
Overview

This section of the Provider Manual addresses the respective responsibilities of participating providers.

Primary Care Physician Offices

Primary Care Physicians (PCPs) provide comprehensive medical services to Plan members.

Primary care offices participating in the Plan provider network receive the following benefits:

- Full support from WellCare's corporate headquarters in Tampa, Florida, local Provider Relations, Customer Service, the Provider Service Center and the Utilization Management departments;
- Access to the medical resources of the participating network of providers, hospitals and ancillary services.

Primary Care Physicians Responsibilities

Following is a summary of responsibilities specific to Primary Care Physicians (PCPs) who render services to Plan members. Please also refer to the listing of responsibilities for *all providers*. Additional information can be found in the Provider Agreement and/or the contract with Harmony or through an IPA.

- Coordinate, monitor and supervise the delivery of primary care services to each member and to discuss care for our members;
- Assure the availability of physician services to members in accordance with appointment scheduling, as outlined in this section;
- Arrange for on-call and after-hours coverage in accordance with after-hours services, as outlined in this section;
- Provide access and availability to the Plan or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or

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entity. A *related organization* or *entity* is defined as, having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;

- Submit an encounter or claim for each visit where the provider sees the member or the member receives a Health Plan Employer Data and Information Set (HEDIS[®]) service;
- Submit encounters on a CMS 1500, or electronically via email in the 837P file format;
- The PCP will determine when it is necessary to refer a member to a specialist or other health care provider. Members have certain benefits under the Plan that allow self-referral options, such as behavioral health services. Members may contact Harmony Behavioral Health to access services. The PCP should document the chart with information related to the referral and indicate the following:
 - Name and address of the specialist or other health care provider;
 - Reason for the referral; and
 - The PCP's signature and date.
- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact the Utilization Management department for assistance;
- See members for an initial office visit and assessment within the first 90 days of enrollment in the Plan; pregnant women must be seen for an initial office visit and assessment within one month.
- Ensure sufficient supply and provide immunizations in accordance with the childhood immunization schedule as approved by the Advisory Committee on Immunization

Practices (ACIP) of the U.S. Public Health Service and the American Academy of Pediatrics; or when it is shown to be medically necessary for the child's health.

Domestic Violence and Substance Abuse Screening

Physicians should identify indicators of substance abuse or domestic violence. The screening tools for domestic violence and substance abuse are located in the **Provider Education Materials** section of this manual.

Smoking Cessation

Physicians influence the decisions members make about their health care.

The Plan offers "Breathe EZ", a smoking cessation program that will help members break both the physical and psychological addictions to cigarettes.

PCPs should direct members who smoke, or desire to quit smoking, to call Customer Service and ask to speak with the Case Management department. A case manager will educate the member on national and community resources that offer assistance, as well as the options available to the member by the Plan. All members who call will receive educational material including, "Just Quit," a Tobacco Cessation Program Guide. Additionally, the Plan can assist OB providers when they identify pregnant members who are at risk as a result of smoking. Case managers can provide information and names of support groups available through the local health departments.

More information on smoking cessation is located in the **Provider Education Materials** section of this manual.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of a member age 21 or older. The adult member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the screening tools in the **Provider Education Materials** section of this manual.

Early and Periodic Screening, Diagnosis and Treatment or Healthy Kids Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, also known in Illinois as the Healthy Kids program, is a federally-mandated comprehensive child health program for Medicaid recipients from birth through age 20. It is designed to identify physical and mental defects and provide treatment (or referral when indicated) to correct or ameliorate defects and chronic conditions.

All members younger than age 21 should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT program.

Well-child visits shall consist of age appropriate component parts including:

- Comprehensive health history;
- Nutritional assessment;
- Height, weight and growth charting;
- Comprehensive unclothed physical examination;
- Immunizations;
- Laboratory procedures, including lead toxicity testing;
- Periodic, objective developmental screening using a recognized, standardized developmental screening tool, as approved by the state. Children younger than age 3, who

are screened at-risk for a developmental delay, shall be referred to the state's Early Intervention Program for further assessment;

- Periodic, objective screening for social emotional development using a recognized, standardized tool, as approved by the state. Social emotional screening for infants shall include prenatal depression screening of the mother in the most appropriate clinical setting, i.e., at the pediatric, behavioral health or OB/GYN visit;
- Objective vision and hearing screening; and
- Risk assessment and anticipatory guidance.

Documentation for EPSDT screening must be routinely kept in the member's medical record even when the patient is referred elsewhere to receive some of its components. It is imperative that the patient record reflect the examination components given and also those, if any, that were referred elsewhere.

Members With Chronic or Life-Threatening Conditions

Members with chronic conditions are defined as adult and children who have:

- Any ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities.
- An expected duration of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine.

Following is a summary of responsibilities specific to providers who render services to Plan members who have been identified with chronic or life-threatening conditions:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the member's condition or needs;
- Coordinate with the Plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; and
- Ensure members requiring specialized medical care over a prolonged period of time have access to a specialty care center.

Family Planning Services

Family planning is covered in accordance to the regulations and requirements of the state Medicaid contract. Members will have coverage that is outlined in the state Medicaid contract. Please contact Harmony for information on coverage.

Prior Authorization

Providers must refer members to participating Harmony providers for services not provided in the provider's office. Prior authorization must be obtained from Harmony's Utilization Management department for certain medical services. Please refer to the **Rapid Reference Guide** of this manual.

Some providers may have or be contracted with Harmony through an IPA, please contact Harmony or your IPA if you have questions about particular referrals, or utilize the **Rapid Reference Guide**. The Provider Service Center may also respond to your questions regarding referrals.

The following information is required when requesting prior authorization:

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- Member's complete name
- Member's date of birth
- Member's Harmony ID number, if available
- The hospital name, if appropriate
- Clear description of the member's medical condition, outpatient surgery or procedure(s) to be performed, type of home health service(s) requested and proposed treatment plan
- Diagnosis code(s) and proposed date(s) of service
- Treating physician's name, if other than the PCP
- Place of Service

Requests for prior authorization are required at least 10 business days before the scheduled admission or service. Failure to coordinate medical care without obtaining prior authorization from Harmony may result in denial of payment for these services.

Member Rights and Responsibilities

Harmony members have the following rights:

- To be treated with respect and courtesy by their health care providers and their office staff and all Harmony staff.
- To receive care consistent with sound nursing and medical practices.
- To be told about their treatment plan, before treatment begins. Members have the right to discuss all treatment options even if they are not a covered benefit.
- To refuse treatment to the extent of the law and to be told of the outcome.
- To voice concerns or complaints about the program and receive prompt answers.
- To request information relating to Harmony's Physician Incentive Plan.

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- To request a description of the financial relationships between Harmony and any health care provider. Members can also ask for the percentage of co-payments, deductibles and total premiums spent on health care related expenses and the percentage of co-payments, deductibles and total premiums spent on other expenses, including administrative expenses.

Harmony members have the right to request the following information from Harmony's participating health care providers:

- Copy of the total bill for services received from member's health care provider.
- Educational background, experience, training, specialty and board certification.
- The names of the licensed facilities in Harmony's network where the health care provider presently has privileges for the treatment, illness or procedure for which the member is inquiring.
- Information about the health care provider's participation in continuing education programs.
- Compliance with licensure, certification or registration requirements.
- Languages spoken.
- Whether providers are accepting new patients at the current time.

Harmony members have the following responsibilities:

- To treat their health care providers and their office staff with courtesy and respect.
- To fully inform their doctor about their medical problems.

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- To decide about having a medical treatment or procedure before it begins.
 - To help their PCP obtain their medical records.
 - To not seek care from a specialist, unless referred by their PCP. Except where members have the ability under the plan to self-refer for these benefits.
 - To not seek care in an emergency room for conditions that are not life threatening without contacting their PCP.
 - To keep all scheduled appointments and be on time.
 - To follow the rules and regulations of Harmony Health Plan.

Note: This information is provided to each member.

Member Grievances

If the member expresses dissatisfaction with any aspect of the Plan and he/she is not satisfied with his/her provider (i.e. he/she thinks they have been treated badly, denied services or discriminated against in any way because of a disability or source of payment), he/she has the right to complain to Harmony.

The member may submit his/her grievance on the telephone, in person or in writing. The member may call Harmony's Member Services department to express his/her grievance or write to the address listed on the **Rapid Reference Guide** in this manual.

Living Will and Advance Directives

Members have the right to control decisions relating to their medical care; including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life.

The law provides that each Plan member (age 18 years or older and of sound mind), should receive information concerning this provision, and have the opportunity to sign an Advance Directive Acknowledgement Form to make their decisions known in advance. This allows them to designate another person to make a decision should they become mentally or physically unable to do so.

Forms should be made available in provider offices, and be discussed with the member. The completed forms should be documented and filed in the member's medical record. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

After-Hours Services

The PCP must be available after regular office hours to offer advice and to assess any condition, which may require immediate care. Members must be able to have the ability to reach providers, or covering providers, 24 hours a day, seven days a week. Any covering provider must have admitting privileges and be credentialed by the Plan. This includes referral to the nearest hospital emergency room in the event of a serious illness.

To assure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service;
- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call provider.

Members have the right to use any type of provider, hospital or facility in the case of emergency.

**Out-of-Area
Member
Transfers**

Participating physicians and providers should assist the Plan in arranging and accepting the transfer of members receiving care out of the service area, if the transfer is considered medically acceptable by the Plan physician and/or provider and the out-of-network attending physician.

**PCP Request
for Transfer
of a Member**

A Plan physician or provider may not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by the Plan's member. Membership acceptance must be without regard to color, gender, race, religious belief, national origin or disability of applicant.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The physician or provider should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider or physician shall continue to provide medical care to the Plan member. Care shall continue until such time that written notification is received from the Plan stating that the member has been transferred from the provider or physician's practice.

In the event a participating physician or provider desires to terminate his/her relationship with a Plan member, the physician or provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The physician or provider must complete a **PCP Request for Member Transfer** form, attach supporting documentation and fax or mail according to the information on the form. A copy of the form is available in the **Forms** section of this manual. The provider must continue treatment of the member until Harmony reaches the provider with the action of the request.

Responsibilities of All Providers

This list is an overview of responsibilities for which all Plan providers are accountable. Please refer to the Provider Agreement, or contract, for a more comprehensive list. A provider relations representative may be contacted for reiteration or clarification.

Providers must, in accordance with generally accepted professional standards:

- Use physician extenders appropriately. Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state of Illinois and Plan guidelines.
- The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- ARNPs and PAs should clearly identify their titles to members, as well as to other health care professionals.
- Any member request to be seen by a physician, rather than a physician extender, must be honored at all times.
- Accept treatment for any member in need of health care services they provide.

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- Follow current Clinical Practice Guidelines.
- Refer Plan members with problems outside of their scope of practice for consultation and/or care to appropriate specialists contracted with the Plan.
- Refer members to participating physicians or providers, except when they are not available or in an emergency.
- Admit members only to participating hospitals, skilled nursing facilities and other inpatient care facilities, except in an emergency.
- Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
- Inform Plan in writing, within 24 hours, of any revocation or suspension of their Bureau of Narcotics and Dangerous Drugs number, and/or suspension, limitation or revocation of their license, certification or other legal credential authorizing them to practice in the state of Illinois.
- Inform Plan in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect their status with Plan. These changes must be notified to the Plan in accordance to the provider's contract and also in accordance with the state of Illinois credentialing standards.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Plan member, subscriber, or enrollee other than for supplemental charges, co-payments or fees for non-covered services

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furnished on a fee-for-service basis.
Non-covered services are services not covered in the member's Plan contract.

- Treat all member records and information confidentially and to not release such information without the written consent of the member, except as indicated herein, or as allowed or needed for compliance with state and federal law.
- Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan's Quality Improvement guidelines. All entries in the member record must identify the date and the provider.
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
- Communicate clinical information between Plan providers timely. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party, at no charge, unless otherwise agreed upon.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not discriminate in any manner between Plan members and non-Plan members.
- Fully disclose to members their treatment options and allow them to be involved in treatment planning.

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- Discuss referral decisions and plans with the member, inform member that he/she will have the freedom of choice as long as the provider referred to is affiliated with the Plan. When medically necessary circumstances exist, the provider will discuss referring to non-affiliated providers.
- Inform member of specific health care needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
- Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to plan-sponsored or community-based programs.
- The provider must document the referral to plan-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

The provider will provide all of the following, where applicable, to members upon request:

- Information related to the health care specialty and board certification, if applicable.
- The names of licensed facilities on the provider panel where the health care provider presently has privileges for the treatment, illness or procedure that is the subject of the request.
- Information regarding the health care provider's participation in continuing education programs and compliance with

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any license, certification or registration requirements, if applicable.

A participating health care provider shall provide the following to Harmony upon request:

- Medical records for utilization management and/or quality improvement activities.
- Proof of Ability to Perform and Sustain Services - Providers capitated by Harmony (excluding PCPs) shall submit financial information to Harmony, including, but not limited to Audited Annual Financial Statements. Financial statements shall include Balance Sheet, Income Statement and Cash Flow Statement. These documents are to be used for the purpose of Harmony's evaluation of provider's financial ability to perform and sustain services, as defined in the Provider Agreement with Harmony.
- Provider must maintain all access and availability standards in accordance to contractual and state requirements.
- Provider must provide at a minimum to the Plan 90 days prior to any termination from the Plan. Termination is not effective until the Plan has acknowledged termination and provided the effective date to the provider. Providers must continue to provide services to members. Some members may need to see such provider under the Continuity of Care provision for an additional 90 days.
- Provider must comply with all site inspections. Successful correction passing is expected. Any required corrective action plan is required for full compliance of the provider.

- Provider must comply with all initial and re-credentialing practices within guidelines required by the Plan and in accordance to state and federal credentialing guidelines. Failure to provide timely credentialing and re-credentialing or required information will result in the voluntary termination from the Plan.
- Provider must check eligibility of members prior to providing services, unless it is an emergency medical condition.
- Providers must refer patients that are high-risk OB to appropriate medical professionals in the Plan network.

Women's Health Care Provider Responsibilities

Family practitioners with obstetrical privileges, obstetricians or gynecologists may be designated as a women's health care provider (WHCP).

Female members may access care from any participating WHCP in Harmony's network without a referral.

Women's health care providers are responsible for the coordination of the member's care within the limits of the member's certificate of coverage (COC).

Any inpatient or elective procedures are to be pre-certified by Harmony's Utilization Management department.

Members may also elect a WHCP as a primary care physician where applicable.

Specialist Responsibilities

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. Specialists may not refer to another Plan specialist unless the services are available for the member to self-refer.

Specialists should also:

- Verify the PCP who referred the member prior to rendering services through document confirmation (i.e. referral form), unless the provider has made other arrangements with Harmony.
- Provide only approved services as indicated by PCP on the referral document.
- Notify the member's PCP if another specialist or health care provider is needed to evaluate and treat the member's condition.
- Provide note of consultation to the member's PCP in writing of any recommended ongoing treatment program or elective inpatient admission.

Any inpatient or elective procedures are to be authorized by Harmony's Utilization Management department. Please refer to the **Utilization Management** section of this manual for prior authorization guidelines.

Confidentiality of Member Information and Release of Records

All consultations or discussions involving the member, or his/her case, should be conducted discreetly and professionally in accordance with all applicable state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations.

Any data or information pertaining to the diagnosis, treatment or health of any enrollee obtained from such person, or from any provider by any MCO shall be held in confidence and shall not be disclosed to any person, except to the extent that it may be necessary to carry out the purposes of these regulations; or upon the express consent of the enrollee; or pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of claim or litigation between such person

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and the MCO wherein privileges against such disclosure with the provider who furnished such information to the MCO is entitled to claim.

No health care provider may be penalized for considering, studying or discussing medically necessary or appropriate care with/on behalf of his/her patient.

All physician practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure that there is a: (i) privacy officer on staff; (ii) a policy and procedure in place for confidentiality of members' protected health information (PHI); and (iii) that the practice is following those procedures and/or obtaining appropriate authorization from members to release PHI where required by applicable state and federal law.

Policies and procedures should include protection against unauthorized and inadvertent disclosure of all confidential medical information to include PHI.

All members have a right to confidentiality, and any health care professional or individual person who deals directly or indirectly with the member or his/her medical record must honor this right. Every practice is required to provide to members their Notice of Privacy Practice. Employees who have access to member records and other confidential information are required to sign a confidentiality statement.

Some examples of confidential information includes:

- Any communication between a member and a physician;
- All Protected Health Information as defined under the federal HIPAA Privacy regulations;
- Any communication with other clinical persons involved in the member's health, medical and mental care (i.e., diagnosis, treatment and any

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identifying information such as name, address, Social Security number (SSN), etc.);

- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
- Any communicable disease (such as Acquired Immune Deficiency Syndrome [AIDS] or Human Immunodeficiency Virus [HIV]) testing that is protected under federal or state law.

When an individual enrolls in the Plan, federal law permits the health care provider permission to release his/her medical records to the Plan, members of the provider network, agencies conducting regulatory or accreditation reviews and business associates. The Notice of Privacy Practice (NPP) informs the patient or member of his/her rights under HIPAA and how the provider and/or health plan may use or disclose the members' PHI. HIPAA regulations require each provider and health plan to provide a NPP to each new patient or member, accordingly.

Second Opinions

A member may request a second opinion at any time for determination of a medical decision or confirmation of a specific medical diagnostic procedure, treatment or surgical procedure. The PCP should recommend a qualified provider within the network to accommodate this request. If no qualified provider is known, please contact Harmony or your IPA for assistance.

Appointment Scheduling

Providers must adhere to the following criteria to comply with the following waiting maximums and appointment requirements:

- Provide medical coverage 24 hours a day, seven days a week.

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- Schedule and see routine preventive care appointments within five weeks of the patient's request, but within two weeks for infants younger than six months.
- Triage and provide same-day service to members with more serious problems not deemed emergency medical conditions, if necessary.
- Schedule and see members with problems or complaints that are not deemed serious within three weeks from the date of request.
- Schedule and see initial prenatal care appointment within two weeks for members in their first trimester, within one week for those in their second trimester and within three days for members in their third trimester.
- Ensure office wait times for appointments do not exceed one hour from the appointment time.
- Schedule no more than six PCP appointments within one hour.

You must have at least 20 hours per week over a three day period of time to cover each office that is listed as a participating address with Harmony.

Covering Physicians

In the event participating providers are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf, unless there is an emergency.

In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval. The physician should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agree not to balance bill Plan members. For additional information, please contact the local Provider Relations department.

Provider Billing and Address Changes

Prior notice to the Plan is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and/or fax number
- Termination request from the plan
- Removal of a patient from your roster
- Specialty change
- Open panel or closed panel requests

Provider Termination

In addition to the provider termination information included in your Provider Agreement with the Plan, the provider must adhere to the following terms:

- Any contracted providers must adhere to the without cause termination provisions of the Provider Agreement. Please refer to the contract for the details regarding the specific required days for providing termination notice.

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- Unless otherwise provided in the termination notice, terminations occur on the last day of the month. For example: A termination letter is dated September 15. The required notice is 90 days. Termination is therefore effective December 31.
 - Providers must continue to provide services to their members. Some members may be eligible for continued care with their provider for an additional 90 days under the Continuation of Care provision.
 - Provider will receive an acknowledgment from the Plan with the termination date.
 - Provider may be also terminated from the Plan for failure to comply with the credentialing and re-credentialing standards of the Plan.
 - Providers who receive a termination notice from the Plan may submit an appeal. Please refer to the **Appeals and Grievances** section of this manual for specific guidelines.

The Plan, due to regulatory requirements, will notify in writing all appropriate agencies and/or members upon a provider termination, within 60 days of the termination. This will allow members to utilize the Continuity of Care provision of the Plan if needed.

Disclosure of Information

Periodically members may inquire as to the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, the Plan will provide that information to the member upon request. Members can request the above information verbally or in writing. For more information about how to request this information, members should contact the Plan's Customer Service department.

The toll-free telephone number can be found on the member's ID card for information on how to make a request.

**Delegated
Entities**

All participating providers or entities delegated for Network Management and Network Development should meet all applicable standards and are held to the same standards as defined in this section. Reviews are performed and compliance is monitored on a regular basis. Any other delegated function is subjected to annual audits. The delegate must pass all delegated audits and comply with all corrective action plans.

**Credentialing
Process**

Any and all providers are subject to the regulatory requirements by Centers for Medicare and Medicaid Services (CMS), Illinois Department of Healthcare and Family Services (HFS) and the Illinois Department of Insurance Requirements in accordance to the Standard Credentialing requirements. Providers are credentialed with Harmony prior to being effective with the plan. Re-credentialing follows the standard Illinois process and all providers are required to be re-credentialed. Failure to submit and cooperate with the credentialing process will require the provider to be terminated from the Plan.