YouthCare HealthChoice Illinois

Provider Manual

YOUTHCARE HEALTH*CHOICE* ILLINOIS

Updated 2/1/2020

We thank you for being part of YouthCare's network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. YouthCare works to accomplish this goal by partnering with the providers who oversee the healthcare of our members.

ABOUT US

YouthCare Health*Choice* Illinois was designed by the Illinois Department of Healthcare and Family Services (HFS) and Department of Children and Family Services (DCFS) to serve Illinois members through the HealthChoice Illinois plan. It builds on the local service system, consent process, comprehensive assessments and consent requirements to help improve the safety, well-being and permanency of children who are, or have been in DCFS custody.

The YouthCare program will deliver tailored programs that support health and stability for those in out-of-home placement. Additionally, the program offers long-term support for adoptive families and children, transitional health and social support for youth who age out of the system.

YouthCare has the expertise to improve members' health status and quality of life. Our parent company, Centene Corporation, has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than 30 years. Centene operates local health plans in multiple states and offers a wide range of health insurance solutions to a variety of individuals. Centene also contracts with other healthcare and commercial organizations to provide specialty services. For more information about Centene, visit centene.com.

YouthCare is a physician-driven program that is committed to building collaborative partnerships with providers. YouthCare will serve our members consistently with our core philosophy that quality healthcare is best delivered locally.

MISSION

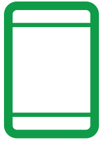
YouthCare focuses on improving members' health status, encouraging successful outcomes, and striving for member and provider satisfaction in a coordinated care environment. YouthCare was designed to achieve the following goals:

- Ensure access to primary and preventive care services.
- Ensure care is delivered in the best setting to achieve an optimal outcome.
- Improve access to all necessary healthcare services.
- Encourage quality, continuity, and appropriateness of medical care.
- Provide medical coverage in a cost-effective manner.

HOW TO USE THIS MANUAL

YouthCare is committed to working with our network of providers to achieve a high level of satisfaction in delivering quality healthcare benefits. The Provider Manual contains a comprehensive overview of YouthCare operations, benefits, policies, and procedures.

Please contact the Provider Services department if you need further explanation on any topics covered in the Provider Manual.



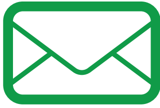
Contact Information

The following chart contains contact information for YouthCare. When contacting any department, please have the following information on hand:

- National Provider Identifier (NPI);
- Tax ID Number (TIN); and
- If calling about a member-related issue, please know the member's ID Number.

YouthCare's hours of operation are Monday – Friday 8:00 a.m. to 6 p.m. (CST)

YouthCare HealthChoice Illinois Member and Provider Services	844-289-2264 TTY: 711
Website	ILYouthCare.com



Claims Contact Information

Use the below contact information when submitting claims-related requests to YouthCare.

CLAIMS TYPE	ADDRESS
FIRST SUBMISSION OF CLAIMS (MEDICAL AND BEHAVIORAL HEALTH)	**YouthCare** **Attn: Claims** PO Box 4020 Farmington, MO 63640-4402
MEDICAL REQUESTS FOR RECONSIDERATION AND CORRECTED CLAIMS	**YouthCare** **Attn: Reconsideration** PO Box 4020 Farmington, MO 63640-4402
MEDICAL CLAIM DISPUTE	**YouthCare** **Attn: Claim Dispute** PO Box 4020 Farmington, MO 63640-3800
BEHAVIORAL HEALTH REQUESTS FOR RECONSIDERATION AND CORRECTED CLAIMS	**YouthCare** **Attn: BH Reconsideration** PO Box 7300 Farmington, MO 63640-3828
BEHAVIORAL HEALTH CLAIM DISPUTE	**YouthCare** **Attn: BH Dispute** PO Box 7300 Farmington, MO 63640-3809
PHARMACY CLAIMS	**Envolve Pharmacy Solutions** 5 River Park Place East Suite 210 Fresno, CA 93720

Payer IDs For Clearinghouses

If you would like to submit your claims through a clearinghouse, please use YouthCare's Payer ID #: **68069**

If you have any questions about submitting claims through clearinghouses, please contact:

YouthCare c/o Centene EDI Department
800-225-2573, ext. 6075525
EDIBA@centene.com

YouthCare Health*Choice* Illinois plan is available in all Illinois counties.

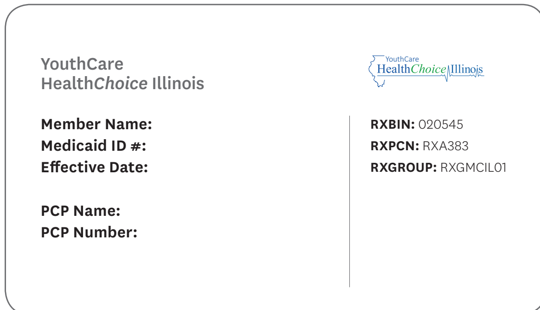
Member Eligibility

MEMBER ID CARD

All YouthCare members receive an ID card (see sample below). Members should present their ID card 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.*

The member ID number, effective date, contact information for YouthCare, and PCP information are included on the ID card. If you are not familiar with the member seeking care, please ask to see photo identification for confirmation. *If you suspect fraud, please contact Provider Services immediately.*

YouthCare Health*Choice* Illinois ID card:



MEMBERS
Member Services, Behavioral Health, Dental, Transportation, 24/7 Nurse Advice Line:
844-289-2264
TTY: 711
ILYouthCare.com

Mailing Address
YouthCare
Health*Choice* Illinois
PO Box 92050
Elk Grove Village, IL 60009-2050

PROVIDERS
24/7 Eligibility and Prior Auth Check:
844-289-2264
Envolve Pharmacy Solutions Help Desk:
800-678-6237

Payer ID #: 68069
Claim and EFT/ERA information on ILYouthCare.com

Paper Claims
YouthCare
Health*Choice* Illinois
Attn: Claims
PO Box 4020
Farmington, MO 63640-4402

VERIFYING ELIGIBILITY

Use one of the following methods to verify a member's eligibility:

1

Log on to the Provider Portal at Provider.IlliniCare.com.

Providers can search by date of service plus any of the following: member name and date of birth, or member ID number. You can submit multiple member ID numbers in a single request.

2

Call our automated member eligibility Interactive Voice Response (IVR) system.

Call Provider Services from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member ID number, the member date of birth, and the month of service to check eligibility.

3

Call Provider Services.

If you cannot confirm a member's eligibility using the first two methods, call Provider Services. Follow the menu prompts to speak to a representative to verify eligibility before rendering services. Provider Services will need the member name or member ID number and the member date of birth to verify eligibility.

Benefit Explanation & Limitations

YouthCare providers supply a variety of medical benefits and services, some of which are outlined on the following pages. All services must be medically necessary and some services require prior authorization. *See page 16 for information regarding the prior authorization process.*

Please note we will NOT authorize services for out of network or non-participating providers, unless the services are necessary for continuity of care reasons. We may also authorize services for out of network providers at our discretion if the services are not available through our in-network providers.

For specific benefit information not covered in this Manual, please contact Provider Services. Providers can also reference ILYouthCare.com for the most recent benefit updates.

COVERED SERVICES

Note: Some services require prior authorization. Always check if services need prior authorization before completing. See page 16 for information regarding the prior authorization process.

- Abortion services in limited situations
- Advanced Practice Nurse services
- Ambulatory Surgical Treatment Center services
- Assisted living
- Audiology services
- Behavioral health outpatient services
  - Community case services
  - Crisis services
  - Inpatient psychiatric services
  - Intensive outpatient services
  - Partial hospitalization services
  - Residential rehabilitation services
- Chiropractic services
- Clinic services
- Dental services
- Durable medical equipment
- Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) services to members under the age of twenty-one (21)
- Family Planning services and supplies
- Home Health Agency visits
- Hospital ambulatory (outpatient) services
- Hospital inpatient services
- Hospital emergency department services
- Imaging services
- Laboratory services
- Medical supplies, equipment, prostheses, and orthoses
- Pharmacy services
- Physician services
- Podiatric services
- Renal dialysis services
- Sub-acute alcohol and substance abuse services
- Transportation to secure covered medical services

ADDITIONAL BENEFITS

YOUTHCARE HEALTHCHOICE ILLINOIS	
No Copays	No copays for medical visits or prescriptions.
Prescriptions	Option for 90-day supply mailed to member's home.
Dental Services	Services provided in school dental programs.
Practice Visits	"Practice visits" to the dentist or certain specialists if needed.
My Health Pays™	Rewards program that provides prepaid debit card with funds added when members utilize certain screenings and preventive care.
Connections Plus	Cell phones provided to eligible members who don't have access to a phone to call providers, 911, or care coordinators.
Vision Services	• $100 credit for eyeglass frames or an $80 credit for contact lenses. • Replacement Glasses: Eyeglasses may be replaced as needed, without pre-authorization
Nurse Advice Line	Members can call a nurse for advice 24 hours a day, 7 days a week.

General Preventive Care Services

- Eye exams. We cover an eye exam every once a year (more if member's eyesight changes a lot). We cover refractions to determine a prescription for glasses.
- Health education programs including: diabetes education, heart health education, nutritional education, etc.
- Child and youth immunizations.
  - Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), and the United States Preventive Services Task Force recommendations.
- Periodic check-ups. A complete history and physical exam every one to three years.
- Cancer screening for cervical, breast, colorectal, prostate, and skin.

Well-Child Care

The Child Health & Disability Prevention (CHDP) program offers:

- Health history.
- Medical, dental, nutritional assessment as well as physical and mental developmental assessments.
- Administration of immunizations.
- Vision and hearing testing.
- Some laboratory tests (e.g., tuberculin, sickle cell, blood and urine tests, pap smears).
- Health education, anticipatory guidance including smoking and information on second-hand smoke.
- Coverage of any test recommended by YouthCare and medical professionals, and that meets medical necessity criteria.

Pregnancy and Maternity Services

- Outpatient services including routine prenatal care before and after delivery for problems or complications resulting from pregnancy or childbirth.
- Inpatient hospital services in participating hospitals and out-of-network emergency labor and delivery services.
- Care from the Comprehensive Perinatal Services Program (CPSP), including a medical/obstetrical, nutritional, psychosocial, and health education assessment at the first prenatal visit, one visit during each trimester thereafter, and at the postpartum visit.
- The newborn child's healthcare for the month of delivery and the month after delivery. By that time, the newborn should be enrolled separately.

Voluntary Contraception Services

YouthCare covers the cost of contraceptives, including the birth control device, and fitting or inserting the device (such as diaphragms, IUDs, Norplant). Members can get services from any qualified family planning provider. He/she does not have to be a participating provider.

Our members do not need a referral from a PCP and do not have to get permission from YouthCare to get these services.

Screening and Brief Intervention, Referral for Treatment (SBIRT)

This is a billable service for primary care providers as a way to screen members and refer them to appropriate behavioral health services. YouthCare also offers training for PCPs on the use of this screening tool.

NON-COVERED SERVICES

Here is a list of some of the medical services and benefits that YouthCare does not cover:

- Services that are experimental or investigational in nature
- Services that are provided by an out-of-network provider and not authorized by YouthCare
- Services that are provided without a required referral or required prior authorization
- Elective cosmetic surgery
- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies

THIRD PARTY LIABILITY (TPL) SERVICES

Providers that have identified changes in their patient's private health insurance information can notify the Department of Healthcare and Family Services of the change in health insurance status by:

- Calling the Third Party Liability (TPL) Inquiry Line at 217-524-2490 and speaking with a Customer Service Representative; or
- Faxing the information to the TPL unit at 217-557-1174. (Provided upon request, is a preferred fax form TPL can either fax or email, which includes all necessary information); or
- Scanning and sending the information by email to the TPL unit at HFS.TPL.1442@illinois.gov.

Providers should also advise their patients to contact the TPL unit directly to report the changes in their private health insurance information. Clients can call, fax or email the TPL unit as outlined above.

When contacting TPL, providers or clients will need to provide the following information:

- Provider name, phone number, and provider # or tax id;
- Patient's RIN (recipient number);
- Patient's Name;
- Patient's DOB;
- Policy holder Name, DOB, & SSN;
- Complete insurance company name and address;
- Policy group # & policy number; and
- Coverage dates.

Please note the above mentioned phone numbers and email address are ONLY for adding or updating private health insurance information. The TPL Inquiry Line will not be able to assist clients with questions that are not related to TPL. Clients should use the following resources, for assistance with other questions:

- Medicare - send an email to DHS.SSAPC@illinois.gov or fax the information to 217-527-7554; or
- Managed Care Program - refer to the Managed

  Care options listed on this website at https://www.illinois.gov/hfs/MedicalClients/ManagedCare/Pages/default.aspx
- Cash or medical eligibility - find or visit the Local

  DHS office at http://www.dhs.state.il.us/page.aspx?, or call the HFS Client Healthcare Hotline at 800-226-0768, or the DHS Helpline at 800-843-6154.

Preventive Screenings

YouthCare encourages our members to undergo routine preventive screenings to diagnose and treat conditions in a timely fashion. Below is an overview of the preventive screenings covered by YouthCare.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, which is mandated by state and federal law.

YouthCare provides coverage for the full range of EPSDT services in accordance with HFS policies and procedures. These services include periodic health screenings and appropriate up-to-date immunizations using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics (AAP) periodicity schedule for pediatric preventative care.

The following services are included in the EPSDT benefit:

- Comprehensive health history
- Developmental history – including assessment of both physical and mental health development
- Comprehensive physical exam (with clothes off when clinically appropriate)
- Laboratory tests (including blood lead level assessment)
- Health education.
- Vision screening and necessary follow-up services
- Dental screening and necessary follow-up services
- Hearing screening and necessary follow-up services
- Other necessary healthcare, diagnostic services, treatment, and other measures to ameliorate defects, physical, and mental illnesses and conditions identified. PCPs should provide inter-periodic screenings, which are Medically Necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes at a minimum vision and hearing screening services. An inter-periodic visit may be performed only for vision or hearing screening services.
- Appropriate children's immunizations

All components of the EPSDT exam must be clearly documented in the PCP's medical record for each member. Minimum record requirements are as stated in the Illinois Handbook for Providers of Healthy Kids Services and must include the following:

- Problem list
- Medication list
- Personal health, social history and family history
- Periodic examination records
- Growth charts
- Objective developmental screening tools or risk assessment screening tools, as applicable
- Health education and anticipatory guidance
- Nutritional assessment, including documentation and interpretation of BMI for children starting at 2 years of age
- Relevant history of current illness or injury, if any, and physical findings
- Immunization records
- Reports of procedures, tests, and results, including findings and clinical impression from screening or assessments
- Allergy history
- Diagnostic and therapeutic orders, including medication lists
- Clinical observations, including results of treatment
- Diagnostic impressions

- Hospital admissions and discharges, if any
- Referral information and specialty consultation reports, if any

YouthCare requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Illinois citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. YouthCare will cooperate and assist providers to identify all members that are not up-to-date with their immunizations.

All PCPs should ensure that appropriate immunizations are available for child members. Vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the federal Vaccine for Children (VFC) program. To enroll in the VFC program or receive more information, visit the Illinois Department of Public Health website.

YouthCare providers shall participate in the Vaccines for Children (VFC) program. Vaccines from VFC should be billed with the specific antigen codes for reimbursement of administration of the vaccine. No payment will be made on the administration codes alone.

PREVENTIVE CARE

The below guides are the recommended preventive care schedules for youth. Members should consult with their PCP to determine which screenings are right for them and when to undergo each screening.

Wellness Visits

Age	Frequency
Under age 21	Annually

Wellness visits include:

- Complete health history
- Comprehensive physical exam
- Preventive screenings (as needed)

Recommended Preventive Screenings

Screening	Recommendation
Alcohol misuse: screening and counseling	Members age 18 and older.
Bacteriuria screening	Youth 12-16 weeks pregnant.
Blood pressure screening	Annually for members age 18 and older.
BRCA risk assessment and genetic counseling/testing	Youth with family members with breast, ovarian, tubal, or peritoneal cancer.
Breast cancer preventive medications	Youth at an increased risk for breast cancer.
Breastfeeding interventions	Youth during pregnancy and after birth.
Chlamydia screening	Sexually active youth age 21 or younger.
Depression screening	General population, including pregnant and postpartum women.
Folic acid supplementation	Youth who are planning or capable of pregnancy.
Gestational diabetes screening	Asymptomatic pregnant youth after 24 weeks of gestation.
Healthy diet and physical activity counseling to prevent cardiovascular disease (CVD)	Members who are overweight or obese and have additional CVD risk factors.
Hepatitis B screening	Persons at high risk for infection. Pregnant youth at first prenatal visit.
Hepatitis C screening	Members at high risk for infection.
HIV screening	Adolescents and adults 15-21 years old. Pregnant youth.
Intimate partner violence screening	Youth of childbearing age.
Obesity screening and counseling	All members.
Preeclampsia prevention: aspirin	Pregnant youth at high risk for preeclampsia after 12 weeks of gestation.
Preeclampsia screening	Pregnant youth.
Rh incompatibility screening	Pregnant youth at first prenatal visit. Repeated test at 24-28 weeks for unsensitized Rh(D)-negative pregnant youth.
Sexually transmitted infections counseling	Sexually active adolescents. Youth with an increased risk for infection.
Skin cancer counseling	Children, adolescents, and young adults age 10-21 with fair skin.
Tobacco use counseling and interventions	All members. All pregnant youth.
Syphilis screening	Members at increased risk for infection. All pregnant youth.

Medical Management

UTILIZATION MANAGEMENT

The YouthCare Utilization Management (UM) Program is designed to ensure members of YouthCare receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care, ancillary care, and behavioral health services.

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

Our program goals include:

- Monitoring utilization patterns to guard against over-or under-utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care coordination and/or disease management for members at risk for significant health expenses or ongoing care.
- Development of an infrastructure to ensure that all YouthCare members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self management.
- Creation of partnerships with members/providers to enhance cooperation and support for UM program goals.

Utilization Management Contact Information

YouthCare Health*Choice* Illinois Phone:
844-289-2264

PRIOR AUTHORIZATION

There are **3 ways** to submit for prior authorization:

1. **Provider Portal:**
Provider.IlliniCare.com

2. **Fax:**
YouthCare Health*Choice* Illinois:
844-931-1229
Medical: 877-779-5234
Behavioral Health: 844-528-3453

3. **Phone:**
YouthCare Health*Choice* Illinois:
844-289-2264

Please ensure that the TIN and NPI provided in prior authorization requests are accurate to avoid downstream claims payment issues.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require authorization by YouthCare are listed on ILYouthCare.com. The PCP should contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. *All out-of-network services require prior authorization*.

Emergency Room (ER) and urgent care services **never** require prior authorization. Providers should notify YouthCare of post-stabilization services such as, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within two (2) business days of the service initiation. If notified after the 2 days, an administrative denial will take place.

Clinical information is required for ongoing care authorization of the service. Failure to obtain authorization may result in administrative claim denials. YouthCare providers are contractually prohibited from holding any YouthCare member financially liable for any service administratively denied by YouthCare for the failure of the provider to obtain timely authorization.

Authorization Timelines

Prior authorization should be requested at least 14 calendar days before the requested service delivery date. YouthCare decisions for requests for standard services will be made within 4 days. "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. The provider and member will be notified of the decision within one business day of the determination. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited requests, a decision is made within 48 hours of receipt of all necessary information. Urgent criteria is defined as a medical/ behavioral health event that could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state. Or, in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. The provider and member will be notified of the decision within one business day of the determination.

Clinical Information

Authorization requests may be submitted by fax, phone, or provider portal. A referral specialist will enter the demographic information and transfer the information to a YouthCare nurse for the completion of medical necessity screening. For all services on the prior authorization list, documentation supporting medical necessity will be required.

YouthCare clinical staff will request clinical information that is minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), YouthCare is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations.

Information necessary for authorization of covered services may include but is not limited to:

- Member name and member ID number
- Provider name and telephone number
- Provider location, if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/ proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Discharge plans

Notification of newborn deliveries should include the mother's name, date of delivery, method of delivery, and weight.

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

Clinical Decisions

YouthCare affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. YouthCare does not specifically reward practitioners or other individuals for issuing denials of service or care.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the YouthCare Medical Director and other clinical staff, is responsible for making utilization management decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Medical Necessity

Medical necessity is defined for YouthCare members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury.
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines.

- Not primarily for the personal comfort or convenience of the member, family, or provider.
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member.
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service.
- Not experimental or investigational or for research or education.

Review Criteria

YouthCare has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. Behavioral health UM uses InterQual in addition to American Society of Addiction Medicine (ASAM) criteria for all inpatient services; state service definitions are used for behavioral health community-based services.

InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services.

Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department. Practitioners also have the opportunity to discuss any medical or pharmaceutical utilization management adverse determination with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination.

The Medical Director may be contacted by calling Provider Services and asking for the Medical Director. A medical management nurse may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

YouthCare
Attn: Prior Auth Appeal
PO Box 92050
Elk Grove Village, IL 60009-2050

RETROSPECTIVE REVIEW

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to YouthCare was not obtained due to extenuating circumstances related to the member. Requests for retrospective review, for services that require authorization by YouthCare, must be submitted promptly upon identification but no later than 90 days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service cases.

REFERRALS

As promoted by the Medical Home concept, PCPs should coordinate most of the healthcare services for YouthCare members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, paper referrals are not required. To better coordinate a member's healthcare, YouthCare encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

SECOND OPINION

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the YouthCare network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network providers will require prior authorization by YouthCare.

ASSISTANT SURGEON

Reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. YouthCare follows the

guidelines for assistant surgeons set forth in the State of Illinois Medicaid fee schedule.

Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

NEW TECHNOLOGY

YouthCare evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the YouthCare population. Centene's Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department.

NOTIFICATION OF PREGNANCY

YouthCare provides care coordination for pregnant members. It is critical to identify members as early in their pregnancy as possible. YouthCare asks that a managing physician notify the YouthCare prenatal team by completing the Notification of Pregnancy (NOP) within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. YouthCare will facilitate the physician's order of a 90-day supply of prenatal vitamins for the member to be delivered to the managing provider's office by the member's next prenatal visit. See the Care Coordination/Case Management section for information related to our Start Smart for Your Baby® Program and our 17-P Program for women with a history of early delivery.

DISCHARGE PLANNING

The YouthCare UM staff will coordinate the discharge planning efforts with the member/member's family or guardian, the hospital's UM and discharge planning departments and the member's attending physician/PCP in order to ensure that YouthCare members receive appropriate post-hospital discharge care.

Pharmacy

YouthCare is committed to providing appropriate, high quality, and cost effective drug therapy to all members. YouthCare works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Prescription drugs and certain over-the-counter (OTC) drugs are covered when ordered by a YouthCare physician/clinician.

The pharmacy program does not cover all medications. Some medications require prior authorization or have limitations on age, dosage and/or maximum quantities. For a complete list of covered medications, please visit ILYouthCare.com.

PHARMACY BENEFIT MANAGER

YouthCare works with Envolve Pharmacy Solutions to administer pharmacy benefits including the prior authorization process. Certain drugs require prior authorization to be approved for payment by YouthCare. These include:

- All medications not listed on the PDL
- Medications in the “Preferred with PA” and “Non-Preferred” tiers

Follow these steps for efficient processing of your prior authorization requests:

1. Complete the Medication Prior Authorization Request Form.
2. Fax to Envolve Pharmacy Solutions at 866-399-0929.
3. Once approved, Envolve Pharmacy Solutions notifies the prescriber by fax.
4. If the clinical information provided does not explain the reason for the requested prior authorization medication, Envolve Pharmacy Solutions responds to the prescriber by fax, offering PDL alternatives.
5. For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the Envolve Pharmacy Solutions Help Desk at 800-460-8988.

All prior authorization requests should be submitted to Envolve Pharmacy Solutions.

Envolve Pharmacy Solutions Contact Information
Prior Authorization Fax: 866-399-0929
Prior Authorization Phone: 866-399-0928
Clinical Hours: Monday - Friday 10:00 a.m.- 8:00 p.m. (EST)

Envolve Pharmacy Solutions
5 River Park Place East
Suite 210
Fresno, CA 93720

When calling, please have the patient information available: member ID number, complete diagnosis, medication history, and current medications.

- If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific members to receive this specific drug.
- If the request is denied, information about the denial and appeal rights will be provided to the clinician.

Clinicians are requested to utilize the PDL when prescribing medication for those patients covered by the YouthCare pharmacy program. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the clinician to request a change to a product included in the YouthCare PDL.

MEDICATION FOR DCFS YOUTH

YouthCare works with the UIC Centralized Consent Unit (CCU) to review all psychotropic medication requests that require consent, pursuant to DCFS Rule 325. To request consent, prescribers should fax the completed DCFS Psychotropic Medication Request Form (CFS 431-A) to 312-814-7015. Psychotropic medications prescribed without prior consent approval from the CCU will be rejected at the point of sale.

Medication not requiring consent may have separate age limits, quantity limits, and/or prior authorization requirements established in partnership with the Illinois Department of Healthcare and Family Services (HFS). For an updated list of drugs and requirements, please see the YouthCare PDL, located on ILYouthCare.com.

SPECIALTY PHARMACY PROVIDER

Certain medications are only covered when supplied by an in-network specialty pharmacy provider. YouthCare works with Envolve Pharmacy Solutions and AcariaHealth Specialty Pharmacy to review and dispense these products, which are listed on the AcariaHealth Supplied Biopharmaceutical document available on the YouthCare website.

Providers can request that AcariaHealth deliver the specialty drug to the office or member. For prior authorization, call AcariaHealth at 855-535-1815 or fax the AcariaHealth prior authorization form to 855-217-0926. If approved, AcariaHealth will contact the provider or member for delivery confirmation. Specialty medication prior authorization forms are available on the YouthCare website.

AcariaHealth Contact Information
Prior Authorization Phone: 855-535-1815
Prior Authorization Fax: 855-217-0926

MAINTENANCE MEDICATIONS

YouthCare offers a 90 day supply (3 month supply) of maintenance medications at most retail pharmacies or through YouthCare's mail order pharmacy, Homescripts. There is no cost to members for utilizing the maintenance program. To call in a new prescription to mail order you may call Homescripts at 888-239-7690.

PHARMACY & THERAPEUTICS COMMITTEE

The YouthCare Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the PDL. The committee is composed of the YouthCare Medical Director, the YouthCare pharmacy program director (Pharmacy Program Director), and several community-based primary care physicians and specialists. The primary purpose of the P&T Committee is to assist in developing and monitoring the YouthCare PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications.

The P&T committee schedules meetings at least quarterly during the year and coordinates therapeutic class reviews with the parent company's national P&T Committee.

PREFERRED DRUG LIST

The YouthCare Preferred Drug List (PDL) describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the independent professional judgment of the physician/clinician or pharmacist; or,
- Relieve the physician/clinician or pharmacist of any obligation to the patient or others.

YouthCare's Pharmacy and Therapeutics (P&T) Committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization. If a patient requires medication that does not appear on the PDL, the clinician can submit a prior authorization request for a nonpreferred medication. The PDL can be found on ILYouthCare.com.

Beginning 1/1/2020, all medications preferred on the YouthCare PDL will be reviewed and approved by the Illinois Department of Healthcare and Family Services (HFS). Providers are encouraged to consider preferred products prior to prescribing those that are non-preferred.

Specific Exclusions

The following drug categories are not covered by YouthCare:

- Drugs manufactured by companies that have not signed a rebate agreement with the federal government
- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Experimental or investigational drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Oral vitamins and minerals (except those listed in the PDL)

- Drugs and other agents used for cosmetic purposes
- Drugs dispensed after the termination date included on the quarterly drug tape provided by the federal Centers for Medicare and Medicaid Services (CMS)
- Over-the-Counter (OTC) Medications (except those listed in the PDL)

The YouthCare pharmacy program covers a variety of OTC medications. All covered OTC medications appear in the PDL. All OTC medications must be written on a valid prescription, by a licensed provider.

Step Therapy

Medications requiring Step Therapy are listed with an "ST" notation throughout the preferred drug list. The Envolve Pharmacy Solutions claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member's profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a prior authorization is required.

Quantity Limitations

Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by the YouthCare P&T Committee and noted throughout the PDL.

Age Limits

Some medications on the YouthCare PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

Unapproved Use Of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by YouthCare. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage.

Generic Substitutions

YouthCare requires that generic substitution be made when a generic equivalent is available, except where branded products are preferred on the YouthCare HealthChoice PDL. All branded products that have an A-rated generic equivalent will be reimbursed at the maximum allowable cost (MAC).

Exception Requests

In the event that a clinician or member disagrees with the decision regarding coverage of a medication, the clinician may request an appeal by submitting additional information to YouthCare. The additional information may be provided verbally or in writing. A decision will be rendered and the clinician will be notified with a faxed response. If the request is denied, the clinician will be notified of the appeals process at that time.

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a patient. Call the YouthCare complaint and grievance coordinator. A response will be rendered within 24 hours of receipt of complete information. In circumstances that require research, a 24 hour response may not be possible.

Behavioral Health

YouthCare offers our members access to all covered, medically necessary behavioral health (BH) services.

YouthCare members seeking mental health or substance abuse services may self-refer to a network provider for twelve (12) standard outpatient sessions per member, but prior authorization is required for subsequent visits. For assistance in identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, please call Member Services.

In the event that the physician or practitioner is unable to provide timely access for a member, YouthCare will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner.

For information regarding behavioral health services, locating providers, or for assistance in coordinating services for the member, contact Member Services.

CONTINUITY OF CARE

When members are newly enrolled and have been previously receiving behavioral health services, YouthCare will make best efforts to maximize the transition of members care through providing for the transfer of pending prior authorization information; and work with the member's provider to honor those existing prior authorizations.

BH PROVIDERS AND PCP COORDINATION

YouthCare encourages PCPs to consult with their members' mental health and substance use treatment practitioners. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required. We encourage all service providers to coordinate care with a member's entire treatment team, including but not limited to PCPs and mental health and/or substance use treatment practitioners. Additionally, YouthCare will offer trainings to PCPs and mental health and/or substance use treatment practitioners focused on the concepts of integrated care; cross training in medical, behavioral and substance use disorder; and screening tools.

BH providers should communicate and coordinate with the member's PCP and with any other behavioral health service providers whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered to the member. Examples of some of the items to be communicated include:

- Prescription medication.
- Results of health risk screenings.
- If the member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
- If the member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse).
- If the member's progress toward meeting their goals was established in their treatment plan.

A form to be used in communicating with the PCP and other behavioral health providers is located on our website at ILYouthCare.com.

BH providers can identify the name and contact information for a member's PCP by performing an eligibility inquiry on the Provider Portal or by contacting Provider Services. Practitioners should screen for the existence of co-occurring mental health and substance use conditions and make appropriate referrals. Practitioners should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

We also offer provider training on screening tools that can be used to identify possible behavioral health and substance use disorders. Resources and training will include referral processes for providers to assist members in accessing supports.

YouthCare requires that practitioners report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the practitioner's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment;
- Written notification of member's noncompliance with treatment plan (if applicable);
- Member's completion of treatment;
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
- The results of functional assessments.

BH PRIOR AUTHORIZATION REQUIREMENTS

Please see the benefit grid online at ILYouthCare.com for the most up-to-date authorization requirements and a comprehensive list of covered benefits.

BH Services, including substance use disorder

- Inpatient Psychiatric
- Partial Hospitalization
- Intensive Outpatient Therapy
- Psychological Testing
- Neuropsychological Testing
- Electroconvulsive Therapy (ECT)
- Substance Use Disorder Treatment/Rehabilitation
- Individual, Family, and Group Therapy

Community Support Services

- Community Support: Prior authorization required after 200 units
- Case Management: Prior authorization required after 200 units
- Psychological Rehabilitation: Prior authorization required after 800 units

Division of Alcohol and Substance Abuse Services (DASA)

- Detoxification
- Residential Rehabilitation
- Day Treatment

Community Mental Health Clinic Services, including crisis services

See the Behavioral Health Billing Guidelines for information about billing YouthCare for behavioral health services, available on ILYouthCare.com.

Children's Mental Health and Mobile Crisis Response Services

YouthCare's HealthChoice Illinois plan includes working with Mobile Crisis Response Program providers to administer crisis intervention services for eligible members who require behavioral health services. Mobile Crisis Response Program providers are responsible for the following:

- Must hold the following credentials:
  - Mental Health Professional (MHP) with direct access to a Qualified Mental Health Professional;
  - Qualified Mental Health Professional;
  - Licensed Practitioner of the Healing Arts;
  - or Crisis Services Program approval from HFS as outlined in Rule 140. Table N(c)(4).
  - If you intend to provide Mobile Crisis Response and/or Crisis Stabilization services, and are seeking Program approval, please contact HFS Bureau of Behavioral Health at HFS.CBH@illinois.gov or 217-557-1000
- Performing a face-to-face crisis screening within ninety (90) minutes of notification that a member is experiencing a behavioral health crisis, which will include, at a minimum, the completion of the IM-CAT and the Crisis Stabilization Plan
- Providing immediate care and stabilization services when a member in crisis can be stabilized in the most appropriate setting;
- Providing the member's family with contact information that may be used at any time, twenty four (24) hours a day, to contact Mobile Crisis Response system in moments of crisis
- Establishing a Crisis Safety Plan unique for members who present in behavioral health crisis and to provide families of Members with physical copies of the Crisis Safety Plan consistent with the following timelines;

- Prior to the completion of the crisis screening event for any member stabilized in the community; and
- Prior to member discharging from an inpatient psychiatric hospital
- The Crisis Safety Plan must be done in collaboration and reviewed with the member and member's family
  - Mobile Crisis Response providers must educate and orient the member's family to the components of the Crisis Safety plan
  - Ensure the plan is reviewed with the family regularly, and detail how the plan is updated as necessary
- Mobile Crisis Response providers must share the Crisis Safety Plan with all necessary medical professionals, including YouthCare Care Coordinator staff as consistent with the authorizations established by consent or release
- Must be available 365 days a year, 24 hours a day
- Members that experience a Crisis event, YouthCare shall convene an Interdisciplinary Care Team (ICT) meeting for the member
  - within fourteen (14) days after the event if the member is stabilized within the community
  - within fourteen (14) days post discharge if the member is hospitalized
- YouthCare will ensure that the member has a scheduled appointment with Behavioral Health Provider and the member's PCP or psychiatric resource within thirty (30) days after the member discharges from hospitalization
- If member has been identified by DCFS as a Youth at Risk, YouthCare will involve DCFS on the members ICT
- Providers are to facilitate the member's admission to an appropriate inpatient treatment setting when the member cannot be stabilized in the community, including education to the member's parents, guardian, caregivers, or residential staff to select an appropriate inpatient treatment setting and network providers

YouthCare will closely follow the process and procedures of the Illinois Crisis and Referral Entry Services (CARES) program. CARES, in addition to YouthCare's Mobile Crisis Response Services, can authorize and dispatch Mobile Crisis Services. In the event that CARES is unable to locate a provider within the YouthCare Mobile Crisis Response Service to provide a face-to-face screening for a member experiencing a behavioral health crisis, CARES will contact the Mobile Crisis Response program to ensure crisis response to the member.

Care Coordination

YouthCare's care coordination model consists of a team of registered nurses, licensed mental health professionals, social workers, and non-clinical staff. The model is designed to help your YouthCare members obtain needed services and assist them in coordination of their healthcare needs whether they are covered within the YouthCare array of covered services, from the community, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice, large multi-specialty group setting, or a home and community-based service provider.

The program is based upon a coordinated care model that uses a multi-disciplinary care coordination team in recognition that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and the member's PCP to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members, completion of their needs assessment tools, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. The PCP is included in the creation of the Care Plan as appropriate to assure that the plan incorporates considerations related to the medical treatment plan and other observations made by the provider. The Care Plan is made available to the provider in writing or verbally. Our care coordination team will integrate covered and non-covered services and provide a holistic approach to a member's medical and behavioral healthcare, as well as functional, social, and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care coordination team is available to help all providers improve the health of YouthCare members. Contact us to refer a member for care coordination.

Care Coordination Department
YouthCare Health*Choice* Illinois:
844-289-2264

INTEGRATED CARE TEAMS

Care Coordinators are familiar with evidence-based resources and best practice standards specific to conditions common among YouthCare members. These teams will be led by clinical licensed care coordinators with experience working with people with physical and/or mental health conditions. In addition, a team will be specifically dedicated to assisting members with developmental disabilities. The teams will have experience with the member population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. YouthCare will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

CARE PLANS

The following YouthCare members can have a Care Plan developed and implemented:

- All members in moderate, high, or complex acuity.

This Care Plan will be developed in conjunction with the member, his or her family and caregiver, as well as individuals in the member's care team. The member will agree to the developed Care Plan, and it will be signed off by a physician before implementation.

For members receiving waiver services, the Care Plan will include services such as home health, home delivered meals, personal emergency response systems, adult day service, home modification, adaptive equipment, etc. Based on each members plan, YouthCare care coordinators will work directly with home and community-based services providers in order to execute the Care Plan. This includes securing the service with the provider and authorizing the number of hours/ units approved. The care coordinator will give an authorization number to the provider. The provider is then able to render the service that has been authorized.

YouthCare's care coordination team will guide members through the process of obtaining covered services. Each member is assigned to a care coordinator. Care coordinators responsibilities include:

- Help members obtain services.
- Visit members in their residence to assess health status, needs, and develop a Care Plan.
- Communicate with providers on services that are authorized according to the Care Plan.
- Discharge planning.
- Support quality of life for members.

Please contact the care coordination department for changes in a member's status, questions regarding services, or other member issues.

TRANSITION OF CARE COORDINATION FUNCTIONS

Once the appropriate state agency determines eligibility, YouthCare will be responsible for all care coordination for YouthCare members. YouthCare has processes and procedures in place to ensure smooth transitions to and from YouthCare's care coordination to other plans/agencies such as another Managed Care Organization, the Department of Rehabilitative Services and the Department of Healthcare and Family Services.

During transitions between entities, YouthCare will assure 180 days of continuity of services and will not adjust services without the member's consent during that time frame.

HIGH RISK PREGNANCY PROGRAM

YouthCare will place high risk pregnancy members in our Start Smart for Your Baby (Start Smart) program which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique prenatal program with a goal of improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period. A care coordinator will work with members at high risk of early delivery or who experience complications from pregnancy. The care coordinators have physicians advising them on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to YouthCare's Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

YouthCare offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, the use of which has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the YouthCare care coordinator who will check for eligibility. The care coordinator will coordinate the ordering and delivery of the 17-P directly to the physician's office. The care coordinator will contact the member and complete an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the YouthCare medical management team with any questions regarding this program.

TRANSPLANTS

A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the YouthCare medical management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

Value Added Services

24/7 NURSE ADVICE LINE

When our members have questions about their health, their primary care provider, and/or access to emergency care, we are here for them. YouthCare offers a 24/7 Nurse Advice Line service to encourage members to talk with their physician and to promote education and preventive care.

Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access. The staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use the Nurse Advice Line to request information about providers and services available in their community after hours, when the Member Services department is closed. The staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse on a daily basis. If you have any additional questions, please call Provider Services or the Nurse Advice Line.

REWARDS PROGRAM

The goal of YouthCare's rewards program is to increase appropriate utilization of preventive services by rewarding members for healthy behaviors. The program encourages members to regularly access preventive services, and promotes personal responsibility for the member's own healthcare.

Health*Choice* Illinois Rewards Program – My Health Pays™ Rewards

My Health Pays™ rewards program is offered to members in the YouthCare Health*Choice* Illinois plan. My Health Pays™ rewards members with a pre-paid debit card to purchase healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Preventive services that may qualify for rewards through the program include completion of an initial health risk screening, primary care medical home visits within 90 days of enrollment, annual adult well visits, certain disease-specific screenings, and completion of prenatal and postpartum care.

TRANSPORTATION

Members can schedule transportation to and from a medical visit. Call Member Services 2 business days in advance and ask for a transportation specialist, and they will arrange appropriate transportation.

MEMBERCONNECTIONS® COMMUNITY HEALTH SERVICES

MemberConnections® Community Health Services is YouthCare's outreach program designed to provide coaching and education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link YouthCare and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of YouthCare within the community. The program has various components that can be provided depending on the needs of the member.

MemberConnections® Community Health Services representatives are non-clinical outreach employees hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. These representatives are an integral part of our Integrated Care Team which benefits our members and increases our effectiveness. Representatives will make home visits to members we cannot reach by phone or that require a face-to-face approach. They assist with member outreach, conduct member home visits, coordinate with social services, and attend community functions to provide health education and outreach.

MemberConnections® Community Health Services works with providers to organize healthy lifestyle events and works with other local organizations for health events. To refer a member, contact us:

Member Connections
YouthCare Health*Choice* Illinois: 844-289-2264

CONNECTIONS PLUS®

Connections Plus® is a program where YouthCare provides phones to high risk members who do not have safe, reliable phone access. Members who qualify receive a pre-programmed cell phone with limited use. Members may use this cell phone to call their case manager, PCP, specialty physician, the 24/7 Nurse Advice Line, 911, or other members of their healthcare team. In some cases, YouthCare may provide MP-3 players with preprogrammed educational programs for those with literacy issues or in need of additional education.

CARE COORDINATION

As a part of YouthCare's services, disease management programs are offered to members. Components of the programs available include:

- Increasing coordination between medical, social and educational communities.
- Severity and risk assessments of the population.
- Profiling the population and providers for appropriate referrals to providers.
- Ensuring active and coordinated physician specialist participation.
- Identifying modes of delivery for coordination care services such as home visits, clinic visits, and phone contacts depending on the circumstances and needs of the member and his/her family.
- Increasing the member's and member's caregiver ability to self-manage chronic conditions.
- Coordination with a YouthCare care coordinator for case management services.

The disease management programs target members with selected chronic diseases which may not be under control. The new members are assessed and stratified in order to accurately assign them to the most appropriate level of intervention. Interventions may include mailed information for low intensity cases, telephone calls and mailings for moderate cases, or include home visits by a health coach for members categorized as high risk.

YouthCare's affiliated disease management company, Envolve Health, will administer disease management programs which include services for chronic diseases such as asthma, diabetes, hypertension, heart failure and obesity. Our specialty pharmacy offers disease management services for YouthCare members with hemophilia.

To refer a member for disease management call:

Disease Management
YouthCare Health*Choice* Illinois: 844-289-2264

ADDED VALUE BENEFITS

Free Gym Membership

Eligible members age 16 years and up can receive a voucher to cover monthly membership fees at participating locations.

To quality for FREE Gym Memberships, members must:

1. Complete a Health Risk Screening
2. Complete an Annual Wellness Visit (for members 18 years and up only)
3. Complete a BMI measurement
4. Go to the gym at least 4 times a month to maintain the program

Free After School Care

Eligible members ages 6-18 years can receive a voucher to assist with after school care feed at participating locations.

To quality for FREE After School Care, members must:

1. Complete a Health Risk Screening
2. Complete an Annual Well-Child Visit

Free School Uniforms

Eligible members in 1st-5th grade can receive three uniforms (shirt, pants and sweater) annually.

To qualify for FREE School Uniforms, members must:

1. Complete a Health Risk Screening
2. Complete an Annual Well-Child Visit
3. Have up-to-date vaccinations
4. Complete a BMI measurement

Billing & Claims Submission

GENERAL BILLING GUIDELINES

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with YouthCare for payment of covered services. It is important that providers ensure YouthCare has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form).
- National Provider Identifier (NPI).
- Tax Identification Number (TIN).
- Taxonomy code.
- Physical location address (as noted on current W-9 form).
- Billing name and address.

Providers must bill with their NPI number in box 24Jb. Providers must bill with their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify YouthCare 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service;
- The service provided is a covered benefit under the member's contract on the date of service; and
- The referral and prior authorization processes were followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual. For additional information on YouthCare billing guidelines, please refer to our Billing Manual available on ILYouthCare.com.

TIMELY FILING

To be eligible for reimbursement, providers must file claims within a qualifying time limit. A claim will be considered for payment only if it is received by YouthCare no later than 180 days from the date on which services or items are provided. This time limit applies to both initial and corrected claims. Corrected claims, as well as initial claims, received more than 180 days from the date of service will not be paid.

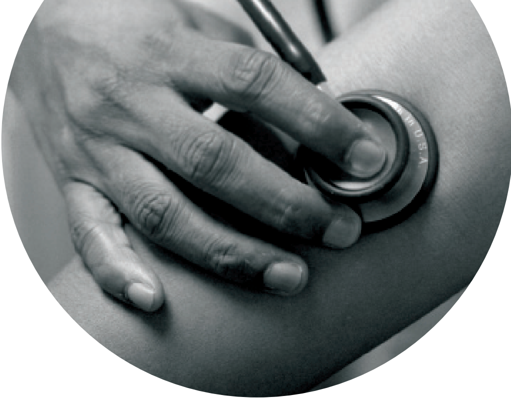
A "request for reconsideration" must be submitted before a claim dispute. Requests for Reconsideration received prior to July 1, 2019 must be submitted within 180 calendar days from the date of service or date of discharge, whichever is later. **Requests for Reconsideration received on or after July 1, 2019 must be submitted within 90 calendar days of the original determination or Explanation of Payment (EOP)**. Claim disputes must be received within 90 days of the reconsideration response date, not to exceed 1 year from the DOS.

When YouthCare is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer.

BILLING FORMS

Submit claims for professional services and durable medical equipment on a CMS 1500. Here are some tips for completing the CMS 1500 claim form:

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



Submit claims for hospital based inpatient and outpatient services, as well as swing bed services, on a UB 04 form.

For detailed requirements for either the CMS 1500 or the UB 04 form, see the Billing Manual.

CLAIMS SUBMISSION

There are 3 ways to submit claims to YouthCare:

1. On the Provider Portal at
   Provider.IlliniCare.com
2. Paper Claims mailed to:
   YouthCare
   Attn: Claims
   P.O. Box 4020
   Farmington, MO 63640-4402
3. Through Clearinghouses:
   Payer ID #: 68069

   For more information about clearinghouses, please contact:
   YouthCare c/o Centene EDI Department
   800-225-2573 ext. 6075525
   EDIBA@centene.com

Dos & Don'ts of Claims Submission

Dos

- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do attach the EOP from the primary insurance carrier when applicable
  - **Note:** YouthCare is able to receive primary insurance carrier EOP [electronically]
- Do submit on a proper original form: CMS 1500 or UB 04

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax

Clean Claim Definition

A clean claim means a claim received by YouthCare for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by YouthCare.

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 30 business days of the receipt
- 99% within 90 business days of the receipt

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the timely filing deadlines.

COMMON CAUSES OF UPFRONT REJECTIONS

- Unreadable Information.
- Missing Member Date of Birth.
- Missing Member Name or Identification Number.
- Missing Provider Name, Tax ID, or NPI Number.
- The Date of Service on the Claim is Prior to Receipt Date of the Claim.
- Dates Are Missing from Required Fields.
- Invalid or Missing Type of Bill.
- Missing, Invalid or Incomplete Diagnosis Code.

- Missing Service Line Detail.
- Member Not Effective on the Date of Service.
- Admission Type is Missing.
- Missing Patient Status.
- Missing or Invalid Occurrence Code or Date.
- Missing or Invalid Revenue Code.
- Missing or Invalid CPT/Procedure Code.
- Incorrect Form Type.

YouthCare will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

COMMON CAUSES OF CLAIM PROCESSING DELAYS & DENIALS

- Incorrect Form Type.
- Diagnosis Code Missing 4th, 5th, and 6th character requirements and 7th character extension requirements.
- Missing or Invalid Procedure or Modifier Codes.
- Missing or Invalid DRG Code.
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete.
- Invalid Member ID.
- Invalid Place of Service Code.
- Provider TIN and NPI Do Not Match.
- Invalid Revenue Code.
- Dates of Service Span Do Not Match Listed Days/Units.
- Missing Physician Signature.
- Invalid TIN.
- Missing or Incomplete Third Party Liability Information.

YouthCare will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

CLAIMS FOR BEHAVIORAL HEALTH

See the Behavioral Health Billing Guidelines for information about billing YouthCare for behavioral health services, available on ILYouthCare.com.

Each month when the Patient Credit File is received, YouthCare will check each member on the file against any previously denied claims. If there are claims that have been denied as a result of the member not appearing on the Patient Credit File, and all other necessary information is included in the claim, YouthCare will process and pay the previously denied claim.

REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES, & CORRECTED CLAIMS

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four effective ways in which the provider can contact YouthCare.

1. Contact Provider Services. Providers may discuss questions regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim to:

   Medical
   YouthCare
   Attn: Corrected Claim
   P.O. Box 4020
   Farmington MO 63640-4402

   Behavioral Health
   YouthCare
   Attn: Corrected Claim
   PO Box 7300
   Farmington, MO 63640-3828

   The claim must clearly be marked as “RESUBMISSION” and must include the original claim number or the original EOP must be included with the resubmission. Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

   Every claim must identify the name and corresponding National Provider Identification number (NPI) as well as Tax Identification Number (TIN) for the health facility or health professional that provided the treatment or service. Always ensure that the NPI and TIN used on the claim corresponds to the actual provider or site of care. Incorrect NPIs/TINs and/or NPIs and TINs that do not match are two of the most common reasons that claims are denied. If you are an atypical provider (i.e. a waiver services provider), submit using your TIN and your HFS Medicaid number.

Providers who have internet access and choose not to submit claims via EDI or on paper may submit claims directly to YouthCare on the secure provider portal at provider.illinicare.com. Providers must request access to the secure site by registering for a user name and password. Providers then may file first-time claims individually or submit first-time batch claims. Providers also have the capability to find, view and correct any previously processed claims. Detailed instructions for submitting via secure provider portal are also stored on the website.

3. Submit a Request for Reconsideration to:

Medical
YouthCare
Attn: Reconsideration
P.O. Box 4020
Farmington MO 63640-4402

Behavioral Health
YouthCare
Attn: Reconsideration
PO Box 7300
Farmington, MO 63640-3828

If a claim does not require any changes, but a provider is not satisfied with the claims disposition, a Request for Reconsideration can be submitted using the Provider Reconsideration Request Form located at ILYouthCare.com. Please ensure all fields on the Provider Reconsideration Request Form are completed. **Do not include a copy of the claim with your Request for Reconsideration**

If the request for reconsideration is related to a code audit, code edit or authorization denial, supporting documentation must accompany the request for reconsideration. Reconsiderations should be submitted by completing the "provider claim adjustment request form" at https://provider.illinicare.com/sso/login?service=https%3A%2F%2Fprovider.illinicare.com%2Fcareconnect%2Fj_spring_cas_security_check

4. Submit a Claim Dispute Form to:

Medical
YouthCare
Attn: Dispute
P.O. Box 3000
Farmington MO 63640-4402

Behavioral Health
YouthCare
Attn: Dispute
PO Box 6000
Farmington, MO 63640-3828

A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration. The Claim Dispute Form can be found in the provider section of our website at ILYouthCare.com. **Do not include a copy of the claim with your Claim Dispute.**

If the claim dispute results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps for escalated reconsideration.

YouthCare shall process, and finalize all adjusted claims, requests for reconsideration, and disputed claims to a paid or denied status within 45 business days of receipt.

THIRD PARTY LIABILITY

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

YouthCare, like all Medicaid programs, is always the payer of last resort. YouthCare providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to YouthCare members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform YouthCare that efforts have been unsuccessful. YouthCare will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, YouthCare will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

ELECTRONIC FUNDS TRANSFERS (EFTS) & ELECTRONIC REMITTANCE ADVICES (ERAS)

YouthCare provides Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. As a provider, you can gain the following benefits from using EFTs and ERAs:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual rekeying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFTs and ERAs services, please contact Provider Services.

OVERPAYMENT RECOVERY PROCEDURES

An overpayment may occur due to, but not limited to, the following reasons:

- Duplicate payment by YouthCare;
- Payment to incorrect provider or incorrect member; or
- Overlapping payment by YouthCare and a third party resource (TPR).

The provider has the option of refunding the overpayment by issuing a check to YouthCare or by requesting a recoupment by contacting their Provider Relations representative. The refund check should be accompanied with documentation regarding the overpayment, including:

- Refunding provider's name and provider identifier;
- Member name and ID;
- Date of service; and
- A copy of the Explanation of Payment (EOP) showing the claim to which the refund is being applied.

Failure to refund an overpayment may result in an offset against future claim payments until the amount of overpayment has been fully recovered. To submit a refund check, please mail the check and supporting documents to:

YouthCare
75 Remittance Drive
Department 6903
Chicago, IL 60675-6903

ENCOUNTERS

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a YouthCare member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. It is mandatory that your office submits encounter data. YouthCare utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

Providers are required to submit either an encounter or a claim for each service that you render to a YouthCare member.

Procedures for Filing Encounter Data

YouthCare encourages all providers to file encounters and claims electronically. See the Electronic Claims Submission section in this Provider Manual and the Billing Manual for more information on how to initiate electronic claims/encounters.

BILLING THE MEMBER

YouthCare reimburses only services that are medically necessary and covered through each YouthCare product. Providers are not allowed to "balance bill" for covered services.

Providers may bill members for services NOT covered by YouthCare or for applicable copayments, deductibles or coinsurance as defined by the State of Illinois.

In order for a provider to bill a member for services not covered under the YouthCare program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment in advance of services being rendered from the member using the following language:

> *I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that YouthCare through its contract with the Illinois Department of Healthcare and Family Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.*

For more detailed information on YouthCare billing requirements, please refer to the Billing Manual available on ILYouthCare.com.

Member Rights & Responsibilities

YouthCare members have the following rights and responsibilities.

GENERAL MEMBER RIGHTS AND RESPONSIBILITIES:

Safety and Respect

- To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law.
- To be honest with providers and treat them with respect and kindness.
- To not be discriminated against because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age. To do so is a federal offense.
- To be free from mental, emotional, social and physical abuse, neglect and exploitation.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To make recommendations regarding YouthCare's member rights and responsibilities policy.
- To exercise his or her rights, and that the exercise of these rights does not adversely affect the way YouthCare and its providers treat the members.

Full Benefits and Plan Information

- To receive information about YouthCare, its benefits, its services, its practitioners and providers and member rights and responsibilities.
- To receive information about your rights and responsibilities, as well as the YouthCare providers and services.
- To receive materials – including enrollment notices, informational materials, instructional materials, available treatment options and alternatives, etc. – in a manner and format that may be easily understood.
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and YouthCare responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive assistance from both Illinois Department of Healthcare and Family Services and YouthCare in understanding the requirements and benefits of YouthCare.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- If you access care without following YouthCare rules, you may be responsible for the charges.
- To receive YouthCare's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To receive information on the following:
  - Benefits covered;
  - Procedures for obtaining benefits, including any authorization requirements;
  - Cost sharing requirements;
  - Service area;
  - Names, locations, telephone numbers of current YouthCare providers, including at a minimum, PCPs, specialists and hospitals;
  - Any restrictions on member's freedom of choice among network providers;
  - Providers not accepting new patients; and
  - Benefits not offered by YouthCare but available to members and how to obtain those benefits, including how transportation is provided.
- To notify YouthCare, Illinois and your providers of any changes that may affect your membership, healthcare needs or access to benefits. Some examples may include:
  - If you have a baby;
  - If your address changes, even if temporarily;

- If your telephone number changes;
  - If you or one of your children are covered by another plan;
  - If you have a special medical concern; or
  - If your family size changes.
- To follow the policies and procedures of YouthCare and the State Medicaid program.
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To receive a complete description of disenrollment rights at least annually.
- To inform YouthCare of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with YouthCare procedures to the best of their ability.
- To call or contact YouthCare to obtain information and have questions clarified.

Quality Care

- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To provide information (to the extent possible) that YouthCare and its practitioners and providers need in order to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers.
- To inform your provider of reasons you cannot follow the prescribed treatment or care recommended by your provider.
- To access preventive care services.
- To get regular medical care from their PCP before seeing a specialist.
- To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services.
- To receive family planning services from any participating Medicaid doctor without prior authorization.

Medical Autonomy

- Make and act upon decisions (except those decisions delegated to a legal guardian) so long as the health, safety and well-being of others is not endangered by your actions. The member may also designate or accept a representative to act on their behalf.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
- To a candid discussion of appropriate or medically necessary treatment options for all conditions, regardless of cost or benefit coverage.
- To make an advance directive, such as a living will.
  - YouthCare is committed to ensuring that its members are aware of and are able to avail themselves of their rights to execute advance directives. YouthCare is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives. PCPs and providers delivering care to YouthCare members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

    YouthCare recommends to its participating providers that they inquire about advance directives and document the member's response in the medical record, and, for members who have executed advance directives, that a copy of the advance directive be included in the member's medical record inclusive of mental health directives.

    If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

- To choose a person to represent them for the use of their information by YouthCare if they are unable to.
- To make suggestions about their rights and responsibilities.
- To get a second opinion from a qualified healthcare professional.

Timely Access to Care

- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To keep your medical appointments and follow-up appointments.
- To keep all your scheduled appointments; be on time for those appointments, and cancel twenty-four (24) hours in advance if you cannot keep an appointment.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services;
  - Emergency services do not require prior authorization;
  - The process and procedures for obtaining emergency services;
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;
  - Member's right to use any hospital or other setting for emergency care;
  - Post-stabilization care services rules, in accordance with federal guidelines.
  - Cultural, Linguistic, and Disability Competency
- To receive full and equal access to healthcare services and facilities, reasonable modifications necessary for accessible services, and effective communication methods to meet their needs.
- To receive, upon request, information regarding accessibility, and languages, including the ability to communicate with sign language.
- To receive accessible, culturally and linguistically competent care.
- To communicate in a manner that accommodates their individual needs and to work with YouthCare to coordinate specialized services (e.g., including medical interpreters for all members, hearing impaired services for those who are deaf or hard of hearing, and accommodations for enrollees with cognitive limitations).
- To receive oral interpretation services free of charge for all non-English languages.
- To be notified that oral interpretation is available and how to access those services.
- To receive services at an Indian Healthcare Provider if the member is an American Indian.

Critical Incident Prevention and Reporting

- To know that YouthCare will report any concerns of critical incidents to promote member safety.
- Members can also report critical incidents if they are concerned that one has occurred.

Patient Privacy

- To expect their medical records and care be kept confidential as required by law.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.

Medical Records

- To request and receive a copy of your medical record.
- To request that your medical record be corrected.

Fraud, Waste, and Abuse (FWA)

- To report any suspected FWA.

Grievances, Appeals, or Medicaid Fair Hearing Procedures

- To receive information on the Grievance, Appeal and Medicaid Fair Hearing procedures.
- To voice grievances or file appeals about YouthCare decisions that affect their privacy, benefits or the care provided.
- Be free to file grievances, appeals, or Medicaid Fair Hearing and be free from retaliation.

Provider Termination

- To be notified that their provider is leaving YouthCare.
- If their provider is a PCP, members may select a new PCP. If the member does not select a PCP

prior to the provider's termination date, YouthCare will automatically assign a PCP to them.

- To continue to receive covered services until 60 calendar days after termination or until YouthCare can arrange appropriate healthcare for the member with a participating provider.
- To continue to receive covered services for 90 calendar days if the member is undergoing active treatment related to a chronic or acute condition.
- To continue to receive covered services if the member is in the second or third trimester of pregnancy.

SPECIFIC MEMBER RIGHTS AND RESPONSIBILITIES:

Members receiving the Persons with Disabilities, Persons with HIV or AIDs, and Persons with Brain Injury HCBS Waivers have specific rights and responsibilities, which include:

- Apply or reapply for waiver services.
- Receive a timely decision on eligibility for waiver services based on a complete assessment of member's disability.
- Receive an explanation in writing, should they be determined ineligible for waiver services, telling the member why services were denied.
- Receive an explanation about waiver services that the member may receive.
- Partner with care coordinator in making informed choices for waiver services care plan.
- Appeal any decision with which the member does not agree.
- Be informed of the Client Assistance Program (CAP).
- Be provided with a form of communication appropriate to accommodate the member's disability.
- Fully participate in the waiver services care plan.
- Set realistic goals and participate in writing waiver services care plan with care coordinator.
- Follow through with member's plan for rehabilitation.
- Review rehabilitation case record with a staff member present.
- Communicate with care coordinator and ask questions when member does not understand services.
- Keep a copy of waiver services plan and any amendments related to the plan.
- Keep original documents and send only copies to care coordinator's office.
- Notify care coordinator of any change in personal condition or work status.
- Be aware of financial eligibility requirements for some services.
- Participate with care coordinator in any decision to close member's case.

MEMBER FREEDOM OF CHOICE

YouthCare ensures that members have freedom of choice of the providers they utilize for waiver services. YouthCare members have the option to choose their providers, which includes all willing and qualified providers.

Subject to the member's care plan, member access to in-network non-medical providers offering wavered services will not be limited or denied except when quality, reliability or similar threats pose potential hazards to the well-being of our members. Freedom of choice with network providers will not be limited for plan participants, nor will providers of qualified services be stopped from providing such service as long as the goal of high quality, cost efficient care is met or exceeded and providers adhere to the contractual standards outlined in the YouthCare contract with the state of Illinois. We encourage our providers to share this information with members as well.

Provider Rights & Responsibilities

All YouthCare providers have the following rights and responsibilities.

GENERAL PROVIDER RIGHTS AND RESPONSIBILITIES:

Safety and Respect

- Be treated by their patients and other healthcare workers with dignity and respect.
- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Follow all state and federal laws and regulations related to patient care and patient rights.

Full Benefits and Plan Information

- Contact YouthCare's Provider Services with any questions, comments, or problems, including suggestions for changes in the QIP's goals, processes, and outcomes related to member care and services.
- Obtain and report to YouthCare information regarding other insurance coverage.
- Participate in YouthCare data collection initiatives, such as HEDIS and other contractual or regulatory programs.

Quality Improvement and Utilization Management

- Cooperate with Quality activities and allow use of performance data.
- Receive accurate and complete information and medical histories for members' care.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their directions, such as taking the right amount of medication at the right times.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments;
  - Provide information regarding the nature of treatment options;
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered; and
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment.
- Have access to information about YouthCare's quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
  - Including information on safety issues.
- Review and adhere to evidence-based clinical practice guidelines adopted by YouthCare. A list of practice guidelines is available on our website.
- Comply with YouthCare's Medical Management program as outlined in this manual.
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Contact YouthCare to verify member eligibility or coverage for services, if appropriate.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

Medical Autonomy

- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.

- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect members' advance directives and include these documents in the members' medical records.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.

Timely Access to Care

- Provide members, upon request, with information regarding office location and hours of operation.

Cultural, Linguistic, and Disability Competency

- To follow YouthCare's policies and procedures on providing accessible, culturally and linguistically competent care.
- Provide full and equal access to healthcare services and facilities, make reasonable modifications necessary to make services accessible, and provide effective communication methods to meet the needs of all members, including those with disabilities.
- Provide flexible scheduling to meet the needs of their members.
- Provide members, upon request, with information regarding accessibility, and languages, including the ability to communicate with sign language.
- Provide accessible, culturally and linguistically competent care.
- To communicate with members in a manner that accommodates their individual needs and work with YouthCare to coordinate specialized services (e.g., including medical interpreters for all members, hearing impaired services for those who are deaf or hard of hearing, and accommodations for enrollees with cognitive limitations).
- To provide oral interpretation services free of charge for all non-English languages.
- To notify members that oral interpretation is available and how to access those services.
- To receive services at an Indian Healthcare Provider if the member is an American Indian.

Critical Incident Prevention and Reporting

- To follow YouthCare's policies and procedures related to reporting Critical Incidents such as Abuse, Neglect, and Exploitation.

Significant Event Reporting

- To follow State mandates and YouthCare's policies and procedures related to reporting Significant Events such as Abuse and Neglect.

Patient Privacy and Security

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To follow YouthCare's policies and procedures on Patient Privacy, Confidentiality, and Security.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their personal health information.
- All health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Medical Records

- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

Billing, Claims, and Preventing Fraud, Waste, and Abuse

- To follow YouthCare's policies and procedures on preventing Fraud, Waste, and Abuse, and billing and claims.
- Disclose overpayments or improper payments to YouthCare.

- Not be excluded, penalized, or terminated from participating with YouthCare for having developed or accumulated a substantial number of patients in the YouthCare network with high-cost medical conditions.
- Disclose to YouthCare, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial fi nancial risk between YouthCare and the physician or physician group.

Member Suspension

- Make a complaint or file an appeal against YouthCare and/or a member.

Provider Termination

- Notify YouthCare in writing if the provider is leaving or closing a practice.
- Providers must give YouthCare notice, in writing, if they wish to initiate voluntary termination procedures following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to YouthCare or the member.
- YouthCare will notify affected members in writing of a provider's termination. If the terminating provider is a PCP, YouthCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, YouthCare will automatically assign one to the member.
- Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until YouthCare can arrange for appropriate healthcare for the member with a participating provider.
- Upon request from a member undergoing active treatment related to a chronic or acute medical condition, YouthCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, YouthCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

PCP RESPONSIBILITIES

The Primary Care Provider (PCP) is the cornerstone of YouthCare's service delivery model. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, eliminates redundant services, and ultimately improves outcomes in a more cost effective way.

YouthCare offers a robust network of PCPs to ensure every member has access to a PCP within reasonable travel distance standards. Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, and Family and General Practitioners. Non-physicians who may serve as PCPs include physician assistants and nurse practitioners. Physicians, physician assistants, and nurse practitioners in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Health Department setting may also serve as PCPs.

YouthCare offers pregnant members, or members with chronic illnesses, disabilities, or special healthcare needs the option of selecting a specialist as their PCP. A member, family member, caregiver or medical consenter may request a specialist as a PCP at any time. A member of our Integrated Care Team (ICT) will contact the member, caretaker or medical consenter, as applicable, within three (3) business days of the request to schedule an assessment. Our Chief Medical Officer will review assessment results and approve requests after determining that the member meets criteria and that the specialist is willing to fulfill the PCP role. The ICT member will work with the member and previous PCP if necessary, to safely transfer care to the specialist.

PCP Rights and Responsibilities include:

- Educating members on how to maintain healthy lifestyles and prevent serious illness.
- Providing screening, well care, and referrals to community health departments and other agencies in accordance with HFS provider requirements and public health initiatives.
- Obtaining authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization.

- Being available for, or provide on-call coverage through another source, 24-hours a day for management of member care. After-hour access to the Health Home or covering YouthCare provider can be via answering service, pager, or phone transfer to another location; recorded message instructing the member to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes.
- Agreeing to all of YouthCare's provider compliance policies and procedures, including those related to patient privacy, confidentiality, and security; preventing fraud, waste, and abuse; and reporting critical incidents such as abuse, neglect, and exploitation.
- YouthCare PCPs should refer to their contract for complete information regarding providers' obligations and mode of reimbursement.

Primary Care Case Management (PCCM) Program

To promote the "medical home" concept, YouthCare allows PCPs to participate in our "Primary Care Case Management" (PCCM) Program. Providers who participate in this program are eligible to receive a monthly capitation amount for each member who either selects the provider as his/her PCP, or who has been assigned to him/her as a PCP. A provider must be willing to meet the criteria described below in order to qualify for the PCCM program reimbursement:

1. Participate in or coordinate the member's care during and after an inpatient admission;
2. Provide members with comprehensive primary care services and covered preventive services in accordance with the recommendation of the U.S. Preventive Health Services Task Force: medically indicated physical examinations, health education, laboratory services referrals for necessary prescriptions and other services such as mammograms and pap smears;
3. Provide or arrange for all appropriate immunizations for members;
4. Maintain office hours of no less than thirty (30) hours per week for PCP's in an individual (solo) practice. PCP's in a group practice may have office hours less than twenty four (24) hours per week as long as their group practice hours equal or exceed forty (40) hours per week;
5. Maintain the appointment accessibility standards defined on page 14 and, upon notification of a member's hospitalization or emergency room visit, a follow up appointment available within seven days of discharge;
6. Coordinate with YouthCare's Disease Management program including collaborating with case managers as requested;
7. Set up a recall system to outreach to members who miss an appointment to reschedule the appointment as needed;
8. Educate members and remind them of preventive and immunization services, or preventive services missed or due based on the periodicity schedule;
9. Use electronic claim submission for claim transactions YouthCare is able to accept, within six months of the execution of the provider's agreement; and
10. Register with YouthCare Electronic Funds Transfer (EFT) vendor to receive electronic claim payments and remittance advices, upon execution of the Provider Agreement.

Assignment To PCP

For members who have not selected a PCP prior to their enrollment date, YouthCare will use an auto-assignment algorithm to assign an initial PCP by the 1st day of the month. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look for a previous relationship with a provider.
2. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member's family, such as a sibling, is or has been assigned.
3. Appropriate PCP type. The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.
4. Geographic proximity of PCP to member residence.

Terminating Care of a Member

A PCP may terminate the care of a member in his/her panel if the member:

- Repeatedly breaks appointments;
- Repeatedly fails to keep scheduled appointments;
- Is abusive to the provider or the office staff (physically or verbally); or
- Fails to comply with the treatments plan.

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

1. The incidents have been properly documented in the member's chart;
2. A certified letter has been sent to the member documenting the reason for the termination, indicating the date for the termination, informing the member that the provider will be available for emergency care for the next 30 days from the date of the letter, and instructing the member to call YouthCare's member services department for assistance in selecting a new primary care provider; and
3. A copy of the letter must be sent to YouthCare and a copy must be kept in the member's chart.

SPECIALIST RESPONSIBILITIES

The PCP is responsible for coordinating the members' healthcare services and making referrals to specialty providers when care is needed that is beyond the scope of the PCP. The specialty physician may order diagnostic tests without PCP involvement by following YouthCare referral guidelines. The specialty physician must abide by the prior authorization requirements when ordering diagnostic tests; however, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation.

Specialist Rights and Responsibilities include:

- Maintaining contact with the PCP and coordinate the member's care.
- Obtaining referral or authorization from the member's PCP and/or YouthCare Medical Management department (Medical Management) as needed before providing services.
- Providing the PCP with consult reports and other appropriate records within five business days.
- Being available for or providing on-call coverage through another source 24-hours a day for management of member care. After-hours access can be via answering service, pager, or phone transfer to another location; recorded message instructing the member to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes.
- Agreeing to communicate with enrollees in a manner that accommodates the enrollee's individual needs and work with YouthCare to coordinate specialized services (e.g., interpreters, hearing impaired services for those who are deaf or hard of hearing and accommodations for enrollees with cognitive limitations).

HCBS WAIVER PROVIDER RESPONSIBILITIES

HCBS Waiver Service Provider Rights and Responsibilities include:

- Working collaboratively with YouthCare's care coordination team to provide services according to the care plan.
- Providing only the services as outlined in the care plan. If you believe a change is necessary for the member's well-being, contact YouthCare's Integrated Care Team to discuss the change.
- Maintaining contact with the PCP.
- Obtaining authorization from a YouthCare Care Coordinator as needed before providing services.
- Obtaining authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization.

Suspending Waiver Services

A home and community-based services provider may suspend the services of a member if the member or authorized representative causes a barrier to care or unsafe conditions. Any incidents of barriers to care and/or unsafe conditions should be reported to the YouthCare Care Coordinator by calling Member Services. The Care Coordinator will work directly with the provider to resolve any potential issues, and if necessary, temporarily suspend services.

HOSPITAL RESPONSIBILITIES

YouthCare utilizes a network of hospitals to provide services to YouthCare members.
Hospital Rights and Responsibilities include:

- Obtaining authorizations for selected outpatient and ALL inpatient services as listed on the current prior authorization list. Emergency Room care does not require prior authorization.
- Notifying YouthCare's Medical Management department of emergency hospital admissions, elective hospital admissions and newborn deliveries within 24-48 hours of the admission.

- Notifying the PCP, when possible, within 24-48 hours after the member's visit to the emergency department.
- Notifying YouthCare's Medical Management department of members who may benefit from care coordination services – such as members who may have frequent visits to the emergency room.
- Notifying YouthCare's Medical Management department of YouthCare member emergency room visits for the previous business day. This can be done via fax or electronic file. The notification should include member's name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number, if available.

YouthCare hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

VOLUNTARILY LEAVING THE NETWORK

Providers must give YouthCare notice, in writing, if they wish to initiate voluntary termination procedures following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to YouthCare or the member.

YouthCare will notify affected members in writing of a provider's termination. If the terminating provider is a PCP, YouthCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider's termination date, YouthCare will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until YouthCare can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, YouthCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, YouthCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Provider Accessibility Standards & Procedures

APPOINTMENT ACCESSIBILITY STANDARDS

YouthCare follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. YouthCare monitors compliance with these standards on an annual basis. Providers must offer hours of operation to YouthCare members no less than those hours offered to commercial enrollees or Medicaid fee-for-service enrollees.

The following table outlines the scheduling timeframe for each type of service that must be followed by all providers:

TYPE OF SERVICE	SCHEDULING TIMEFRAME
Emergency Care	Immediate
Urgent Care	One (1) business day
Non-Urgent Symptomatic	Within three (3) weeks
Routine Preventative Care	Within five (5) weeks
	For infants under the age of six (6) months: Within two (2) weeks
Pregnant Youth Visits	1st Trimester: 2 weeks
	2nd Trimester: 1 week
	3rd Trimester: 3 days
Average Office Wait Time	Equal to or less than one (1) hour
Provider Appointment	No more than six (6) scheduled per hour
After Hours	24/7 coverage (voicemail only not acceptable)

In addition to the above accessibility standards and in accordance to the requirements set forth by the Illinois Department of Healthcare and Family Services, a PCPs panel size may not exceed 600 YouthCare members.

TELEPHONE ARRANGEMENT STANDARDS

PCPs and Specialists must:

- Answer member telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and reschedule no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes.
  - Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record.

YouthCare will monitor appointment and after hours availability on an on-going basis through its Quality Improvement Program (QIP).

COVERING PROVIDERS

PCPs and specialty physicians must arrange for coverage with another YouthCare network provider during scheduled or unscheduled time off. The covering provider must have an active Illinois Medicaid ID number and an active NPI number in order to receive payment. The covering physician is compensated in accordance with the terms of his/her contractual agreement.

24-HOUR ACCESS

YouthCare's PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- After-hours, a provider must have arrangements for:
  - Access to a covering physician,
  - An answering service,
  - Triage service, or
  - A voice message that provides a second phone number that is answered.
- Any recorded message must be provided in English and Spanish.

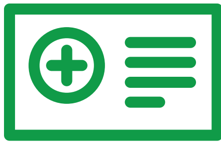
The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

YouthCare will monitor providers' offices through scheduled and unscheduled visits conducted by our Provider Relations staff.

MEMBER PANEL CAPACITY

All PCPs reserve the right to limit the number of members they are willing to accept into their panel. YouthCare DOES NOT guarantee that any provider will receive a certain number of members. If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact YouthCare Provider Services. A PCP shall not refuse to treat members as long as the provider has not reached their requested panel size.

Providers shall notify YouthCare in writing at least 45 calendar days in advance of their inability to accept additional Medicaid covered persons under YouthCare agreements. In no event shall any established patient who becomes a covered person be considered a new patient. YouthCare prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.



Credentialing & Re-credentialing

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by YouthCare, as well as government regulations and standards of accrediting bodies. All providers who participate in YouthCare HealthChoice Illinois must be a Medicaid provider in good standing.

CREDENTIALING

Providers must submit at a minimum the following information when applying for participation with YouthCare:

- Complete signed and dated Illinois Standardized Credentialing application or authorize YouthCare access to the CAQH (Council for Affordable Quality Health Care) for the Illinois Standardized Credentialing application.
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation.
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Illinois regulations regarding malpractice coverage.
- Copy of current Illinois Controlled Substance registration certificate, if applicable.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate.
- Copy or original of completed Internal Revenue Service Form W-9.
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
- Copy of current unrestricted medical license to practice in the state of Illinois.
- Current copy of specialty/board certification certificate, if applicable.
- Curriculum vitae listing, at minimum, a five (5) year work history (not required if work history is completed on the application).
- Signed and dated release of information form not older than 120 calendar days.
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training.
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable.

YouthCare will verify the following information submitted for credentialing and/or re-credentialing:

- Illinois license through appropriate licensing agency.
- Board certification, or residency training, or medical education.
- National Practitioner Data Bank-Health Integrity Practitioner Data Bank (NPDB-HIPDB) for malpractice claims and license agency actions.
- Hospital privileges in good standing at a participating YouthCare hospital.
- Review five (5) year work history.
- Review federal sanction activity including Medicare/ Medicaid services (OIG-Office of Inspector General and EPLS- Excluded Parties Listing).
- Site visits may be performed at practitioner offices within 60 calendar days of any member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than eighty percent (80%), the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

Once the application is completed, the YouthCare Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

RE-CREDENTIALING

To comply with accreditation standards, YouthCare conducts the re-credentialing process for providers at least every three years, in compliance with the Illinois Register Department of Public Health, Section 965.300 Single Credentialing Cycle. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the YouthCare network.

In between credentialing cycles, YouthCare conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Illinois state licensing agency, board, or commission for a review of newly-disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, YouthCare reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare and/or Medicaid programs.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as Illinois licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, etc. that have expiration dates prior to the next review process.

A provider's agreement may be terminated if at any time it is determined by the YouthCare's Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.

CREDENTIALING COMMITTEE

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

NOTE: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Right to Review & Correct Information

All providers participating within the YouthCare network have the right to review information obtained by YouthCare to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the State Licensing Agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the YouthCare credentialing department. Upon receipt of this information, the provider will have 14 calendar days to provide a written explanation detailing the error or the difference in information to the YouthCare credentialing department. The YouthCare Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join YouthCare have the right to be informed of the status of their application upon request. To obtain status, contact the YouthCare Provider Relations department.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to

appeal the decision in writing within 14 calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the YouthCare network.

Appeals will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

Disclosure of Ownership & Control Interest Statement

The Enrollment Disclosure Statement Form (HFS form 1513 - http://www2.illinois.gov/ hfs/SiteCollectionDocuments/hfs1513.pdf) is required documentation and verification of your eligibility to provide services. In addition, the federal regulations set forth in 42 CFR 455.105 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency certain business transactions. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

42 CFR 455.105 states in relevant part:

"(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) Denial of federal financial participation (FFP).

(1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure). (2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied."

Grievance & Appeals

MEMBER GRIEVANCE

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

FILING A GRIEVANCE

A member grievance is defined as any expression of dissatisfaction by a member about any matter other than an Action. The grievance process allows the member, or the member's authorized representative (guardian, caretaker, relative, PCP or other treating physician) acting on behalf of the member, to file a grievance either verbally or in writing, using any medium, at any time. If a member contacts YouthCare Member Services with a complaint, the Member Services staff member will attempt to resolve the issue immediately. If the issue is not resolved on the call to the satisfaction of the member, the Member Services representative will explain to the member their grievance rights. If the member wants to file a grievance, the Member Services representative will route the grievance to the G&A department. YouthCare values its providers and will not retaliate in any way against providers who file a grievance on a member's behalf.

Acknowledgment

YouthCare shall acknowledge receipt of each grievance in writing within forty-eight (48) hours of receipt. The YouthCare Member Services representative will document the substance of an oral grievance, and attempt to resolve it immediately. For informal complaints, defined as those received verbally and resolved immediately to the satisfaction of the member or appointed representative, the Member Services representative will document the resolution details.

Timeframe & Notice of Grievance Resolution

Grievance investigation and resolution (for those grievances not resolved informally) will occur as soon as possible but not exceed ninety (90) calendar days from receipt of the grievance. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, YouthCare shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease [see 42 CFR § 438.406].

Written notification of the grievance resolution will include the results of resolution process and the date it was completed.

Medicaid Grievances may be submitted verbally or in writing to:

YouthCare
Attn: Grievance and Appeals
P.O. Box 92050
Elk Grove Village, IL 60009-2050

or faxed to (877) 668-2076;
or emailed to gareferrals@centene.com

YouthCare Health*Choice* Illinois: 844-289-2264

MEMBER APPEALS

YouthCare has a formally structured Appeals system that is compliant with the State of YouthCare contract, Section 45 of the Managed Care Reform and Patient Rights Act, the Health Carrier External Review Act and Subpart F of Section 438 of the Code of Federal Regulations. An appeal is the request for review of a decision made by the Contractor with respect to an Adverse Benefit Determination.

Filing an Appeal

The appeal may be requested orally or in writing within 60 days of YouthCare's Notice of Adverse Action to the member, oral requests for appeals must be followed by a written request. All appeals must be registered initially with YouthCare and if YouthCare's decision is adverse to the member, the member may file an appeal for a Fair Hearing with the state of Illinois.

Acknowledgement

YouthCare will notify the filing party, within two (2) days of receipt. Appeals will be fully investigated without deference to the denial decision.

Timeline and Notice of Appeal Resolution

The appeal will be reviewed by an appropriately licensed clinical peer who was not involved in any previous level of decision making regarding the request. YouthCare will render a decision and provide written notification within fifteen (15) business days after receipt of appeal. An extension of up to fourteen (14) calendar days may be requested by the member, or YouthCare as the plan can establish that the delay is in the interest of the member. For Medicaid only: A member or an authorized representative may request a standard or expedited External Independent Review (EIR) of an adverse determination. For MMAI Medicaid and Medicare/Medicaid service appeals: If the appeal decision is not fully in favor of the member, YouthCare must forward the appeal to the Independent Review Entity contracted by CMS (Maximus)

Expedited Appeals

Expedited appeals may be filed when either YouthCare or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

YouthCare will notify the filing party within 24 hours of receipt, of any additional information required to evaluate the appeal request. YouthCare will render a decision and provide notification within 24 hours after receipt of required information, not to exceed 72 hours of receipt of the initial request. YouthCare will make reasonable efforts to provide the member, PCP and any healthcare provider who recommended the service with prompt verbal notice of the decision followed by written notice within three (3) calendar days after the initial verbal notification.

Notice of Appeal Resolution

Written appeal resolution notice shall include the following information:

- The decision reached by YouthCare
- The date of decision
- For YouthCare Health*Choice* Illinois appeals not resolved wholly in favor of the member, the right to request a State fair hearing, and information as to how to do so
- For YouthCare Health*Choice* Illinois appeals not resolved wholly in favor of the member (except for denial of HCBS Waiver services), the right to request a review by an external independent entity within thirty (30) calendar days of the date of the appeal decision
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the YouthCare decision.

Appeals may be submitted verbally or in writing to:

YouthCare, Attn: Grievance and Appeals
PO Box 92050
Elk Grove Village, IL 60009-2050

or faxed to (877) 668-2076;
or emailed to gareferrals@centene.com

YouthCare Health*Choice* Illinois:

844-289-2264

STATE FAIR HEARING PROCESS

Any adverse action or appeal that is not resolved wholly in favor of the member by YouthCare may be appealed by the member or the member's authorized representative to HFS for a Fair Hearing conducted in accordance with 42 CFR § 431 Subpart.

Please contact:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street
4th Floor
Chicago, IL 60602

Toll-free: 855-418-4421
TTY: 800-526-5812
Fax: 312-793-2005

YouthCare is responsible for providing to the HFS an appeal summary describing the basis for the denial. YouthCare will comply with HFS' fair hearing decision.

REVERSED APPEAL RESOLUTION

In accordance with 42 CFR §438.424, if YouthCare or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, YouthCare will authorize the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the state hearing decision. Additionally, in the event that services were continued while the appeal was pending, YouthCare will provide reimbursement for those services in accordance with the terms of the final decision rendered by HFS and applicable regulations.

Provider Complaint

YouthCare has established a provider complaint system that allows a provider to dispute the policies, procedures, or any aspect of the administrative function, including the proposed action.

NOTE: The process for appeals of medical necessity decisions (actions) is outlined above in the Member Appeals Section of this Manual.

Providers may submit a complaint via telephone, written mail, electronic mail or in person. YouthCare has designated a Provider Complaints Coordinator (PCC) to process provider complaints. Provider complaints will be thoroughly investigated using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying YouthCare's written policies and procedures. After the complete review of the provider complaint, the PCC will provide a written notice of resolution to the Provider within thirty (30) days from the date of the decision.

Provider Complaints may be submitted verbally or in writing to:

YouthCare
Attn: Provider Complaints
PO Box 92050
Elk Grove Village, IL 60009-2050

YouthCare Health*Choice* Illinois: 844-289-2264

In addition to communicating the provider complaint process through this Manual, YouthCare communicates the provider complaint process during provider orientation and on its website.

Fraud, Waste, & Abuse

YouthCare takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a fraud, waste and abuse (FWA) program that complies with the State of Illinois and federal laws. To report FWA, call Provider Services at 866-329-4701 or our Fraud and Abuse hotline at 866-685-8664.

YouthCare, in conjunction with its management company, Centene, successfully operates a Special Investigation Unite (SIU) that manages the review and investigation of reported concerns. YouthCare performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this manual. SIU performs back end audits which in some cases may result in taking the appropriate actions against those who, individually or as a practice, commit fraud, waste and/or abuse, including but not limited to:

- Remedial education and/or training around eliminating the egregious action;
- More stringent utilization review;
- Recoupment of previously paid monies;
- Termination of provider agreement or other contractual arrangement;
- Civil and/or criminal prosecution; and
- Any other remedies available to rectify.

Some of the most common FWA issues include:

- Unbundling of codes;
- Up-coding;
- Add-on codes without primary CPT;
- Diagnosis and/or procedure code not consistent with the member's age/gender;
- Use of exclusion codes;
- Excessive use of units;
- Misuse of benefits;
- Claims for services not rendered;
- Conflicts of Interest;
- Self-Referrals; and
- Accepting gifts from a company, for example a DME company or pharmaceutical company, in exchange for directing your Medicare and Medicaid patients to use those companies

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our free anonymous and confidential hotline at 866-685-8664. YouthCare and Centene take all reports of potential fraud, waste and/or abuse very seriously and investigate all reported issues. YouthCare and Centene have a no retaliation policy for anyone reporting a concern.

Authority & Responsibility

YouthCare's Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of YouthCare's compliance program. YouthCare is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The YouthCare provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

Critical Incidents

Providers and YouthCare are mandated by the Centers for Medicare and Medicaid Services and the Illinois Department of Healthcare and Family Services to report critical incidents. A critical incident is any actual or alleged incident or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of an individual.

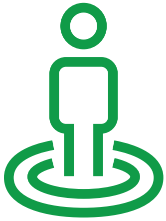
Examples of critical incidents include, but are not limited to:

- Abuse (i.e., physical, verbal/emotional and sexual).
- Neglect (i.e., passive neglect, willful deprivation, isolation and self-neglect).
- Exploitation (i.e., illegal use of assets or resources of a member with disabilities).
- Suicide attempts.
- Unauthorized use of restraints and restrictive interventions on patient.
- Patient's use of physical violence that results in harm or injury to provider.

All critical incidents involving YouthCare members must be reported to:

YouthCare Provider Services: **844-289-2264**

- For youth ages 18 years and over, contact **Adult Protective Services Hotline (1-866-800-1409).**
- For children under the age of 18, contact **Child Abuse Hotline (1-800-252-2873).**
- For members who have disabilities and who reside in or receive services from DHS-operated or DHS-funded agencies, contact **DHS / Office of the Inspector General (1-800-368-1463).**



Significant Events

Providers and YouthCare are mandated by the Illinois Department of Healthcare and Family Services and the Illinois Department of Children & Family Services (DCFS) to report significant events. A *significant event* is a significant, sometimes traumatic occurrence that impacts children and youth served by DCFS.

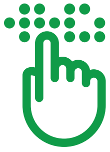
Examples of significant events include, but are not limited to:

- Death Reports Involving Children and Youth;
- Reports of Missing or Abducted Children and Youth in Care;
- Alleged Child Abuse/Neglect and Human Trafficking Involving Children and Youth in Care;
- Encounters with Law Enforcement Involving Children and Youth in Care;
- Behavior Related Incidents Involving Children and Youth in Care;
- Sexualized Behavior Incidents Involving Children and Youth in Care;
- Medical/Psychiatric Incidents Involving Children and Youth in Care; and
- Identification of a Pregnant and Parenting Child or Youth in Care.

All significant events involving YouthCare enrollees must be reported to Provider Services 866-329-4701. State reporting requirements include but are not limited to:

- Child's DCFS/POS Worker
- State Central Register Hotline 800-252-2873 for incidents of child or youth deaths, suspected child abuse or neglect and human trafficking.
- Child Intake and Recovery Unit 800-503-0184 for incidents involving children or youth missing or abducted from their placement. Incidents must be reported within 1 hour.

Please contact Provider Services or refer to DCFS Procedures 331 for further details on Significant Event Reporting.



Cultural, Linguistic, & Disability Access Requirements & Services

CULTURAL COMPETENCY

Cultural Competency requires the tailoring of services and supports to meet the unique social, cultural, and linguistic needs of your patient. Studies show that culturally diverse groups, those with limited English proficiency, and people with disabilities experience inadequate access to care, lower quality of care, and poorer health outcomes. To help mitigate this reality, YouthCare maintains a Cultural Competency Plan that monitors the availability of the following services at the health plan and provider level:

- Language Services;
- Transportation services; and
- Reasonable accommodations for members with disabilities to access services and/or facilities.

In addition, YouthCare and participating Providers share responsibility for:

- Informing patients of the availability of cultural, linguistic and disability access services, at no cost to Medicaid patients;
- Providing diversity and cultural competency training to all staff; and
- Promoting a culturally, linguistically and disability diverse workforce that reflects the diversity of its patients.

LEGAL & REGULATORY FRAMEWORK

Health plans and Providers must adhere to federal and state laws and regulations that prohibit discrimination on the basis of race, color, national origin, sex, age, or disability. The National Culturally and Linguistically Appropriate Services (CLAS) Standards consist of 15 operating principles that assist health care organizations in this effort. Specifically, the CLAS Standards are a set of recommended action steps intended to help organizations implement and maintain culturally and linguistically appropriate services.

For a copy of the National CLAS Standards, please visit https://allianceforclas.org//wp-content/uploads/2011/05/EnhancedNationalCLASStandards.pdf.

LANGUAGE SERVICES

Effective communication with patients who have limited English proficiency or who are deaf, hard of hearing, or speech disabled is crucial to ensuring better health outcomes.

YouthCare offers the following language services at no cost to you:

- Language Line (200+ languages available 24 hours a day, 7 days a week)
- Interpreters in your office or hospital (5-7 business days advance notice preferred)
- Materials in other languages and formats.

When working with an interpreter, the American Academy of Family Physicians recommends that practitioners:

- Use professional interpreters rather than family and friends
- Speak directly to the patient rather than the interpreter
- Keep sentences short and pause to allow time for interpretation

ACCOMMODATING PEOPLE WITH DISABILITIES

The Americans with Disabilities Act (ADA) defines a person with a disability as:

A person who has a physical or mental impairment that substantially limits one or more major life activity, and includes people who have a record of

impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability.

People with disabilities are entitled, by law, to fair and equal access to healthcare services and facilities. YouthCare ensures equal access in partnership with participating providers by maintaining an ADA Plan. The ADA Plan monitors the following:

- Physical accessibility of Provider offices
- Quality of the Health Plan's free transportation services
- Complaints related to the Health Plan and/ or Provider's failure to offer reasonable accommodations to patients with a disability

Accommodations for people with disabilities include, but are not limited to:

- Physical accessibility
- Accessible medical equipment (e.g., examination tables and scales)
- Policy modification (e.g., to permit use of service animals)
- Effective communication (e.g., minimize distractions and stimuli for members with intellectual and developmental disabilities).

RESOURCES

Please contact Provider Services for language or transportation services.

Please visit ILYouthCare.com

- ILYouthCare.com's Cultural Competency Plan
- Provider-specific Cultural Competency educational materials. Providers interested in additional education and training can contact Provider Services.

Quality Program

The Quality Program utilizes a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring to improve the quality of clinical care and non-clinical services our members receive. Areas subject to quality oversight include:

- Health plan programs and services.
- Appropriate utilization of healthcare resources.
- Continuity and coordination of care (including Behavioral Health).
- Patient Safety and Peer Review.
- Practitioner adherence to clinical practice guidelines. A list of evidence-based practice guidelines adopted by the health plan are available on our website ILYouthCare.com.
- Member Satisfaction with the health plan and providers.
- Provider Satisfaction with the health plan.
- Health plan and Provider compliance with federal and state cultural, linguistic, and disability laws and regulations.

QUALITY PROGRAM ACTIVITIES AND PERFORMANCE

YouthCare communicates activities and outcomes of its quality improvement program to both members and providers through avenues including, but not limited to:

- Member newsletter
- Provider newsletter
- Web portal

To request additional information on the Quality program and/or the program's progress in meeting performance goals, please contact Provider Services.

PRACTITIONER INVOLVEMENT

YouthCare recognizes the integral role practitioner involvement plays in the success of our programs and services. YouthCare encourages practitioner representation on key quality committees including, but not limited to:

- Quality Improvement Committee
- Utilization Management Committee
- Credentialing Committee
- Peer Review Committee
- Pharmacy and Therapeutics Committee

If you are interested in joining a Committee, please contact Provider Services.

PROVIDER PERFORMANCE & FINANCIAL INCENTIVES

Provider evaluation in key performance areas is a required part of YouthCare's contract with the Department of Healthcare and Family Services (HFS) and NCQA Health Plan Accreditation. YouthCare reviews provider specific performance data including, but not limited to:

- HEDIS measurement data (see below)
- Complaint and appeal data
- Sentinel events and/or adverse outcomes
- Adoption of clinical practice guidelines
- Medical record keeping practices

Provider Financial Incentives Program (P4P Program)

YouthCare maintains a PCP-drive pay-for-performance (P4P) program with a focus on preventive and screening services. Performance is evaluated using administrative HEDIS measurement data. Each measure included in the P4P program is assigned its own incentive dollar amount.

Providers who meet or exceed established HEDIS performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by YouthCare in publications such as newsletters, bulletins, press releases, and recognized in our provider directories.

Provider-specific HEDIS scorecards are available on the Provider portal: provider.illinicare.com.

HEALTHCARE EFFECTIVENESS DATA & INFORMATION SET (HEDIS)

HEDIS reporting is a required part of NCQA Health Plan Accreditation and YouthCare's contract with the Department of Healthcare and Family Services to measure performance on important dimensions of care and service. HEDIS is used to:

- Compare the performance of health plans
- Make improvements to quality of care and services
- Award accreditation status to health plans
- Assist consumers in selecting health plans and providers

What can be done to improve HEDIS scores?

- Understand HEDIS measure requirements and timelines for completion
- Review gaps-in-care reports
- Engage your patients early each year to promote preventive care and schedule visits for needed services
- Submit claim/encounter data for each and every service rendered
- Accurate and timely submission of claim/encounter data will reduce the number of medical record reviews required for HEDIS rate calculation
- Bill CPT codes for HEDIS measures such as diabetes, eye exam, and blood pressure
- Establish a supplemental data feed with YouthCare to combat claims lag and receive credit for services not easily captured via claims submission
- Ensure chart documentation accurately reflects all services provided
- Notify Provider Relations immediately with any updates to your provider roster.
- Encourage your patients who are not listed as part of your panel to update their assigned PCP with the health plan

For more information, please contact Provider Relations. We offer on-site education and assistance to help you improve overall HEDIS performance.

PROVIDER SATISFACTION SURVEY

YouthCare conducts an annual provider satisfaction survey. Participants are randomly selected to participate in the survey which is anonymous. The survey measures provider satisfaction with YouthCare and includes questions related to key health plan functions:

- Billing/Claims
- Utilization Management
- Quality Management
- Network/Coordination of Care
- Pharmacy
- Health Plan Call Center Services Staff
- Provider Relations

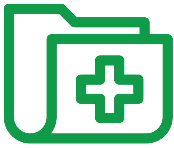
Survey results are used to develop quality initiatives to improve provider satisfaction with the health plan.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER SYSTEMS (CAHPS) SURVEY

The CAHPS survey is an annual survey that measures patient satisfaction with health plan and practitioner services. The survey includes questions that evaluate satisfaction with the following:

- Overall Satisfaction with Personal Doctor
- Overall Satisfaction with Specialist
- How Well Doctors Communicate
- Shared Decision Making
- Care Coordination
- Getting Care Quickly
- Getting Needed Care
- Health Plan Customer Service
- Overall Satisfaction with Health Plan

Patient responses to the CAHPS survey are used to improve the quality of our programs and services, and to monitor our member's satisfaction with our provider network. Member feedback is shared with providers as part of our improvement efforts.



Medical Records Standards

YouthCare Providers must keep complete and accurate medical records in accordance with state and federal regulatory and contractual requirements. Regulatory standards for practitioner documentation and maintenance of medical records address:

- Medical record content and organization
- Ease of medical record retrieval
- Maintaining confidentiality for all protected health information (PHI)

At a minimum, the Illinois Department of Healthcare and Family Services (HFS) requires that entries in the medical record are dated and signed by the rendering practitioner, and include the following information, where applicable:

- Past medical/surgical history, social history and family history, with updates as needed
- Preferred language and interpretation/ translation needs
- Disability access needs
- Obstetrical history and profile
- Immunization record
- Risk assessment
- History of present illness and physical findings
- Weight and height information and, as appropriate, growth charts
- Diagnostic assessments
- Diagnostic and therapeutic orders
- Instruction for follow-up care
- Referral information
- Reports of procedures, tests and results
- Practitioner review of consult/referral reports, and diagnostic test results
- Unresolved and/or continuing problems are addressed in subsequent visit(s)
- Health education and anticipatory guidance provided
- Family planning and counseling
- Hospital admissions and discharges

MEDICAL RECORDS RELEASE

Medical records should be kept in a secure location and only accessed by authorized personnel. Copies of medical records may only be released to authorized persons upon request, and the information contained therein must be limited to the "minimum necessary". Members have the right to request a copy of their medical records, and to request that the records be amended or corrected, as specified in 45 C.F.R. part 164.

MEDICAL RECORDS TRANSFER FOR NEW MEMBERS

Medical records must be provided to any new PCP to whom a patient transfers. For newly assigned YouthCare patients, PCP's must document in the medical record any attempts to obtain the patient's historical medical records.

MEDICAL RECORDS AUDITS

YouthCare is required by CMS and HFS to conduct randomized medical record audits to ensure maintenance of the medical record keeping standards outlined above. YouthCare will provide official verbal and/or written notice prior to conducting a medical record audit and inform you of the outcome of the audit.

Our Approach

YouthCare strives to work with the provider community to ensure members' individual needs are met leveraging our care coordination approach. This approach includes:

- Focus on early identification before condition worsens
- Facilitate communication and coordination of services across medical and behavioral health specialties
- Identify and engage high-risk consumers
- Identify barriers to adherence with current treatment plans and goals
- Coordinate with consumer, their support system, and physicians to customize a plan of care
- Holistic model: Care coordination can link to local community resources such as shelter/ housing, clothing, utilities assistance, and domestic violence agencies

To reach the Medical Director or Vice President of Medical Management for additional information on our approach, please contact:

Clinical Management
YouthCare Health*Choice* Illinois: 844-289-2264

MODEL OF CARE
Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to YouthCare members.

YouthCare's Model of Care includes the following elements:

- Measurable goals
- Staff structure and care management roles
- Interdisciplinary care team
- Provider network having special expertise and use of clinical practice guidelines
- Model of care training
- Health risk assessment
- Individualized Care Plan
- Communication network
- Care Management
- Performance and health outcome measurements

YouthCare ensures all of our members have:

- Access to essential available services such as medical, behavioral and social services
- Access to affordable care
- Care coordination through an identified point of contact
- Seamless transitions of care
- Improved access to preventive health services
- Appropriate utilization of healthcare services
- Overall improved health outcomes

Health Risk Screening
Completed by all new members within 60 days of enrollment to identify those with unmet or ongoing needs. The HRS allows us to assess:

- Functional Abilities
- Physical and Behavioral Health Conditions
- Social, Environmental, and Cultural Issues
- Exposure to Trauma
- Developmental Delays
- Medications
- Other needs that form the basis of our care plans

For high risk members, a more comprehensive Health Risk Assessment (HRA) will be conducted, either in-person or over the phone, and an individualized plan of care will be developed within 90 days of enrollment.

Member Outreach

- Explain benefits, provide health education, including how to access care (i.e., appropriate Emergency Room utilization).
- Participate in community events and establish partnerships with local community agencies, churches, and high volume provider offices to promote healthy living and preventive care.
- Influence consumers' beliefs and behaviors because they are hired from within the community.
- Identify and engage high-risk consumers.
- Facilitate communication across medical and behavioral health specialties.

Provider Resources

YouthCare is dedicated to providing the tools and support providers need to deliver the best quality of care to our members. Below are a few resources providers can utilize.

YOUTHCARE WEBSITE

Providers should use ILYouthCare.com as their main source of information related to our plan and products. Providers can access the following information at ILYouthCare.com:

- Provider Manual and Billing Manual.
- Member Handbook and benefit information.
- Prior Authorization Check Tool.
- Clinical Guidelines.
- Provider Forms.
- Policies and Procedures.
- Quarterly Newsletters and other YouthCare news.
- And more!

We are continually updating our website with the latest news and information, so save ILYouthCare.com to your Internet “Favorites” list and check our site often!

PROVIDER PORTAL

The YouthCare Provider Portal allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and send/receive messages to communicate with YouthCare staff. YouthCare’s contracted providers and their office staff have the opportunity to register for our Provider Portal in just four easy steps.

The Provider Portal offers tools which make obtaining and sharing information easy! It’s simple and secure! Go to illinicare.com/providers.html to get started.

Through the Provider Portal, you can:

- View the PCP panel (patient list);
- View and submit claims and adjustments;
- View and submit authorizations;
- View payment history;
- View member gaps in care;
- View quality scorecard;
- Check member eligibility; and
- Contact us securely and confidentially.

For further information regarding billing and claims submission, please refer to https://iamhp.net/providers.

Please contact your Provider Relations representative for a tutorial on the Provider Portal.

INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

What’s great about the IVR system? It’s free and easy to use! The IVR provides you with greater access to information. Through the IVR you can:

- Check member eligibility.
- Check claims status.
- Access YouthCare information 24 hours a day, seven days a week, 365 days a year.

PROVIDER SERVICES

Provider Services are providers’ first point of contact at YouthCare. This department works with all other departments to ensure that providers and their support staff receive the necessary assistance and information.

If you have questions about YouthCare’s operations, benefits, policies, and/or procedures; contact the Provider Services department.

PROVIDER RELATIONS

YouthCare’s Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within YouthCare. The Provider Relations department is responsible for providing the services listed below which include but are not limited to:

- Initial Point of Contact regarding Provider Data Management.

- Maintenance of existing YouthCare Provider Manual.
- Development of alternative reimbursement strategies.
- Researching of trends in claims inquiries to YouthCare.
- Pool settlement updates/status.
- Network performance profiling.
- Individual physician performance profiling.
- Physician and office staff orientation.
- Hospital and ancillary staff orientation.
- Ongoing provider education, updates, and training.

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to YouthCare enrolled membership.

To contact the Provider Relations representative for your area by phone, please call the Provider Services toll free help line. If you prefer to send an email, please include your name, call-back phone number, and provider Tax ID with your inquiry to ILYouthCare@centene.com.

Top 10 Reasons to Contact your PR Representative

1. To report any change or additions indicated to your universal roster template (i.e., practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance).
2. To obtain assistance with the provider portal.
3. To schedule an in-service training for new staff.
4. To conduct ongoing education for existing staff.
5. To obtain clarification of policies and procedures.
6. To obtain clarification of a provider contract.
7. To request fee schedule information.
8. To obtain responses to membership list questions.
9. To obtain responses to escalated claim questions.
10. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.

ILYouthCare.com