.

To be completed for ALL requests. Please print clearly. Incomplete or illegible information will delay the review process.

<table>
<thead>
<tr>
<th>Reason for Request:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Not Available in Network</td>
</tr>
<tr>
<td>☐ Unable to Schedule in Timely Manner</td>
</tr>
<tr>
<td>☐ Other [please specify]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Health Alliance ID Number</th>
<th>Patient Birthdate</th>
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</table>

<table>
<thead>
<tr>
<th>Requesting Physician’s Name</th>
<th>Requesting Physician’s Phone Number</th>
<th>Requesting Physician’s Fax Number</th>
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<table>
<thead>
<tr>
<th>Diagnosis Code:</th>
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</table>

<table>
<thead>
<tr>
<th>Procedure Code:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Procedure:</th>
</tr>
</thead>
</table>

| ☐ Inpatient Procedure (services provided may result in admission) |

| ( ) | ( ) |

<table>
<thead>
<tr>
<th>Facility</th>
<th>Practitioner</th>
<th>Provider Phone Number</th>
<th>Provider Fax Number</th>
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<table>
<thead>
<tr>
<th>Physician Signature</th>
<th>Date</th>
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**Tertiary/Out-of-Network Referrals**

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</table>

<table>
<thead>
<tr>
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<th>Facility</th>
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</table>

<table>
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<th>Physician Phone Number ( )</th>
<th>Physician Fax Number ( )</th>
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<table>
<thead>
<tr>
<th>Service Reason:</th>
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</thead>
<tbody>
<tr>
<td>☐ Consult</td>
</tr>
<tr>
<td>☐ Consult and Treatment</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th># Visits:</th>
<th>Length of Referral:</th>
</tr>
</thead>
</table>

| ☐ The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider. |

<table>
<thead>
<tr>
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**Pharmacy Medical Exception/Rx Preauthorization** *(Fax to 217-255-4598)*

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<th>Drug Requested</th>
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Health Alliance • 301 S. Vine St. • Urbana, Illinois 61801

217-337-8061 • Fax 217-337-8440

com-refmrv3-0314
Pharmacy Benefits

Prescription Drug Benefit Administration

Health Alliance Connect administers pharmacy benefits for the FHP, MMAI and ICP/SPD programs. Activities of the Pharmacy Department include performance of the following functions either directly or through the designated Pharmacy Benefits Manager:

- Pharmacy network development and maintenance
  - Contracting
  - Monitoring/auditing
- Third-party claims processor relations, contract development and management
- Medication reviews of members including medication reconciliations
- Coordination with the Medication Therapy Management (MTM) vendor for members who need comprehensive medication reviews (CMR’s) or other medication interventions
- Making pharmacy exceptions and drug coverage decisions
- Manufacturer discount contracting
- Pharmacy & Therapeutics Committee support
- Standard Drug List (formulary) coordination and management
- Medical Management Department clinical support
- Medical Directors Committee and Administrative support
- Quality Improvement Committee support
- Pharmacy utilization reporting and physician support
- Customer Service Department and Claims Department support
- Medicare Part D Formulary coordination and management

Prescription Plan

Health Alliance Connect offers one prescription benefit for the FHP, MMAI and ICP/SPD programs.

The Health Alliance Connect formulary is separate and distinct from the formularies for other Health Alliance products (including Medicare Advantage). The Health Alliance Connect pharmacy combines Medicare Part D drugs with Medicaid drugs such as OTC’s and prescription vitamins. The formulary only has two tiers: brand and generic.

To view the complete Formulary go to HealthAllianceConnect.org.

Health Alliance Connect members have either no copays or a low co-pay amount as determined by the Medicare program.

Formulary

The Health Alliance Connect Formulary has been created under the guidance of physicians and pharmacists representing most specialties. The Pharmacy and Therapeutics Committee (P&T) evaluates the needs for most patients, use of products, and cost-effectiveness as factors to determine the formulary choices. The formulary has been created to maximize the use of generic drugs when possible. In all cases, available bioequivalence data supply and therapeutic activity are considered.

The P&T Committee meets on a regular basis to evaluate the changing needs of physicians and patients. We urge you to provide recommendations. It is our belief that the Health Alliance Connect Formulary can enhance their ability to provide quality, cost-effective care.

To reach the Health Alliance Connect Pharmacy Department, please call 1-800-851-3379, extension 8048. To view our formulary online, visit HealthAllianceMedicare.org and choose “Health Alliance Connect Formulary” from the
Changes to the Formulary

There are currently several thousand medications, combinations of medications and dosage forms available in the United States. Inclusion of all of the products would compromise the ability of the formulary to control cost and optimize patient care.

The P&T Committee can add/change a product with a majority vote. A product may be tabled for the next meeting if more information is needed.

The additions/changes of drugs to the formulary will be based on a comparative efficacy, pharmacoeconomic data and drug-specific parameters such as side effect profiles, pharmacokinetics and contraindications. Evaluations will be based on information from peer-reviewed medical references, primary literature and standard of practice guidelines. Cost will be considered a major factor in making additions/changes to the formulary when little or no difference exists in comparative and drug specific parameters. Specific considerations are listed below:

Proper Indication
The medication must have an indication that would benefit patients in an ambulatory/outpatient setting.

Efficacy
The medication must be clearly proven as effective in the outpatient population. It must also offer a distinct advantage over existing products in the same therapeutic category. These advantages must include, but are not limited to:
- Distinct or unique therapeutic feature
- Greater efficacy against other products in the same therapeutic category that can be clearly shown in clinical trials
- Improved dosing schedule, decrease in adverse effects, or fewer contraindications which clearly show superiority over existing products
- Cost savings over products in the same therapeutic category

Information
Decisions from the P&T meeting will be communicated to all physicians in our electronic newsletter inforMED. You can view the updated Health Alliance Connect Formulary at HealthAllianceMedicare.org.

General Exclusions of the Formulary

The following are not covered:
A. Drug products not listed in the Health Alliance Connect Formulary or specifically listed as not covered
B. Any drug products used for cosmetic purposes
C. Experimental drug products or any drug product used in an experimental manner
D. Replacement of lost or stolen medication
E. Foreign drugs or drugs not approved by the United States FDA
F. Anorexics or drugs for weight loss or gain
G. Fertility agents
H. Agents for hair growth
I. Agents of symptomatic relief from cough and colds
J. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
K. Medical supplies and items not considered drugs
L. Erectile dysfunction drugs
Preferred Pharmacy Program

Health Alliance Medicare members receive Tier 1 prescriptions for a $0 copayment at all Wal-Mart and Sam’s Club pharmacies.
Provider Appeals Process

**Standard Appeal**

If a member, physician, legal representative or authorized representative does not agree with a decision made by Health Alliance, he or she may appeal.

If a member decides to proceed with the standard appeals/reconsideration process, the process will follow the Health Alliance Connect Appeals Policy:

1. Health Alliance Connect will abide by Medicare and Medicaid requirements set forth for the population and applicable services with regards to the appeals process.
2. Members will have the opportunity to appeal an adverse determination made by Health Alliance Connect.
3. Appeals will be reviewed within fifteen (15) business days of receipt or as expeditiously as possible based on the member’s health status. Expedited appeals will be reviewed within twenty-four (24) hours.
4. Member care will not stop during the appeal process.
5. If member care has not yet begun, it will start within 72 hours of appeal decision in member’s favor or when mutually agreed upon.

**Process for Requesting an Appeal**

*Who May Request an Appeal:* Appeals may be requested by the member, member’s representative or a member’s prescriber. If other than the member, written consent must be obtained by the member unless the request is expedited.

*How and When:*

Within ninety (90) calendar days from the date printed on the coverage notice, an member, a member’s authorized representative or physician/prescribing provider may request an appeal of denial either by phone, in writing, fax or via the Health Alliance Connect web site. Translation assistance as well as any other support required for making this request will be provided by Health Alliance Connect. If the request is not expedited and being made by the member’s representative or the provider, Health Alliance Connect will request written consent from the member. The member, physician/prescribing provider or authorized representative will be provided time to hand-deliver or present in writing evidence and allegations of fact or law related to the issue.

The timeframe maybe extended for good cause. The Health Alliance Connect will consider the circumstances that kept the party from making the request within the 90-day timeframe. The party requesting the appeal should indicate the reason why the appeal was not filed on time. If the request to review the appeal is denied, then the member may file a complaint, however the denial not to process the appeal request cannot be appealed.

During business hours, an oral request for an appeal will be transferred to a Health Alliance Connect employee designated to appropriately document in the member’s Centralized Member Record (CER) and start the appeal process. All Member Resource Coordinators (MRC) and Nurse Care Managers (NCM) will have a list of these individuals. After hours, the nurse and/or pharmacist on call will be trained to initiate the appeals process, if necessary. Oral requests will reflect the member’s words and will be repeated back to the member as documented.

**Review of Request**

*Acknowledgement:* If the appeal request is in writing, an acknowledgement of the receipt will be sent to the member and member’s representative or the prescriber, if the prescriber has requested the appeal.

*Evidence:* Health Alliance Connect will accept evidence by telephone, fax, and secure email or delivered. If Health Alliance Connect requires additional medical information in order to make a decision for an appeal, Health Alliance Connect will make the data request within 24 hours of receiving the appeal request and make a second request if
Provider Appeals Process

needed. The member and/or member’s authorized representative will be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.

**Decision Maker:** A Medical Director who is not involved in the treatment of the member, or did not make the initial coverage determination, and is not a subordinate of the initial reviewer. The reviewer must possess the appropriate level of training and expertise to evaluate the necessity of the request.

**Expedited Appeals:** If a request is made to expedite an appeal, it will be granted.

**Timeframes**

**Requests for First Level Appeals:** Members or their designee will have ninety (90) calendar days from the date of initial coverage determination.

**Requests for Second or Third Level Appeals:** Members will have thirty (30) calendar days from the Health Alliance Connects notice of disposition (i.e., resolution) to request a State Fair Hearing for Medicaid-only services.

Members will have thirty (30) calendar days from the notice of the right to a State Fair Hearing following the Independent Review Entity’s (IRE) adverse disposition (i.e., resolution) to request a State Fair Hearing for Medicare-Medicaid overlapping services. The member will receive notice of his or her right to request a State fair hearing from his or her Health Alliance Connect and/or the State.

**Resolution Time Frames:** All initial Appeals must be resolved by the Health Alliance Connect within fifteen (15) business days of their submission for Standard Appeals and within 24 hours of their submission for Expedited Appeals.

A member can extend the time frame by fourteen (14) days if the delay is in the best interests of the member.

For Medicare services automatically forwarded to the IRE, the IRE must notify the member of an expedited decision within seventy-two (72) hours, a pre-service decision within thirty (30) calendar days and a payment decision within sixty(60) calendar days.

For Medicaid-only services appealed to a State Fair Hearing, Standard Appeals will be resolved within ninety (90) calendar days of the filing of an Appeal with the Health Alliance Connect, not including the number of days the member took to subsequently file for a State Fair Hearing, and Expedited Appeals will be resolved within three (3) business days from the filing of an Appeal with the State Fair Hearing Agency.

For Medicare-Medicaid overlap services, if the member requests a State Fair Hearing for his or her Medicaid benefits, Standard Appeals will be resolved within ninety (90) calendar days of the member Health Alliance Connects notice of Disposition, not including the number of days the member took to file for a State Fair Hearing, and Expedited Appeals will be resolved within three (3) business days from the filing of an Appeal with the State Fair Hearing Agency.

**Continuation of Benefits Pending an Appeal and Following an Adverse Appeal Decision**

A member’s benefits will continue to be covered when an appeal has been filed if the following conditions are met: The member or authorized representative files the appeal on or before the following:

- Within 10 working days of the mailing the NOA; or prior to the proposed date for termination of services; and,
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment where the services were ordered by an authorized provider; the authorization period has not expired; and the member is requesting the extension of benefits.
Provider Appeals Process

Benefits will be continued until one of the following occurs:

- The member withdraws the appeal;
- Ten (10) calendar days pass following notice to the member of an adverse appeal decision unless the member, within the ten (10) day time frame, requests a state hearing with continuation of benefits and therefore the benefits must be continued;
- A state hearing regarding the continuation of the benefits is decided adverse to the member; or
- The initial time period for the authorization expires or the authorization service limits are met.

All Medicare Parts A and B, and non-Part D benefits will be required to be provided pending the resolution of the appeal process. This means that such benefits will continue to be provided by providers to members, and Health Alliance Connects must continue to pay providers for providing such services pending the resolution of appeal process.

For Medicaid-only service and Medicare-Medicaid overlap service Appeals: If the request for an Appeal is filed with the Health Alliance Connect within ten (10) calendar days of the notice of Action, services will be required to be provided pending the resolution of the Health Alliance Connect Appeal process.

For appeals of Medicare-Medicaid overlap services, the Appeals will be forwarded to the IRE and services will be provided and paid for pending the resolution. If the resolution of the IRE is not wholly in favor of the member, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process, if the member files an Appeal with the State Fair Hearing Agency within ten (10) calendar days of the notice of disposition from the IRE.

Withdrawal of Request

Withdrawal of an Appeal Before a Decision is Made:

- Appeal will be dismissed upon receiving a written request; or,
- Appeal will be dismissed upon receiving an oral request, with a written confirmation sent to the member within three (3) days of the withdrawal request

If Health Alliance Connect receives a withdrawal of a case already sent to the IRE or State Hearing the request would then be forwarded to the IRE or State Fair Hearing

Communication of Decisions

When a decision is made, the member will receive initial notification via the phone when possible. This will be followed with written notification.

Effectuations

Approvals for services not yet started will be in place within seventy-two (72) hours of the decision. Appeals for Medicare A and B services will be automatically forwarded to the Medicare Part C Independent Review Entity (IRE) if the Health Alliance Connect upholds its initial denial.

For Medicaid-only benefits, if the resolution following the appeal process is not wholly in favor of the member, such member or their authorized representative may request a State Fair Hearing.
Provider Appeals Process

For services where Medicare and Medicaid benefits overlaps (including home health, durable medical equipment and skilled therapies, but excluding Medicare Part D), these services will be defined in a unified way via the State of Illinois – Center for Medicare and Medicaid Services Three-way Contract and as required Demonstration Health Alliance Connect benefits.

- If the resolution following the Health Alliance Connect appeal process is not wholly in favor of the member, the Appeal related to these services will be forwarded to the IRE by Health Alliance Connect.
- If the resolution of the IRE is not wholly in favor of the member, the member or their authorized representative may then request a State Fair Hearing and/or file a request for hearing with an Administrative Law Judge.
- Any determination in favor of the member will require payment by the Health Alliance Connect for the service or item in question.
Member Appeals Process

Grievances/Complaints

We want the member to be happy with services they get from Health Alliance and our doctors. If they are not happy, they can file a grievance (complaint) or appeal.

A grievance is a complaint about any matter other than a denied, reduced or terminated (ended) service or item.

Health Alliance takes member grievances very seriously. We want to know if something is wrong, so we can make our services better. If they have a grievance about a doctor or about the quality of their care or services, they should let us know right away. Health Alliance has special steps in place to help members who file grievances. We will do our best to answer their questions or help to fix the problem. Filing a grievance will not change their health care services or their benefits coverage.

These are examples of when Members might want to file a grievance:

• Their doctor or a Health Alliance employee did not respect their rights.
• They had trouble getting an appointment with their doctor in an reasonable amount of time.
• They were unhappy with the quality of care or treatment they received.
• Their doctor or a Health Alliance employee was rude to them.
• Their doctor or a Health Alliance employee was insensitive to their cultural needs or other special needs they may have.

They can file their grievance on the phone by calling Client Services toll-free at 1-877-933-8480, TTY 1-800-526-0844 or 711.

They can also file their grievance in writing by mail or fax at:

    Health Alliance
    Attn: Grievance and Appeals Dept.
    301 South Vine Street, Urbana, IL 61801
    Fax #: 1-877-933-8223

In the grievance letter, give us as much information as you can. For example, tell us the date and place the event happened, the names of the people involved and details about what happened. Be sure to include their name and their member ID number. You can ask us to help you file their grievance by calling Client Services at toll-free at 1-877-933-8480.

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file their grievance. If you are hearing impaired, call the Illinois Relay at 1-800-526-0844 or 711.

At any time during the grievance process, you can have someone you know represent you or act on their behalf. This person will be their “representative.” If you decide to have someone represent you or act for you, tell Health Alliance in writing, the name of their representative and his or her contact information (name, phone number and address).

We will try to fix the problem right away that their grievance explains. If we can’t, it will go to our Grievance Committee. We may contact you for more information. The Grievance Committee will make a recommendation within 60 calendar days from the date you filed their grievance. You will get a letter from us with our resolution (decision).

Appeals

You may not agree with a decision or an action made by Health Alliance about their services or an item you requested. An appeal is a way for you to ask for a review of (or second look at) our actions. You can appeal within 60 calendar days of the date on our Notice of Action form. If you want their services to stay the same while you appeal, you need
Member Appeals Process

to tell us when you appeal, and you need to file their appeal no later than **10 calendar days** from the date on our Notice of Action form.

The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item their doctor asks for
- Stopping a service that was approved before
- Not giving you the service or items quickly
- Not telling you of their right to freedom of choice of doctors
- Not approving a service for you because it was not in our network

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a “Notice of Action” letter from us. This letter will tell you:

- What action was taken and the reason for it
- Their right to file an appeal and how to do it
- Their right to ask for a State Fair Hearing and how to do it
- Their right in some cases to ask for an expedited (quicker) appeal and how to do it
- Their right to ask to have benefits keep going during their appeal, how to do it and when they may have to pay for the services

**File an appeal by:**

1) Calling Client Services toll-free at 1-877-933-8480. If they file an appeal over the phone, they need to follow it with a written signed appeal request.

2) Mailing or faxing their written appeal request to:

   Health Alliance  
   Attn: Grievance and Appeals Dept.  
   301 South Vine Street, Urbana, IL 61801  
   Fax #: 1-877-933-8223

If they do not speak English, we can provide an interpreter at no cost to them. Please include this request when they file their appeal. If they are hearing impaired, call the Illinois Relay 1-800-526-0844 or 711.

**Can someone help them with the appeal process?**

They have many choices for getting help. They can:

- Ask someone they know to help represent them. This could be their PCP or a family member, for example.
- Be represented by a legal professional (lawyer).
- If they are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, they can also call CAP (Client Assistance Program) to ask for help at 1-800-641-3929 or 1-888-460-5111 (TTY).

To choose someone to represent them, either:

1) Member should send us a letter letting us know that they want someone else to represent them and include in the letter their contact information (name, phone number and address) or

2) fill out the Authorized Representative Appeals form. They can find this form on our website at HealthAllianceConnect.org.

**Appeal Process**

We will send them a letter within three business days saying we got their appeal. We will tell them if we need more information and how to give us this information in person or in writing.

A doctor with the same (or close) specialty as their doctor will look over their appeal. It will not be the same doctor who made the first decision to deny, reduce or stop the medical service. Health Alliance will send our decision in writing to them within 15 business days of the date we get their appeal request. We may ask for an extension up to 14
more calendar days two weeks to make a decision on their case if we need to get more information before we decide. They can also ask us for an extension if they need more time to get extra documents to support their appeal.

We will call them to tell them our decision and send them and their chosen representative the Decision Notice. The Decision Notice will tell them what we will do and why.

If our decision agrees with the Notice of Action, they may have to pay for the services they got during the appeal review. If our decision does not agree with the Notice of Action, we will approve the services to start right away.

Keep these things in mind during the appeal process:
- At any time, they can give us more information about their appeal, if needed.
- They have the choice to see their appeal file.
- They have the choice to be there when we look over their appeal.

**How can you expedite (speed up) their appeal?**
If the member or their doctor feels that our standard timeframe of 15 business days to make a decision on their appeal will seriously risk their life or health, they can ask for an expedited (quicker) appeal by writing or calling us. If they write to us, member needs to include their name, member ID number, the date of their Notice of Action letter, information about their case and why they are asking for the expedited appeal. We will let them know within 24 hours if we need more information. Once we have all the information, we will call them within 24 hours to tell them our decision, and we will also send them and their chosen representative the Decision Notice.

**How can you withdraw an appeal?**
Members have the right to withdraw (remove) their appeal for any reason, at any time, during the appeal process. However, they or their chosen representative must do so in writing; using the same address they used for file their appeal. Withdrawing their appeal will end the appeal process, and we will not make a decision on their appeal request.

Health Alliance will recognize the withdrawal of their appeal by sending a letter to the member or their authorized representative. If you need further information about withdrawing their appeal, call toll-free at 1-877-933-8480, TTY 1-800-526-0844 or 711.

**What happens next?**
After you receive the Health Alliance Appeal Decision Notice in writing, they do not have to do anything—their appeal file will be closed. However, if they disagree with the decision made on their appeal, they can take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of their appeal within **30 calendar days** of the date on the Decision Notice. They can choose to ask for both a State Fair Hearing Appeal and an External Review, or they may choose to ask for only one of them.

**State Fair Hearing**

They can ask for a State Fair Hearing Appeal within **30 calendar days** of the date on the Decision Notice, but they need to ask for a State Fair Hearing Appeal within **10 calendar days** of the date on the Decision Notice if they want to continue their services. If they do not win this appeal, they may be responsible for paying for these services given to them during the appeal process.

At the State Fair Hearing, just like during the Health Alliance Appeals process, they can ask someone to represent them and speak for them, like a lawyer, relative or friend.
Member Appeals Process

Member can ask for a State Fair Hearing in one of these ways:

- Their local Family Community Resource Center can give them an appeal form to request a State Fair Hearing and will help them fill it out, if they need help.
- If they want to file a State Fair Hearing Appeal related to their medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send their request in writing to:

  Illinois Department of Healthcare and Family Services
  Bureau of Administrative Hearings
  401 S Clinton Street, 6th Floor
  Chicago, IL 60607
  Fax: (312) 793-2005

  Or Member can call (855) 418-4421, TTY: (800) 526-5812

- If they want to file a State Fair Hearing Appeal related to Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services or any Home Services Program (HSP) service, send their request in writing to:

  Illinois Department of Human Services
  Bureau of Hearings
  401 S Clinton Street, 6th Floor
  Chicago, IL 60607
  Fax: (312) 793-8573

  Or they can call (800) 435-0774, TTY: (877) 734-7429

State Fair Hearing Process
The hearing will be led by an Impartial Hearing Officer authorized to conduct State Fair Hearings. The appropriate Hearings office will send the member a letter telling them the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that they read this letter carefully.

At least three business days before the hearing, they will get information from Health Alliance. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. Member needs to give all the evidence they will present at the hearing to Health Alliance and the Impartial Hearing Officer at least three business days before the hearing. This includes a list of any witnesses who will appear on their behalf and all documents they will use to support their appeal.

Member will need to tell the appropriate Hearings Office of any accommodation (special help) they may need. Their hearing can be done over the phone. Please be sure to give the best phone number to reach member during business hours in their request for a State Fair Hearing. The hearing may be recorded.

Continuance or Postponement
Member can request a continuance during the hearing, or a postponement before the hearing, which may be granted if good cause exists. If the Impartial Hearing Officer agrees, member and all parties to the appeal will be told in writing of a new date, time and place. The time limit for the appeal process to be completed will be extended by the length of the continuation or postponement.

Failure to Appear at the Hearing
Their appeal will be dismissed (thrown out) if member, or their chosen representative, do not appear at the hearing at the time, date and place on the notice and they have not requested postponement in writing. If their hearing is conducted over the telephone, their appeal will be dismissed if member does not answer their telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.
Member Appeals Process

Their hearing may be rescheduled, if they let us know within 10 calendar days from the date they received the Dismissal Notice, if the reason for their failure to appear was:

- A death in the family
- Personal injury or illness which reasonably would prohibit their appearance
- A sudden and unexpected emergency

If the appeal hearing is rescheduled, the Hearings Office will send you or their chosen representative a letter rescheduling the hearing with copies to all parties to the appeal.

If we deny their request to reset their hearing, member will get a letter in the mail telling them of our denial.

**The State Fair Hearing Decision**

A Final Administrative Decision will be sent to member and all involved parties in writing by the appropriate Hearings Office. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as 35 days from the date of this letter. If member has questions, please call the Hearing Office.

**External Review (for medical services only)**

Within 30 calendar days after the date on the Health Alliance appeal Decision Notice, member can choose to ask for a review by someone outside of Health Alliance. This is called an external review. The outside reviewer must meet the following requirements:

- Board certified doctor with the same (or close) specialty as their doctor
- Currently practicing
- Have no financial interest in the decision
- Not know them and will not know their identity (name) during the review

External Review is not available for appeals related to services member got through the Elderly Waiver; Persons with Disabilities Waiver; Traumatic Brain Injury Waiver; HIV/Aids Waiver; or the Home Services Program.

Their letter needs to ask for an external review of that action and should be sent to:

Health Alliance  
Attn: Grievance and Appeals Dept.  
301 South Vine Street, Urbana, IL 61801  
Fax #: 1-877-933-8223

**What Happens Next?**

- We will look over their request to see if it meets the qualifications for external review. We have five business days to do this. We will send member a letter letting them know if their request meets these requirements. If their request meets the requirements, the letter will have the name of the external reviewer.
- You have five business days after getting the letter to send any extra information about their request to the external reviewer.

The external reviewer will send you and/or their representative and Health Alliance a letter with their decision within five calendar days of getting all the information they need to do their review.

**Expedited External Review**

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an expedited external review. You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Client Services call toll-free at 1-877-933-8480, TTY 1-800-526-0844 or 711.
Member Appeals Process

To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Health Alliance
Attn: Grievance and Appeals Dept.
301 South Vine Street, Urbana, IL 61801

What happens next?
- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will also send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Health Alliance know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Health Alliance with the decision within forty-eight (48) hours.
Overview

Health Alliance supports a member’s right to express preferences about his or her medical care through “advance directives.”

An advance directive is a written statement or document completed by a person in advance of serious illness about how the person wants his or her health care decisions made. Illinois law recognizes two types of advance directives: a “living will” and a “durable power of attorney for health care.”

A living will allows a person to state in advance what types of medical treatments are desired in the event the person develops a terminal illness. A durable power of attorney for health care permits a person to name someone to make health care decisions for him or her if he or she is unable to do so.

If a member chooses to have an advance directive, he or she should give a copy to their office to be included as part of his or her current medical record. A lawyer or a family member should also know about the member’s advance directive and its location. A member may change or cancel these documents at any time. Any change should be written, signed and dated, and copies given to all who may have copies of the original.

Contracted providers are obligated to honor any advance directive a member initiates.

Members are not required to initiate an advance directive and will not be denied care without an advance directive.

Members can obtain more information about advance directives by referring to the brochure entitled “Planning Ahead,” which is provided with their other member materials. We also encourage members to contact one or more of the following sources for assistance in planning an advance directive:

- Attorney
- Local Hospital
- The Illinois Department on Aging
  421 E. Capitol Avenue
  Springfield, IL 62701
  Senior Help Line: 1-800-252-8966
  TTY: 1-888-206-1327
  http://www.state.il.us/aging/
- The Illinois Attorney General’s Office
  500 S. Second Street
  Springfield, IL 62706
  (217) 782-1090
  TTY: 1-877-844-5461
  http://illinoisattorneygeneral.gov/
- Land of Lincoln Legal Assistance Foundation, Incorporated
  Executive Director’s Office
  8787 State Street, Suite 201
  East St. Louis, IL 62203
  (618) 398-0574
  http://lollaf.org/
Mandated Reporting for Suspected Maltreatment of Members

Providers must report suspected maltreatment immediately when they have reasonable cause to believe that a member may have been abused or neglected.

Persons Age 18 through 59

For participants aged 18 and older, mandated reporters under 59 Illinois Administrative Code 50 includes Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers and subcontractors). More details on the Administrative Code may be found at this link: http://www.ilga.gov/commission/jcar/admincode/059/05900050sections.html

Reporting Procedures, 18 through 59

At the time when the Division of Rehabilitation Services (DRS) central office is made aware of an incident, a Home Services Program (HSP) Counselor is assigned to the case. HSP counselors assist with reporting and remain involved in the case to help protect the customer from harm and to see that an adequate plan of care is in place. DRS also works with each case until there is satisfactory resolution. The Department of Human Services (DHS) Office of the Inspector General, which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged abuse, neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or developmental disabilities in DHSfunded community agencies. To make a report of abuse, neglect, or exploitation, call the DHS OIG Hotline at 1-800-368-1463 (voice and TTY). The DHS Office of Inspector General Adults with Disabilities Abuse Project has statutory authority to respond to allegations related to Adults with Disabilities between the ages of 18 and 59 who reside in domestic situations. DHS OIG has the authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records and pursue guardianship. With the individual’s consent, substantiated cases are referred to DHS for development of a service plan to meet identified needs.

Elderly (Age 60 and over)

Under the Elder Abuse and Neglect Act (320 ILCS 202/f-5), persons required as mandated reporters while carrying out their professional duties in working with the elderly population include:

- A professional or professional’s delegate while engaged in:
  - Social services
  - Law enforcement
  - Education
  - The care of an eligible adult or eligible adults
  - Any of the occupations required to be licensed under the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Dental Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Licensing Act, the Medical Practice Act of 1987, the Naprapathic Practice Act, the Nurse Practice Act, the Nursing Home Administrators Licensing and Disciplinary Act, the Illinois Occupational Therapy Practice Act, the Illinois Optometric Practice Act of 1987, the Pharmacy Practice Act, the Illinois Physical Therapy Act, the Physician Assistant Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, the Veterinary Medicine and Surgery Practice Act of 2004, and the Illinois Public Accounting Act
- An employee of a vocational rehabilitation facility prescribed or supervised by the Department of Human Services
- An administrator, employee, or person providing services in or through an unlicensed community based facility
- Any religious practitioner who provides treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious denomination, except as to information received in
Mandated Reporting for Suspected Maltreatment of Members

any confession or sacred communication enjoined by the discipline of the religious denomination to be held Confidential

- Field personnel of the Department of Healthcare and Family Services, Department of Public Health, and Department of Human Services, and any county or municipal health department
- Personnel of the Department of Human Services, the Guardianship and Advocacy Commission, the State Fire Marshal, local fire departments, the Department on Aging and its subsidiary Area Agencies on Aging and provider agencies, and the Office of State Long Term Care Ombudsman
- Any employee of the State of Illinois not otherwise specified herein who is involved in providing services to eligible adults, including professionals providing medical or rehabilitation services and other persons having direct contact with eligible adults
- A person who performs the duties of a coroner or medical examiner
- A person who performs the duties of a paramedic or an emergency medical technician

A full version of the Elder Abuse and Neglect Act can be found on the Illinois General Assembly website at the following link:

Reporting Procedures Elderly (60 and over)
Persons can report suspected Abuse, Neglect or exploitation to the Department of Aging (DoA) by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. Reports may also be made directly to the local Elder Abuse Provider Agency in the service area.

DoA policy specifically states that if direct service workers witness or identify a case of possible Abuse or Neglect, they are mandated to personally report the allegations to the designated Elder Abuse Provider Agency or to DoA’s Hotline numbers. DoA’s Office of Elder Rights maintains a tracking system of ANE investigations and statistical reports are generated annually.

Persons with Developmental Disabilities in Residential Facilities
For participants aged 18 and older

For participants aged 18 and older, mandated reporters under 59 Illinois Administrative Code 50 include Medicaid Agency and Operating Agency staff and community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors). More details on the Administrative Code may be found at the following link:
http://www.ilga.gov/commission/jcar/admincode/059/05900050sections.html

Reporting Procedures (Persons with Developmental Disabilities in Residential Facilities)
The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency. Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (four hours if Abuse or Neglect is suspected). Anyone may make a report under either rule by calling the DHS Office of the Inspector General 24-hour hotline at 1-800-368-1463 (voice and TTY).
Mandated Reporting for Suspected Maltreatment of Members

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it.

Long Term Care Facility Residents

Persons required to make reports or cause reports to be made as defined by the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) include:

- Any long term care facility administrator, agent or employee
- Any physician, hospital, surgeon, registered nurse, dentist, osteopath, chiropractor, podiatrist, coroner, social worker, social services administrator, or law enforcement officer
- Any accredited religious practitioner who provides treatment by spiritual means alone through prayer in accordance with the tenets and practices of the accrediting church
- Field personnel of the Department of Healthcare and Family Services and the Illinois Department of Public Health and County or Municipal Health Departments
- Personnel of the Department of Human Services (acting as the successor to the Department of Mental Health and Developmental Disabilities or the Department of Healthcare and Family Services), the Guardianship and Advocacy Commission, the State Fire Marshal, local fire department inspectors or other personnel, the Illinois Department on Aging or its subsidiary Agencies on Aging, or employee of a facility licensed under the Assisted Living and Shared Housing Act
- Employees of the State of Illinois who are involved in providing services to residents, including professionals providing medical or rehabilitation services and other persons having direct contact with residents
- Employees of community service agencies who provide services to a resident of a public or private long term care facility outside of that facility
- Any long term care surveyor of the Illinois Department of Public Health who has reasonable cause to believe in the course of a survey that a resident has been Abused or Neglected and initiates an investigation while on site at the facility shall be exempt from making a report under this Section but the results of any such investigation shall be forwarded to the central register in a manner and form described by the Department

In addition to the above persons required to report suspected resident Abuse and Neglect, any other person may make a report to the Department, or to any law enforcement officer, if such person has reasonable cause to suspect a resident has been Abused or Neglected.

A full version of the Abused and Neglected Long Term Care Facility Residents Reporting Act can be found on the Illinois General Assembly website at the following link:
http://www.ilga.gov/legislation/iles/ilcs3.asp?ActID=1222&ChapAct=210%26nbsp%3BILCS%26nbsp%3B30%2F&C hapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Abused+and+Neglected+Long+Term+Care+Facility+Residents+Reporting+Act%2E

Reporting Procedures

The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must also report allegations if they are told about Abuse or Neglect, if they witness it, or if they
suspect it. Reports are to be made to the Department of Public Health (DPH) Long Term Care/Nursing Home Hotline at 1-800-252-4343.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (only four hours if Abuse or Neglect is suspected).
CRITICAL INCIDENT/ABUSE/NEGLECT/EXPLOITATION

REPORTING REQUIREMENTS

AFFILIATED PROVIDER ACKNOWLEDGEMENT FORM

Name: ________________________________________________________________ (please print)
Title/Department: _______________________________________________________ (please print)

This is to certify, that as a Mandated Reporter, I must report to the Adult Protection Service Hotline any of the following incidents of abuse that I observe in my professional capacity or within the scope of my employment:

1. Any incident that I have observed or have knowledge of that reasonably appears to be abuse, neglect, financial exploitation or self-neglect; or
2. If an elder or dependent adult says that he or she has experienced behavior constituting abuse, neglect, financial exploitation or self-neglect; or
3. If I reasonably suspect abuse.

I will call the designated Adult Protection Service Agency in the member’s area. If that number cannot be reached, I will contact the Department on Aging 24-Hour Adult Protection Hotline at 1-866-800-1409 or (1-888-206-1327 (TTY)).

- Reports regarding members in Nursing Facilities must be made to the Department of Public Health’s Nursing Home Complaint Hotline at 1-800-252-4343.
- Reports regarding members in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services’ SLF Complaint Hotline at 1-800-226-0768.

Elder Abuse refers to the following types of mistreatment to any member 60 years of age or older and members ages eighteen (18) through fifty-nine (59) who have a mental or physical disability:

- **Abuse** – physical, sexual or emotional maltreatment or willful confinement
- **Neglect** – failure of a caregiver to provide the member (60 years or older and ages eighteen (18) through fifty-nine (59) who have a mental or physical disability) with the necessities of life, including, but not limited to food, shelter and medical care. Neglect may be either passive (non-malicious) or willful
- **Financial exploitation** – misuse or withholding of the member’s resources by another, to the disadvantage of the member, or the profit or advantage of someone else
- **Self-Neglect** – a condition that is the result of a member’s inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his/her own health, including: providing essential food, clothing, shelter, and health care; and obtaining goods and services to maintain physical health, mental health, emotional well-being, and general safety

I hereby attest that I have knowledge and understand my obligation to report abuse, neglect, exploitation or other critical incidents and will fulfill this obligation.

Signature: ____________________________________________________    Date: __________________

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PURPOSE OF THE POLICY

To comply with critical incident, abuse, neglect and exploitation reporting and training requirements of DHS-DRS, DoA and HFS HCBS Waivers. To comply with the Federal Waiver Assurances for the health, safety and welfare of the member set forth in the HCBS Waivers.

STATEMENT OF THE POLICY

Any Health Alliance employee, member, member’s family member(s), Affiliated Provider and/or vendor who has reason to believe that a member, who because of dysfunction is unable to seek assistance for him/herself, has, within the previous twelve (12) months, been subjected to abuse, neglect, financial exploitation or self-neglect, the Health Alliance employee is a mandated reporter and shall, within 24 hours after developing such belief, report this suspicion to the Illinois Department on Aging or designated agency and provide the agency with the appropriate information or supporting documentation.

Health Alliance employees, Affiliated Providers and/or vendors (as appropriate to their jobs) are required to be familiar with and comply with state laws and company policies in regard to the reporting if suspected abuse and/or neglect concerning disabled adults and elderly members. The Adult Protection Service reporting requirements may not be impeded by management. No employee, Affiliated Provider and/or vendor who is a Mandated Reporter shall be subject to any retaliation, retribution, harassment or penalty for making the report.

A Health Alliance employee, Affiliated Provider and/or vendor who is asked to disclose more Personal Health Information (PHI) than is required under state reporting laws, in a case of abuse or neglect, are directed to discuss with Senior Vice President of Corporate Affairs & General Counsel, Compliance Officer or Privacy Officer before making such disclosures if possible without causing delay that could endanger the victim of the abuse and/or neglect.

Disclosures made under this policy must be tracked as an accountable disclosure.

Health Alliance will provide annual training to ensure Mandated Reporters are making reports that are consistent with state laws and regulations. Health Alliance will establish internal procedures to facilitate reporting, ensure the confidentiality of members, and management notification.

Pursuant to the Elder Abuse and Neglect Act (320 ILCS 20/4(e)), any Mandated Reporter who fails to report elder abuse, neglect or exploitation is guilty of a Class A misdemeanor.
DEFINITION OF ABUSE OR NEGLECT
Abuse refers to the following types of mistreatment to any member.

- **Abuse** – physical, sexual, mental or emotional maltreatment or willful confinement
- **Neglect** – failure of a caregiver to provide the member (60 years or older or ages eighteen (18) through fifty-nine (59) who have a mental or physical disability) with the necessities of life, including, but not limited to food, shelter and medical care. Neglect may be either passive (non-malicious) or willful
- **Financial exploitation** – misuse or withholding of the member’s resources by another, to the disadvantage of the member, or the profit or advantage of someone else
- **Self-Neglect** – a condition that is the result of a member’s inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his/her own health, including: providing essential food, clothing, shelter, and health care; and obtaining goods and services to maintain physical health, mental health, emotional well-being, and general safety

For other Critical Incidents, please review to Illinois Department of Human Services – Division of Rehabilitation Services Critical Incidents Definition Table.

MANDATED REPORTER (as defined in the Elder Abuse and Neglect Act 320 ILCS 20)
A Health Alliance “Mandated Reporter” means any of the following persons while engaged in carrying out their professional duties:

- Any of the occupations required to be licensed under:
  - Clinical Psychologist Licensing Act
  - Clinical Social Work and Social Work Practice Act
  - Dietetic and Nutrition Services Practice Act
  - Illinois Nursing Act
  - Illinois Occupational Therapy Practice Act
  - Illinois Physical Therapy Act
  - Illinois Speech-Language Pathology and Audiology Practice Act
  - Marriage and Family Therapy Licensing Act
  - Medical Practice Act of 1987
  - Pharmacy Practice Act of 1987
  - Physician Assistant Practice Act of 1987
  - Podiatric Medical Practice Act of 1987
  - Professional Counselor and Clinical Professional Counselor Licensing Act
  - Respiratory Care Practice Act

PROCEDURES

1. **Health Alliance Employees, Affiliated Providers, Vendors**

1.1 A Health Alliance employee, Affiliated Provider and/or vendor who suspects that a member is a victim of abuse and/or neglected by another should report as follows:

- Members who are age 18 and older and living in the community are to be made to the Illinois Department on Aging’s **24-Hour Adult Protective Services Hotline** at 1-866-800-1409 (1-888-206-1327) (TTY).
• Members age 18-59 receiving mental health or developmental disability services in DHS operated, licensed, certified or funded programs are to be made to the Illinois Department of Human Services Office of Inspector General Hotline at 1-800-368-1463 (voice and TTY).
• Reports regarding members in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services’ SLF Complaint Hotline at 1-800-226-0768.
• Reports the abuse of a child under the age of 18, call the Illinois Child Abuse Hotline: 1-800-25-ABUSE (1-800-252-2873), 1-800-358-5117 (TTY).

2. Member or Member’s Family Member

2.1 The Member Handbook provides education to the member and/or member family member(s) on signs of Abuse, Neglect or exploitation and what to do if they suspect Abuse, Neglect or exploitation.

2.2 MRC or Nurse Care Manager will review the critical incidents, abuse, neglect and exploitation materials during the Initial Assessment Visit and provide the brochures to the member and member’s family/PCA.

3. Reporting Requirements

3.1 A Mandated Reporter must report to the Adult Protection Hotline any of the following incidents of abuse or neglect that he or she observes in his or her professional capacity or within the scope of his or her employment:
   • Any incident that he or she has observed or has knowledge of that reasonably appears to be a abuse, neglect, financial exploitation or self-neglect; (including detection of unauthorized use of restraint, seclusion or restrictive interventions) or
   • If an elder or dependent adult says that he or she has experienced behavior constituting abuse, neglect, financial exploitation or self-neglect; or
   • If he or she reasonably suspects abuse.

3.2 Information required when filing a report:
   • Member name, address, telephone number, sex, age and general condition
   • Alleged abuser’s name, sex, age, relationship to member and condition
   • Circumstances that led the reporter to believe that the elderly member is being abused, neglected or financially exploited, with as much specificity as possible
   • Whether the member is in immediate danger; the best time to contact the member, if member knows of the report, if there is any danger to the worker going to investigate
   • Whether the reporter believes the member should be able to self-report
   • The name, telephone number and profession of the reporter
   • The names of others with information about the situation
   • Whether the reporter is willing to be contacted again
   • Any other relevant information

3.3 If a Health Alliance Mandated Reporter believes he or she is aware of a member that is in immediate or life-threatening danger, that employee is directed to call 911 immediately.

3.4 Critical events and incidents must be reported and issues that are identified must be routed to management for review and, when required or otherwise appropriate, to the investigating authority.

3.5 Health Alliance shall maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed.

3.6 Health Alliance shall have systems in place to report, monitor, track, and resolve critical incidents concerning restraints and restrictive interventions.

3.7 If a critical incident rises to the level of abuse, neglect or exploitation it must be reported to the appropriate agency.
4. Follow up and Remediation

4.1 Follow up with member on the abuse, neglect, financial exploitation or critical incident and determine if any changes need to be made in the service plan for the member’s health, safety and welfare.
4.2 Upon a death of a member based on an abuse, neglect or critical incident review case to determine if any additional training or other remediation including sanctions or termination of provider.
4.3 Upon restraint, application, seclusion or other restrictive interventions where appropriate intervention occurred by the nurse case manager, review case to determine if any additional training or other remediation including sanctions or termination of provider.

5. Internal Documentation

5.1 An Critical Incident/Abuse/Neglect Mandated Reporter Form written report must be completed within two (2) working days of report being made to Hotline for abuse, neglect or exploitation and upon notice of other critical incidents and submitted to Manager or Director.
5.2 Enter note on member record of date and time hotline report made and attach the completed Critical Incident/Abuse/Neglect Mandated Reporter Form.
5.3 Upon notification from DHS-OIG regarding a new case or existing case, document report on member record and any DHS-OIG recommended changes in the customer service plan within 30 days.

6. Tracking of disclosure

6.1 The Mandated Reporter who disclosed PHI of an member in connection with a report of suspected abuse, neglect, financial exploitation or self-neglect must complete the Accounting of Disclosure – For Internal Use Form.

7. Training

7.1 All Health Alliance employees, Affiliated Providers and/or vendors who are Mandated Reporters receive required training upon hire/contracting and annually that includes:
   • signs and symptoms if elder abuse
   • indicators of elder abuse, neglect, financial exploitation or self-neglect
   • reporting requirements and methods
   • required documentation

7.2 Employees must sign the following Critical Incident/Abuse/Neglect Reporting Requirements Acknowledgement Form-EMPLOYEE attesting they understand and will comply with Elder Abuse reporting requirements under state law.

7.3 Affiliated Providers may either request to participate in Health Alliance scheduled training or submit a signed attestation that they have completed required training Critical Incident/Abuse/Neglect Reporting Requirements Acknowledgement Form-PROVIDER.

Vendors may either request to participate in Health Alliance scheduled training or submit a signed attestation that they have completed required training Critical Incident/Abuse/Neglect Reporting Requirements Acknowledgement Form-VENDOR.

8. Compliance

8.1 Maintains an internal tracking system to report to HFS or in the case of IPH, the appropriate representative.
8.2 Critical Incident reports will be submitted to HFS or IPH representative within the required timeframes.
   • Detailed report – monthly
   • Summary report – quarterly
8.3 Provide HFS and IPH representative, upon request, our protocol for reporting and assuring the health and safety of the member after a reported allegation.
## CRITICAL INCIDENT/ABUSE/NEGLECT/EXPLOITATION

**MANDATED REPORTER FORM**

**Return Form:** Within 2 working days of the Hotline Report for Abuse, Neglect or Exploitation
Within 2 working days of notice of other critical incidents

<table>
<thead>
<tr>
<th>REPORTER INFORMATION</th>
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<tbody>
<tr>
<td>Name of Individual Who Reported Incident:</td>
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<tr>
<td>Type/Source:</td>
</tr>
<tr>
<td>Employee Name:</td>
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<tr>
<td>Date of Report:</td>
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<tr>
<td>Department:</td>
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<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Member #:</td>
</tr>
<tr>
<td>Medicaid #:</td>
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<tr>
<td>Is the member on a waiver or in a nursing home?</td>
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<tr>
<td>If Yes:</td>
</tr>
<tr>
<td>Is the member aware a report was made?</td>
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<table>
<thead>
<tr>
<th>INCIDENT INFORMATION</th>
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</thead>
<tbody>
<tr>
<td>Incident Type:</td>
</tr>
<tr>
<td>Name of alleged abuser(s):</td>
</tr>
<tr>
<td>Incident Date:</td>
</tr>
<tr>
<td>Relationship to victim:</td>
</tr>
<tr>
<td>Description of alleged abuse incidents and/or conditions of neglect. Include dates, times and specific facts (use additional pages if necessary):</td>
</tr>
<tr>
<td>Was medical treatment required immediately?</td>
</tr>
<tr>
<td>Describe treatment received:</td>
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<tr>
<td>Did the reporter believe the situation constituted an emergency?</td>
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<tr>
<th>GOVERNMENT AGENCY INFORMATION</th>
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<tbody>
<tr>
<td>Reported to Agency:</td>
</tr>
<tr>
<td>Date Reported:</td>
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<tr>
<td>Agency Name:</td>
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Within two weeks of report – Complete this section of the form and submit to Compliance for tracking and reporting purposes.

<table>
<thead>
<tr>
<th>SUMMARY OF RESOLUTION</th>
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<tbody>
<tr>
<td>Date of Resolution:</td>
</tr>
<tr>
<td>Description of Resolution:</td>
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</table>
Abuse, Neglect, Exploitation

It is estimated between one and two million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone who they depend on for care or protection.

Of those elderly or disabled who are abused only one in every seven cases are reported.

Abuse takes many forms, and in most cases victims are subjected to more than one type of mistreatment. In Illinois, 57% of elder abuse reports allege financial exploitation; approximately 21% allege physical abuse; 38% allege active or passive neglect; and 44% allege emotional abuse.

Elder or persons with disability abuse is a term referring to any negligent act by a caregiver or any other adult that causes harm or a serious risk of harm to a vulnerable adult. Illinois law defines abuse, neglect and exploitation as:

- Physical Abuse – inflicting physical pain or injury to an older person
- Sexual abuse – touching, fondling, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced.
- Emotional abuse – verbal assaults, threats of abuse, harassment, or intimidation
- Confine – restraining or isolating an older person for other than medical reasons
- Passive neglect – the caregiver’s failure to provide an older person with life’s necessities, including, but not limited to, food, clothing, shelter, or medical care
- Willful deprivation – willfully denying assistance to an older person who requires medication, medical care, shelter, food, therapeutic device, or other physical assistance, thereby exposing that person to the risk of harm.
- Financial exploitation – the misuse or withholding of an older person’s resources by another, to the disadvantage of the elderly person and/or the profit or advantage of another person.
Critical Incident/Abuse/Neglect/Exploitation

Abuse, Neglect, Exploitation

Critical Incidents other than abuse, neglect and financial exploitation may include:
• Member or Provider arrested and charged with or convicted of a crime
• Member missing
• Member displays physically aggressive behavior
• Member causes property damage in the amount of $50 or more
• Suicide attempt
• Member displays or threatens with a weapon
• Suspected of alcohol or substance abuse
For the entire list refer to the policy and procedure.

Abuse, Neglect, Exploitation

The Abuser...
• is most often a family member – adult child, spouse, grandchild and other relative, but could be a non-relative caregiver;
• may lose control due to the stress associated with care giving;
• may have an alcohol or substance abuse problem; and
• may be frustrated or isolated.
Interventions must take into account, wherever possible, most seniors’ desire not to sever family ties.

Abuse, Neglect, Exploitation

The Victim...
• is most often a white female with an average age of 79 – 75% of elder abuse victims are white, 20% are black and about 5% are Hispanic, other or unknown
• may suffer from some form of dementia or physical impairment, often suffering from multiple disabilities which make him/her dependent on others for care;
• tends to be isolated;
• may suffer from more than one type of abuse;
• may be reluctant to admit his/her loved one is an abuser; and
• may be fearful of reporting abuse, thinking it could lead to further harm, nursing home placement or total abandonment.
These characteristics make intervening more complicated and cases more difficult.
Employees (such as nurses, psychologists, social workers, etc.) who are in personal contact with members are called Mandated Reporters and must report any of the following incidents of abuse that he or she observes in his or her professional capacity or within the scope of his or her employment:

- Any incident that he or she has observed or has knowledge of that reasonably appears to be abuse, neglect, financial exploitation or self-neglect; or
- If an elder or dependent adult says that he or she has experienced behavior constituting abuse, neglect, financial exploitation or self-neglect; or
- If he or she reasonably suspects abuse.

If you believe or are aware of a member that is in immediate or life-threatening danger, you must call 911 immediately.

Mandated Reporters must report incidents to:

**Illinois Department of Aging**

**Adult Protective Services Hotline**

1-866-800-1409 (TTY 1-888-206-1327)

- Reports regarding members in a nursing home must be made to the Department of Public Health Nursing Home Complaint Hotline at 1-800-252-4343.
- Reports regarding members in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services' SLF Complaint Hotline at 1-800-226-0768.

Mandated Reporters must report Abuse, Neglect and Exploitation incidents immediately to your manager.

The Health Alliance Critical Incidents/Abuse/Neglect/Exploitation form must be completed within two working days of the Hotline report for Abuse, Neglect and Exploitation incidents and upon notice of other critical incidents and forwarded to the Compliance Officer.

The Compliance Programs Manager tracks all critical incidents, including reported abuse, neglect and exploitation incidents, and provide a detailed report on a monthly basis and a summary report on a quarterly basis to HFS.
References

Illinois Department on Aging:
• Break the Silence brochure
• Elder Abuse and Neglect Program – Annual Report brochure
• Elder Abuse and Neglect – How You Can Help brochure
• Elder Abuse and Neglect and Related Laws brochure
• Reporting Elder Abuse – What Professionals Need to Know brochure
• Be Safe – Protect Yourself from Financial Exploitation brochure
• Be a Savvy Senior brochure
**Physician/Provider Information:**

- **ADD**
- **CHANGE**
- **TERM**

*Illinois legislation requires contracted providers to give 90 days written notification of their intent to terminate their contract.*

**If provider is terming please note reason in comments below.**

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<th>Name</th>
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<th>Medicaid #</th>
<th>Effective Date</th>
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**Midlevel Practitioner/Eligible Biller Information:**

- **ADD**
- **CHANGE**
- **TERM**

*(additional space on other side)*

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<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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<thead>
<tr>
<th>DOB</th>
<th>UPIN</th>
<th>DEA#</th>
<th>License #</th>
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<tr>
<th>NPI#</th>
<th>Effective Date</th>
<th>Supervising Physician</th>
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<th>Medicaid #</th>
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**General Office/Billing Information:**

- **ADD**
- **CHANGE**
- **TERM**

*(additional space on other side)*

**Physical Practice Location:**

- **Office Name**

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
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<table>
<thead>
<tr>
<th>Email Address</th>
<th>Tax ID#**</th>
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</table>

**Billing Location:**

- **Company Name**

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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</thead>
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**If you have a Tax ID# change, please remember to submit a new W-9 Form to Health Alliance.**

If claims are filed electronically, list the vendor and contact person.

**Vendor**

<table>
<thead>
<tr>
<th>Contact Person</th>
<th>Phone</th>
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If Health Alliance has questions about the addition/change of a provider, who can we contact?

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
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**Comments**

Please mail or fax copies of DEA certificate (if applicable) and state licenses for all providers.

**Mail to:** Contracting & Provider Services

**Health Alliance Medical Plans**

**301 S. Vine St.**

**Urbana, IL 61801**

**Fax to:** Contracting & Provider Services

Attention: Provider Relations Specialist

**(217) 337-3438**

*cps-provchange-0214*
*Illinois legislation requires contracted providers to give 90 days written notification of their intent to terminate their contract. *If provider is terming please note reason in comments below.

**ADDITIONAL MIDLEVEL PRACTITIONER/ELIGIBLE BILLER INFORMATION:**  [ ] ADD  [ ] CHANGE  [ ] TERM*

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**ADDITIONAL GENERAL OFFICE/BILLING INFORMATION:**  [ ] ADD  [ ] CHANGE  [ ] TERM*

**PHYSICAL PRACTICE LOCATION:**  OFFICE NAME

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<tr>
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**COMMENTS**

** If you have a Tax ID# change, please remember to submit a new W-9 Form to Health Alliance.
Please complete a copy of this form for each midlevel and fax it to Kendra Pearman’s attention at (217) 337-3438.

Start Date __________________________________________________________________

Name (last, first, MI) __________________________________________________________________________

Degree ________________________________________________________________________________________

NPI # _____________________________   Medicaid # ______________________________

SSN # or Tax ID # ________________________________________________________________________________

Office Name _____________________________________________________________________________________

Address _________________________________________________________________________________________

City ___________________________________________________________________________________________

State __________________________________________________________________________________________

Zip _____________________________________________________________________________________________

Phone _________________________________________________________________________________________

Fax _____________________________________________________________________________________________

Email _________________________________________________________________________________________

Name of Supervising Physician ________________________________________________________________________________

Is midlevel supervised by this physician more than 50% of the time?   yes ____   no ____

DEA Number* (if applicable) ______________________________________________________________________

Expiration Date _________________________________________________________________________________

*Copies of State License, State Controlled Substance License and DEA Registration Certificate REQUIRED. Behavioral Health providers who do not prescribe medications are required only to submit a copy of their State License.